NURSING RITUALS

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Scholars see rituals as part of the fabric of human existence. Rituals serve to express symbolic meanings important to groups of people functioning within a culture or subculture. Words, actions, objects, gestures and relationships are important to ritual performance (Bosk, 1980; Douglas, 1966; Fox, 1979; Malinowski, 1954; McCreery, 1979; Tambia, 1968; Turner, 1969; VanGennep, 1960). Turner (1969) defined rituals as dramas of social events which emphasize the importance of the event they symbolize or represent; rituals are standardized, repetitive dramatizations of social crises, functioning to minimize the effects of crisis. Malinowski (1954) also viewed rituals as being associated with crises — among these, illness, birth, marriage, death and socialization to new roles.

Seldom have nursing practices and procedures been studied for ritual content. Nurses who have described and criticized rituals within the context of professional nursing see rituals as valueless and often condemn them. Huey (1986) considered some nursing rituals to be cherished beliefs in need of abandonment. She called on nurses to save time and money and to expose and replace unnecessary practices with more scientific actions. Huttmann (1985) equated nursing rituals with time-honored, time wasting practices. According to Huttmann, nurses who use these routines are on "automatic pilot". Both Huey and Huttmann consider rituals to be obsessive, repetitive, traditional tasks, without meaning.

Another nurse, Walker (1967), found that the ritualistic behaviours used by nurses satisfied individual needs rather than organizational goals. Ritual behavior was considered dysfunctional and anxiety-relieving. However, she identified latent functions and beneficial aspects of nurses' ritualistic practices. Schmahl (1964) determined that rituals served no purpose, were non-therapeutic and were automatic. She described ritual as an unnecessary form or routine employed to avoid facing new goals, thereby associating rituals performed by nurses with their anxiety.

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Research Questions

In order to explore nursing rituals from another perspective, the definition of ritual identified by DeCraemer, Vansina and Fox (1976) was used during an ethnographic study: ritual is patterned, symbolic action that refers to the goals and values of a social group. Using this definition of ritual, it was possible to examine the beliefs, values and patterns of rituals present in a group of nurses working on a medical unit.

The research questions of this ethnographic study were the following.

1. What actions, words and objects make up nursing rituals?
2. What are the types of nursing rituals demonstrated by nurses caring for adult patients on a hospital unit?
3. What explicit or manifest meanings and implicit or latent meanings do these rituals have for nurses, patients, families, physicians and other hospital personnel?
4. How are nurses, patients, families, physicians and other hospital personnel involved in these rituals?
5. How do nursing rituals emerge in the context of the routines, procedures and reports of the nursing unit?

The following nursing practices and procedures were examined as situations in which nursing rituals may occur: post-mortem care; medication administration; admission to and discharge from the hospital; change of shift report; and, the bath and other medical aseptic practices. The study's conceptual orientation justified investigating these nursing practices and procedures as situations in which nursing rituals could be present. It was assumed that nursing rituals did not necessarily function positively, negatively or neutrally for nurses (Wolf, 1986; Wolf, 1988).

Method

This study of nursing rituals was conducted on a 32-bed medical unit of a large urban American hospital. Participant observation, event analysis and semi-structured interviews were the major data collection methods. Nursing staff, patients, family members and other hospital personnel were the informants of the study. The study was reviewed by the institutional review board of the hospital and was approved following an expedited review. Informants signed consent forms.

Data collection extended over a 12-month time period. Data were collected during the day, evening and night shifts. The investigator was an outsider to the setting. Field notes were kept by the researcher; these notes were analyzed and indexed. Shift reports were audiotaped and included in the field notes, after being transcribed verbatim. Three nursing staff who were key

informants reviewed the results of the study and attested to the validity of the description.

Descriptive Analysis

Investigating nursing rituals illuminated aspects of the nursing subculture that had been not been fully explored and described previously.

Post-mortem care: *Therapeutic nursing ritual*

Post-mortem care, the hands-on care that nurses gave to their dead patients, was embedded in the context of the events preceding death. Patients' deaths were influenced by the "do not resuscitate" (DNR) or "resuscitate" (code) status of each patient and resuscitation decisions were shared among nurses, patients, family members, physicians and other hospital personnel. The technological equipment used in cardiopulmonary resuscitation added to the pressures surrounding death events.

Description and analysis of pre-death events revealed four code categories used by nurses and others as they cared for dying patients. A "no code" classification meant that the patient was categorized as a DNR (do not resuscitate) and no resuscitation efforts were to be initiated. "Almost no code" suggested to the staff that the patient's family had given verbal DNR permission; however, resuscitation efforts would be initiated. The category of "slow code" indicated that the patient's family refused to give hospital staff "do not resuscitate" permission. However, because of the hospital staff's misgivings about prolonging life, the code call was delayed and slow-paced resuscitation efforts were begun. "Full code," also called "regular code," meant that the family or the patient refused to grant the DNR permission, or the hospital staff had not yet been able to, or thought to, ask the patient or family for a code status. "Full codes" were characterized by energetic efforts on the part of the staff. Notwithstanding the fact that hospital policy and procedures mandated that there were two code categories, "no code" and "full code," nurses and other hospital staff used four code options.

Post-mortem care was given by nurses who usually knew their patients well. Nurses did not merely care for dead bodies after death. They cared for dying patients, returning day after day as they witnessed their suffering. They rejoiced in peaceful deaths, glad that these patients escaped the resuscitation drama.

Neophytes used resuscitation and post-mortem care as a sort of "proving ground" of their ability to handle death. More experienced nurses checked the inexperienced to see how they performed the techniques and procedures of resuscitation, the influx of hospital personnel at the code, the aftermath of death or survival and post-mortem care.

After death, as nurses gave post-mortem care, it was clear that the patient was seen as still present, surrounded by spirit and requiring care. They cared for dead patients in a respectful manner, aware of patients' humanness. Nurses touched these patients gently, as they washed away and removed evidence of previous suffering. They tacitly insisted that the patient's body was respectfully treated.

Clearly, post-mortem care was more than a step-by-step procedure. Instead of consulting the hospital's policy and procedure manual, nurses shared beliefs, values and information about after death care as they demonstrated how to perform post-mortem care. Working as a group during post-mortem care, nurses helped each other ease the realities of death. Their washing of the patient and straightening of the hospital room represented, on a latent level, the purification of the patient and the room. Thus, some of the soil and profanity of death was removed.

The post-mortem care that nurses gave their dead patients was a private event, one seldom witnessed by other hospital staff and family. Post-mortem care ended, almost officially, their tenure of moral responsibility for the patient. Post-mortem care was a therapeutic nursing ritual. Nurses performed symbolic healing actions that improved the condition of patients, removing the traces of suffering, even after death.

Admission to and discharge from the hospital: *Patient ritual*

As patients needing hospitalization were separated from their usual home environment, were incorporated within the hospital environment, were healed or became stabilized and left the hospital for home, certain nursing rituals could have been evident. However, no nursing beliefs and values specific to admission and discharge emerged from the descriptive data.

Admission and discharge procedures contained themes that suggested that patient rituals could be included within these incorporation and separation routines. Nurses efficiently greeted patients, helped them change into hospital clothing or their own bedclothes and gathered information about current illnesses, previous hospitalizations, surgical procedures and prescribed over-the-counter medications. As hospital rules were imposed on patients by nurses during admission routines, patients admitted their feelings of vulnerability and awaited diagnostic studies, medical treatment or surgery.

Patients' vulnerability and lack of privacy were emphasized in the hospital setting. Removing patients' street clothes and wearing hospital clothes confirmed this. Explicitly, patient clothes made it easier for nurses to care for ill patients. As patients' conditions improved, they often exchanged hospital clothes for their own bedclothes. Differences in dress helped the staff distin-

guish patients from hospital personnel. Patients dressed like patients; wearing patient clothes was equated with the symbolic taking on of the patient role.

Procedural and task-oriented in their approach, nurses efficiently prepared patients for discharge from the hospital. They taught patients and their families about drugs they would take while at home, gave last minute treatment instructions and made medical and radiology appointments.

Discharge from the medical unit and hospital was a relief for patients. Patients eagerly asked nurses to cut off identibands prior to discharge, or borrowed nurses' scissors in order to do this for themselves. As identibands and bedclothes were removed, and street clothing put on, the association of these symbols with anonymity, vulnerability, illness and patienthood was evident. With a change of clothing and their usual roles assumed, patients became less vulnerable.

Nurses valued the procedures and customs associated with discharge. When patients evaded these procedures, leaving the unit without instructions from nurses and physicians, nurses were surprised. However, admission and discharge procedures and practices did not contain strongly held beliefs and values for nurses. Admission and discharge procedures may once have been associated with nursing rituals, but seemed more symbolically significant to patients.

Medication administration: Therapeutic nursing ritual

Medication administration was a highly visible and time-consuming part of nursing care, and was classified as a therapeutic nursing ritual. Medications were healing substances, given to improve patients' conditions.

Explicitly, nurses viewed medications as a high priority nursing function. Interestingly, the vague possibility that hospital staff other than nurses might some day administer medications to patients aroused fear in nurses. Implicitly, nurses regarded medication administration as a serious trust, shared with physicians. This trust was embedded in the value or therapeutic goal that the nurses held about the care of their patients: do good and avoid harm. Medication administration represented nursing's emphasis on the reciprocal relationship between patient trust and nursing responsibility.

Nurses classified the therapeutic actions of medications in the following manner. Stabilizing medications were given to maintain function; curing medications removed the signs and symptoms of disease; preventive or prophylactic medications slowed or stopped the onset of disease and kept patients from becoming ill; and placebo medications were given to placate patients - the drugs would do no harm and might do some good.

Nurses used shortened, ethnocentric language when communicating among themselves and with physicians as they gave medications. This special language was intended to reduce the time needed in discussions concerning medications. It, as well as the recording style for chart and kardex notation, served to maintain an aura of secretiveness and preserve the territoriality that marked the nursing function of administering medications.

The ritual aspects of medication administration were obvious as nurses relied on the "three-time check" to insure that the correct medication was given to the right patient. This practice, used to prevent nurses from making medication errors, has persisted for years in nursing literature dealing with giving medications (Groff, 1896).

Nurses continued using supplies, such as the small paper souffle cup, in a manner that seemed inefficient. Souffle cups were often stuffed to overflowing with unit-dose medications, still in their identifying package. Some nurses said that the drugs were left in the packaging and placed in souffle cups so that drugs could be reviewed immediately before giving them to patients, and in order that nurses could review actions and side effects with patients.

Medication administration was a clearly identifiable, visible nursing function. Many hospital staff shared in the work of medications. Many hospital forms were used to record this public nursing function. At the same time that medication administration was public, it was also somewhat parochial. New graduate nurses were gradually initiated into the special knowledge needed for medication administration.

The seriousness and moral concern with which nurses viewed medication administration emerged when they made medication errors. They openly, yet hesitatingly, admitted their own and each other's guilt in the arenas of staff meetings, change of shift report and incident reports. These open admissions of guilt served a latent function. Through public confession, the nurses were able to share both the error and guilt of their medication-related mistakes. In this manner, the guilt, blame and punishment were shared by nurses in a corporate or group way. They often blamed medication errors on failure to follow procedure, on other staff and on problematic events. However, medication errors symbolized failure of responsibility and patient trust, of inadvertently doing harm to those who needed their help.

The bath and other medical aseptic practices: *Therapeutic nursing ritual*

Within the broad area of medical aseptic practices, three specific hygienic practices were examined as sources of nursing ritual: the bed bath; methods of handling excreta; and methods of handling the products of infection.

Nurses comforted and improved patients' conditions by means of the bath; as such, the bath was a therapeutic nursing ritual. Patients were helped to remain or become clean through "self," "partial," or "complete" baths. Bathing patients and keeping them clean through other means, including changes of bed linens, were clearly the nurses' domain. Seasoned nurses discussed and demonstrated some of the finer points of the bath when patients' conditions necessitated modifications and special considerations.

Failing to keep patients clean violated a nursing norm. When emergencies such as codes or other problems delayed bathing activities, nurses apologized. Avoiding giving baths to patients was considered a violation of patients' and families' wishes.

On an explicit level, the bath was used as an opportunity for cleansing, checking patients' skin and assessing general condition. It also provided an opportunity to listen to, talk with or teach patients. The value of "good" personal hygiene for patients was internalized. Thus, nurses resisted changing the daily baths on the day shift to bathing patients every other day. On an implicit level, bathing patients was a nursing ritual because it represented purification, care of the patient by the laying-on-of hands and the opportunity to heal by washing away disease, or at least some of its traces.

There were opportunities for repeated bathings during each 24-hour cycle of nursing time. On day shift the daily bath was given; on the evening shift, P.M. care again provided a bathing opportunity. During the night shift, A.M. care was another scheduled time for patients to be washed. The timing of bathing activities gave structure and organization to the nursing work of each shift, and implicitly served to impose order on the easily disordered events of the patient unit. Nurses took comfort in the fact that their patients' baths were completed.

Nurses were in close, personal contact with their patients and commonly handled excreta and secretions. They feared infection from patients who had or were suspected of having communicable diseases. At times, their fear of infection overrode their scientific knowledge. Handwashing, wearing gloves and using other medical aseptic practices helped them to protect themselves and others and to prevent the spread of infection. When in doubt as to the handling of infected patients, they consulted more experienced nursing staff instead of the infection control manual (a source of scientifically-based techniques).

Nurses responded to their contacts with profane materials in a matter-of-fact manner, with humor, complaining, tolerance and magical thinking. At times they expressed a fearlessness about handling infected materials, demonstrating a strong sense of responsibility, bravery or denial. For the

most part they accepted personal risks, but openly acknowledged their fear of carrying infection to their families.

Nurses were experts at keeping the clean and the dirty separate. More than other hospital personnel, they cared directly for infected patients and handled their bodily products. Despite fear of infection, most upheld the standard that they were responsible for all patients, and that even infected patients deserved care that was respectful.

Change of shift report: *Occupational nursing ritual*

Change of shift report was a occupational nursing ritual, or ritual of socialization; the interactions among the nursing staff facilitated the transition of the neophyte graduate nurses into their professional role. Shift report was used as a testing ground for them. During report, graduate nurses were evaluated, shaped, taught and corrected. They learned what it meant to be a nurse.

Shift report was a challenging arena for new as well as seasoned nurses. Standards of nursing care were set, repeated and checked from shift to shift. They warned each other to watch for situations in which error could take place. They also openly acknowledged and shared errors as they occurred. Change of shift report served as a major forum for accountability and responsibility for patient care.

Change of shift report was clearly the domain of the registered nurse, although contributions of licensed practical nurses and nursing assistants were also valued. While explicitly concerned with the passing of information about patients, report served as a sacrosanct time. They tolerated some interruptions during the hallowed time of report. Those that were more favorably viewed were directly related to nurses' work with patients. Physicians' interruptions were seldom graciously endured.

As nurses interacted, exchanging information during report, they used hospital-bound, nursing-specific language. The language kept the meaning of report somewhat secret and was intelligible only to those who were initiated into nursing life in the hospital.

Nurses used shift report as a place to complain, and to express humor and concern. This enabled them to diffuse some of the difficulties of the nursing role. For example, anger at a difficult patient was openly discussed with others during report. They helped each other and tried to resolve shared patient and professional problems.

During change of shift report, nurses were temporarily able to freeze time in order to focus on the events of the previous shift and to anticipate those of

the on-coming shift. Those working on the next shift were able to begin work from an orderly perspective. Professional behavior was demanded during change of shift report.

The fact that nurses helped each other complete unfinished business after shift report emphasized the shared responsibility they felt toward their work. The continuous coverage commitment and responsibility toward their patients was symbolically portrayed during the transfer of patient ownership at change of shift report. Other means of guaranteeing patient coverage and assuming the burden of patient care were in place on the medical unit. Shift report, however, functioned as the principal occupational ritual where nursing responsibility to patients was taught, tested and reinforced by the group. Clinical knowledge, standards of care and values were transmitted shift to shift among the nurses.

Discussion and Implications

Nursing rituals coexisted with science, technology and procedure as nursing staff cared for their patients. Nurses' work combined elements of the sacred and the profane aspects of human life, as it incorporated the extreme contrast of the mysteries of death and suffering and the handling of the gross products of excretion and infection. Nursing rituals helped nurses to reaffirm some of the beliefs and values of nursing, such as doing good and avoiding harm. Furthermore, nurses passed on their subcultural knowledge by word of mouth and by demonstration.

Rituals have received negative reactions from nurses as being purposeless practices or as procedures to be discarded. However, they are worth examining from the perspective of the definition used. Rituals are patterned symbolic actions that refer to the goals and values of a social group (DeCreamer, Vansina, & Fox, 1976, p. 469). A system of nursing rituals exists in hospital nursing, with latent and manifest levels of meaning. These rituals enable nurses to carry out caring activities for patient who are acutely or chronically ill, old and dying.

The embedded and hidden aspects of nursing rituals and of nurses' work illuminate the fact that much of our work may be largely unknown to the public. The personal, profane and sacred nature of part of the work may obscure our contribution to health care. Many fail to realize what we do, emphasizing technical and physical functions. Disclosing part of the hidden work of nursing by investigating nursing rituals may encourage different public reactions to nursing care.

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RÉSUMÉ

Rituels et soins infirmiers

Cette recherche se fonde sur une méthode eth- nographique dont l'objet est de décrire et d'analyser les rituels propres aux soins infirmiers sur lesquels il existe par ailleurs peu de documents. Les soins post- mortem, les procédures d'admission et de congé, l'administration des médicaments, le bain et les pratiques d'aseptisation ainsi que les changements d'équipes sont examinés en fonction des rites qui peuvent s'y rattacher. L'étude s'est déroulée dans un service pour adultes de 32 lits d'un grand hôpital urbain. Les observations des participants, l'analyse des événements et la tenue d'entrevues semi-structurées constituent l'essentiel des méthodes utilisées pour réunir des données à ce chapitre. Le personnel infirmier, les patients, les membres de leur famille ainsi que d'autres membres du personnel hospitalier ont participé à cette étude. Les résultats comprennent une description ethnographique des cinq catégories de rites. Les soins post-mortem, l'administration des médicaments et le bain sont des rituels propres aux soins infirmiers thérapeutiques ou des actes symboliques visant à améliorer l'état des patients. Les changements d'équipe, rituel professionnel ou rituel de sociali- sation, sont empreints de gestes symboliques qui facilitent la transition du statut de néophyte à celui de professionnel. L'admission et le congé des patients sont assimilés à des rites qui relèvent exclusivement des patients.