

# **Comprehensive Examination One**

Nursing through the Lens of Culture: A multiple gaze

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## Nursing through the Lens of Culture: A multiple gaze

### Introduction

Nursing culture is a notion that may appear concrete, even simple to define, yet if researched and reflected on, sparks a complex variety of diverse definitions, descriptions and analyses. The culture of nursing can be compared to a kaleidoscope, a multifaceted lens that creates an unique image based on the interplay of illumination, reflection, and patterns. This concept embraces the rich complexity of each of the terms involved: both nursing and culture, as presented in selected literature.

Like the shifting kaleidoscopic mirrors, various disciplinary and philosophic lens can be used to analyze and savor nursing culture. These lens include disciplinary glimpses from anthropological and cultural studies theory, cultural psychology, post-modernism and postcolonialism which all help to explore nursing culture in unique ways.

Examining culture without context and process is a barren and meaningless exercise, thus nursing culture is viewed using these various lens to analyze:

- cultural essence of nursing through specific disciplinary lens;
- culture becoming through the process of nursing education;
- cultural context where nurses' work is situated within larger organizational cultures;
- cultural being where the nurse enters the rich world of clients and their families;
- cultural knowing which reflects professional and research cultural activity; and
- cultural shaping of nursing in preparation for the future.

## Cultural Essence

To begin to appreciate the essence of nursing culture, a clear definition of culture is necessary.

However, dictionary consultation introduces several viable definitions that could all be applied to nursing culture. For instance, culture is defined as:

- “the act of developing the intellectual and moral faculties especially by education;
- enlightenment and excellence of taste acquired by intellectual and aesthetic training;
- acquaintance with and taste in fine arts, humanities, and broad aspects of science as distinguished from vocational and technical skills;
- the integrated pattern of human knowledge, belief, and behavior that depends upon man's capacity for learning and transmitting knowledge to succeeding generations;
- the customary beliefs, social forms, and material traits of a racial, religious, or social group;
- the set of shared attitudes, values, goals, and practices that characterizes a company or corporation” (Merriam Webster, 2005).

This tentative list reflects some of the disciplinary definitions of culture, which emerge from the varied notions of how culture is conceptualized: whether through mental/affective learning; artistic and aesthetics development; socialization or acculturation; patterns; worldview, or symbolic acts. Various disciplines use one or more of these lens to define and examine culture and its meaning to human development, action, and ways of being. “Culture is partly defined as a circuit of power, ideologies, and values in which diverse images and sounds are produced and circulated, identities are constructed, inhabited, and discarded, agency is manifested in both individualized and social forms, and discourses are created, which make culture itself the object of inquiry and critical analyses. Rather than being viewed as a static force, the substance of culture and everyday life – knowledge, goods, social practices, and contexts – repeatedly mutates and is subject to ongoing changes and interpretations”

(Giroux, 2004, p. 60).

It is evident then, that nursing culture can be looked at in a number of different ways. Nurse-anthropologist, Margaret Leininger described nursing culture as “the learned and transmitted lifeways, values, symbols, patterns, and normative practices of members of the nursing profession of a particular society. A subculture of nursing refers to a subgroup of nurses who show distinctive values and lifeways that differ from the dominant or mainstream culture of nursing” (1994, p. 19). Leininger (1994) went further to distinguish both ideal and manifest attributes of culture, by defining an ideal culture as one that reflects the “...attributes that are most desired, preferred, or the wished for values and norms of the group” while manifest culture is “...what actually exists and is identifiable in the day-to-day world as patterns, values, lifestyle patterns, and expressions” (p. 19).

### ***Anthropological Notions of Culture***

The field of anthropology has a long well-researched history of viewing culture as its central tenet of study. The definitions and theories related to culture are profuse and diverse. A basic tenet of culture in the eyes of anthropology is that it is learned, reveals strong patterning, and represents an integrated whole (Archer, 1996). Anthropological theories of culture began with the study of various geographically defined categories of ethnic cultures and races, developing into what is currently known as cross-cultural anthropology. This cultural focus on race and ethnicity is critically important to nurses in at least two contexts: nurses work intimately with clients and other health care professionals with a diverse multicultural background; and (at least in Western society), most nurses (a conservatively estimated 80 per cent) are white. Both of these points will be integrated into subsequent sections of this analysis.

Cross-cultural anthropology is not the only branch of anthropology that is relevant to nursing, however. Clifford Geertz, a key traditional researcher of symbolic anthropology, devoted years to study the role of thought or symbols that guide human action. He felt humans express culture in symbolic

forms to communicate with others and to develop their own knowledge and values/attitudes about the world around them. Culture imposed meaning on the world, it made it understandable through semiotic means. “Believing, with Max Weber, that man is an animal suspended in webs of significance he himself has spun, I take culture to be those webs” (1973, p. 4). Geertz elaborated that culture is a pattern of meanings that is historically transmitted to its members, is embodied in symbols, and manifests as a system of inherited/transmitted conceptions. Nursing scholar Patricia Benner applied Geertz's cultural views to the context of nursing: to Benner, meanings are not individualized and private, but rather public and shared, and ultimately, grounded in culture (1994). These cultural meanings, including linguistic expressions create what is noticed, and are inscribed on the body: symbols act as vehicles of culture. Geertz's webs of significance has meaning to the act of nursing by drawing attention to the beliefs and practices, cultural customs, social interactions, attitudes, behaviours, myths, rituals, and material constructions embodied by its members within a practice context.

A group of contemporary cultural anthropologists, Beals, Hoijer and Beals (1977) identified five major components of any cultural system within society:

- a group or society consisting of a set of members
- an environment or context where the members carry on characteristic activities
- a material culture consisting of the equipment and artefacts used by the members
- a cultural tradition that represents the historically accumulated decisions of the members
- the human activities, rituals, and behaviours emerging out of complex interactions among the members, the environment, the material culture and the cultural tradition.

Holland (1993) examined nursing culture using Beals' description with a particular eye for ritualistic expression. Patterned symbolic action ritual occurred in response to the goals and values of

nursing but also of the hospital context. Two examples described at length included the nursing shift change report and the wearing of uniforms. Within the surrounding organizational culture of the hospital (and even wider culture of the health care system in general) nurses act and ritually function and perform to provide care for assigned patients. “The organization of the hospital and its management still retain the power to confirm and organize the overall content of the nurse's and patient's days” (p. 1468). The rituals of caring for and healing the sick “takes place in 'ritual time' and 'ritual space' “ (p. 1468).

Cultural anthropologist, Edward Hall (1989) examined how culture influences perceptions of time. He pointed out that most of Western culture operates according to monochronic time (M time) systems which entail schedules, promptness, and perform actions linearly. Contrary to M time, other (usually non-Western) cultures function using polychronic (P time) time systems where several actions or events occur all at once, with an emphasis on the interactions and relatedness amongst the actors involved, in a flexible, non-linear way. An emphasis on M time is blatantly apparent in most Western health care settings, which obviously influences the way nursing culture is performed and how patient care is organized. Although many expert nurses are proficient in multitasking as they juggle care components for their varied assigned clients, there is little time or room for flexible care based on the client's altered sense of time or their unique needs. This fact supports the systemic agenda of the organizational milieu where care tasks are attended to, but misses the point as far as engaging in true holistic, client-centered care.

### ***Cultural Psychology Notions of Culture***

Psychology is another traditional discipline that has included culture as a variable of study, especially related to cognitive development as well as the individual and collective psyche. A particularly poignant version of culture as seen through the lens of contemporary cultural psychology is

the articulation of agency in culture. This view describes people as participatory players who actively make and remake culture: they are creators, not passive recipients or 'victims' of culture. (Ratner, 2000). Rather, people choose on a moment-by-moment basis, whether to embrace or reject cultural suggestion and expectations from their surrounding world. "Co-construction grants primacy to the individual's decision about how to deal with culture...most of human development takes place through active ignoring and neutralization of most of the social suggestions to which the person is subjected in everyday life" (Valsiner, 1998, p. 393).

Jerome Bruner (1982) elaborated by describing culture as symbolic meanings that are interpersonally negotiated through linguistic discourse. Like Geertz, he studied semiotic symbols but from a psychological perspective; a semiotic negotiation of meanings is the way agency actively constructs culture. People became cultural agents by the negotiation of meaning as one expressed their opinions and notions of cultural things to others. "It is the forum aspect of a culture (in which meanings are negotiated and renegotiated) that gives the participants a role in constantly making and remaking the culture – their active role as participants rather than as performing spectators who play out canonical roles according to rule when the appropriate cues occur" (p. 839).

On the other hand, Pierre Bourdieu (2000) presented the concept of habitus to describe intentional action by agency that is socially situated and often, contained. Habitus was described as a set of culturally related expectations, assumptions, and dispositions to react: these develop over time and within space through particular forms of social experiences and conditions. This notion purports that human action is not freely constructed through individual agency, but rather is guided by the socially built-up habitus. "Social experience is not only internalized intellectually; it becomes inscribed in our bodies. Personal experiences do not transcend normative cultural patterns. They are minor variations within patterns" (Ratner, 2000, p. 423).



This notion of culture stresses the fact that in contemporary capitalist society, the agency of most people is limited and almost always personally focused on the decisions and interactions of normal everyday life. “The agency of most people does not control the manner in which social activities such as work, religion, education, government, and medical care are socially organized” (Ratner, 2000, p. 425). This common focus on personally related tasks creates a specific form of agency that is “historically situated” and “culturally specific”(p. 426). Since agency has a social essence that acts within social relations, individual agency is constrained in most people: it only becomes empowered, fulfilled or even creative within social relations that allow this within the cultural boundaries that have been historically situated and currently supported.

### ***Cultural Studies Notions of Culture***

Simon During (2005), a devoted researcher in cultural studies, looked at how culture is engaged in contemporary every-day life, including work life. During defined culture as “...not a thing or even a system: its a set of transactions, processes, mutations, practices, technologies, institutions, out of which things and events are produced, to be experienced, lived out, and given meaning and value to in different ways within the unsystematic network of differences and mutations from which they emerged to start with” (p. 6).

Within cultural studies, cultural objects are also 'texts' that have meaning, as well as experiences and events (During, 2005). Avoiding objectification yet encouraging self-reflection, culture is engaged in, as well as a 'field of power-relations involving centres and peripheries, status hierarchies, connections to norms that impose repressions or marginalizations” (p. 9).

### ***Postcolonialist Notions of Culture***

Closely aligned to During's description of cultural studies, postcolonialism looks at the way white

cultural privilege influences people, everyday life (including work), as well as health and illness experiences. The notion of the culture of whiteness stems from the historical European colonization of much of the world's peoples, who were viewed as “Other” or non-white. Not only were they viewed as different, but also as deviant; as 'not normal'. White was/is “normal”. This notion made it easier to rationalize the atrocious acts of marginalization, assimilation, and even genocide purported in the name of cultivation of the “best” from civilization.

A postcolonialist lens can reveal some realistic problems in nursing culture, since “over 80 per cent of registered nurses are white, some statistics show as many as 90 per cent and more in some countries” (Health Resources Service Administration, 2000). The notion of whiteness also includes 'acting white' which is “required for full assimilation in the nursing establishment on the part of students, faculty, and clinical nurses. Acting white means adhering to the behaviours, values, beliefs, and practices of the dominant white culture” (Puzan, 2000, p. 195).

Postcolonialism offers a critical lens that helps nurse to view experiences of marginalization within the practice context as well as power and historical/structural dynamics (Reimer-Kirkham & Anderson, 2002, Anderson, 2001; Kirkham & Anderson, 2002). A look at geographical culturalism or multiculturalism reveals a tendency to exoticize ethnic culture, to disenfranchise, to stereotype, and further the notion of culture as 'difference' and othering; while white culture remains “transparent and unspoken for the most part, positioned as normal” (p. 6). This lens positions culture as individual and collective human experience situated within the larger 'contexts of mediating social, economic, political, and historical forces” (p. 13).

### ***Postmodern Notions of Culture***

A postmodern lens contextualizes nursing culture as both an activity and discipline-based, and analyzes how societal and cultural changes have shaped the culture of nursing. Parallels can be drawn

between current societal discourses and the cultural discourses in nursing. Recent disciplinary development in nursing has been described as modernist, especially within the enterprise-based, health care system (Bojtor, 2003). This particular lens provides a strong focus on power, and an analysis of “the plural, fragmentary, and subjective nature of reality and self” (Lister, 1997, p. 41) Nursing culture emerges from “dispersed, adaptable, and relational positions of power through close connections with families and communities” and with other health care providers (Puzan, 2000, 194).

Foucault sought to identify, investigate, and expose those contemporary cultural practices and rituals that threatened equality. He analyzed discourses in language to uncover the relationship between power, knowledge, and subjectivity. (Arslanian-Engoren, 2002). Discourses frame the material practice of everyday work, giving it meaning and providing a way of conceptualizing professional relations, aspirations, and achievements. Such strategic language provides a means of connecting the professional identity, knowledge, and power of nursing and other health care professionals. “For Foucault, knowledge is power over others, the power to define others. The value of narratives, of professional depictions of self at whatever level, is that these act as cultural resources to convey the virtues of professional acts” (May & Fleming, 1997, p. 1099).

Holmes and Gastaldo (2004) presented a metaphor for postmodern self-examination in nursing, using the notion of Rhizomatic Thought in contrast to traditional linear discourse or “Arborescence”. They explained that the rhizome is open at both ends, and does not conform to historical linear thinking. Rather, it emerges and grows in simultaneous, multiple ways and represents the ideal cultural essence of nursing since all life is a process of assemblages, connections and interactions. Rhizomatic thought is postmodern in essence, and acknowledges, accepts and promotes multiple discourses within nursing, even if they compete with one another. It embodies in a particular type of discourse that challenges the status quo and regimes of truth that are taken for granted within the health care context,

promotes alternative discourses and suggests paths toward “lines of flight” (resistance). Characterized by freedom, movement, and flux that serves to deconstruct historical nursing dogma, rhizomatic thought and discourse provides a means for nurses to examine their own mode of cultural being and governmentality within the current health care system and the wider context of society at large.

This brief introduction to disciplinary cultural definers of nursing provides some cursory background and insight to the way nursing culture can be conceptualized – this analysis is by no means exhaustive. Each of the disciplines introduced is rich with other cultural definitions and possibilities. As well, many other disciplines offer alternate explanations. To further apply conceptual understandings of nursing culture in a meaningful way, it is useful to deconstruct the focus into arbitrary subtopics. It seems most practical to begin at the beginning – by looking at how individuals become actual members of nursing culture through the institutionalized nursing education system and process.

## **Culture Becoming: Nursing Education**

Like many other disciplinary cultures, nursing education has undergone a profound metamorphosis in the past two decades. Traditionally, nursing students were educated using an apprenticeship model of instruction framed within a distinct biomedical, positivist, behaviourally-focused paradigm. As nursing education moved from an exclusive clinical setting into colleges and later university settings, a shift towards the humanities and a more holistic paradigm was adopted, though nursing education and culture still occurred within a deductive modernist framework. Remnants of this still exist, coupled with humanistic, critical social theory, and feminist-postcolonial lens to ultimately cultivate neophyte nurses who are empowered, engage in dialogue, reflection and praxis, and who provide care that is distinctly phenomenological, client-focused and salient to the individual

client's health needs and situation.

Yet, the culture taught in nursing schools, with professional ideals of autonomy, empowerment, and reflective practice clashes with the “highly bureaucratic institutions in the health care system” (Clare, 1993, p. 1034). As students gain experience within the clinical milieu, they often experience a discrepancy between the ideal culture taught in school, and the manifest culture experienced within the hospital and community care settings. “There is a cultural crossroads created when two or more cultures come into contact” (Blackford, 2003, p. 239) but this crossroads can become an area of contention, disillusion and distress, rather than an intersection of compatibility and congruence: sometimes to the point of “culture shock”.

Nursing education begins with a concrete focus on understanding the workings of the human body and mind, and how these are influenced by various health challenges. Three themes of conceptual structure in nursing are incorporated with this focus:

- principles and laws related to life processes, well-being, and optimal functioning of humans
- patterning of human behaviour in interaction with the environment in critical life situations
- processes by which positive changes in health status are affected (Hayne, 1992).

All Western nursing education now occurs within degree-granting configurations, where nursing students gain practical and theoretical experience in working with clients on various specialty units as well as in the community, including in-home care, clinic-based work, public schools and other community service areas. Students are enculturated to influence change, conduct both qualitative and quantitative research, to inquire in phenomenological ways, to advocate, to empower, and to develop empathy and respect for the unique lives, beings, and saliency of each unique client and their supportive families and circles.

### ***Ways of Knowing***

Nursing students are taught several different ways of knowing, including personal knowing, in order to holistically plan and provide comprehensive client care. “Personal knowing is the most problematic and difficult pattern to master and teach. It is the ability to see an event from the perspective of another and recognizing the other as a subject rather than as an object. Personal knowing is the discovery of self and others, which is arrived at through reflection, synthesis of perceptions, and connecting with what is known. It is captured through retrospective accounting of an interaction. The creative dimension of personal knowing is the process in which one becomes genuine, authentic, real and more whole” (Jacobs, 1998, p. 25). Personal knowing is engrained through therapeutic reciprocity or the therapeutic use of self. This application of self promotes integrity and wholeness in personal encounters with clients and with other student and practicing nurses. By creatively blending personal knowing with empirical, aesthetic, ethical and socio-political knowledge (Carper, 1987), student nurses learn to perform within a therapeutic caring culture that is holistic and salient to the client's health condition and recovery. This “...shows patients and their families that the nurse understands their world and can interpret some of their decisions and experiences in an enlightening context that will facilitate their growth and understanding of the difficult situation. Personal knowing is central to nursing since illness is radically subjective” (Holmes & Gastaldo, 2004, p. 28).

Conscientization, the process of education, reflection, and consciousness raising, is a dawning of awareness of the competing human interests and power structures that both manufacture and perpetuate social situations and affect culture (Friere, 1972). Friere purported that education that frees the oppressed to see through the consciousness imposed by the dominant group is a liberating force and as such, the development of critical thinking and critical consciousness is required. Nursing education is often based on a model of transformatory learning and emancipatory action. Transformatory education encourages experiential freedom and the right to interpret the stimulus events in life as one

chooses, adopting from the manifest culture what one will, and discerningly refraining from emulating the more base, less desirable aspects of manifest culture in the workplace (Freshwater, 2000).

### ***Cultural Socialization***

How students learn to navigate in the overwhelming sea of tasks, rules, and interpersonal deep waters of the average hospital ward culture is one of the most challenging aspects of nursing education. One of the most natural means is through socialization during clinical practice times working either with faculty supervision or directly under assigned clinical nurse mentoring. The incongruence between the culture taught in the school setting and that experienced in the clinical milieu can be quite overwhelming for students. The socialization process includes enculturation (how the students learn about and identify with their own professional culture) and acculturation (how students assimilate selected aspects of other professional cultures) (Hong, 2001). “For nursing students, enculturation is a process through which neophytes acquire a collection of cultural 'lens' or way of seeing the world. Acculturation occurs when individuals from one culture interact with members of a different cultural group within a particular context; changes occur at both a personal and collective level. (p. 5).

Fortunately, students are not mere passive recipients of socialization, they can actively construct and impact the world around them (Francis, 1999). Faculty spend a lot of time helping students recognize the constrictive institutional structures and influencing forces that make the clinical setting a challenging place to provide holistic client care. They are also encouraged to question practice that is not grounded in an empowering, emancipatory culture, and to move beyond fear of the “eating our young” behaviour sometimes exhibited by practicing nurses.

### ***Intention to Nurse***

Part of the ideal culture of nursing is valuing the profession as a knowledgeable practice and

supporting nursing students to cultivate an intention to nurse. According to Locsin (2002), the lens of the intention to nurse is the unifying concept underlying nursing practice and culture. “Promoting nursing values, facilitating health, and inspiring a positive human health experience for those nursed are directions for nursing that reveal the intention to nurse. Intention to nurse is the dynamic that is expressed through the prevailing lens of being authentically present with the other in the moment” (p. 2). Two central tenets to the intention to nurse are the ethico-moral principles of beneficence, to do good, and of nonmaleficence, to do no harm. To successfully practice these tenets within nursing culture, students need to learn to negotiate and re-negotiate an economy of performance despite the audit culture that often prevails, with a personalized, professional ecology of practice. Benner (1984) pointed out the importance of presence and just being with a client rather than doing for them, to meet common needs within the practice context. “The metaphor for professional is pulse rather than push. The teleology of the utopian professional self and the ontology of the vocationally oriented human being operate in a pulse like way. An accommodation between the actual and the ideal, the possible and the desirable” must occur (Stronach, Corbin, McNamara, Starke & Warner, 2002, p. 131).

### ***Cultural Development of Expertise***

Expertise or tacit knowledge is a manifestation of an individual's experiential knowledge acquired over the life course. Adaptation of tacit knowledge to new situations requires that experts have well developed thinking and reflective skills. Reflectivity is associated with the expansion of an expert's horizon. “Thinking progresses through cycles where the tacit and silent components become intertwined with expert knowledge, activity, efficiency, and service” (Viitanen & Piirainen, 2002, p. 180).

In her landmark study, *From Novice to Expert: Excellence and Power in Clinical Nursing Practice*, Patricia Benner (1984), described how nursing students are enculturated to develop what she



calls “nursing connoisseurship,” a hallmark of growing expertise within nursing culture. Students need to learn to recognize and describe “the context, meanings, characteristics, and outcomes of their connoisseurship” (p. 5). Benner applied Stuart and Hubert Dreyfus' (1980) model of skill acquisition to nursing, where students are seen as progressing through five levels of proficiency: novice, advanced beginner, competent, proficient and expert. As students move through these five stages, they learn to apply intuitive plus linear, calculative thinking to their work within the organizational culture.

As well as intuition, reflective or meditative thinking is very important for ideal nursing practice and culture. “Meditative thinking is, in many ways the opposite of calculative thinking. Instead of computing new results and possibilities, meditative thinking is more concerned with reflecting upon the meaning implicit in the experiences encountered in daily life – to examine reflectively our most immediate and personal experiences” (Severtsen, 2005, p. 2). Meditative thinking helps nursing students to learn about the culture and profession of nursing much more clearly than calculative thinking can. Student nurses primarily learn about the nursing culture and profession through the lived experience of the clinical practice that they are exposed to, rather than classroom experiences. Thus reflection on their experiences within the clinical milieu aids in self-initiated, deliberate enculturation into nursing culture.

As nursing students prepare to enter the work world of the health care system, they undergo confronting transitional passages of culture. Holland (1999) described a three stepped process or rites of passage that all nursing students experience to some degree or other: rites of separation, transition, and incorporation (p. 229). As they move through these transitional stages, nursing students move from the periphery, across the boundaries of student to that of practitioner, become members and move into the central margins of nursing culture. No longer protected by the role of student, the neophyte nurse must learn to perform within the clinical culture of the health care system and be accepted into the dominant nursing culture of the employing institution.

## **Cultural Context: Nurses' Work and Organization Culture**

Despite the myriad of cultural lens evident across disciplines, including nursing, one unifying concept appears constant across the theories: the concept of context. Nursing culture is situated within the bureaucratic context of the health care system, manifested across various institutional settings, including hospitals, community health agencies, and other specialized offices and clinics (Locsin, 2002). These settings are operationalized by the organizational cultures formed to govern and implement health care. “The health system has become a production process with structured input – output flows (selection, prioritization, performance/quality control, discharge/disposal, serving consumption (consumers of the product/commodity). It has a command structure (hierarchy) and a complex division of labor. It has an ideology: mental patterns codified in policies and procedures, rules and regulations” (Hunt, 2004, p. 200). Health organizational culture is based on a bureaucratic, service-quality model that “shapes the environmental stimuli and experiences to which one is exposed and to which one will react” (Gifford, 2002, p. 14).

### ***Modernist Excellence Contexts***

Since the early 1980s, major health care institutions have tended to move toward a modernist excellence tradition that focuses on a culture of service quality. “Excellent organizations are the way they are because they are organized to obtain extraordinary effort from ordinary human beings. Promoting culture as a social glue and source of increased productivity, they engaged with the reproduction of the strong cultural claims” (Beil-Hildebrand, 2002, p. 259). Organizational culture is most clearly witnessed and experienced by nurses through the influence of structure, function, process, time and space/place.

The structure of health care is reminiscent of the centralized bureaucratic control described by

Weber (1946). Cost control, resource restraints, and modernist structure create enormous pressure for nurses within the workplace culture. “Management has the power to control the supply of the other things necessary for the provision of health care, e.g. Type of cases, number of clients per nurse, and the supply of health care professionals” (Beil-Hildebrand, 2002, p. 267).

### ***The Discourse of Best Practice***

Organizational culture is ultimately co-constructed by the various participatory groups within the functional and structural confines established by the upper bureaucratic power holders (Wong & Tierney, 2001). One process that is commonly applied within health care that perpetuates the dominance of modernist discourse is the application of 'best practices'. Best practices relates to the use of benchmarked standards for health care service quality that shapes and often confines nursing care to adhere to the manipulation and constriction of time, resource use, and energy expenditure when providing nursing care within the organizational culture. “Uncritically adopting best practices is inadequate unless it addresses the power relationships that shape the consciousness of the players. Failure to expose the power relationships between employers, employees, consumers and the organization to whom best practice is benchmarked ignores the social context in which particular best practices are located. Further, it reflects the power of dominant groups to shape its direction” (Smith & Sulton, 1999, p. 103).

Nurses are the largest group of health care professionals, and they work, perhaps unknowingly, to support the modernist discourse of health care. Although medicine is considered a more powerful discipline, the work and status of physicians is less controlled, and more flexible within the context of health care service (Beil-Hildebrand, 2002). Nursing culture is shaped by management initiatives such as best practices which creates a stasis, a performance marker which may support the achievement of standards, but restricts the activity and autonomy of nurses in general. “Maybe language that

incorporates the use of the term 'better practice' is more indicative of reality as it indicates a practice that is progressive and dynamic. It indicates a practice that is continually evolving and improving rather than having reached a pinnacle of performance” (Smith & Sulton, 1999, p. 103).

### ***Time and Space in Context***

Time is another concept that is used to control nursing practice within organizational culture. “Monochronic cultures are oriented towards tasks, schedules, and procedures and measured by the external standard of the clock which conceptualizes time as existing outside the individual with dehumanizing effects as the external order of the clock is enforced at the cost of blindness to the humanity of its members” (Jones, 2001, p. 153). Andrew Abbott (1997) described the notion of locatedness, credited to the Chicago School mode of thought, as the context for “social facts and the importance of contextual contingencies” (p. 1158). “...one can not understand social life without understanding the arrangements of particular social actors in particular social times and places. No social fact makes any sense abstracted from its context in social (and often geographic) space and social time. Social facts are located” (p. 1152).

Space/place plays a critical role in how nursing culture is expressed in context. “Hospitals are comprised of multiple and distinctive spaces within which nursing is practiced and nursing identities are constructed and performed” (Halford & Leonard, 2003, p. 201). Nursing culture operates within constrictive spaces (usually hospital units); nurses are also “agents of power in their use of organizational space” (p. 202). As nurses and other health care providers colonize the organizational space to provide health service, organizational space is constructed and becomes a mode of action. Hospital units become the stage where nursing performance occurs and culture is expressed.

Halford and Leonard (2003) observed how nurses used movement within the organizational space to communicate power, authority and to perform nursing practice. “Often, nurses move quickly

with purpose but in chore-driven ways: always busy, buzzing around, repetitive spatial patterns, communicating with each other in passing, in snatched conversations” (p. 205).

As nursing culture moves to more non-traditional community-based settings, a culture of place continues to be an important influence on nursing, as it becomes “more than a physical setting but instead, a set of situated social dynamics” (Poland, Lehoux, Holmes, & Andrews, 2005, p. 171). A culture manifest or distinctive culture of place is created by the routine interactions of the participants and socially controlled organizational processes and structures.

### ***Power in Context***

The power relations inherent in organizational culture are situational and relational, occurring within organizational time and space/place. Three dimensions of power can be identified that help to explain situated practice:

- control of material resources
- control of human resources
- control of ideas (Poland et al, 2005).

These three characteristics mirror three types of cultural forms also identified by Poland et al. (2005), namely:

- material objects or artefacts
- social relations or sociofacts
- ideas or mentifacts

As Foucault pointed out, “power is fluid and circulates among and through bodies. Power acts upon individuals as they, in turn, act upon others” (cited in Holmes & Gastaldo, 2002, p. 559). Despite

advances to the contrary, nurses still “experience non-egalitarian, historically situated, non-privileged positions within society, the health care system, and even within nursing” (p. 558). Yet, it is the efficiency and industriousness of nursing culture that makes the perpetual modernist workings of the organizational cultural structure possible. Nurses have less power compared to the administrative hierarchies and the profession of medicine. Yet, within the health care system, nurses express both governmentality and other forms of power, especially pastoral power. Governmentality is exercised as an aim to influence the conduct of individuals, in this case, clients and their families. Foucault defined governmentality as “the ensemble formed by the institutions, procedures, analyses, and reflections, the calculations and tactics, that allow the exercise of this very specific albeit complex form of power which has its target population as its principle form of knowledge, political economy, and as its essential technical means, apparatuses of security” (1979, p. 20).

One such security apparatus prevalent in nursing culture is pastoral power, exhibited through care provision using specific standardized therapeutic regimes that promote appropriate normalized activities and ways of living. “The power of normalization imposes homogeneity by setting standards and ideals for human beings. Governmentality connects the question of government and politics to the self” (Holmes & Gastaldo, 2002, p. 560). Nurses are the agents that engage in the regulation, promotion, modification, maintenance, and monitoring of client-environmental interaction and set the stage for therapeutic experiences within the organizational context (Hilton, 1997). Often, the culture witnessed in practice is far different from the espoused culture held dear in the heart of ideal nursing culture (Manley, 2000). Nursing engages in a discourse of holistic care yet operates within a constricted time-space context that reduces care to fragmented regimes (Francis, 1999). “Economical constraints require cheap labor, task-oriented care, and ritualisation of nursing practice provisions” (Mantzoukas, 2002, p. 16) since organizational culture shapes the context and experiences in which

nurses act and react (Gifford, 2002).

### ***Nursing Work Culture***

The bureaucratic social structure in which nursing culture operates can be an overwhelming context for the new graduate nurse, as well as nurses with seasoned experience (Philpin, 1999). A palpable tension exists between the industrial organizational culture “with its emphasis on the systematic and procedural work culture necessary for mass production” (Hunt, 2004, p. 189) and the ideal nursing culture espoused and initiated during nursing education. As new graduates enter the work culture, they must learn about and adapt to the collective culture through enculturation and acculturation (Hong, 2001). This socialization process acquaints the new nurse to the norms, beliefs, and values of the nursing culture within the specific health care culture of the hospital or community unit. However, neophyte nurses are not “passive sponges who gradually soak up the collective culture in which they are embedded” (p. 12). They can choose to participate, they can also choose to transform it, at least internally, by rejecting aspects that do not feel right, and embracing those that do. “Individual providers construct and reconstruct their own personal version of the collective culture” (p. 12).

### ***Cultural Relations and Horizontal Violence***

An unfortunate backlash of the tension and pressure of the organizational culture that surrounds nurses is a high incidence of horizontal violence, or staff conflict, especially poor colleague relationships (Farrell, 2001). When this is experienced by new nurses, it can be particularly paralyzing, as “junior nurses are quickly socialized into a culture of nurse-to-nurse abuse. This helps to demonstrate the hierarchical structures and preserve the status quo” (p. 28).

Horizontal violence, a notion originally developed to describe the intergroup violence that emerged due to the oppression during Africa's colonization by the British, “embodies an understanding of how oppressed groups direct their frustrations and dissatisfactions towards each other as a response to a system that has excluded them from power” (Freshwater, 2000, p. 482). This behavior is seen as an expression of power, but one that can be quite disempowering, especially for those targeted by the abuse.

If nurses feel alienated, with no control over their own practice, they may experience resentment and frustration which is expressed to those near at hand, usually other nurses and perhaps even their own clients. Nurses are expected to be constantly vigilant, in a “state of watchful attention, of maximal physiological and psychological readiness to act and having the ability to detect and react to danger” (Meyer & Lavin, 2005, p.1). This vigilance coupled with heavy workloads, extreme time pressures, and limited space in which to work creates a very real cultural context of contention. If one nurse sees another nurse as doing less, making mistakes, or invading their space, violent or abusive behaviors can easily occur, perpetuating the cycle of tension and distress. Wesorick (2002) addressed this issue by encouraging health care management and nurses to create healthy, healing work cultures in nursing, “to transform practice cultures so the essence, uniqueness, and outcomes of professional practice will be realized” (p. 18). She points to cultural transformation as the key, which “requires continuous commitment to create a space worthy of the presence, efforts, and needs of those who provide and receive care” (p. 24). This is important not only for a strong healthy nursing culture in context, but for the optimal provision of client-centered, holistic care.

## **Cultural Being: Entering the Client's World**

Nursing culture is situated within organizational culture that is further situated within the



overarching culture of the health care system. Another critical component of this configuration is the client culture – a cross-cultural field of people from all walks of life, experiencing a variety of diverse health challenges, who are usually surrounded by and supported by their unique families and significant others. “Nurses, because of the nature of their work, have the rare opportunity to experience life in ways few have the privilege. They are present at birthing, birth, across the lifespan, in schools, homes, churches, neighborhood gatherings, work settings, and again at death and dying” (Wesorick, 2002, p. 31). This client field is the arena where nursing culture is ultimately performed; ideally as a dance of reciprocity between client and nurse; a dialogic partnership that forms as nursing care is delivered and received (Jonsdottir, Litchfield & Dexheimer, 2004). It is safe to say that the majority of nurses would prefer that these client-nurse relations be enacted in an atmosphere of calm, healing, caring, and respect, according to the client's preferences and needs. Unfortunately, the situation is often very different than the ideal.

“Traditional nursing culture with a focus on task orientation, rigid hierarchical structures and resultant disempowerment of staff is an impediment to delivery of patient-centered care. The rituals, routines, and cultures that have developed in nursing serve to prevent nursing from achieving this ideal model of care. Rigid hierarchical structures, disempowerment, the routinism of care combined with negative nursing attitudes, behaviours and language dehumanize nursing and reduce care to a series of tasks. Nursing cultures that allow nurses to nurse must center on the patient and their long-term needs and wishes” (Tonuma & Winbolt, 2000, p. 214). All too often, “patients are seen as problems to be corrected rather than mysteries to behold and attend to” (Jonsdottir, Litchfield & Dexheimer, 2004, p. 241).

The service delivery model that governs much of present day health care forces nurses to direct their focus on the management of treatments, and adhering to schedules rather than spending the time needed to develop a relational bond with clients, and creating space for clients to get in touch with their

own feelings, experience, and ways of dealing with their illness or trauma. The biomedical approach that is still prevalent in most health care institutions limits client input into the construction, evaluation, and experience of their own illness experience. Biomedical approaches to illness decontextualize disease, making it very difficult to fully co-plan healing activities with clients, or move beyond the assembly-line approach so common in hospital unit schedules and procedure manuals (Faber, De Castell & Bryson, 2003). Nurses are educated and able to provide much more than pathophysiological care, but the context and situatedness of the caring space has to be conducive to this. Nurses need to join with clients in a process of collaboratively seeking meaning in their complex and often chaotic health circumstances, to adopt a participatory stance (Jonsdottir, Litchfield & Dexheimer, 2004).

### ***Dialogic Relations***

Most nursing graduates who enter the world of present day nurses have been well versed in forming dialogic relations with their clients. They know how to be fully present with their clients, with full attentiveness, unconditional warm regard, be mutually responsive yet non-directive, stepping back and letting the client lead the dialogue to reach a deeper understanding of their health and the illness challenges that they are currently experiencing. Ideally, in a co-participant way, “The nurse, having no prescriptive agenda other than attending to what is going on for the patient in their health predicaments, embraces whatever emerges and goes with the conversational flow as new meaning unfolds” (Jonsdottir, Litchfield & Dexheimer, 2004, p. 243). Wesorick described five characteristics of relational dialogue that can be incorporated into nursing culture for peer and/or client communication:

#### *Principles of Dialogue*

1. Intention – create a safe space for all parts of ourselves to emerge
2. Listening – to self, others, the collective and between the lines
3. Advocacy – share, not defend your thinking
4. Inquiry – genuine, curious questions
5. Silence – wisdom and presence without words (2000, p. 27)

“Dialogue teaches about the sacredness of one's words and is fundamental for ensuring mutuality and engaging patients and family in decision making” (Wesorick, 2002, p. 27).

This form of attentive dialogue and caring presence leads to insight as action, which allows the nurse to understand the meaning of health and the illness experience from the client's point of view. Actions are not predicted beforehand, but emerge from the dialogic relationship. “From a sociocultural standpoint, person and environment combine to create the action taking place and the agency by means of which it is accomplished – there is no such thing as a person in isolation” (Faber, De Castell & Bryson, 2003, p. 145). All too often, despite the best efforts of nurses to the contrary, clients are left out of the discourse that surrounds and officiates the planning of nursing care. Even the language used to describe the recipients of care is unsupportive in the hospital environment. Most nursing students are encultured to name these receivers as “clients” rather than “patients”. Yet, in the work culture common in Western society, most are still called “patients”. “All language has a cultural and historical base and the word patient is no exception. Few would argue that in this society patient denotes notions of ill health, passivity, pain, sadness, and someone in need of care. Being labeled as a patient affects both how people act and how others react to them. Thus, being in the position of patient is often negative and disempowering” (p. 148).

Clients may lack the biomedical or pathophysiological “knowledge” about their health challenge, but all are acutely aware of their own experience of the event. Yet, this knowledge is not often acknowledged as part of the care discourse (Faber et al, 2003). “For the sick person, the potential to express experience and be listened to is a condition upon which trust in care provision is founded” (Skott, 2001, p. 249). The discourse concerning health challenges is localized in social relations and linguistic practice. Nurses are challenged to dissolve the barriers that separate “the socially established explanatory model (biomedicine), the mediating institution in which care takes place (the health care

institution), and the individual's embodied experience of illness and nursing care – experience expressed in conversation and narrative” ( p. 249).

Clients experience health challenges as painful disintegrations of both self and their personal world in everyday life. Most often, help is needed to heal this “lived disintegration of body, world, and self” (Skott, 2001, p. 249). Nurses need to listen to their client's narrative with a caring, professional and ethical approach that does not privilege biomedical knowledge. “The nurse is often required to take on a role as interpreter and mediator when the linguistic order of medicine meets the personal experience of sickness clothed in narrative language. Biomedical knowledge and personal experience represent two different arenas of knowledge, both of which are real and meaningful” (Skott, 2001, p. 250).

Medical science and the biomedical approach often exhibited within nursing culture formulates the human body and illness in a culturally distinctive manner, and constructs the work world in a particular way. All too often, nurses and other health care professionals accept the objective biomedical “facts” as the reality of illness, but experienced illness is actually quite different. “For the nurse to provide holistic care even at its most elementary level, stepping outside the purely biomedical, objectifying and essentially modernist approach is essential” (Huntington & Gilmour, 2001, p. 906). The human body and disease are represented according to biomedical science as 'naturally biological' but biology does not exist outside culture (Skott, 2001, p. 250). Within the biomedical paradigm, client care is provided as if it were a commodity, thus suffering becomes a technical problem, “which utterly transforms its existential root. It is enacted within a context of power relations, and the experience of suffering is transformed: the political becomes the medical” (Skott, 2001, p. 251). This makes it very difficult to find both the time and space to fully engage in the client's personal experience of illness, since this experience is shaped in a specific context where social and cultural forces are integrated in a

biomedical discourse, one that is foreign to most clients.

### ***Caring Presence***

Despite the harried pace of the common hospital context, it is important that nurses cultivate a cultural construction of sickness from the client's perspective (Skott, 2001). An important part of this cultivation is the assurance of caring, demonstrated by authentic caring presence. Caring presence is a state of being most readily observed through the bodily, sentient, enunciated caring behaviours demonstrated by nurses who ensure that they take the time to form a relationship with their clients. “Caring presence is mutual trust and sharing, transcending connectedness, and experience. This special way of being, a caring presence, involves devotion to a client's well-being while bringing scientific knowledge and expertise to the relationship” (Covington, 2005, p. 169). Clients pick up cues from nurses and can perceive whether they are authentically present or merely performing the care tasks in a mechanical way. A client's whole lifeworld is altered with hospitalization, and they need and long for an attentive caring presence coupled with true compassion that allows them to explore and find meaning in their illness experience (Lindholm & Eriksson, 1993). Together, the client and nurse “shape and create multidimensional cultural structures” (Suominen, Kovasin & Ketola, 1997, p. 188).

Inherent to caring presence is an attitude of sensitivity, a sense of life, and attentive and alert mindfulness: the ability to be and to act in the here and now, being totally present for the client. (Hunt, 2004). “The modus operandi of a sense of life in action is awareness of and attention to the life one has before one. It is mindfulness of this person's life here and now. The carer is entering into someone's life, not just manipulating it “from the outside”” (Hunt, 2004, p. 200). The moral work of nursing includes helping clients find meaning in their health challenge experience. Through caring presence, nurses can facilitate client agency to develop or regain the capacity to initiate meaningful action within

their own lifeworld. This can support them to regain a sense of normalcy, to feel like once again, they have a life and a sense of agency, and to masterfully reoccupy social, cultural and political space. (Mendyka, 2000). Nurses demonstrate caring presence by “being there” for clients showing a willingness to relate to their experience; “being with” to enable the feeling of comfort, and “being in tune” while creating the future (Wallace & Appleton, 1995). “When a nurse is "with" us, in the sense of being present, we feel the security of her protective gaze, we feel valued as a person, the focus of her attention. We know we do not need to hide behind the suffering we experience-what we say or how we look will not change this attitude. The nurse has learned to look for the indicators of disease and pain. We sense the nurse is close enough to *feel* with us, sharing the loss that accompanies the dis-ease we are experiencing in a sensitive, intimate way. Her understanding is more than an intellectual exercise. She *understands*. When a nurse is truly present, seeing and feeling all these things, we sense a kind of hopefulness. The presence of someone hopeful provides a moment of companionship, a moment of being "with." For a moment, we are not alone” (Bottorff, 2002, p.4).

Another important aspect of caring presence is the use of gnostic and pathic touch (van Manen, 1989). The probing gnostic touch entails a skilled, technically aware touch where each movement is deliberate and calculated, in a caring yet somewhat depersonalized way. The gnostic touch is usually linked to the medical culture, but nurses also use it to measure vital signs, skin conditions, and such: applying empirical biomedical knowledge to the interpretation of what is felt. On the other hand, the pathic caring touch is a skilled touch of another kind. “This hand does not touch a body of blood vessels, muscles, nerves, and bones, but rather, it touches the body of a living person. This pathic caring hand is guided by a knowledge of a sensitive kind, a knowledge which has as its end thoughtful, caring action” (p. 2). With it, nurses touch the man, woman, child, or infant themselves, not their anatomical parts. It is an intimate, soothing, highly charged touch that is distinct from the personal touch associated with sensual intimacy. Through it, touch conveys the essence of comfort, compassion,

caring, and hopeful support. “Thus, the caring hand that gently supports a patient as she turns to find a new position in bed does not touch the skin which encloses a body, but this hand touches the woman herself. The gentle contact of the hand and the woman's body is a direct contact between two human beings, the nurse “with” the patient” (Bottorff, 2002, p. 5).

### ***Community Based Caring***

In the past two decades, a greater emphasis on community health care has been cultivated within health care culture. More and more, clients are seeking and receiving health services in community based clinics, drop-in centers, in their own homes, on-line, or through other specialized community programs. Nurses with community health and development expertise, as well as advocacy and change agent skills, often practice within these community contexts, engaging with clients within their own community environments. Community care is ideally provided in response to the expressed needs of the community in question, as well as the individual clients who frequent the services.

“Cultural and contextual circumstances necessitate a critical appraisal of the needs of the community and the corresponding attributes of those who provide health-care services” (McKinstry & Trainor, 2004, p. 235).

Clarke and Mass (1998) described client reactions to a small community based Nursing Centre developed in Western Canada as a pilot project to demonstrate holistic, innovative nursing practice in a community context. “Clients reported great satisfaction, especially with the collaborative nurse-client relationship, changes in their health behaviours and status, and ability to make and act on their own choices. Collaboration and empowerment were deemed to be core concepts of the nursing centre” (Clarke & Mass, 1998, p. 217). Although not readily embraced by other health care professionals, particularly physicians, the community that accessed the centre valued the nurses' expertise, mode of relating, and services which spurred the move to acquire further funding so that the centre could

continue past the two year development funding stage. This initiative not only ensured that the nursing centre would remain in the community, but also helped the community members involved to develop coalition-building, advocacy and political action skills.

The nursing culture described promoted healthy work relationships with other nurses and allied health professionals open to the project. The nurses also felt comfortable and free to develop intimate nurse-client relations and to engage in “shared planning, decision-making, and responsibility” with their clients (Clarke & Mass, 1998, p. 219). As each client initiated service contact with the nursing staff, they were invited to tell their own story, which enabled the client to explore their health concerns within the context of their own life-space, and find personal meaning from this exploration. It was clear from the start that the client was entering a partnership where they were in charge of the decisions that needed to be made, and that the nurses were there to support them, as directed by the client. This Nursing Centre is one example of how nurses and clients can meet in truly collaborative relations, and the clients' knowledge and experience can become part of the discourse of health care culture. It is also an excellent example of how advanced nursing knowledge and research can help nursing move into a position of more autonomy where nursing culture can truly be enacted in a holistic, healing way that advances the professional image and mandate, as well as widen cultural acceptance of nurses in both health care and the community at large.

## **Cultural Knowing: Professional and Research Culture**

Like many other work-related cultures, nursing has worked hard to be accepted as a legitimate profession and discipline. Two key methods used to achieve this are theory development and research (Closs & Cheater, 1994).. Early nursing theory and research were centered in the physical sciences and behaviourism, but towards the last quarter of the 20<sup>th</sup> century, the focus moved to the social sciences,



making qualitative study equal to, if not stronger than quantitative work. “In the transition, the sense of 'understanding' became less of a way of knowing and more of a way of being in the world” (Cushing, 1994, p. 408). In all aspects of nursing culture, including education and practice, nursing theory and research has struggled to shift from the margins to the central regions.

### ***Disciplinary Power***

Theorists like Meleis and Im addressed the marginalization of nursing that stemmed from the belief that nursing was/is not a true profession, which makes nurses feel peripheralized within the health care system, especially in relation to power, decision-making, and autonomy. They have worked diligently to change this perspective by attempting to articulate universal nursing theory and research that uniquely demonstrates the domain of nursing culture and knowledge in context. “Knowledge also develops in resistance to the limits set by the power relations, particularly when there is an awareness of the effect of power on the nature of knowledge, and when this awareness translates to strategies to change or transcend the power differential” (1999, p. 98). Inherent in this work is the reshaping of the ideology that governs health care, and overshadows nursing culture. “Ideology is a means of maintaining power at the expense of those with less power. Power, ideology, and conflict are always closely connected” (Taylor, 1997, p. 443).

Foucault (1982) wrote about disciplinary power as a very important form of power that emerged in 17<sup>th</sup> century Europe and gained ground quickly in the modern Western world. He observed that despite its often being seen as repressive in nature, this kind of power is also productive in advancing the disciplinary culture of an emerging discipline/profession (Holmes & Gastaldo, 2002). Disciplinary power is used to influence individuals or groups to “produce effects on their conduct, habits, and attitudes in order to help them achieve particular skills and new ways of thinking or to render them ready for instruction” (p. 561).

Disciplinary power operates through distinct activities including:

- hierarchical observation (unrelenting surveillance of captive clients, clients at risk, communities)
- normalizing judgment (creation of norms)
- examination (clinical gaze, use of time and space, creation of individual cases).

A large per cent of current nursing theory and research focuses on holistic models of nursing care that are centred around the 'lived experience' of health and health challenges and locates illness as only one part of a complex matrix. Recent nursing research addresses the phenomenology of the client and their experience in the health care system. (May & Fleming, 1997). The discourses that frame nursing literature and practice experiences give meaning and provide ways to conceptualize professional relations, aspirations, and achievements. They provide strategic language that serves to connect professional identity, knowledge, and power. “The discourse of holism with its focus on the 'lived experience' or phenomenology of patienthood is reflected across the range of narratives, institutional and personal, that characterize the professional imagination” (p. 1098). Narratives within the discourse act as cultural resources to convey the essence of disciplinary and professional acts. Yet, the reality of the nursing culture manifested often is not reflective of this holistic centre (Wolf, 1988).

### ***Evidence Based Practice***

“Professional culture is a form of professional life comprised of a cluster of material and symbolic practices organized around a body of specialized knowledge shared by a group of qualified professionals” (Hong, 2001, p. 5). A strong move towards the use of research and theory in practice dominates current nursing literature (Eriksson, 2002). Nurses are now expected to apply research findings to their practice despite the hurried pace they routinely work within (Hallam, 2000). There is a strong emphasis on “the need to create a positive research culture, a whole system where research is

perceived more favourably, and used more proactively by the majority of practitioners. Strategies must be grounded in an appreciation of this research culture” (Le May, Mulhall & Alexander, 1998, p. 429).

In order to promote the application of evidence based practice, nursing leaders and theorists have attempted to promote a change in nursing culture. “Changing the culture is sometimes necessary for revitalization. This needs to take account of factors such as: the dominant ideology, the locus of power and decision making, the organizational structure, career opportunities and paths, communication, heroes and villains, stories and anecdotes, rites and rituals, and image” (Thompson, 2003, p. 144). In response to this process, LeMay et al (1998) asked an important question: “Do practitioners feel pressured by the current culture of nursing which is urging them to base their practice on research?” (p. 434). The boundaries and constituents of professional nursing culture are still fragile, and sometimes difficult to enact due to the demands and regulation imposed by organizational culture. The move to evidence based nursing is promoted in the nursing literature as a sound method for improving client care and addressing the theory-practice gap. However, it is also an initiative now supported and postulated by many organizations, but usually without the necessary resources, such as easy access to research findings, extra time for study, or workload adjustments. Thus, evidence based practice often becomes just another modernist method of control and stress for nursing culture participants that is added on to their already overwhelming case load.

### ***Reflection and Praxis***

Another emerging cultural norm that has gained popularity in nursing literature and in organizational culture is the practice of reflection and praxis. Taught in most nursing educational programs, reflection is a process “undertaken in order to gain understanding, insight, and new knowledge about practice. Because of this it is often called praxis” (McKenna, 1999, p. 148). Reflection combines Habermas' (2003) critical philosophy and Bourdieu's (2000) theory of practice where nursing practice is “viewed as a form of social life, in which different forms of domination,

distortion, and misunderstandings are possible” (Kim, 1999, p. 1206). Nurses need time and space in order to reflect well: to integrate and dwell on their intuitions, experiences, knowledge, and the situation at hand. “It encompasses both reflection-in-action focusing on the process of knowledge-use-in-action and reflection-on-action, focusing on the mode with which professionals gain additional knowledge from their experiences” (p. 1206).

Nursing culture is expected to exhibit the behaviours and outcomes of reflection and praxis within their day-to-day practice as well as perform the daily tasks of client care. This process is promoted in the nursing literature as encompassing three critical phases:

- *Descriptive Phase:* The nurse describes specific instances of practice (narratives) including actions, thoughts, feelings, circumstances, features of situation. This is an analytical phase, where the nurse becomes engaged in conscious efforts to view self and their actions
- *Reflective Phase:* Narratives are reflected on and compared to the nurse's personal beliefs, assumptions and knowledge. The nurse reflects on standards and theories, situation, and intentions. This is the basic premise of action science where nursing practice involves three aspects, scientific, ethical and aesthetic.
- *Critical/Emanicipatory Phase:* The nurse corrects or changes less-than-good or ineffective practice, moving forward to the future, and assimilates new innovations that emerge from practice (Kim, 1999, p. 1208).

Through critical reflection, nurses are able to recover and examine the historical and developmental circumstances which shape nursing's cultural “ideas, institutions, and modes of action, as a basis for formulating more rational ideas, more just institutions, and more fulfilling forms of action” (McKenna, 1999, p. 150).

Cotton (2002) described the current emphasis on reflective practice in nursing as an essentially modernist, disempowering and devaluing experience by arguing that reflective practice imposes a degree of surveillance on health care professionals and represents a postmodern 'technology of power'. If nurses are expected to combine reflection and praxis, evidence based practice, and exert disciplinary power in a client-centered, supportive manner, changes are needed in the organizational, health care, and nursing cultures: changes that afford nursing the luxury of time, space, equality, and resources to practice as they were educated to do: in a phenomenological, respectful, mindful way that offers full support to clients without controlling the client's ability to choose, act, and heal in their own unique way (Brencick & Webster, 2000).

### **Culture Shaping: Preparing for the future**

The literature makes it very evident that there is a huge discrepancy between the ideal nursing culture described in various nursing theories and research studies, and taught in most Western based nursing education programs and the manifest culture experienced in the day-to-day world of nursing practice. Major organizational and nursing culture change is necessary if this gap is ever going to become manageable, let alone bridged. Evidence appears to support the notion that phenomenological nursing is the most conducive way to engage with clients, and enact genuinely open, supportive nursing care (Heidegger, 1966, 2002). "Hermeneutic phenomenology works in nursing since nurses see whole persons who create personal meanings, a consideration of contextually meaningful experiences, a seeking to understand daily living and practical concerns, and the consideration of nurses and patients as entities or beings of Being" (Annels, 1996, p. 709).

### ***Notions of Boundaries***

In order to succeed, nurses need to examine the boundaries that divide the ideal from the manifest in nursing culture. Abbott (1993, 1995a) described professions as living in an ecology that exhibits boundaries and divisions. “Boundaries are the zones of action because they are the zones of conflict” (p. 857). He presented a notion of professions as fields that were situated with secure heartlands deep behind boundary territories with “...social and cultural mapping of jurisdiction between professions and their turfs” (p. 857). It takes experience, energy, time, commitment and workable ideas to dissolve these old patterns and boundaries (Lowenstein, 2003). Boundaries that separate nurses as caregivers and clients as “patients” also need to be dissolved, with an emphasis on the dyadic nature of the nurse-client partnership (Richardson, 2004).

Intentionality can help to reduce these boundaries, since it focuses on the natural way that people experience the world around them (Asp & Fagerberg, 2005). “Consciousness is directed partly toward objects in the world and partly towards the subject, in the form of self-reflection” (p. 4). It implies that there is a mutual influence between day-to-day occurrences in the life-world of both nurses and clients. As well, the notion of circularity between the lived body and the life-world means “that individuals can not be isolated from the contexts of meaning in which they live, because they have access to the world within and through their bodies” (p. 4). Language, meaning, and experience also interact in circularity: a fact that is very important to consider if nurses are to truly understand how clients perceive their experiences while receiving nursing care.

### ***Culture Embodied***

The ideas of lived body, lifeworld, intentionality, and circularity are underpinnings for Merleau-Ponty's (1962) philosophy of language and have relevance to the exploration of nursing and client culture. Nurses need to ponder on their use of language in their practice, since it has

phenomenological, semiological, and pragmatic dimensions that influence their relations with their clients within the organizational context. Since nurses as well as clients are embodied souls who find themselves together within the context of health care, nurses need to develop an awareness of this embodiment and apply it to their caring practice. “Nurses can experience themselves as embodied souls engaged in mutual creative processes with those cared for and appreciate the need to honor and care for self as well as other. The focus is the soulfulness of engagement as communion, at whatever level of care the person needs, be it a wound-dressing change for a person in coma or a dialogue about the loss of a child. With this orientation to practice, education, and research, nurses can honor the reverence of each unique human life in a new way, opening up to the creative potential inherent in all activity. This is an essential aspect of compassion and care for embodied souls” (Picard, 1997, p. 4).

Nurses can also forge deep, narrative knowledge that can help them to respond to their clients' unique needs by listening to the stories shared by clients in the context of nursing practice. “The persistent concern with the dehumanization of modern health care is, in large part, a response to the loss of the wholeness of patients and to the denigration, as unscientific, of their 'stories of sickness', adversity, and triumph. There is something profound about the struggle to recapture the patient in the story and the story in the case history. In recent years, nurses have come to (re)value narrative knowing. They have described narratives as means to discover knowledge, to uncover the knowledge embedded in practice, and to recover the art of nursing” (Sandelowski, 1994, p. 23).

### ***Concluding Thoughts***

If nurses value the meaning, embodiment, subjectivity, dialogue, and life-world of each client; and work together to influence organizational structure to petition more time and space to dwell with their clients in a meaningful way, nursing culture would move closer to its ideal form within the health

care context. This would also help to extinguish the horizontal violence still prevalent in nursing practice, since respect and compassion for self and others could develop within the layers of culture that nurses practice within. As well, the discipline and profession of nursing would be promoted and better recognized as unique and meaningful to the system of health care and society at large. It is time to begin to build this awareness, this intentionality and mindfulness, and to shape nursing culture to become what it aspires to be (Chapman, 2002). To clearly embody the rhetoric and make it a reality is not an easy task. Paradigm shifts never are.



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