

# **Enlivening the Rhetoric of Family Nursing: “there, in the midst of things, his whole family listening”**

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## **Abstract**

At the time that this study was conducted, family nursing practice in acute care hospital settings had received little attention in nursing research and theory. A hermeneutic inquiry explored nursing practices that involved families on three cardiac medical-surgical units in two hospitals in a large urban health care region in Canada. Data for the inquiry were generated through field observations with fifteen nurses and interviews with ten nurses. Nurses supported and enabled family presence in these units but demonstrated limited evidence of deliberate family assessment and intervention. Nurses espoused a familiar rhetoric that claimed that family nursing exists because of the inevitability of encounters with family members throughout daily work. Nurses wished to appear to include family members in their practice and emphasized the importance of family teaching. Still, nurses' ability to articulate the nature of this practice was limited. Family nursing rhetoric is explored as a potentially legitimate discourse that underlies current trends influencing nursing of families, particularly the impact of early discharge and increased reliance on family members to provide care at home during early recovery.

## **Keywords**

family nursing, family presence, family intervention, hermeneutics, Gadamer

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“there, in the midst of things, his whole  
family listening”  
(Wallace, 1988, p. 110)**

Illness in families is an inescapable presence inherent in our human condition. Some illnesses are minor and create little, if any, disruption to family life. Other illnesses, either acute or chronic, time limited or life limiting,

can have an enormous impact on families at every level of functioning. It is when illness arrives, and the intersection of nurses and families is necessitated through health care encounters and environments, that the practices of family nursing are, in theory, called

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into action. What is not known, however, is how often these practices truly live up to that which they aspire to in theory.

In this paper, we describe a hermeneutic inquiry that guided an exploration of these questions with nurses working on three cardiac medical-surgical units in two hospitals in a large urban health region in Western Canada. Through this inquiry, a rhetoric of family nursing became apparent that was seemingly uninformed by deliberate family nursing assessment and intervention. We highlight the importance of family nursing rhetoric as a discourse that underlies practice since nurses are increasingly obligated to include family members to achieve shortened length of hospital stay, and to prepare family members to provide care at home during early recovery.

### Background and Literature Review

At the time of the conduct of this study, the nursing of families of adult patients in hospital medical and surgical units had received little attention from nurse researchers and theorists. The literature, however, reflects longstanding interest in family-centered care related to hospitalization of children and maternal-child care in labour and delivery. Exploration of family needs in critical care settings has been extensively documented over the past two decades (Ågård & Harder, 2007; Brown, Deeny, & Mellroy, 2000; Chien, Chiu, Lam, & Ip, 2006; Davidson, 2009; Engström & Söderberg, 2007; Hickey, 1990; Leske, 1991; Mitchell, Chaboyer, Burmeister, & Foster, 2009; Stahan & Brown, 2005). More recently, there has been interest in family presence during invasive procedures and during resuscitation in emergency departments (Basol, Ohman, Simones, & Skillings, 2009; Baumhover & Hughes, 2009; Eichorn et al., 2001; Fernandez, Compton, Jones, & Velilla, 2009; Funk & Farber, 2009; Happ et al., 2007; Henderson & Knapp, 2006; McMahon-

Parkes, Moule, Benger, & Albarran, 2009; Maclean et al., 2003; Miller & Stiles, 2009). Tucker (2002) noted, with irony, the slow shifts in health care professionals' acceptance of family presence in hospital settings. In the 1970s, hospital labor and delivery units allowed for fathers and family members' presence at the beginning of life (Draper, 1997, Friedewald, Fletcher, & Fairbairn, 2005, Leavitt, 2003; Martin-Arafeh, Watson, & Baird, 1999). Decades later, there is increasing acceptance of family presence at the end of life (Andershed, 2006; Fridh, Forsberg, & Bergbom, 2009; Meert, Briller, Schim, & Thurston, 2008; Teno, Casey, Welch, & Edgman-Levitan, 2001; Truog et al., 2008).

There has been increasing interest in the impact of chronic and life-threatening illnesses on family members. With shifting demographics that reflect the "graying" of the North American population, there is interest in the roles of family members in care of the elderly and the potential for caregiver burden. The nature of the family-nurse relationship has been explored in critical care settings (Chesla, 1996; Chesla & Stannard, 1997), long term care (Gladstone, Duuis, & Wexler, 2007; Gladstone & Wexler, 2001; Ward-Griffin, Bol, Hay, & Dashnay, 2003), and community settings (Hunt, 1991; Kellett & Mannion, 1999). Åstedt Kurki, Lehti, Paunonen, and Paavilainen (1999) explored the impact of hospitalization on families with a member in a neurological ward and in acute care settings in Finland (Åstedt-Kurki, Paavilainen, Tammentie, & Paunonen-Ilmonen, 2001). May, Ellis-Hill, and Payne (2001) examined everyday interactions between family members and multidisciplinary health care providers.

Yet, within most of this older literature, the family-nurse relationship and the practice of family nursing on adult hospital medical and surgical nursing units had remained un-

der-theorized and relatively invisible. In more recent years, there has been increased focus on this relationship (Azoulay et al., 2003; Benzein, Johansson, Årestedt, & Saveman, 2008; Gavaghan & Carroll, 2002; Lefebvre, Pelchat, & Levert, 2007; Maxwell, Stuenkel, & Saylor, 2007; Pryzby, 2005; Tarnowski Goodell & Harmon Hanson, 1999; Van Horn & Kautz, 2007; Yetman, 2009). It is this aspect of the family-nurse relationship that led to this study and these questions guided an exploration of aspects of family nursing practice and perspectives: What is the character of hospital nurses' interventions and interactions with family members? How do nurses involve family members during hospital care and how do they address family concerns?

### **Family Nursing Practice Study**

This study was motivated by the observation that, despite good intentions, family-focused nursing care in adult hospital settings continues to be a remote goal in Canadian health-care systems. Our purpose in this inquiry was to explore and describe family nursing practices that support involvement of family members in health care encounters and address the concerns and difficulties of families with a member hospitalized with cardiac health problems.

### **Research Approach**

This interpretive inquiry was guided by the philosophical hermeneutics tenets of Hans-Georg Gadamer (1976, 1960/1989). As a contemporary and student of Heidegger, Gadamer extended a tradition of hermeneutic thought that is increasingly the basis of interpretive research in nursing (Fleming, Gaidys, & Robb 2003; Geanellos 1998; Moules, 2002; Walsh 1996). Gadamer's unique contribution included his explication of genuine conversation as a distinctive mode of understanding in the human sciences. He explored hermeneutic

conversation as the dialectic of question and answer, the playful to and fro of dialogue, and the stance of holding out the possibility within dialogue that the other might be right (Binding & Tapp, 2008; Gadamer 1960/1989). Gadamer revealed the productive possibility of our pre-understandings or prejudices and challenged the concept of prejudice as a negative or limiting bias in human understanding. Prejudices come into play in the hermeneutic circle, a metaphor for interpretive understanding where beginning conjectures are developed and put into play in writing, practice, and dialogue to sound out their merit and credibility. Conjectures are revised, reconsidered, and recycled until a sufficient description of the phenomenon can be offered. A productive account explores and extends understanding by addressing traditions of meaning (e.g. cultural, professional, and social discourses) that the author or participant could not or did not explicitly consider. Gadamer's work guides nursing research through a philosophical stance rather than a methodological framework for generating and analyzing text.

### **Prejudices and Pre-understandings**

While we acknowledge that it is impossible to specify in advance the biases and prejudices that shape our understandings of the research topic, there are some beginning understandings that informed the research team's approach to this inquiry. We assumed that nurses in hospital settings do nurse family members and that such practices are relational and occur in dialogue. As such, there is a risk that family nursing practices are less amenable to measurement and observation, and thus less visible to those concerned with evidence of the impact of nursing interventions on health care outcomes. We believed not only that family members ought to be included in hospital care but also that those families want to be acknowledged and involved. We believed that resources, unit routines, and hospital pol-

icies powerfully shape nursing of families. In addition to interviewing nurses about their practices, we wanted to account for organizational supports and constraints that shape nurses' work with families. We anticipated that fieldwork would enable us to witness nurses' engagement with families and to appreciate the complexity of family nursing practice in acute care hospital settings.

### **Research Process**

Participants included 15 staff nurses on three cardiac nursing units at two teaching hospitals in a large health region in Western Canada. Nurses were recruited through small group presentations to nurses on each unit. In qualitative work, the goal of recruitment is to engage participants who can best speak to the phenomenon of interest (Moules, 2002). This may also be the most significant limitation of this inquiry: participating nurses may be those who were most interested in family nursing and thus most inclusive of families. Though their perspectives and practice may not be representative of their colleagues, this was not the goal of the inquiry. The aim was to reveal family nursing as it appears in these particular nursing units rather than to claim that the descriptions that follow constitute typical nursing practice.

A total of 34 field visits (170 hours) were conducted. Most nurses were job-shadowed (non-participant observation) on at least two occasions by the lead researcher or a graduate student. Researchers were interested in observing routine nursing practice to witness encounters between nurses and family members. They were present on a variety of shifts from early morning until late evening. Ethical approval was obtained from the Conjoint Health Research Ethics Board of the University of Calgary. Informed consent was obtained from nurse participants, and the researcher obtained verbal consent from pa-

tients and family members to whom the nurse was assigned for the shift. Immediately following each observation, researchers wrote fieldnotes based on recollections and brief notes made during the visit.

Several months later, 10 of these nurses were interviewed. The time delay was not related to the observation process but more a function of the research process. It was not intended that observations and interviews be linked. Two nurses declined participation in the second phase of the study and three others could not be located. Using unstructured interviews, we explored instances of family nursing that they believed reflected their everyday practice or that stood out as significant to them. These dialogues provided opportunities to inquire about particular thematics that became apparent within the initial interpretations of the field notes. Interviews were audiotaped and transcribed verbatim. The research team was comprised of two faculty members, two graduate students (one doctoral and one master of nursing), and one registered nurse who worked as a staff nurse on one of the participating nursing units. All research team members were involved in the interpretation of text generated through field notes and interviews by independently reviewing all transcripts and preparing interpretive memos. The findings presented here offer a weaving of these interpretive writings, as our understanding of the phenomenon of the family-nurse relationship in this setting was uncovered through this process.

### **Family Presence**

Each of the three participating units had visiting guidelines but nurses had significant discretion regarding implementation. Though it was usually family members who were present during the morning hours, general visitors were increasingly present throughout the afternoon and evening. In the telemetry areas,

nurses were more likely to enforce an afternoon rest period and ensure an early bedtime. Each unit had a small number of private rooms and a larger number of two-bed rooms. Two units had a few four-bed wards and a small cardiac telemetry unit for patients requiring more intensive monitoring. The physical environment had a significant impact on family presence as the semi-private, four-bed wards, and telemetry units afforded very little physical space or privacy to accommodate family visiting. Both hospitals were built 20 to 40 years ago and were not designed to provide facilities for family members. Each unit had a large waiting room with couches, television, and telephone access. None of these units provided overnight facilities for family members. An exception might occur if the patient spoke no English and family members were needed to assist with translation and communication. If a family member wished to stay overnight, nurses occasionally placed a reclining chair or stretcher at the patient's bedside in a private room. This was typically discouraged in other rooms.

Nurses in this study implicitly accepted family presence in a manner that would have been considered extraordinary in hospitals thirty years ago. Some nurses commented on differences they noticed over time in hospital policies and practices regarding visiting hours. Within the limitations of physical space and visiting policies, there was a prevailing ethos that recognized family entitlement and desire to be present. Nurses anticipated that family members are entitled not only to be present but also to ask questions, receive information, and know details of diagnostic and treatment plans. Although variations were observed and reported in nurses' comfort with family presence during routine activities, many nurses actively encouraged family presence.

*Anytime I want to do something with the patient, the family is usually there and I*

*usually tell them "Okay I'm going to do this" or, I want to give them (the patient) some information about bypass surgery or having a pacemaker put in ...And if they make as though they're going to leave I say "No, no that's fine, just stay cause I'd like you all to have this information." So I usually, unless I'm doing something personal with the patient it's obviously not appropriate to have family there, I prefer to have them stay and listen.*

Nurses knew how to make the system more accommodating of families and sometimes found creative ways to enable family presence when they would normally not be allowed. Exceptions were more likely made when the patient did not speak English and family members were required to translate. Nurses frequently commented on benefits to the patient when the family could be present. Family members were not expected to assist with physical care but were recognized as a source of emotional and social support to the patient. By involving family members in incidental patient teaching and structured group classes, nurses believed that the family would be prepared to help the patient manage symptoms and the treatment plan more effectively at home. Nurses appreciated that family members would reinforce important information about recovery at home. Nurses believed that information helped family members understand illness and recovery, reducing family stress and anxiety.

*For me, knowing what's really going on with a patient is knowing what's going on in their family and who is visiting them and how does that impact them ...To really care for that patient you have to know who the family are and what they're about and what is the relationship. And just letting them understand what's going on, I think helps that person as well...What do they have to offer to this situation as well.*

*You can gain lots of information that you might not gain from your patient even, from the family.*

Nurses recognized family members as a resource, having something “*to offer to the situation.*” They acknowledged that the family is more able to interpret the patient’s behavior, needs, and responses because they know the patient better. Family members can speak for patients’ preferences in situations where patients cannot. Nurses acknowledged the importance of family involvement to maintain vigilance regarding patient safety, and the occasional need for family members to advocate for the patient. Some family members wished to assist with aspects of physical care.

### **Acknowledgement of Family Presence**

Nurses in this study implicitly accepted family presence at the bedside. The extent to which family members were acknowledged by nurses and engaged in dialogue varied greatly. Nurses practice in individual ways, with their own rituals for introductions at the beginning of the shift. Nurses’ introductions typically focused on patients, with varying attempts to address family members or visitors. Visitors who were at the bedside early in the day were more likely to be family members or significant caregivers; those visiting throughout the day were not necessarily family members. Nurses displayed tact and discretion as they encountered others at the bedside. What kind of visitor is this: a relative, neighbour, pastor, friend, or caregiver? A clarification of the kind of visitor helped ensure that when information was offered to appropriate persons and with the patient’s consent.

Some nurses made negligible attempts to greet, engage, or acknowledge family members present at the bedside. They might not direct any comments to those present unless

the member first addressed the nurse or asked a question. The nurse might assume that if the patient did not introduce others, they did not want them involved. Sometimes nurses launched immediately into a start-of-shift assessment or problem-focused dialogue, asking visitors to leave for the sake of privacy. These nurses tended to be patient focused and pragmatic about the patient’s physical needs and concerns. Such instances occurred both in situations when nurses were pressed for time, and when the unit pace was more relaxed.

How might acknowledgement of family members matter in nursing practice? To acknowledge is to recognize or accept something or someone as valid, to show and admit a noticing (Pearsall & Trumble, 1996). To acknowledge is to make visible. When acknowledged by nurses, family members come to light as connected to the patient and as meaningful to the health care situation. Providing appropriate and sensitive care rests upon understanding of the involved persons’ unique concerns that contribute to possibilities for healing and recovery (Benner, 1999). Levine (1998) suggested that family members want recognition that they, too, are undergoing something; are important in the life of the patient; and make a contribution to the patient’s well-being and recovery. When family members are over-looked at the bedside, does this diminish their expectation or willingness to express their own needs, seek information, or offer their perspectives?

Despite increased family presence in hospital settings, we observed that nursing practice on these units remains extensively patient rather than family focused. Even when family members were present, nurses typically attuned their gaze and attention almost exclusively to the patient. Any gaze carries responsibility and obligation. If a nurse engages the family, there is a necessary responsiveness to what emerges within the encounter: if I hold

my gaze too long and family members engage me, I am obligated to address their concerns. Although nurses usually did not directly inquire about how individual family members were coping with the hospitalization, they did engage in introductions, comments, and a gaze of looking directly at families, and this seemed to have the effect of recognizing family presence and putting them at ease. The word “engage” means to occupy, hold another’s attention, and commit or promise (Pearsall & Trumble, 1996). Family members most often appeared to be distinctly in the nurse’s peripheral vision where the nurse, by avoiding the family members’ direct gaze, could also limit their questions and contain the time required at the bedside if necessary. May, Ellis-Hill, and Payne (2001) proposed that this is a deliberate relational practice by which nurses control demands on their time and the nature of their work. Hupcey (1998) identified strategies used by both families and nurses in the process of developing the family-nurse relationship in the intensive care setting. Nursing strategies that inhibited the relationship included refusing to chat, avoiding eye contact, refusing to acknowledge family members, being too busy to answer family questions, and maintaining an efficient attitude that focused on physical care. Each of these strategies was evident at times in the fieldwork undertaken for this inquiry.

### **On Being a Visitor**

In one sense, both patients and family members are visitors to the hospital setting, in a terrain where they may not have previous experience. There are explicit rules for visiting hours, rest periods, and numbers of visitors allowed. There are informal and unwritten norms about relationships with health care providers, and ways to access information and influence decision-making. Nurses have latitude, discretion, and power to bend rules, helping patients and families navigate this

terrain. In this geography of limited space, shared rooms, and interrupted schedules, nurses often attempted a semblance of privacy behind thin curtains, creating a comfortable space for patients and family to feel more “at home” than visiting.

We observed many nurses at the start of the shift postponing assessments or tasks with patients when there were visitors present. They would purposefully pass by the room and return to see the patient later. This could be understood as avoidance or a missed opportunity to meet and engage family members. Nurses might also view family presence as an obstacle to care, perhaps assuming that the assessment of the patient would take longer. In some instances when nurses purposely did not approach patients with visitors, the nurses seemingly assumed visitor status *for themselves* and avoided interrupting the family’s time together. In these circumstances, nurses recognized themselves as the outsider or visitor to the patient/family relationship. In this awareness, nurses respectfully avoided intrusion on family terrain, creating space and small moments of privacy for families.

### **Bringing the Family and the Nurse into the Situation**

There were no formal approaches to family assessment observed in practice or described in the interviews. When nurses did inquire about the family situation, it was typically in the context of what might be construed as social conversation; the simplicity of the questions asked by nurses was remarkable. The nurse might ask a couple “*How are you two making out?*”, or ask a spouse “*How are you managing at home?*” Questions were sometimes open ended but often linear and closed: “*Tell me about your family*”, or “*Is your wife well?*” or “*What kind of work does your husband do?*”, or “*Do you have kids or grandkids?*” Nurses purposefully pursued casual

lines of questions woven throughout their work as a way to get to know the person and family, to understand what kind of support and information were needed, and to prepare for returning home. This inquiry was typically described as being in service of nurses' emphasis on patient teaching.

Some nurses noted that families vary greatly in their need for support from nurses. For many patients and families, hospitalization is an unexpected crisis. It may involve a new diagnosis, or may be an omen of progressive health deterioration. Nurses described the discretion and judgment required as they interpreted family distress.

*They stand farther back, they're afraid to get involved, they're afraid to ask questions. Not all families are like that, but you see it often. They're afraid. They don't know what to do. They don't know what to say. They don't know where to stand ...They are clearly very upset and not knowing what to do ...You can maybe see the stress, or they don't say anything to anyone, they just sit there kind of blank.*

Patient and family distress is heightened when they experience a cardiac hospitalization as a life-threatening event, an existential threat leaving them feeling groundless. In this instance, not knowing "where to stand" occurs on multiple levels as both patient and family try to understand cardiac illness and how to navigate the hospital environment: What do I need to know? What should I ask? Whom should I ask? What should we be looking for? What does the future hold? How will our lives be changed? As nurses read the family situation, they are taking into account where and how the family is standing on this unfamiliar and shifting terrain. Nurses gradually brought patients and family along, encouraging them to ask questions and voice concerns, helping them to interpret diagnostics and treatment

plans, and guiding them to anticipate important features of recovery for their return home.

Much of this work of "reading the family situation" is unspoken in practice. Many of the cues that nurses read to interpret anxiety, distress, coping, and need for support are non-verbal. Nurses struggled to explain their practice with distressed families, offering inarticulate, vague, and uncertain descriptions of how they came to understand these situations.

*My nature is just seeing. I can see a lot by just seeing.*

*I'm just reading their cues, like just reading their body language [for] tiredness, frustration.*

Even more difficult were nurses' attempts to explain how they addressed situations that called for emotional support, conveying caring through dialogue, presence, and touch. Although nurses knew something important was needed and something was happening, they could not find language that embraced such actions or meanings.

Nurses made efforts to bring family into the hospital situation and help them feel comfortable and secure in this foreign terrain. In nurses' practice and stories of practice, it was also obvious that they brought themselves into the family situation, and described this as an intention to build rapport with the family.

*That joking, that superficial stuff, it has meaning...It has a way of breaking the ice and letting them, and sharing some of your life with them. I think that really helps. ...Cause if you're willing to share your life with them, they're willing to share their frustrations and whatever is happening with them.*

Nurses felt connected to families by virtue of similar circumstances in their own families, family relationships that held special meaning to them, or personal experiences that resonated with family encounters in hospital. Sometimes nurses commented on these personal experiences with patients and families, or during the research interview they acknowledged the impact of these personal circumstances on their practices. Many nurses noted that their commitment to family nursing was bolstered by a personal experience with an ill family member.

*Just put yourself in that person's or that family's situation and see...how would you feel if that was your dad, what would you want out of it? I went through something like that with my mom. And I remember some good experiences and some not so good experiences that I had with the nurses and with the staff. And really the good ones outweigh the bad ones.*

Although nurses connected with families in ways that brought them into family situations, some family members also brought nurses into their particular situations. Occasionally, family members engaged nurses by remembering a nurse's name, seeking the nurse out to ask questions, inquiring about the nurse's own family or personal life, and offering non-verbal cues of acknowledgement and recognition. Family members often initiated interaction with the nurse by volunteering responses to questions directed to the patient, or cautiously seeking information, frequently with an apology offered for consuming the nurse's time. This reciprocity of nurse and family bringing each other into this particular situation was significant. How family members participate in this relationship does make a difference to the ways they are included. The nurse needs to get comfortable with the patient and family, and to feel acknowledged and respected by them.

### **Family Teaching and Discharge Preparation**

Although nurses varied in the extent to which they deliberately engaged family members and viewed themselves as responsible for providing emotional support to family, nurses consistently described their practice with families as patient teaching and discharge preparation. Some apologized at the end of a field visit that family members were not present to be able to show the researcher more teaching interventions. Many nurses immediately launched into their research interviews by claiming the importance of family teaching within their practice.

*We deal with families every day. So it's encouraged to get information, and because we do a lot of focus on discharge planning and getting the person ready to go home. You have to deal with families and loved ones to get information and find out their needs to plan this. Facilitate them going home. That's a big part of contact with families.*

The constantly reiterated belief about nursing of families in this practice setting was that family members need teaching.

*And it's a teaching thing...because one way to get the patient out quicker is if the family is there and they know exactly what to deal with these things [that] get stressful at home if they don't know what to deal with and what to expect. So if we're teaching and reassuring and reinforcing things everyday, like, "this is how he's doing right now and this is what he needs to work on", and that makes them feel better, too.*

Embedded through these explanations was the explicit drive to teach family members as part of discharge preparation. This work was

clearly motivated by nurses' roles in moving patients through the system to maintain effective bed utilization.

*First day they're in, it's looking at going home because it's quick and you got to be on that plan all the time.*

Impromptu teaching in the midst of other nursing activities was both described and observed in practice. Nurses typically practiced with awareness that family members were present, watching, and listening.

*For example, if I'm doing incision care, I'll go over what we do with the incision, looking for signs of infections, that type of thing .... If we're doing morning care or evening care, then it's a good time for teaching .... A lot of it is for discharge teaching. But a big part of that is how are they going to cope at home, in terms of them and their families. And do they have help at home.*

This nurse believed that families are informed and reassured "there, in the midst" (Wallace, 1987, p. 110) of practice, as she talked aloud during the dressing change or staple removal, or explained what nurses do about feet swelling. As she made her nursing care audible, she uncovered her observations about the patient's needs and progress for the family. Much of the family teaching was informal and embedded as nurses provided information, responded to, and encouraged family questions.

This emphasis on family teaching may be a way to categorize interactions between the nurse and the family. The event of teaching might be included in the list of responsibilities and tasks that the nurse accomplishes. The continued reliance on the categorization and language of "family teaching," however, suggested something else to this research team.

This language may be a way to offer description of something that exists but is not articulated, that might be held up as something more legitimate in the professional context than listening, being present, or inquiring into the family's emotional domain. The latter might be viewed within scientific or medical discourse as a softer, less valid role of nursing. Alternately, family teaching might be regarded as a more vital and significant nursing activity. It might offer a context for interaction with the family, an opportunity for time, concern, attention, and caring. We began to question whether "family teaching" provides a name in which to capture a complexity of work with families that is often beyond description or articulation.

### **Rhetoric of Family Nursing**

This inquiry intended to show the character of nurses' practices as they addressed family concerns and involved family members during hospitalization for cardiac illness. Hermeneutic inquiry begins with a sense of heightened attunement to something in particular. There is anticipation of un-concealment, the possibility of revealing new understandings, and the prospect of practicing differently because of understanding differently. In many regards, one could say that the findings reported are commonly shared meanings of everyday nursing practice that contribute little to new understandings of family nursing. How do we accommodate this disappointment of the familiar? How can we understand differently when what is uncovered is seemingly obviously present, previously stated, or widely known and appreciated?

There was also a disappointment that, at the time of this study, family nursing theory seemingly had little impact on the clinical practice we were exploring. We discovered that discrete events of family assessment and intervention were exceedingly rare. None of

the nurses overtly used genograms, ecomaps, or other family assessment tools within their practice. Nurses rarely inquired about the impact of the hospitalization on other family members. It was extremely rare that nurses intentionally engaged family members to address a particular therapeutic goal or intervention. Family nursing was most often equated with family teaching activities. Involvement of family members frequently focused exclusively on discharge preparation. We witnessed superficial conversation with families, missed opportunities to inquire more meaningfully into family concerns, and dutiful questioning of family without attunement to their responses. Nursing of family members seemed to occur in a haphazard manner rather than as a deliberate consideration in the nurse's practice.

Nurses, however, described themselves as welcoming and valuing family presence. During the fieldwork, nurses were respectful of families and consistently responsive to questions from family members. In the interviews, we frequently heard declarations of interest in families, and their sense that family nursing is an inherent part of practice.

*It just seems like an everyday thing  
...Families are involved every day.  
I'm big on family.*

*Families are always involved. And certainly on the unit I'm on, with these patients waiting to go for bypass surgery or waiting for anything, families are very very concerned and so forth, and they're always around.*

*We have to involve the families because they need to be a part of the care-giving process after the surgery.*

There were oft-repeated echoes of the importance of family teaching to help the patient, reduce family members' anxiety, and ease the

transition to discharge. Some nurses even noted that family members need information to prevent heart disease for themselves. We observed that nurses constantly gleaned information through both formal and social conversations about the context in which the patient lived and to which they would be returning. Participants often found it difficult to offer exemplars of family nursing, describe their nursing practice with families, and articulate what family nursing means to them. Is the presence, support, and inclusion of families so ingrained in practice that one can barely comment upon it? Does it mean that family nursing is *not* happening if nurses have difficulty explaining and illustrating it?

Nurses were keen to have their practice appear as family-oriented. In these endorsements of the significance of family nursing, however, their declarations often appeared as rhetoric that fell short within the simple instances of family nursing that they offered during the interviews. Within this rhetoric, it was assumed that family presence is related to the inherent necessity of family nursing in hospital settings: families simply are present and thus deserve to be addressed in some way. The rhetoric was undercut even further when contrasted with the observations of practice from the field visits. There was extremely limited evidence of intentional family assessment or intervention within their practice. We began to question whether there is a gap between the espoused ideal of family nursing and the realities of everyday practice. These nurses seemed to believe that happenstance encounters with family members, responding to members' family questions, or simply asking about or referring to family members constitutes family nursing. Might these limited practices be insufficient yet constitutive of family nursing? Is family nursing just so much rhetoric?

At first glance, rhetoric can be understood as language that is pretentious, showy, or elaborate but essentially void of meaningful ideas or sincere emotion (Agnes & Guralnik, 1999). Do declarations that family nursing is valued and significant truly hold up in meaningful ways in everyday practice? At one point a decade ago, Baumann (2000) asserted that family nursing is nursing theory anemic and deprived, but the theory has evolved since then. Even though accessible in theory, however, our study suggested that family nursing theories and practice models do not generally appear to be useful, or actively applied, in practice in acute care hospital settings. How do we understand that the practice of family nursing in generalist hospital practice settings has been under-theorized and resistant to description and explanation? Must we persist with rhetorical statements that value family nursing without explicating more fully the contribution that such practice might make to health care?

If there is truth and significance in family nursing rhetoric, we must understand rhetoric differently.

We came to realize that family nursing rhetoric makes a statement of import. Another version of rhetoric is “the art of speaking well” that carries conviction and is convincing “as long as we do not trivialize it” (Gadamer 1986, 17). Rhetoric coming from the Greek “rhetorica” is the art of persuasion. Skepticism of nurses’ declarations of the importance of family presence and involvement might invite us to overlook something of significance that is happening in their practice. At a most basic level, families are a feature of hospital nursing practice. They are present. They will continue to be present in hospitals for the foreseeable future. It is no longer a choice whether or not to nurse families. Shortened

length of hospital stay has an impact on family members, who assume responsibility (whether desired or not) for a much greater proportion of post-discharge recovery than was the case in past. Nurses recognize this impact on family members, and they require the assistance of family members to be able to move patients through the system efficiently.

*In the past, it was more or less, okay you dealt with the patient, that’s it. Now we’re seeing that ... family members have to be involved in their care. When we’re sending people home, especially in our elderly population, they need to know what medications they’re on, they need to have some concrete information on what’s happening with their loved one. And it’s the whole thing has just shifted.*

This raised the awareness of the research team that, as our expectations of family members shift, we need to consider how the boundaries, obligations, and relational capacity to families must shift as well.

If there is truth and significance in family nursing rhetoric, we must understand rhetoric differently. Bruns (2002) proposed that rhetoric is a call to action in the context of complex systems where one must understand at least provisionally in order to survive.

Rhetoric is... a mode of responsibility rather than, purely and simply, a mode of knowledge; it responds to the need for action by producing a consensus in the absence of sufficient (that is, self-evident) reasons.... rhetoric is a real world construction of a provisional order of reason, a practical construction of what is reasonable in a world where randomness and contingency can not be eliminated. (p. 51)

Family nursing practice is a relational practice that occurs in dialogue and relationship, ex-

change and reciprocity. These elements of nursing practice are most resistant to measurement, specification, prediction, and control. Family nursing occurs in those happenstance and haphazard moments when families are present and when questions, needs, and concerns are visible. The apparent lack of deliberation and therapeutic intention could be as much a feature of the fragmented nursing practice context as it might be a criticism of the awareness or skillfulness of the nurse.

### **Responsibility Borne by Family Nursing Rhetoric**

Family nursing rhetoric offers a mode of attunement to families in the midst of everyday nursing practice. Hamrick (2002) proposed that such attunement is always particularized in some definite mood, a disposition of feeling that persistently attends to the welfare of the other. Attunement does not happen in isolation but always in harmony with, and relationship to, something or someone else. The attunement that lies at the heart of family nursing rhetoric creates possibilities for nurses to become available to families and responsive to their needs. Such rhetoric is a reflection of nurses' felt obligation to engage and involve family members. The productivity of this rhetoric in the present and future lies not simply in a verbal tribute to the significance of family nursing but in the action and responsiveness that needs to occur in practice.

Family nursing rhetoric claims that family nursing exists because of the inevitability of encounters with family members throughout nurses' daily work. It would appear that enabling and acknowledging family presence is important but, in itself, insufficient. How does family nursing rhetoric shed light on the responsibilities that nurses bear towards families? Benner (1999) highlighted the crucial significance of nurses' actions that enabled family presence in critical care settings: fami-

ly presence provided information that oriented the family to the patient's critical condition and trajectory, helping "grasp [the] changing clinical relevance" of the situation (p. 318). This served, in some instances, to sustain hope for recovery and, in others, to prepare for the patient's impending demise. There is a future orientation to such meaning-making that resonates deeply with nurses' intent to provide families with information in the context of this study, but it is differently nuanced. The extent to which nurses in this study emphatically laid claim to their teaching roles with family members becomes more understandable. Nurses consistently cited their obligation to family teaching to prepare family members to support the recovery of the patient at home. Nurses know that family members will bear the work that is imposed by earlier hospital discharges.

When an understanding of rhetoric shifts from a meaningless and insincere showing to a persuasive language of argument that serves to extend and share common and important insights, nurses move into a new awareness of obligation. This obligation consists of learning how to live up to an embraced rhetoric. Rhetoric is created and sustained by its own repetition; it argues for itself in its apparentness and the compelling evidence of its very presence. The obligation and responsibility that is birthed in a rhetoric embraced in family nursing is one that involves more than simple acknowledgement of family presence or family teaching. It calls for a relational attunement to family, a commitment to family nursing and living up to the rhetoric that defines it. In the midst of major life events of illness, hospitalization, healing, or death "the whole family" watching and listening, family nursing takes a place and assumes a shape that must necessarily live up to itself and all that it claims.

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