Nursing care practices and workplace relations in a Thai surgical ward:

An exploration of clinical decision-making

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Submitted in fulfilment of the requirements of the degree of

Doctor of Philosophy

June 2009
STATEMENT OF AUTHORSHIP

This thesis is entirely my own study. To the best of my knowledge and belief, it contains no material previously published or written by another person, except where due reference is made in the thesis itself. Neither the thesis, nor any sections, is currently under consideration, in press or published elsewhere, and has been previously submitted towards a degree or diploma in any university or other university.

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

Khomapak Maneewat
STATEMENT OF RESEARCH PROJECT

This study was conducted with the approval and permission of the Griffith University Human Research Ethics Committee (HREC) and the Ethics Committee of Songklanagarind hospital, Faculty of Medicine, Prince of Songkla University (see Appendix 1). The ‘Principle of Professional Responsibilities’ of the Council of the American Anthropological Association in 1971 (cited in Spradley, 1980) and the principles of ethical research were extensively employed in every step of the study, data collection, analysis, and interpretation. These principles consist of considering informants first, safeguarding informants’ rights, interests, and sensitivities, communicating research objectives, protecting the privacy of informants, not exploiting informants, and making reports available to informants (Spradley, 1980). In this study, these principles were enacted with particular attention to informed consent and confidentiality of the participants.
ABSTRACT

This thesis offers a study of how a local ward culture underpins nursing actions of Thai surgical nurses in order to account for issues such as lack of sustainability, and failure to use research, including evidence-based nursing practice and the new multimodal model of care which has been officially adopted in the Thai hospital context. The study was conducted at a Thai surgical ward to illuminate and describe the culture of the Thai surgical nurse, including the ways in which the organizational culture influences or guides their thinking, decision-making, and actions in a patterned way. The knowledge about how the Thai surgical nurses allocate care, and make clinical decisions in the surgical ward in the context of social relations and staff culture is constructed through an ethnographic approach based on fieldwork at the non-private general surgical wards of one university hospital in Southern Thailand. A better understanding of the diversity of Thai surgical nursing practice is then enacted from a typical day in the life of the Thai surgical nurses, which consists of the realities, ritualised practices, relations, and integration both with within their group and with others.

The study results represent the way that nursing organizational culture informs the practices, decision-making, and the predictions of the nurses’ possible response to change. The pre- and post-operative cares allocated by the nurses of the TSW are routinised, almost ritualised, and reflect fixed assumptions about the way cares ought to be delivered, including those reflecting the lack of commitment to implementing new multimodal models of care as well as research utilization and evidence-based practice. The study raises significant concerns about the status of professional nursing
in Thailand in terms of professional autonomy and the status of the nurses within the Thai hospital context. Empowering professional nursing is therefore recommended as a first priority to change Thai nursing culture. The ritualised practices, task-oriented working system, and the dominance of the medical model in the Thai nursing culture further reflect the need to establish an evidence-based nursing culture to create professional identity and improve the quality of care.
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<th>Description</th>
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<tr>
<td>TSN</td>
<td>Thai surgical nurse</td>
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<tr>
<td>TSW</td>
<td>Thai surgical ward</td>
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<tr>
<td>CDM</td>
<td>Clinical decision-making</td>
</tr>
<tr>
<td>KI</td>
<td>Key informant</td>
</tr>
<tr>
<td>PSU</td>
<td>Prince of Songkla University</td>
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<tr>
<td>MOPH</td>
<td>Ministry of Public Health</td>
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<tr>
<td>NAT</td>
<td>The Nurses’ Association of Thailand</td>
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<tr>
<td>B.E.</td>
<td>Buddhist Era</td>
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<tr>
<td>B.N.S.</td>
<td>Bachelor degree in Nursing and Midwifery</td>
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<td>RN</td>
<td>Registered nurse</td>
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<td>PN</td>
<td>Practical nurse</td>
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<td>APN</td>
<td>Advanced practice nurse</td>
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<tr>
<td>NP</td>
<td>Nurse practitioner</td>
</tr>
<tr>
<td>CNS</td>
<td>Clinical nurse specialist</td>
</tr>
<tr>
<td>H.R.H.</td>
<td>His Royal Highness</td>
</tr>
<tr>
<td>EBP</td>
<td>Evidence-based practice</td>
</tr>
</tbody>
</table>
Head nurse          HN
Surgical care team   SCT
Outpatient department OPD
Intensive Care Unit  ICU
Operating Theatre    OR
Thai Medical Doctor  TMD
Pre-operative        Pre-op
Post-operative       Post-op
Nothing per oral     NPO
After Midnight       AMN
Intake-output        I/O
Intravenous Fluid    IV
Acute Pain Service   APS
Incentive Spiro-meter Tri-flow
Visual Analogue Scale VAS
Prescribed as needed PRN
Cardio Vascular Tract CVT
From routine to research to routine R2R2R
Hospital Accreditation HA
ACKNOWLEDGEMENTS

As I had travelled through the journey of undertaking my PhD on the culture of the Thai surgical nurses and its impact on the way nurses make decisions, there were times when my own decisions had to be made, when the choices were hard, and solutions seemed scarce. Quite often my soul was weak, disheartened, and sometimes the difference between success or failure depended on a little encouragement or kind words and the support from my family, supervisors, critical friends, colleagues, and the Thai surgical nurse participants. Also, an act of caring and kindness from those kinds of people was such a light which could help me overcome a large darkness of fear of the unknown and uncertainty and made me learn that ‘the hopelessness is hope given to me – just don’t look back and think about failures’, and assuring me that ‘I’m not alone’.

To my supervisors, Professor Marianne Wallis and Dr. Suzanne Goopy, who shared the first and second half respectively of my journey, I made a list about everything I appreciate and am grateful about you but I ran out of paper. I can never thank you to you enough but I will try. Few persons can make a difference and both of you have. Thanks a million for your wisdom and all your help. Thank you for being such superb and versatile supervisors. I highly appreciate and am grateful for your unconditional patience, kindness, and wonderful guidance. Your kindness and thoughtfulness will always be remembered. I particular forever thank Su for kindly sharing your wonderful field study expertise and for helping me in getting insight in writing ethnography and developing my thesis. This appreciation is also extended to Dr. Jane Truscott who contributed in a supervisory role in the first year of my candidature. I
also wish to extend thanks to William Hatherell for his kind assistance in editing my thesis.

Highly appreciations and gratefulness to Professor Wendy Moyle: it's nice to know that there are people like you. Thank you for your generosity, your kindness, your hospitality, and thanks for everything you've done for me so far. Abundant thanks for your fabulous support and inspiration to make me stay balanced and to maintain a good quality of life in Australia. With sincere appreciation, I wish there are more people like you.

I would like to acknowledge my gratitude to Prince of Songkla University and the Faculty of Nursing for providing the scholarship to support study. Also, I would like to add abundant thanks to my colleagues in surgical nursing department, in particular, my ex-nurse educators, for their compassion and for their trust and respect in my capability, even though I'm just your junior staff. Thank you and deep appreciation from the bottom of my heart (but for them my heart has no bottom) to the head nurses and surgical nurses, included staff auxiliaries at 'male surgical ward I' and 'female surgical ward', for always sending kind regards to me and being my good co-workers for a long time, especially providing help and support through ten months of my field study. Special thanks and acknowledgements to Songklanagarind hospital, nursing department, and surgical nurse supervisor, for giving me a great chance to carry out this study. To my critical friends, Kanittha, Aree, Natenapha, Prapaphan, and Kimby:

Some people come into our lives and quickly go, some stay for a while and leave footprints on our hearts, but we are never, ever the same. Sincerely thank you for your best wishes, unending compassion, support, and concern for my happiness and
compassion during my loneliest and most frightened time as a PhD student, including patience with my stubborn, querulous, weepy, and hyperactive nature.

Finally with my gratefulness, respect, and sincerest thanks, I would like to devote the virtues and value derived from this study to my wonderful Dad and Mom, and my sister who always gave unconditional love and support no matter how old I've grown, who always trust and believe on me, especially for Dad and Mom who never got a chance to see my success and celebrate together as I wish you were here – since you passed away when I was writing the thesis discussions. So many times that I wanted to give up but I never do because of you. Dad; although I could not be number one everywhere in the big world, I always be number one in your heart and all my success means yours.

‘Who never failed, no victory has sought’

‘Who never doubted, never really thought and learned’

‘Whose soul was never troubled has not known the sweetness

and the peace of real content’
CHAPTER ONE

INTRODUCTION

Scope of the study

This thesis explores a particular group of Thai surgical nurses (TSN) and the nursing culture within their workplace at one university hospital in Southern Thailand. The central aim of the thesis is to highlight the relationship between the organizational cultures as it exists within this hospital (and in particular within the surgical ward areas referred to in this thesis as the Thai surgical wards (TSW) and the way in which the nurses undertake their daily nursing practice and the decisions they make regarding patient care. With this in mind this thesis seeks to illuminate and describe the ways in which this particular group of Thai surgical nurse live and work together, including the ways in which the organizational culture influences or guides their thinking, decisions, and actions in patterned ways. As the study focuses on the way of life of the Thai surgical nurses and the patient care decisions they make (and how these in turn affect direct patient care), a wide variety of environmental and socio-cultural elements will be explored.

It is important to state from the outset that this thesis does not seek to present solutions to this issue but, rather, highlight the complexity that will underpin any moves towards changing the ways in which nurses, such as those of the TSW, make clinical decisions on a day-to-day basis. In addition, the thesis is presented as a largely descriptive work aimed at presenting the polemics and realities of nursing in a TSW rather than reducing them to a set of limited rituals, routines or activities.
social features are shown to play a central role in the shape that nursing practices take and the decisions that nurses make in the TSW. The level of analysis that does occur is only provided for the purpose of rendering these practices understandable, and it is a deliberate feature of the work that they are not analysed beyond this point. While it would be, in many ways, ‘easy’ to critique the practices and clinical decisions of the TSN in relation to the broader, in particular, Anglophone literature about ‘best practice’, ‘evidence-based practice’ and ‘clinical decision making’, it is argued that this would detract from the central aim of this thesis, which is to consider the influence of local culture in understanding the day-to-day practices of nursing and in turn the reality of workplace management and organization as distinct from, in the case of the TSW, the official drive towards adopting universally prescribed nursing practices.

Cultures of practice are variable and complex, reciprocally linked to the wider socio-cultural background, political, and economic dynamics in the health and social systems of which practitioners are a part (Cook & Yanow, 1993). The culture of different wards in healthcare organizations has also been considered as nursing culture (Suominen, Kovasin, & Ketola, 1997). The particular culture of each organization is the way of life of its members: the collection of ideas and habits which they learn, share and transmit from generation to generation that guides their thinking, decisions, and actions in patterned ways, and works as mental rules guiding behaviour (Burnard, 2005).
The culture of an organization becomes one of the environmental forces that influence individuals, the way people make decisions, and the boundaries that individuals create for themselves in order to frame and make decisions. The social context in which the clinician functions also has an important impact upon their clinical decisions (Thomas, Wearing, & Bennett, 1991). Organizational culture influences the way in which individuals do perceive their role within the decision-making process (Lee, Newman, & Price, 1999). Consequently, the organizational culture controls the way members make decisions, the ways they interpret and manage the organization’s environment, what they do with information, and how they behave (Cook & Yanow, 1993); organizational culture underpins members’ decision-making (Hancock & Easen, 2003). Hence, an understanding of the local organizational culture and the way it influences members’ decision-making is one of the first steps in relating nursing care to patient outcomes. This understanding can influence nursing education and ultimately contribute to the improvement of patient care (Parker, Minick, & Kee, 1999).

The complexity of human experience means that it needs to be researched through close and sustained observation of human behaviour, a need acknowledged by the methodology of ethnography (O’Reilly, 2005). The study of nursing culture is usually undertaken under the umbrella of ethnography (Burnard, 2004). Ethnographic study is collecting whatever data are available to throw light on the issues that are the focus of the study by participating in people’s daily lives, watching what happens, listening to what is said, and asking questions (Hammersley & Atkinson, 1995).
In addition to the practices of more classical ethnography, which are drawn upon in this thesis, I have also taken inspiration from auto-ethnography in informing my approach and my role as researcher and an insider in this research study. The influence of this has, in part, meant that it has been possible to combine a post-modern and at times autobiographical element to the thesis allowing for it to sit outside a more traditional, positivist analytical ethnography (Reed-Danahay, 1997). Indeed, the acknowledgement of the self (the researcher, the auto) in this thesis opened up possibilities for its presentation that would not exist within a more traditional positivist approach. In appropriating elements of auto-ethnography through such things as responses made or reactions felt to observations gathered and descriptions offered, it is my intention to open up rather than close down conversation (Ellis, 2004) around the complex question of what it means to be a TSN. Aspects of the research presented are therefore unapologetically influenced by my experience as not only a researcher but also my role as an educator within the TSW.

The personal knowledge, and indeed prejudices that I brought with me into this project have I believe, while problematic at the start, given insight into problems often overlooked in culture — in this particular case issues such as the nature of nursing identity and practices, or in other words what it means to be a nurse in the TSW (see in particular chapters 4 and 5). In addition to helping me, the researcher, make sense of my individual experiences the elements that have been borrowed from auto-ethnography and incorporated in my work are, inevitably political in nature as they engage the readers in important issues and ask the readers (and indirectly the participants) to consider things, or perhaps even, in the end, to do things differently. In borrowing and incorporating elements of auto-ethnography I have, as Chang (2008)
argues, been able to gain a cultural understanding of myself in relation to others, and the competing expectations that exist between ideals, policy and practice. It is hoped that in presenting these observations and insights the first steps towards the formation of a cross-cultural coalition may be built between self and others.

Ethnography, in its more classical sense has a strong presence in this thesis as it is being used with increasing frequency to examine selected concepts central to the provision of nursing care in order to discover how new nursing knowledge is perceived or experienced by nurses – with a primary focus on the implications for nursing. Philosophically, ethnography can explain how beliefs about correct and appropriate action in specific situations (norms), including persons who hold specific positions, are developed in particular cultures (Triandis, 1994). The ethnographic method is therefore employed in order to understand the values, beliefs, norms, and life-ways of Thai surgical nurses because of its strength in attempting to understand everyday nursing culture in its naturalistic setting.

Observation and particularly participant observation are the primary data collection techniques used in this study. According to Lecompte (1999, p. 91), participant observation is “the process of learning through exposure to or involvement in the day-to-day or routine activities of participants in the research setting”. Participant observation is the process enabling the researcher to learn about the activities of people under study in the natural setting through observing and participating in those activities (Kawulich, 2005). Generally, people learn their culture by observing other people, listening to them, and making inferences. In doing field work, ethnographers make cultural inferences from the way people act, from the language and the artefacts
they use. This means the researcher can observe nursing as it occurs in its naturalistic settings (Field, 1991). For these reasons, observation and particularly participant observation are the primary data collection techniques used by ethnographers, while interviews are subsequently used to explore and develop a deeper understanding of particular aspects of the culture being researched (Taylor, 2005).

The importance of individual interviews is manifest in person-centred ethnography, focusing on individuals and how their experiences both shape, and are shaped by, social and cultural processes (Sharkey & Larsen, 2005). The aim of the interview is to explore the ‘insider perspective’ and to capture the participants’ own words, their thoughts, perceptions, feelings and experiences. Formal open-ended interviewing is the dominant approach used in ethnography since it lets the informant’s ideas, world views, and information be revealed rather than those of interviewer. It is a two-way process where researcher and participant engage in a dialogue to explore the issue and meanings people hold for their everyday activities (Taylor, 2005).

Essentially, the open-ended interview type is ideal to elicit ‘emic’ data and get ‘inside the head’ or obtain the world view, thoughts and experiences of the informants. Allowing the informant to interpret, demonstrate, clarify, verify or confirm data is most essential to the ethno-nursing interview method. Listening to and then repeating a statement or question with context referents permits researchers to share accurate and meaningful data. The researcher engages in observation supported by interviews, in which participants’ insight guide researcher decisions about what to observe (Kawulich, 2005). For these reasons, interviews are also used in this study to check and ascertain the observed activities that were not clear to validate the observational data.
Observations and interviews for this study were conducted across two public general surgical wards, both of which mainly care for non-critical surgical patients who have had general surgery. Unlike the global understanding of the term ‘general surgery’, the ‘general surgical wards’ in this particular hospital setting, as well as other tertiary level Thai hospitals, admit not only patients undergoing general surgery (e.g. appendectomy, gallbladder removal), but heard also specialist surgeries such as vascular surgery (e.g. varicose vein surgery, aortic aneurysm repair), colo-rectal surgery (e.g. stoma formation), surgical oncology (e.g. breast surgery, tumour resections), plastic and maxillofacial surgery (e.g. release scar), open heart and thoracic surgery (e.g. Coronary Artery Bypass Graft), head and neck surgery (e.g. oesophago-gastrectomy), and urological surgery (e.g. prostate surgery), included surgical patients with further treatments after surgery (chemotherapy, post-op. complication). The patients’ conditions vary from healthy to dying.

The diversity of procedures that these two Thai surgical wards (TSW) support through nursing care indicates the complexity of nursing practices that face the nurses of these wards. Based on my experiences (I had worked as a nurse and have been working as a nurse educator in a TSW of Songklanagarind hospital), similarly to critical care nurses, the nurses in these ‘general surgical wards’, as well as nurses in other non-critical wards in Thailand, have to make decisions on matters such as administering oxygen, ventilating patients, and weaning patients from a mechanical ventilator. Consequently, the wide mix of patients and the variety of patients’ conditions within these general surgical wards require nurses to be competent decision-makers in implementing decisions from simple to complex in order to respond to dynamic and uncertain client needs and to solve client problems in the context of varieties and
complexity. Here, prior to develop nurses’ competency in making quality decisions as well as develop their day-to-day nursing practices, ethnographic study to examine the distinct nursing culture and staff relations underpinning their patterned works and behaviours is needed. Recommendations and suggestions can be drawn from the findings for nursing administration, education, practice and research regarding the improvement of nursing practice in Thai hospitals.

**Database for the thesis**

Organizational culture consists of the common ways in which its members of an organization have learned to think, feel, and act. This is different in many aspects from national cultures as it distinguishes the member of one group or category of people from others. Organizational cultures are created as standards for behaviour within a group of people that are visible to outsider observers but which the insiders cannot see. National cultures on the other hand, establish and integrate from many nations, different groups, even less integrated minorities. The studies about national cultures however, useful for the understanding of organizational culture (Hofstede & Hofstede, 2005).

A particular meaning which is only recognized and considered as socially essential by those who share the culture is carried via created symbols and rituals such as the way language is used in text and talk, in daily interaction, in communicating beliefs, in greeting and paying respects to others, and in social and religious ceremonies. For example, workplace activities that are organized for seemingly rational reasons often serve mainly rituals purposes, such as reinforcing group cohesion (Hofstede &
Hofstede, 2005) which promotes a sense of belonging, and belonging reciprocally evokes a feeling of loyalty to a place. Organizational culture has been found to be an important factor influencing the care giving behaviours of nurses (Parker, Minick, & Kee, 1999).

Generally, the core of organizational culture is formed by values, including basic values, which are broad tendencies to prefer certain state of affairs over others (Hofstede & Hofstede, 2005). Thai culture is one of the fundamental structures underpinning professional nursing in Thailand (Hallinger & Kantamara, 2000). It is therefore necessary to have an understanding of Thai culture to gain clear understanding of the culture of nursing in the Thai context (Burnard & Naiyapatana, 2004).

A framework for discussion

In order to understand the Thai surgical ward organizational culture, two paradigms of cultural perspective and theory proposed by Hofstede (1991) and Douglas (1978) are very useful in analysing and presenting the local research culture. The grid/group theoretical framework proposed by Douglas has been primarily used for describing particular social units and for exploring intra-societal cultural diversity, including controlling comparisons between social units in different societies (Caulkins, 1999). The utility and feasibility of four grid/group types to analyse and compare different societies has been reported by a number of researchers and scholars (Goopy, 2000). For these reasons, the ‘grid/group’ theory is selected as guidance or navigator in studying and explaining social relations of the Thai surgical nursing organizational
culture and the forms of social organization that support them. Additionally, Douglas’s cultural theory is combined with Hofstede’s perspectives in ease looking at the Thai surgical nurse’s organizational culture to identify the linkage between organizational culture and basic social structure. The works of Hofstede also provide insight to understand Thai culture which overwhelms the development of Thai nursing culture. The main arguments of ‘grid/group’ theory and the societal perspective of Hosftede and their relevance to this study are addressed and outlined in the following.

**Grid and group: Exploring commitment and control in Thai nursing culture**

Anthropologist Mary Douglas developed a two-dimensional framework for cultural comparisons: (a) grid or constraint by rules, and (b) group or incorporation into a bounded social unit. According to Douglas (1978), cultural ways of life and affiliated outlooks can be characterized both within and across all societies at all times along two dimensions, which she called “group” and “grid”. The Douglas model proposes that an individual's behaviour, perception, attitudes, beliefs, and values are shaped, regulated and controlled by constraints that can be grouped into two domains, labelled as group commitment and grid control. According to Douglas and her colleagues, the four grids/group types constitute stable social configurations that are associated with distinctive values or ideologies: individualism, fatalism, hierarchy, and egalitarianism. It is a generic model which proposes a conceptual framework for comparing organizations, organizing and change. The model identifies particular configurations of social relationships, dictating 'ways of life' or organizational cultures which are both exclusive and differentiating.
Group, the horizontal coordinate, represents the extent to which people are driven by or restricted in thought and action by their commitment to a social unit larger than the individual. High group strength results when people devote considerable time and attach great importance to interacting with other members of their unit. In general, the more things they do together and the longer they spend doing them, the higher the group emphasis. The group strength also tends to be high where admission to the social unit is hard to obtain, making the unit more exclusive and conscious of its boundary. Conversely, an emphasis on 'doing it my way' also implies that interaction (networking) becomes optional, rather than normative. On the other hand, group strength is low when people negotiate their way through life on their own behalf as individuals, neither constrained by, nor reliant upon, a single group of others.

Grid, the vertical coordinate, is the extent to which people’s behaviour is constrained by role differentiation either within or without membership of a group. Grid is high strength whenever roles are distributed on the basis of explicit public social classifications such as sex, colour, and position in a hierarchy, office, descent, or point of progression through an age-grade system. It is low in strength when the classification does not limit the range of social choices or activities open to people. A low-grid social environment is one in which access to roles depends upon personal abilities, skills and qualifications, or even of formal regulations for taking equal turns. In either case, where access to roles is not dependent on any ascribed characteristics of rank or birth, we would recognise a low-grid condition. The four possibilities of social life represented in Figure 1 result from the simultaneous consideration of control over the individual, group commitment and grid controls (Gross & Rayner, 1985). Each quadrant, therefore, represents a clustering of grid and group factors. The
four quadrants are composites, which allow the characterization of discrete and marked differences.

Grid

<table>
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<tr>
<th>B</th>
<th>C</th>
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<td>Isolate</td>
<td>Hierachist</td>
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<table>
<thead>
<tr>
<th>A</th>
<th>D</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individualist</td>
<td>Enclavist</td>
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</table>

Group

*Figure 1. Grid/group matrix (Fardon, 1999, p. 224).*

- **Quadrant A: Low grid/low group**

Low grid/low group of quadrant A represents a social context dominated by strongly competitive conditions, volatile circumstances and a prescription for individual autonomy. This context allows the individual maximum options for negotiating contracts or choosing allies. Consequently, it also allows for individual mobility up and down the ladder of prestige and influence. No one cares about the past or about one's ancestry. Each person is responsible for oneself and for whomever else he or she chooses, not for the weak or the needy, unless one wishes it so.

- **Quadrant B: Strong grid/weak group**

Quadrant B is a social context dominated by insulation. The way a person may behave is strongly regulated according to social assigned classifications. In its extremity, the sphere of individual autonomy is minimal with little scope for personal transactions.
The organizational correlate will be a hierarchical environment in which persons are classified according to well established and formalizes. Perhaps the classifying criterion is ancestry, and all roles are based on its correlatives. The criterion might also perhaps be age, so that each person passes through a stream of age-related categories.

- **Quadrant C: Strong grid/strong group**

Quadrant C is a social context with two strong controls: of individual behaviour and of the group boundary. Here everyone knows one's place, though that place might vary with time. Personal security is obtained at the expense of overt competition and social mobility. Examples of this type of social organization include bureaucracies that base their roles on seniority (an ascribed basis) rather than merit (an achieved basis), or a cohesive tribal society with hereditary roles. Such a bureaucratic environment might occur in the civil service or a strongly unionized industry where promotion is based on length of service rather than competitively upon competence.

- **Quadrant D: Weak grid/strong group**

Quadrant D is a social context in which the external group boundary is typically the dominant consideration and the social experience of the individual is shaped by the 'we' versus 'them' ethos. All other aspects of interpersonal relationships are ambiguous and open to negotiation, with emphasis on egalitarianism and active participation. Leadership tends to be charismatic and lacking clear rules for succession. The suspicion of infiltration by outsiders or betrayal by group members is rampant here. Organizational forms, such as professional practices and egalitarian communities are driven by such a cosmology.
As seen in Figure 1, the group is a general boundary around a community shown on the horizontal axis, and grid is regulation presented on the vertical axis. The group dimension measures how much of people’s lives are controlled by the group they live in. An individual needs to accept constraints on his/her behaviour by the mere fact of belonging to a group. For a group to continue to exist at all there will be some collective pressure to signal loyalty. Obviously it varies in strength. The other important difference between groups is the amount of control their members accept. This is supplied on the other dimension: grid gives a measure of structure. Some people live in a social environment where they are equally free of group pressure and of structural constraints. This is the zero start where everything has to be negotiated ad hoc. Moving from zero to more comprehensive regulation the groups are likely to be more hierarchical.

At the extreme top right, strong on grid, strong on group, will be a society in which all roles are ascribed, all behaviour governed by positional rules, all the constituent groups contained within a comprehensive larger group. Its cultural bias supports tradition and order. Roles are ascribed according to birth or gender or family, and ranked according to function and tradition. This sector was originally called “hierarchy” in the sense of a rational system.

A “high group” way of life exhibits a high degree of collective control, whereas a “low group” one exhibits much lower control with a resulting emphasis on individual self-sufficiency. A “high grid” way of life is characterized by conspicuous and durable forms of stratification in roles and authority, whereas a “low grid” one reflects a more egalitarian ordering, collectivist (“low grid,” “high group”) focus, which
gravitates toward fear of environmental disaster as a justification for restricting commercial behaviour productive of inequality. By contrast, individualistic ("low group") and hierarchical ("high grid") orientations resist claims of environmental risk in order to shield private orderings from interference, and to defend established commercial and governmental elites from subversive rebuke (Rayner, 1989).

Goopy (2000, p 47) also argued and suggested nursing specific features regarding in using grid-group matrix of Douglas to analyse a hospital or sub hospital unit as a limited social world. From her point of view, the grid axis indicates the extent to which nurses in specific unit are more or less responsive and answerable to a body of formal, abstract rules which direct their daily conduct in the hospital. While group indicates the degree of importance in daily work of solidarity with immediate colleagues. Her suggestions on particular features of nursing culture were used in combination with the primary grid-group matrix of Douglas in analysing the local Thai nursing culture.

To conclude, using Douglas’s cultural theory in analysing and explaining the Thai surgical nursing culture provides clear and concrete understanding of the culture which provides basis to understand their relations and ritualised activities of their everyday life. Although this study does not attempt to measure the Thai surgical nurse organizational culture, approaching this local culture via the lens of Douglas’s theory helps the researcher to compare this particular nursing culture with others systematically.
Social relations: Thai culture, Thai society, and Thai organization

Hofstede (1991) has studied culture all over the world from a sociological perspective. He describes four concepts that he believes characterise social relations within any society: (i) power distance between levels within the society, (ii) collectivist-individualist, (iii) level of uncertainty avoidance, and (iv) feminine - masculine. The evidence of cultural differences between Thai and Western societies has been explored. The difference between collectivist and individualist cultures seems to be the major difference between these two societies. According to Hofstede (1991), Thailand ranks high as a collectivist culture. A study of Leung and Lind (1986) also concludes that Asian and South American countries have collectivist cultures, whereas English-speaking and European countries have individualist cultures.

The largest difference in cultural values between the United States (US) and Thailand is indicated by the individualism/collectivism dimension (Morakul & Wu, 2001). The difference between individualism and collectivism is a primary concern for oneself in contrast to a concern for a group(s) to which one belongs (Berry, Poortinga, Segall, & Dasen, 2002). Achievement, self-sufficiency, competition, and autonomy are meaningful to people of individualist societies. In collectivist societies, people are concerned about what others think of their actions and try to gain respect by acting in a way that meets the expectations of the individuals around them, including the concern for saving face. Newcomers to collectivist societies mostly learn the new culture and the expectant results if they break the rules and norms of the organization from people who are generally ‘senior’ and thus serve as model for newcomers to imitate and form their behaviour (Hofstede & Hofstede, 2005).
Since interpersonal harmony dominates in collectivist society, including the feminine dimension of Thai culture, such societies place a strong emphasis on social relationships and a key outgrowth of this norm lies in the importance of paying attention to spirit in the workplace, harmonious group relationships and non-threatening social relations as a necessary condition for effectiveness in Thai organizations (Hallinger & Kantamara, 2000). Thais view work as a social function and want personal relationships between people. Thais create family-like ties with persons who are socially integrated into one’s in-group such as they mostly sincerely interested in peers’ families and socialize beyond working hours. A mutual dependence relationship both practical and psychological and strong cohesive in-groups is then developed between the in-group and the person. Consequently, Thais think of themselves as part of a “we” group who belong to ‘they’ group which is distinct from other people in society and the secure protection against others is the “we” group.

Thais place great emphasis on living and working in a pleasurable atmosphere and on fostering a strong spirit of community through social relations. Anything that threatens the harmonious balance of the social group (e.g. change) will create resistance. Open criticism is seen as a form of violence for Thais since it destroys peace and harmony in society. As a result in communication and discussion is likely to be ‘round about’ rather than direct and to the point (Burnard & Naiyapatana, 2004). From this, they sometimes behave so indirectly that they are considered devious and deceptive by westerners. Similarly, decision-making may cause disagreement and confrontations as a result of delaying decision-making until a problem resolves itself – Thais would rather lose time than face (Hall, 1996).
The expectant and ideal Thais behaviours, for instance, are influenced by the Buddhist teaching which place a positive religious value on avoidance of emotional extremes, commitment, and confrontation. Ideal behaviour and good character are associated with qualities such as gentleness, politeness, generosity and gratefulness and Thais are expect to avoid expressing anger, hatred, or displeasure overtly; ‘avoidance of social confrontation’ is highly valued in preserving harmonious social relationships. Consequently, dislike, disagreement, and distrust often hide with a friendly smile as well as a less than frank reply to avoid ‘offence’; indefinite postponement rather than abrupt refusal is common. Since about ninety-five percent of Thais are Buddhist, Buddhist values pervade every aspect of Thai life (e.g. speech, behaviour, social activities). Brahmical ceremonies and ritual also play important role in strengthening morale, maintaining psychic balance, resolving tensions and anxieties, and stabilizing social force in Thai organizations.

Thailand is a hierarchical society in which privilege and power are given to males, seniors, and the rich. Thai society is characterised by inequality and social relationships are marked by superiority and inferiority. Power worship has always existed in Thai society and there is a hierarchical tradition when people occupy differently ranked social positions. Importance will be attached to the status of the two people and one person is always likely to defer to the other as, in general in Thailand, ‘equal status’ is rare (Choowattanapakorn, 1999). Power distance is defined by Hofstede and Hofstede (2005, p. 46) as “the extent to which the less powerful members of institutions and organizations within a country expect and accept that power is distributed unequally”. The high power distance characterising Thai culture shapes the behaviour of administrators, teachers, students and parents to show
unusually high deference towards those of senior status in all social relationships. Seniority, which is determined by who is more senior or junior, highly influences relationships in the Thai context (Burnard, 2004). According to Thai culture, Thai people are constantly assessing their position and status in terms of those of other people (Burnard & Naiyapatana, 2004; Vongvapanond, 2003).

Education is a highly valued in Thailand so that official respect and authority increase with the level of education (Ekintumas, 1999). The hierarchical system is based on this existential inequality so that all Thai relational relationships are pervaded by hierarchy (Klausner, 1993). In the large-power-distance situation, parent-child inequality is perpetuated in the teacher-student inequality that ensures that the need for deference is well established in the student’s mind. Respect for parents and other elders are seen as a basic virtue. Thai children are taught to please elders, not to argue with seniors, and not to disagree with those who have more power. In Thai schools, colleges, and universities, teachers are highly respected and often viewed as surrogate parents (Hofstede & Hofstede, 2005). The relationship between teacher and student is a strong manifestation of the senior/junior relationship (Prpic & Kanjanapanyakom, 2004).

In Thai society, the learning environment is highly teacher-centred (Prpic & Kanjanapanyakom, 2004). According to Hofstede and Hofstede (2005), the educational process is highly personalized: what is transferred is not seen as an impersonal “truth” but as the personal wisdom of the teacher. It is not easy to get Thai students to challenge a teacher: what a teacher has to say is important and to challenge him or her, and for the teacher to be wrong would mean a loss of face for both parties.
The teacher would lose face for being wrong and the student would lose face for causing the teacher the embarrassment of being wrong (Burnard & Naiyapatana, 2004).

Learning in Thailand is perceived as acquiring and retaining a body of knowledge. From the western point of view, it appears that much of learning that takes places is rote learning: students simply copy down what the teacher says and later reproduce it in exams and papers. There is, of course, a long tradition of this form of ‘oral learning’. Many of the great religious traditions rely on faithful transmission of ‘the truth’. Sometimes, this faithfulness in teachers mystifies teachers visiting from the West, where there is an opposite tradition: in the West, students are encouraged to challenge what their teachers say and to engage in free and open debate with them. It is conceivable that a problem arises out of this deep respect for teachers by their students. With Thai reticence to challenge or question, forms of teaching and learning often involve rote learning. Students are not particularly required to be critical of what they learn and would certainly not openly challenge what is taught. This attitude of the ‘unquestioned’ knowledge of the teacher permeates the educational system, from early schooling to university education.

Hierarchies as well as occupational differences prevail in Thai workplaces due to the differences of classes, educational level, and occupation. This existential inequality provides a basis for the hierarchical system in organizations, as a result in creating counter-dependent relationships between bosses and subordinates in Thai workplaces. In the large-power-distance situation, superiors and subordinates consider each other as existentially unequal. Generally, superiors’ role is to give commands to their direct
subordinates, while to respect and obey their superiors are the roles of subordinates. In general, Thai business organizations and Thai government bureaucracies are vertical, hierarchical system and underpinned by the patron system designed to fulfil cultural needs for authority and conformity (Leppert, 1996). Although social ranking can be found in many societies around the world, the ‘patron-client’ relationship influences Thais to define their mutual obligations distinctively. Superior and subordinate relationships are maintained on the basis of favour reciprocity and mutual support (Manosilapakorn, 2003). A superior therefore provides protection, influence, and favours while the one who benefits is obligated to do something in return, namely, “bunkhun” or ‘gratefulness’ by a subordinate (Klausner, 1993).

Thais readily accept hierarchies and show instant and deep respect for authority as subordinates are expected to be told what to do and relationships are frequently loaded with emotions (Hofstede & Hofstede, 2005). In Thai organizations, superiors and subordinates consider each other as existentially unequal. Although Thais enjoy relaxed and informal exchanges, they rarely show lack of respect and have a great deference for ranks, which is indicated by proper gesture and subdued behaviour. Respectful behaviour is expected to be shown by a lower-ranking person (e.g. keeping his/her head below that of a superior) (Burnard, 2004). The Thai personality quickly changes when confronted with a social superior, for example by showing an extreme deference bordering on obsequiousness and they are unlikely to approach and contradict their bosses directly (Leppert, 1996). People are also reticent to seek help or ask for something desired from a superior unless it is absolutely necessary (Klausner, 1993).
According to Hofstede and Hofstede (2005), employees in low-power-distance countries (such as Australia, US and Canada) express a preference for a consultative style of decision-making whereas the preference is for decision-making made by a boss autocratically or paternalistically without involving employees in high-power-distance societies such as Thailand. In Thai business, for instance, decision-making rests exclusively with top officials and managers of companies. These relationships result in a pervasive and socially-legitimated expectation that decisions should be made by those in positions of authority (Hallinger & Kantamara, 2000; Hofstede, 1991). Also, the traditional Thai enterprise has an autocratic and a paternalistic management so that the boss does not expect initiatives and challenging ideas from his subordinates and seldom delegates power (Hall, 1996).

The high level of uncertainty avoidance means that Thais are strongly socialised to conform to group norms, traditions, rules and regulations. They evince a stronger tendency to seek stability and to find change disruptive and disturbing than in ‘lower uncertainty avoidance’ cultures (Hallinger & Kantamara, 2000; Hofstede, 1991). As a rule, confrontation and conflict are to be avoided. It is sometimes better for a person to say what the other person wants to hear than to risk being controversial or confrontational. Gossip is likely to be a common feature of Thai communication, as is the use of compliments to ensure that both parties are respected and made to feel comfortable. Thai people talk quietly and use limited eye contact – particularly across sexes, or between two people who are not of equal status. In contrast, while the person’s looking in another direction is a sign of lack of interest in American society, direct eye contact in Asian culture represents a sign of disrespect. Turn talking, between two people is likely to be less marked than may be the case in many western
cultures. Both parties will seek to maintain ‘kreng jai’ or ‘awe heart’, to make sure that each feels comfortable and that neither party is compromised (Burnard & Naiyapatana, 2004).

The behavioural pattern of ‘kreng jai’ is the dominant basic virtue of Thais and dominates their relations with others. It is most often displayed as proper and appropriate behaviour toward one higher in rank, social status, and age scale. *Kreng jai* behaviour can be observed at all level of Thai society. Showing *kreng jai* towards one who is higher in rank and seniority also means showing consideration as well as respect (Klausner, 1993). *Kreng jai* is diffidence, deference and consideration merged with respect for those perceived as being senior to you (Burnard & Naiyapatana, 2004; Niratpattanasai, 2002; Vongvipanond, 2003).

The elements underpinning *kreng jai* are 1) unequal age status (respect for elders), 2) unequal power status (respect for/fear of powerful), 3) unequal rank status (respect for superior), and 4) self-effacement (Prpic & Kanjanapanyakom, 2004). All of this leads to indirectness and reticence, both in language and behaviour (Burnard & Naiyapatana, 2004; Niratpattanasai, 2002; Vongvipanond, 2003). The notion of *kreng jai* influences Thais’ behaviours of always thinking of the other person first, of refusing to worry another person with your own problems, of respecting those perceived as being senior to you. It is more than mere politeness. It is an active reluctance to impose upon or bother another person, to avoid imposing on other people and to avoid confrontations which suggest dissent.
The dominant virtues of Thai culture and basic structures of Thai society provide a context to examine the cultural behaviour of Thai nurses and Thai nursing and the influence of the organizational culture behind the behaviour. While the ‘grid/group’ theoretical framework provides a way of distinguishing a particular culture based on four ways of life, including a preference for social relations characterized by scores on the grid and group, the Hofstede’s societal perspectives further provide a clear understanding of Thai culture underpinning social relations and social organization.

Philosophy and method of the study: Ethnography and participant observation

An ethnographic approach is utilized by using fieldwork, in this case in the general surgical ward of one university hospital in Southern Thailand to examine the organizational culture and its influences on patient care decision-making. Philosophically, ethnography can offer explanations about beliefs and actions in specific situations as developed within particular cultures and informing the way people live in any given society. The culture of society is the way of life of its members: the collection of ideas and habits which they learn, share and transmit from generation to generation (Triandis, 1994).

Ethnographic study seeks to shed light on the issues that underpin cultural practices and beliefs (Hammersley & Atkinson, 1995). The focus on culture is unique to ethnography as it seeks to build a systematic understanding of all human cultures. In accordance to Spradley (1979, p. 5), culture refers to the “acquired knowledge that people use to interpret experience and generate social behaviour”. For this reason, ethnography becomes the most appropriate tool in seeking to understand the
organizational culture of Thai nursing and its influences on the nurses’ decision-making in the clinical area.

Participant observation has been selected as a vital tool for this study because of its appropriateness to studying organizational culture and day-to-day activities of the Thai surgical nurses in real clinical situations. Since this study aims to explore a Thai nursing organizational culture and the way in which the organizational culture influences their everyday experiences, activities, relations, and the way they make clinical decisions, the method of participant observation serves these desires. Participant observation provides an opportunity for me to become immersed in the world of the Thai surgical nurses to more deeply understand their culture, social relations, and how these impact their day-to-day practices.

The strategies of participant observation make me learn the Thai nursing organizational culture by observing them, listening to them, and making inferences. Theoretically, as mentioned earlier, in doing field work, ethnographers make cultural inferences from the language people use, from the way they act, and from the artefacts people use. This means the researcher can observe nursing as it occurs in its naturalistic settings (Field, 1991). For this reason, observation and particularly participant observation are the primary data collection techniques used by ethnographers, while interviews are used to explore and develop a deeper understanding of particular aspects of the culture being researched (Taylor, 2005).
My own experiences as a registered nurse and nurse educator in this clinical setting motivate me to study my own nursing culture. Day-to-day nursing care carried out by nurses in the organization, for example, tended to remain the same traditionally since when I was a nursing student despite new global trends in surgical care. For instance, I found the literature reviews reveal the flourish of implementing ‘fast track’ multimodal model of care in other healthcare regions but no evidence of implementation within the Thai surgical wards.

Importantly, I realize that much knowledge constructed in my surgical nursing textbooks probably was not evidence-based. For example, the literature reviews regarding evidence-based nursing reveal that there was no evidence for early mobilization and bowel function of patient after abdominal surgery, I however, have believed in this relationship throughout my nursing journey. Hence, prior making any changes or development of the day-to-day nursing practices in this nursing context as well as Thai nursing, I need to carefully look at my own nursing culture so that I understand on my own culture, in particularly what we value as the meaningful and important in this nursing culture.

The culture of the Thai surgical ward and the typical day in the life of the Thai surgical nurses are approached by interviewing and observing the key informants and registered nurse participants. The participants’ activities and interactions that occur in the setting were recorded and described without judgement in detail. The interactions and communications between staff-staff (nurse & nurse, nurse & medical doctors or allied health workers), staff-patient/family member were observed. I participated, made observations, and listened to communication/discussion while nurses performed
hand-over activity, pre-working conferences, meal meetings at the tea room, preparing medications at the medication room, including communicating with medical doctors and other allied health. I participated in the special events such as annual merit-making and moving to the new building. The frequency and duration of those activities/interactions, informal and unplanned activities, and nonverbal communications were observed and recorded.

Conversations were observed and recorded in terms of content, who speaks to whom, who listens, silences, included my own behaviour and how my role affects those one is observing, and what one says or thinks. The surgical ward context, the surrounding of the setting, and the activities, in which informants participate as a part of culture, were observed and provided a written description of the context. A physical map of the setting and description of the physical surrounding was drawn, including a portrayal of where participants are positioned over time. Then, gradually more and more focused observations took place. The specific activities and questions were selected or identified for later visits and observations.

Participant observations involved a variety of activities and considerations for me, in particular ethical considerations. Since the results of this study reflect the particular organizational culture, routines and rituals, protection of the participants’ identity is highly important. Data collection was conducted after the proposal was approved by the Griffith University Human Research Ethics Committee (HREC) and the Ethics Committee of Songklanagarind hospital, Faculty of Medicine, Prince of Songkla University (see APPENDIX 1).
The ‘Principle of Professional Responsibilities’ of the Council of the American Anthropological Association of 1971 (cited in Spradley, 1980) and the principles of ethical research were considerably employed in every step of the study, data collection, analysis, and interpretation. These principles consist of considering informants first, safeguarding informants’ rights, interests, and sensitivities, communicating research objectives, protecting the privacy of informants, not exploiting informants, and making reports available to informants (Spradley, 1980). In this study, these principles were enacted with particular attention to informed consent and confidentiality of the participants. Importantly, due to my prior relationship with the participants, I made clear to them that a decision not to consent or participate in the study will not affect their job, position, and relationship with the researcher.

Since the participant observation involved participation in observing the whole setting, and included unplanned informal interviews with the nurse participants, informed consent was sought from the all staff nurses, included informing all the ward staff at the setting. As the results of this study reflect the culture of a particular organization as perceived by insiders, the key informants were informed that only the researcher knew about the selection process and the list of key informants. The key informants were given numbers and pseudonyms which disguised identities by using ‘KI’ or ‘key informant’ follow by number such as, ‘KI 1’. The key informants were also informed about how results will be published and quotations used in publications approved by the key informants. Most of them directly told me while interviewing and observing which portions of the interview/events that they did not want included in the research reports. The head of the ethical committee of the hospital allowed use of the hospital name in publication.
As I mentioned earlier, registered nurses served as participants and key informants in this study and their interactions/communications in caring for patients and making decisions were observed. While field notes have formed the basis for this thesis I have also drawn on combinations of informal and semi-structured interviews. The interviews were both spontaneous – as I sought clarification for what I observed – as well as more formal as result of my studying my data and uncovering questions that required answering. An interview guide related to the research questions was developed and used to explore the Thai surgical ward organizational culture, routines and ritualised activities and decisions. The interview guide was developed and utilized so that the same basic information was obtained from each of the informants (see Spradley, 1979) and piloted with general informants in the setting before use with the key informants. However, it needed to be revised to fit with each key informant’s experiences and backgrounds. The informants were assured that data were collected only on process and descriptive of their activities and not on quality of care given and decisions made. The observations were emphasized and supported by interview, in which participants’ guided my decisions about what to observe.

The information presented in the thesis comes mainly from the sixteen registered nurses since in-depth interviews were conducted with sixteen key informants. Most of the registered nurses working at the research setting are Southerners, practitioners of Theravada Buddhism, and graduated from Faculty of Nursing, Prince of Songkla University. Most of the key informants are Buddhist, except for one is Islamic. All had worked in this area for a minimum of two years and all had completed a minimum of two years post-graduate nursing experiences extend to twenty-four years experiences (see Table 1).
Table 1

**Distribution of the key informants**

<table>
<thead>
<tr>
<th>Key Informants (KI)</th>
<th>Age</th>
<th>Educational Level</th>
<th>Years after graduation</th>
<th>Work experience (years)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>43</td>
<td>Bachelor PSU</td>
<td>4</td>
<td>14</td>
</tr>
<tr>
<td>2</td>
<td>24</td>
<td>Bachelor PSU</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>3</td>
<td>45</td>
<td>Bachelor PSU</td>
<td>17</td>
<td>17</td>
</tr>
<tr>
<td>4</td>
<td>27</td>
<td>Bachelor PSU</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>5</td>
<td>27</td>
<td>Bachelor PSU</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>6</td>
<td>33</td>
<td>Bachelor PSU</td>
<td>10</td>
<td>10</td>
</tr>
<tr>
<td>7</td>
<td>46</td>
<td>Bachelor &amp; Master PSU</td>
<td>24</td>
<td>24</td>
</tr>
<tr>
<td>8</td>
<td>26</td>
<td>Bachelor PSU</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>9</td>
<td>28</td>
<td>Bachelor PSU</td>
<td>7</td>
<td>6</td>
</tr>
<tr>
<td>10</td>
<td>28</td>
<td>Bachelor PSU</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>11</td>
<td>37</td>
<td>Bachelor KU</td>
<td>13</td>
<td>12</td>
</tr>
<tr>
<td>12</td>
<td>43</td>
<td>Bachelor PSU</td>
<td>21</td>
<td>21</td>
</tr>
<tr>
<td>13</td>
<td>41</td>
<td>Bachelor PSU</td>
<td>13</td>
<td>13</td>
</tr>
<tr>
<td>14</td>
<td>48</td>
<td>Bachelor PSU</td>
<td>27</td>
<td>5</td>
</tr>
<tr>
<td>15</td>
<td>35</td>
<td>Bachelor PSU &amp; Master CU</td>
<td>13</td>
<td>13</td>
</tr>
<tr>
<td>16</td>
<td>38</td>
<td>Bachelor PSU</td>
<td>16</td>
<td>15</td>
</tr>
</tbody>
</table>

* PSU, Prince of Songkla University, KU, Khon Kaen University, CU, Chulalongkorn University

As seen in Table 1, the age range of the key informants is varied from 24 to 48 years with the average of 35.56 years. The average of the key informants’ nursing experiences is 10.75 years while the average of years after graduation is 12.31 years. The majority of the association between the numbers of years after graduation and the years of working experiences at the ward reflects the low turnover rate at the TSW.
As mentioned previously, the paradox of my being an ‘insider’ researcher is highly significant as I study my own nursing workplace. Prior to undertaking the field study, I did my clinical practice and nurse internship before turning to work as a registered nurse for two years after graduation, followed by four years experiences as a nurse educator. Therefore I had to be mindful of the knowledge, prejudices, and biases that I carried from my experience. My prior relationships and experiences with the setting gave me a unique and privileged position in gaining access to the research setting and establishing rapport with the participants. However, in the first part of fieldwork, I found it difficult to situate myself as researcher as I knew the ‘automatic’ working of the ward so well and the staff knew me as a nurse educator, someone who worked, assisted and guided not someone who watched and asked questions. In order to see the culture in a new way, noticing things that I had previously not noticed or taken for granted, I had to detach myself from the previous role, re-invent myself as ‘researcher’ and position myself as ‘outsider’. Overtime, however, my role as researcher gradually became easier as both the nurses in the ward and I become more comfortable with this new role.

The practice of participant observation is central to this study and because of my familiarity with the ward at times it was even difficult for me not to simply participate. However, by imposing a degree of distance on me and my ex-colleagues at the outset meant that it was gradually possible for them to come to recognize me in my new role. Remaining objective throughout this study was at times difficult and in fact, the objectivity, the sorting of experiences and the analysis of the data has come only after completion of my field trip. Being able to take on the role of researcher meant that I gradually began to notice and see taken-for-granted nursing practice in a
new light. I soon realized that within the Thai surgical ward what it meant to nurse – to care for a patient – to make decisions about care – was influenced by a vast range of issues. It is these issues that I will uncover in the later chapters of this thesis.

The data from participant observations, informal and formal interviews were merged and analysed to produce a coherent view of the organizational culture of Thai nursing to readers who are not experienced in the culture to understand the world and lives of the Thai surgical nurses. The trustworthiness of the study can be claimed for a number of reasons. Firstly, the inquiry and its results achieve the goals of the study and the findings fit into a Thai context, fulfilling what Schwandt (1994) calls ‘functional fit’. Secondly, in order to provide safeguards against the researcher’s biases and to ensure in-depth understanding, care and concern was taken through prolonged engagement in data collection and analysis to prevent distortions resulting from the researcher’s presence and biases about the manner in which the data were collected, analysed, and interpreted. Clarification of observation was also made to validate interpretation of observations, consistent with use of a plurality of methods as a principle of triangulation. Data derived from participant observation were validated by in-depth interviews with the key informants and related documents, while the contents derived from interviews were also validated by making participants observation and documenting data.

As a Thai surgical nurse myself, undertaking this project gave me the unique opportunity to re-look at practice that I had until this point taken for granted. Doing participant observation at the Thai surgical wards helped me rethink the daily routines, rituals, and cultural working patterns of the Thai surgical nurses. Through
my ten months of fieldwork I gradually began to re-evaluate and see differently and understanding the Thai surgical ward workplace in a new way. Knowledge about a Thai nursing organizational culture and how its influences day-to-day nursing practices constructed from this study can be applied to nursing in Thailand generally and used as an example or particular case for further examination and analysis to better understand Thai nursing culture.

**Structure of the thesis**

This ethnographic field study explores the Thai surgical ward organizational culture and the everyday lives of the Thai surgical nurses with particular focuses on patient care decisions. The thesis is divided into six main chapters. Chapter 1 ‘Introduction’ provides a detailed orientation for the thesis and outlines the theoretical framework. A framework for discussion purposed by Hofstede (1991) and Douglas (1978), including a brief overview of the basic features of Thai society and culture, and the overall relations and structures in Thai organization, are discussed and addressed under ‘Database for the thesis’. The key individuals of the procedures and processes that are central to the study are also introduced in this section under ‘philosophy and method of the study’.

To provide further understanding of the Thai surgical nurses, the detailed milestones in developing the nursing profession and education in Thailand is intensively discussed in Chapter 2. I start this chapter by giving general information on the healthcare system in Thailand, and then detailed historical information about the nursing profession and nursing education in Thailand. In order to provide a basis to
understand the Thai surgical nurses’ clinical decision-making (CDM), meaning and factors relating to both global and Thai nurses’ CDM in Thai nursing culture and issues and trends of professional Thai nursing and Thai nurses’ CDM in the era of information technology and evidence-based practice are discussed at the end of this chapter.

To help the readers see the physical and social features of the setting, I then move to Chapter 3 to orient and highlight the readers in detail to the research setting, in particular to specific physical and social features. The significance of the space as the stage and the backdrop upon and against which all nursing activities and decisions are made is also explored in detail. The detail of how the researcher entered the field is addressed later in this chapter to orient the readers clearly to the scenes witnessed by the researcher.

Chapters 4 through 6 provide the space for me to present my observations and discussion on the findings of this study. Chapter 4 deals with the focus on my observations and discussions with the nurses of the Thai surgical ward. A typical day in the life of the Thai surgical nurse, including the hierarchical relationships as they play out in the daily routines of the TSW, is outlined, with a particular focus on how the structure of hierarchy affects nurses’ decision-making. The discussions in this chapter provides insight to explain the way and degree of integration the TSN use to bind the members under the hierarchical relations within the context of the TSW in the upcoming chapter (Chapter 5).
In Chapter 5, my direct observations of the ways in which the nurses of the TSW establish and maintain the strong boundaries surrounding their group (against/protect outsiders), including the impact of the group strength when they make and employ decisions, are discussed. Also, this chapter explains the cultural way that solidarity influences the process and the complexities that drive the nurses of the TSW to make the decisions they do.

Lastly, conclusions and recommendations are drawn in Chapter 6 which are intricately tied and linked to the all previous chapters. This chapter discusses how social relations of the TSW, particularly Thai surgical nursing hierarchy and solidarity impact on the Thai surgical nursing activities, care given, and decision-making of the nurses. The careful observation of this care and the way the cultural factors influence when the Thai surgical nurses make decisions is then reflected on and detailed in this chapter. Some analysis and discussion of the ritual of pre-and post-op. care and the current surgical care of the Thai surgical ward are offered by giving detailed examples of what I observed in relation to these practices.

The summary is drawn precisely to interconnect all the major findings and themes from the whole ethnographic stories of the Thai surgical nursing organizational culture. The implications of the theoretical and substantial issues of Thai surgical nurse organizational culture are discussed, including those relating to their clinical decision-making and care given. The recommendations and usefulness in using the ‘grid/group’ theoretical framework of Mary Douglas and Hofstede’s perspectives in exploring and analysing the commitment and control in Thai nursing culture,
including the possibility of studying other specific local nursing cultures, are additionally addressed at the end of this chapter.
CHAPTER TWO

NURSING IN THAILAND:
PROFESSIONAL AND EDUCATIONAL DEVELOPMENT

In Thailand the main provider of health services is the Ministry of Public Health (MOPH). Over the past hundred years, the Thai healthcare system has evolved from self-reliance, using local Thai wisdom to the current modern bio-medical health service system. The availability of most traditional and modern medicine for patients has become one of the most dominant characteristics of healthcare services in Thailand. The shift in focus of healthcare services to health promotion and primary care services was launched in 2000 when new health and nursing services that integrate modern and traditional medicine were launched. Improving health promotion and disease prevention intervention strategies for non-communicable diseases, including reducing the number of traffic accidents become the new challenge for health care in Thailand. As a result of the ageing population and increased longevity, there is also an urgent plan for care of the older population (The Nurses’ Association of Thailand, 2004).

In the past, medical care benefits from the Thai government were only received by government officers, state pensioners, and those who work with a semi-government firm or state enterprise (e.g. state railway) including their immediate families. Later, the medical care was delivered to Thais through employee health insurance for low-income families and for vulnerable groups, and private agencies. The average minimum daily income of a Thai worker is presently 150-203 baht per day (one Australian dollar is equivalent to approximately 24.5 Thai baht). As a response to the
problem of more than 20 percent of the population not having health insurance, the ‘30 baht Universal Health Care’ policy was fully introduced by the government in 2001. It covers approximately 45 million people (The Nurses’ association of Thailand, 2004). Currently, most of patients admitted to non-private wards of government hospitals, for instance, the general surgical wards of Songklanagarind hospital are under this insurance scheme.

The Universal Health Care scheme aims to provide the same quality of service as those provided by other forms of insurance. Under this scheme, Thai people buy a ‘gold card’ that entitles the holder to medical care and treatment for a single fee of 30 baht. This health insurance scheme package includes inpatient/outpatient treatment at the registered primary care facilities and referrals to secondary and tertiary care facilities such as, dental care, health promotion/prevention services, and drug prescription (Bureau of Health Policy and Plan Office, 2001). The accessing health service has to follow the referral system from the primary health centre or the nearby hospital, which are registered under the project. For emergencies and accidents, the insured can access any government health services. Under this 30 Baht Universal Coverage Policy, the insured will receive the same quality health services as offered by other health schemes. This insurance scheme covers most care and operations, but excludes more advanced treatment such as kidney dialysis and antiretroviral drugs. At present, the service package includes most health services except cosmetic care, obstetric delivery beyond two pregnancies, drug addiction treatment, organ transplantation, infertility treatment, and other high cost interventions. However, with more resources and disease priorities, the inclusions can expand over time (Ministry of Public Health, 2001).
The system is financed jointly from government revenue, out of pocket payments, and contributions by workers and employers to a social fund. Healthcare providers, usually individual hospitals, receive payment through a capitation system. For each person registered, the provider receives an annual allowance of 1,200 baht a year. In this system, the government organizes health legislation so all people can access the same basic health services, with pooling of risks for providers and vertical equity of health financing. However, the gap between the ideals that underpin the policies and the realities is evident through delays in payments to hospitals, which can leave hospitals under-resourced and, in turn, jeopardize patient care. Many hospitals have been unable to cope if they overspend, and many large hospitals around the country have been forced to cut back on staff and close beds amidst fears of bankruptcy. Moreover, there is no competitive pressure to help maintain adequate quality or contain the budget (Hughes & Leethongdee, 2007).

**Nursing profession in Thailand: From historical perspective to the present and the future**

Nurses and midwives comprise 70 percent of all the health personnel of Thailand’s healthcare system. In Thailand, the nurse to population ratio was 1:1,092 in 1995 and improved to 1:700 in 1998, compared with the World Health Organization’s standard of 1:500 (Srisuphan et al., 1998). In 2002, Thailand had 84,683 nurses, which increased to 97,942 and 105,398 in 2005 and 2007, respectively. Only 88,440 nurses are working as registered nurses in hospitals while the demand of nurses to serve the needs of 40 million outpatients and about 9 million inpatients has seen the shortage of nurses in 2005 at 31,260.
Thai nursing in the 21st century finds itself situated within a healthcare system that has shifted to address healthcare reform through universal health insurance and a focus on primary care in accordance with national policy (The Nurses’ Association of Thailand, 2004). The current nursing service system includes primary, secondary, and tertiary care, including the recent development of primary care units (PCU) to promote service accessibility and serve the basic healthcare needs of people in all regions of Thailand (Hanucharurnkul, 2007). This change has influenced Thai nursing education in revising the nursing curriculum to focus more on primary care. On the other hand, the current health profile of Thai population still indicates the significance of chronic and tertiary care provided by specialist carers and high technology medical equipment, in particularly at University hospital, as well as the primary care through a better living standard and the improvement of medical technology and public sanitation, included a dramatically ageing population (The Nurses’ Association of Thailand, 2004). Additionally, the high workloads of Thai nurses resulting from the shortage of nurses affect the quality of care, and ensure a focus on treatment and cure rather than promotion and prevention (Srisuphan, 2007).

There are two major independent organizations promoting career advancement of professional nursing in Thailand: The Nursing Council of Thailand and the Nurses’ Association of Thailand (NAT). These two professional organizations have a strong commitment to collaborate in professional advancement. The NAT was established in 1929 to promote the continued development of the nursing profession and facilitate career advancement, including morale and the spiritual well being of Thai nurses. The NAT has, under the Royal Patronage of Her Royal Highness the Princess Mother since 1957, facilitated nursing research, education, and practice and worked closely with the Nursing Council of Thailand (The Nurses’ Association of Thailand, 2004).
The Nursing Council of Thailand was established in 1985 under the Royal Decree of Professional Nursing and Midwifery Act B.E. 2528 (1985). The goals, objectives, and policies of the council are established in accordance with government legislation. The council meets regularly to shape regulatory policy and debate issues that influence the quality of nursing care in Thailand. The council has the authority to register, issue, and suspend the license of nursing, midwifery, and nursing-midwifery, to certify the educational and training curricula in nursing and midwifery, and endorse and accredit academic institutions of nursing and midwifery.

Since 1978 nursing in Thailand has been studied as a four-year Bachelor in Nursing and Midwifery to produce professional nurses. Additionally, Ministry of Public Health: MOPH had offered a two-year program to produce technical nurses in response to the shortage of nurses since 1980; however, this program is now closed and technical nurses have been encouraged and supported to continue studying for additional two years to become professional nurses. A diagram depicting the nursing education level from high school graduate to undergraduate study and post-graduate studies in nursing is shown in Figure 2. All professional Thai nurses, on graduation from a four-year Bachelor degree in Nursing and Midwifery (B.N.S.) are qualified to work as professional nurses in all settings. Since 1998, however, prior to starting work, they have to obtain the Professional Nurses License granted by Thailand Nursing Council. Generally, registration and licensing is classified into two categories: 1) a first-class license provides for professional nursing, midwifery or a combination of both for professional level or a four-year program or a degree or a diploma of not less than three years; 2) a second-class midwife or a second-class technical nurse following a two-year program. License renewal is required every five years and must be accompanied by at least 50 hours of continuing education.
Figure 2. Nursing Education Level in Thailand (Chinlumpresert, 2004).
Since 2002, continuing education has been compulsory for Thai nursing. The Centre for Continuing Nursing Education (CCNE) was established in 2004 to manage continuing education and promote life-long learning for nurses in collaboration with nursing institutes (NAT, 2004). The continuing education has mostly been in the form of conferences and workshops. The nurses then join in these activities to get 50 hours of continuing education in order to renew their license.

Nursing services in Thailand both in public and private sectors comprise service, administrative and quality systems. In the health service, most nursing organizations use the quality assurance system of each hospital to continue the quality improvement for their systems. In hospitals, nursing administrative systems have a unique organizational structure and management system. In general, the nursing director is the top administrator of a nursing department and the responsibilities of nursing organizations are usually managed by committees and sub-committees. Hospital accreditation (HA), which was introduced in 1999, has been implemented in many Thai hospitals, including activities such as annual hospital accreditation national forum, post and re-accreditation. Songklanagarind hospital, for example, has been approved for hospital accreditation, Thailand Quality Award (TQA), and Thailand Quality Class – TQC, complied with using best practice in controlling the hospital quality.

In accordance with The Professional Nursing and Midwifery Act B.E. 2528 (1985), “professional practice of nursing” means “nursing practice to individual, family, and the community in the following actions:
- provide education, advice, counselling, as well as solving health problems
- assist individual’s physically and mentally, including their environment, in order to solve problems of illness, alleviate symptoms, prevent dissemination of diseases and provide rehabilitation
- provide treatment, as mentioned in primary medical care and immunisation
- assist physicians in performing treatments

According to the Thai Nursing Council, these actions shall be based on scientific principles and the art of nursing in performing health assessment, nursing diagnosis, planning, nursing intervention and evaluation consistent with codes of practice to patients or clients, and courtesy for colleagues and other staff members (NAT, 2004). According to The Nurses’ Association of Thailand (2004), caring is essential for Thai nursing and all other regions. Thai nurses provide holistic nursing care, integrating bio-psycho-social and spiritual aspects to individuals and families in healthcare settings. Thai nurses have a goal of nursing care to achieve healthcare needs, promoting good health and quality of life. They also incorporate nursing philosophy, theoretical foundation, and research into nursing practice to provide care that meets healthcare need. Generally, practice models used in Thailand are developed based on three dimensions:

- analysing concepts, principles, and theories of nursing knowledge with an application to clinical problems and health promotion
- investigating clinical problems from theory testing that contributes to an expansion of knowledge based on nursing science and practice
- using case management to solve clinical and organizational problems in healthcare delivery systems and services
The milestones in developing professional Thai nursing relate to the hierarchy, power distance, and the occupational differences in Thai society. The nursing profession in Thailand has existed for about 100 years having been initiated and supported by the Monarchy, in particularly the present King’s mother who graduated from a nursing program and devoted much of her life to improving the health status and quality of life of Thai people. Before the shift of nursing education into the university system in 1956, professional Thai nursing had developed and been undertaken in hospitals under the supervision of male physicians. As a result of the medical control over the nursing profession, the public view of nursing has tended to highlight and value technical skills much more than independent decision-making. While the development of academic nursing within the university system and as an independent faculty assumed a high priority within the nursing profession and was deemed essential to the growth of nursing as profession, nursing continues to battle old, ingrained understandings and imaginings of nursing in the wider community. So while Thai nursing has finally become a professional discipline independent of medicine at the University, it still faces many challenges (as this study findings and discussions will demonstrate in later chapters) within its own cultural heritage and, more generally the cultural heritage of the Thai people.

The hierarchical structure of the healthcare profession, power sanctions and imbalances between the cultures of professional nursing and medicine are still evident in Thailand. Hierarchical levels are found among healthcare providers within and outside the Thai nursing profession (Sripichyakan, Thungpunkum, & Supavititpatana, 2003). In Thai culture medical doctors are traditionally held in very high regard: people are usually unwilling to criticize them (Tangcharoensathien et al., 1999; Tyson
& Pongruengphant, 2004) and they are likely to be deferred to (Pichitpornchai, Street, & Boontong, 1999). The study by Burnard and Naiyapatana (2004) reported a perception of nurses that they were inferior in the hierarchy of Thai society. This issue was further complicated by the nurse’s own position in the healthcare hierarchy. The predominantly masculine nature of healthcare organizations and health policy is responsible for the systematic devaluing and under-development of nursing (Buckingham & Adams, 2000). In the past, most Thai nursing educational programmes had predominantly feminine characteristics. This history means that Thai nurses have largely been subordinate executors of medical doctors’ orders. As such professional Thai nursing had continued to be the female branch of healthcare delivery and nursing education has followed medical disease-oriented model.

In Thailand, a hundred percent of midwives and 92.5 percent of nurses are female (Muecke & Srisuphan, 1989). According to Lerdmaleewong and Francis (1998), as the great majority of nurses are female, traditional values and customs which ascribe a subordinate position to Thai women, as followers and homemakers, may lead to gender discrimination in areas of health. According to Muecke and Srisuphan (1989), nursing in Thailand was originally understood as an exclusively female field, and the social status of nursing was historically associated with this linkage: in the post-war period, nursing has been understood as the female branch of medical practice, sequestered in urban hospitals under the supervision of male physicians. In Thailand, nursing is a career for Thai women within a country where femininity is highly prized and girls are often told by their parents to be discreet, obedient and grateful. At the beginning of his/her career, a Thai nurse is taught to respect the wisdom of seniors and to avoid conflict in relationships. She/he has a positive attitude towards authority
and expects instruction and guidance from seniors, but is sensitive to coercion. It is easy to make Thai nurses feel insecure, and they tend to use avoidance when facing problems. They show deference, reservation and shyness when facing authority (Ekintumas, 1999).

With higher educational standards, Thai nurses are required to be more independent, autonomous, confident, and creative than in the past. They are also expected to behave in Thai ways, which sometimes can contrast with the more recently recognised desirable attributes in the nursing literature. Thai nurses are expected to strike a balance between innovation and the expectations associated with the modern profession and tradition (Ekintumas, 1999). While it is expected that Thai nurses will respond to global trends in education and in meeting health service needs, they are also compelled by broader Thai social and cultural norms to exhibit their traditional Thai feminine manner (Saksomboon, McMillan, & Cholowski, 2002).

In recent times, career advancement of professional nursing in Thailand has been significantly improved. Advanced practice nurses (APN), both nurse practitioners and clinical nurse specialists, demonstrate competency in a clinical specialty for promoting quality health care and also serve as clinicians, consultants, and educators. Nowadays, registered nurses who obtain further education required for upgrading as nurse practitioner (NP) certified by Thailand Nursing Council play the major roles in providing holistic nursing care. Registered nurses with master degrees who practise in advanced nursing practice area are recognised as clinical nurse specialists (CNS). Additionally, the advanced practice nurses are expected to be more available in the healthcare system and provide cost quality care effectively. It is expected that this role
will be expanded to cover nationwide health promotion, disease prevention and symptom management of Thai population (NAT, 2004).

**Nurse education in Thailand: A century of development**

In Thailand, nursing education has been provided by 1) the Office of Commission of Higher Education or OCHE (restructured from Ministry of University Affairs: MAU); 2) Ministry of Public Health (MOPH); 3) Ministry of Defence; 4) Bangkok Metropolitan; 5) Private universities and colleges; and 6) The Red Cross Society (NAT, 2004). The nursing educational system in Thailand was first developed under the Faculty of Medicine and later provided by other Thai nursing colleges and universities. The basic course developed from a three-year programme at diploma level to a four-year programme at university level.

In the past, the factors most influencing Thai women entering to nursing profession were “its cultural definition as a female career”, and their cultural values of “family obligations, and ideals of social service” (Muecke & Srisuphan, 1989). With a changing focus on better employment, and opportunities in business, engineering, medicine, dentistry, and pharmacy, Thai high school students now find themselves with more choice and while there has been a change in the understood cultural value of professional nursing – as not only for a female career – it has had to compete with new opportunities for women in the workplace. The impact that this has had is most clearly seen in the reasoning underpinning the new generation of Thais entering professional nursing: parental or peer pressure rather than a sound understanding or realization of the actual roles and responsibilities of nurses (Juethong, 1998; Muecke & Srisuphan, 1989). The fallout from this has been as Juethong (1998) points out, that
the numbers of Thais enrolling in Faculty of Nursing has been decreasing and along with this it is argued so is the professional standard of nursing.

The first Thai school of nursing was established in 1896 and extended to three schools in 1923 where the teaching process was based on hospital training. The turning point in Thai nursing education occurred between 1925 and 1935, with the Monarchy’s recognition of the potential contributions that nurses could make to health care. This recognition played a major role in helping transform the social standing of Thai women. In 1926, a program of nursing education was fully developed when H.R.H. Prince Mahidol of Songkla (the current King’s father) provided strong support for nursing education. The nursing programs at that time were, however, planned and developed through the assistance of American nurse educators. Nurses and nursing education considerably influenced by foreigners through the Rockefeller Foundation during these years. This foreign organization provided support to Thai nursing students to study abroad. During these times, the visit to Thailand by two American nurse scholars had a major influence on the strengthening of professional nursing. The shift of nursing education from apprenticeship to profession was then established by encouraging the upgrading of the educational level for nurses to a three-year qualification (with an additional six months of midwifery training) and creating licensure with the receipt of a nursing diploma (NAT, 2004).

This first nursing curriculum was western-medical-oriented and it was not until the 1990s that a major change to the curriculum from disease-oriented to community-oriented was introduced. This change was consistent with using a nursing model rather than a medical model and sought to reflect more honestly the realities of the
Thai population and their healthcare needs. The Master degree program in nursing was first developed in 1973, followed by many graduate programs and the first doctoral program in nursing was implemented in 1990 (NAT, 2004).

In Thailand, nursing and midwifery are in the same pre-registration curriculum and graduates are issued with both nursing and midwifery licenses. To enter pre-registration programs requires an education standard of 12 years of schooling or high school graduate. Pre-registration programs, ranging from one to four years, have to be accredited by the Nursing Council. Each nursing institution conducts an internal audit which requires external expertise or school networks every year. The Nursing Council conducts an audit for the readiness of the institutions before students can be admitted for new institutions. Since 2005, the Office for National Education Standards and Quality Assurance (Public Organization) has conducted an assessment of the quality and standards of all education institutions; the first time the country has accredited education institutions (NAT, 2004).

An institute offering a four-year bachelor’s degree in nursing and midwifery or the equivalent must include in its curriculum courses that total 130-150 credits. In comparison, the nursing curriculum is similar to those in America (Anders & Kunaviktikul, 1999), comprising of four course categories: general education (e.g. physiology, microbiology, sociology, English) and free/elective courses, foundation of the nursing profession, professional nursing courses including midwifery, and primary care.
Nursing students in Thailand enter nursing educational programmes with no formal nursing experience. Their views of nursing care, which are important for their professional careers as nurses, develop during their studies. As nurses they may have views of nursing care which partially originate from their education (Lundberg & Boonprasabhai, 2001). To date, nursing education in Thailand aims at producing graduates who can explore options in nursing science, who are articulate, and have the capacity to develop strategies based on reflective decision-making. Problem-based learning, for instance, is employed in combination with traditional pedagogical methods in order to achieve those capabilities (Lundberg & Boonprasabhai, 2001). However, according to Mailloux, (2006) despite the adoption of evidence-based principles as the basis for Thai nurse formation the current learning environment, in particular as it is presented in the clinical areas, remains steeped in traditional ideals. These are neither empowering nor do they prepare students to become autonomous learners (Mailloux, 2006). In my research I not only further demonstrate the reality of this traditional learning environment but also uncover the atmosphere and workplace relationships that are played out in the ward which act to render reform in Thai nursing, beyond a theoretical presence, at best difficult.

Clinical education in Thailand focused on ‘doing rather than learning’. Clinical teachers focus too much on content and students are left to apply theory in practice by themselves. Some Thai behaviour such as ‘non-confrontation’ or ‘uncertainty avoidance’ seems to inhibit student nurses from being critical and effective in clinical conferences (Chuaprapaisilp, 1989; Saksomboon, McMillan & Cholowski, 2002). According to Burnard (2006), when in clinical practice, students nurses are very unlikely to challenge a teacher and even less likely to challenge a medical doctor.
Saksomboon, McMillan and Cholowski (2002) conducted a study to evaluate the baccalaureate-nursing program within the Ministry of Public Health (MOPH), in Thailand. The study revealed that abilities related to life-long learning and critical thinking were needed and that concepts in the curriculum plan were not fully translated into practice. The rules and atmosphere of colleges hindered nursing students from being active and independent. Relationships between students and teachers were also noted as important factors that encourage or obstruct the development or self-confidence or autonomy. Thai nursing students are unlikely, by choice, to read very much and will depend on teachers to point them to particular passages. Students are likely to reproduce what their teachers expect of them, in examinations and projects.

Currently, according to Hagbaghery, Salsali, and Ahmadi (2004), most nursing curricula in Thailand seem to contain a vast range of theoretical content, mostly based on the medical model, and faculty members feel pressured to find a way to present the massive amount of content necessary to facilitate passing of the final and licensing examination. They spend more time on theoretical education, leaving less time for practical and student-centred learning and developing students’ clinical decision-making skills. Their educational methods are teacher-centred. They use lectures as the most important method of education. As a result, the manner in which nurses are trained is rigid, controlling and encourages conformity, passivity, dependency and subordination. According to Hagbaghery, Salsali, and Ahmadi (2004), if self-confidence is a basic requisite for making effective clinical decisions, it seems that nursing education along with organizational structures have decreased nurses’ self-confidence in applying their professional knowledge and skills. Nursing curricula
concentrate on content rather than fostering decision-making and critical thinking skills (Slater, 1999). As a result, the content of the curriculum is a barrier to nurses’ CDM (Hagbaghery, Salsali, & Ahmadi, 2004).

The classic arguments from the study in Thai nursing students by Chuaprapaisilp in the last twenty years are still current issues of Thai nursing education as evidenced in the results of this study. According to Chuaprapaisilp (1989), clinical nursing practice in Thailand is still not generated by ‘experiential learning’ but rather by ‘doing in order to learn’. Clinical learning in Thai nursing students is still perceived as the process by which students render care to patients. The nature of clinical teaching is that clinical teachers assign students to provide total nursing care to patients while clinical teachers are still portrayed as being supervisors or helpers in the hospitals. The pre-and post clinical conference was focused more on subject matter than benefit from experience. Her study also found that nurse educators tended to be authoritarian of nurse educators and nursing students to act as passive learners in the clinical conference.

Currently, the aim of nursing educational programmes in Thailand is to produce graduated nurses who can explore options in nursing science, who are articulate, independent, creative, decisive, and have the capacity to develop strategies based on reflective decision-making as assertive thinkers (Lundberg & Boonprasabhai, 2001). The Thai schools of nursing also aim to educate nursing personnel to meet the needs of both basic and advance of the nation workforce, including promoting excellence in research. However, the majority of strategies used in clinical nursing teaching still remain the same, for example, short lectures while performing conferences as well as
nursing students’ passive memorization of textbook knowledge and ‘un.questioned’ knowledge of the teacher. Additionally, the hospital-based nursing curriculum still remains and influences clinical nursing practice even though most nursing curricula are changing towards community-based nursing consistent with a national policy of primary health care. The medical model of focusing on cure and medical tasks still has a strong influence in the Thai nursing profession (Juethong, 1998).

The majority of Thai nursing education at the graduate level is rapidly following the pattern developed in the U.S.A. and is keeping abreast with the increasing academization of all major fields of study in Thailand (Muecke & Srisuphan, 1989). At the same time, however, Thai nursing education faces the dilemma of whether it is appropriate simply to use western nursing philosophy. This study also highlights the tension between this Thai nursing education and the realities in the ward at the day-to-day practice level.

The development of professional nursing in Thailand demands that Thai nurses should be aware of their cultural biases as they adopt the Western way of critical thinking and adapt the nursing process to their own country’s thinking and needs (Ekintumas, 1999). The inability of professional schools to provide an education which is congruent with the needs of the professionals in the practice situations is a continuing problem in professional practice education (Jenks, 1993). In the field of surgical nursing, nursing education has the responsibility for preparing future practitioners to meet the needs of surgical patients in efficient and cost-effective ways without neglecting the need for increased patient advocacy in today’s healthcare environment (Holmes, 2004). Also, changing demographics, technology, health care,
and the implementation of evidence-based practice in clinical practice have increased the complexity, importance, and the need to understand nurses’ clinical decision-making (Cader, Campbell, & Watson, 2005). Therefore in the following section I move to explain the features of decisions that the Thai nurses make in clinical practice in a hospital context.

Clinical decision-making in Thai nursing culture

Clinical decision-making (CDM) is the process nurses use to gather information about patients, evaluate it and make judgements in deciding which evidence to use and with which patients that result in the provision of nursing care (Muir, 2004). CDM is an inherently social activity, involves teams of people, often from a variety of professional disciplines. The social context in which the clinician functions has an important impact upon CDM. The culture of an organization is one of the environmental forces that influence individuals and the way people make decisions and the boundaries that individuals create for themselves in order to frame and make decisions (Thomas, Wearing, & Bennett, 1991).

Organizational culture influences the way in which individuals do in fact perceive their role within the decision-making process (Lee, Newman, & Price, 1999). Existing hierarchical structures both within the healthcare system and within and between the different professional groups are manifest in the existence of a largely deferential culture which emphasizes the routine in practising CDM (Newman, Papadopoulos, & Sigsworth, 1998). In the Thai nursing profession, as discussed earlier, attitudes to nursing are a major obstacle preventing Thai nurses from acquiring professional status. The discrepancy between the actual decision-making and desired level of
decision-making warrants consideration by medical and nurse managers as ward structures may be too hierarchical to accommodate nurses’ desires to make decisions concerning patient care. In hierarchical organizations, decision-making discretion is with more senior staff, not with nurses at the bedside. In Thai nursing organization, the system of seniority, where younger people show respect to older people by not engaging in confrontation, impedes Thai nurses from being independent, active, and creative. This system becomes a barrier for making independent clinical decisions.

Nurses’ failure to use their authority for making decisions may also be related to their education and socialization in a profession dominated by women (Anthony, 1999; Manthey, 1990). In Thai healthcare professions, the nurse-physician relationship stems from an inequity in power relations as nurses have traditionally assumed a subordinate position to physicians. Medical doctors exert direct power in the healthcare system, determining which patients will be admitted as well as the type of treatment to be performed. Their professional and financial status also allows them a degree of political power, their statements influencing the actions of politicians when determining healthcare policies (Gundersen, 2002). Nursing knowledge and CDM are predominantly viewed as tacit, feminine and emotional, whereas medical knowledge and decision-making are viewed as empirical and rational, and therefore accorded greater societal value.

The participation of nurses in CDM was affected by the level of authority, organizational climate, and the nursing system used in the wards (Hancock & Easen, 2003). The culture of nursing has been highly task-oriented and physician-controlled. The expectations that nurses only execute medical doctors’ orders may result in a
diminished relationship with patients and may make nurses choose a functional and
task-oriented nursing system (Hagbaghery, Salsali, & Ahmadi, 2004). Increased time
constraints have resulted from an increased workload effect as nurses had to decide
their priorities to accommodate for limited time in both making and implementing
decisions (Bucknall, 2000). It seems that lack of time for completion of routine tasks
has resulted in little time for nurses to participate in CDM and independent nursing
interventions (Hagbaghery, Salsali, & Ahmadi, 2004).

The relationship the nurse has with other colleagues and patients has been reported as
one of the important factors influencing the CDM ability of the nurse (Jenks, 1993;
Luker, Hogg, Austin, Ferguson, & Smith, 1998). As a result of the power distance and
hierarchy in Thai society, there is often a tension between the perceived ‘universal’
nursing concept of ‘treating everyone the same’ and the problem of that person’s
status. While nurses feel that patients should all be treated the same, very high status
and very low status patients are likely to be talked to differently. Patients are to be
respected, although their perceived status is likely to vary, according to their status
outside of the hospital or health care facility (Bucknall & Thomas, 1997; McCoppin
& Gardner, 1994).

The capacity for decision-making is an indicator of professional autonomy and
accountability is a consequence of autonomy (Smith, 2003). Decision-making
freedom is a theme of most definitions of professional nurse autonomy (Thompson,
1998). According to Hinshaw, Smeltzer and Atwood (1987), autonomy was defined
as the position that allows individual decision-making. Professional autonomy may be
defined as a group’s ability to formulate professional policy and control professional
activity. Another persistent problem underpinning the professional status of nurses is that their CDM has been viewed traditionally as intuitive rather than rational. Nurses have struggled continually to articulate the nature of their expertise and scope of practice: essential components of any claim to professional status. Part of the problem is that much nursing work is believed to be hidden from objective, lay scrutiny because of the subtle, interpersonal nature of many interventions. Blindness to these aspects has led to nursing work being viewed as a series of tasks which can easily be delegated to less qualified personnel (Buckingham & Adams, 2000).

Ineffective use of authority due to a lack of equal autonomy between the nursing and medical professions (Scott, 2001) may be responsible for nurses’ lack of participation in CDM (Anthony, 1999). The role of nurses as multidimensional within healthcare professions has a profound effect on CDM (Bakalis & Watson, 2005; Bucknall & Thomas, 1995). Power sanctions and imbalances between the cultures of nursing and medicine are continuing, although nursing is habitually aligned with medicine. Professional nursing and medicine are classified in professional workers according to category of occupations (Tyson & Pongruengphant, 2004); nursing, however, still struggles to shed the image of dependency on the medical profession. Many nurses perceive that their autonomy is still restricted. This may be related to the overlap of work done by the nursing and medical professions. Even today, to some extent, nursing still suffers the effects of patriarchal dominance by the medical professional (Finn, 2001). Many nurses are uncomfortable with the apparently large power disparity between medical doctors and nurses and wish to increase their autonomy and gain professional status (Bakalis & Watson, 2005). Attempts to increase nurses’
authority for making clinical decision and thus increase their control of practice are futile if nurses do not exercise their authority to make decisions (Anthony, 1999).

**Locating the ideal and the reality of clinical decision-making (CDM) in Thailand**

Historically, the nursing profession in Thailand has evolved from a hospital-based, apprentice training model taught by male physicians, to the development of doctoral programs taught by nurses who are prepared at the doctoral level. Within its own cultural heritage and, more generally the cultural heritage of the Thai people, the public view of nursing has tended to highlight and value technical skills much more than independent decision-making. This tends to impede using a more scientifically or even evidence-based knowledge to underpin nurses’ clinical decision-making. In order to enhance the status of professional Thai nursing as well as increase independent decision-making, the major independent organization promoting career advancement of professional nursing in Thailand, The Nursing Council of Thailand and the Nurses’ Association of Thailand (NAT), was launched to develop Thai nursing practices based on scientific principles as well as the art of nursing (The Professional Nursing and Midwifery Act B.E. 2528/1985).

During the past ten years, there have been a number of studies in Thai nursing, including Thai health care service, which tried to change an opinion-based nursing practice and health service to an evidence-based nursing practice and health service. For instance, the intervention study to find evidence to support the switching from heparinized saline flush to normal saline flush for maintaining peripheral venous catheter potency (Thamlikitkul & Indranoi, 2006). Along with this, the normal saline flush has been used in hospitals around Thailand including in the setting (Songklanagarind) hospital. Additionally, many nursing practices have been improved
and changed based on the findings from research, for example, clinical nursing practices guideline for successful weaning from mechanical ventilation (Wongrostrai, Panpakdee, & Monkong, 2008) and systematic relaxation to relieve post-operative pain (Roykulcharoen & Good, 2004).

Accordingly, the study proposed by WHO (2003) on nursing and midwifery workforce management, “Analysis of country assessments”, revealed that evidence-based decision-making in Thailand and in other countries (Bangladesh, Bhutan, Korea, India, Indonesia, Maldives, Myanmar, Nepal, and Sri Lanka) is weak. Limited information systems, local research, access to evidence bases being developed in other countries were found as barriers to evidence-based decision-making. A desire to improve the use of evidence-based decision-making in clinical practice, management, and education, however, was reported. The current constraints include costs and access to information, the latter evidenced, for example, by continuing to shave, give an enema, and conduct episiotomies on primiparas. The further suggestion was made to stop these activities, including making better use of available data for decision-making and fostering research to provide evidence for policy and operational decisions (e.g. mentoring for action-oriented research) in order to reflect evidence-based practice, reduce costs and increase quality. However, the important role that cultural and social practice place in day-to-day nursing practice, as revealed in Goopy’s 2001 work on Italian nurses, was largely overlooked in this analysis. In keeping with Mailloux (2006), observation that EBP was limited by a traditional learning environment the findings of this thesis add another dimension to our understanding of the barriers that exist for Thai nurses in practicing from within EBP framework.
In 2004, the Thailand Centre for Evidence Based Nursing and Midwifery: A Collaborating Centre of the Joanna Briggs Institute (JBI) Faculty of Nursing, Chiang Mai University was established with aims to promote and support evidence-based nursing practice. Since then, a number of systematic reviews have been published and evidence-based practice workshops and meetings organised, for instance, a completed systematic review of positioning of preterm infants for optimal physiological development (Picheansathian, Woragidpoolpol & Baosoung, 2009), as a result in affecting the focus of nursing research and practice in the other regions of Thailand. However, the absolute capacity of such a centre to alter actual practice in Thailand still appears, from my own personal experience as an educator in a major Thai hospital, to be limited by the very issues that Mailloux, (2006) identified loosely as traditional barriers to change.

Theoretically, according to Sackett, Rosenberg, Gray, Haynes, and Richardson (1996), conscientious, explicit and judicious use of current best evidence in making decisions about the care of the individual expertise with the best available clinical evidence from systematic research contributes to improving patient outcomes. Evidence-based practice enables nursing to provide and justify high-quality, cost-effective care (Simpson, 1996). According to Aunguroch (2008), use of evidence-based practice advances quality of care provided by nurses, increases satisfaction of patients, and in particular refocuses nursing practice away from habits and tradition to evidence and research. From this a culture of evidence-based nursing practice is needed. Evidence-based practice culture implementation model (adapted from RNAO toolkit of clinical practice guideline implementation model) as well as organizational change facilitated by a developmental model (proposed by Richard & Smith, 1990; revised 1994), for examples, were suggested by Aunguroch (2008), in order to create
a culture for evidence-based nursing practice. The fact that this idea has not been put into action, as evidenced by there being no report or study of the trial of these two models in Thai nursing practice, has been a motivation for conducting this research.

Successfully creating a culture of evidence-based nursing practice as well as culture of lifelong learning however, is needed to be created from nursing curriculum through practice nurses and nurse administrators, in particularly within high group strength under hierarchy and social relations of the Thai surgical nurses. According to Aungsturoch (2008), collaboration is needed between administrators in nursing education and practice to assure life-long learning regarding the knowledge, skills, and attitudes essential to maintain high quality nursing care. Since this study aims to describe local Thai and Thai nursing culture which is to consider the influence of local culture in understanding the day-to-day practices of nursing and in turn the reality of workplace management and organization as distinct from, in the case of the TSW, the official drive towards adopting universally prescribed nursing practices, knowledge derived from this study will provide better understanding on factors underpinning Thai nursing practice and see the room and possibility if change is needed to be made sensibly.

Professional nurse has accountability to critique existing practice patterns, discriminative between alternative and often conflicting information, and demonstrate sound decision-making in a manner that can be empirically supported (Aungsturoch, 2008). Educators recognize the need to develop effective strategies for teaching evidence-based practice (EBP) skills, with the ultimate goal of fostering this approach in clinical care. Several curricular strategies for developing clinical decision-making and incorporating EBP in professional education and practice have been done in order
to strengthen the capabilities of nurse educators, students, and practice nurses in the
development of evidence-based practice. Problem-based learning and self-directed
learning, for examples, have been widely used in nursing curriculum both in faculties
of nursing and nursing colleges in Thailand. Evidence-based practice has also been
added as one of the principal topics for Master degree students, and as such is a topic
that is now appearing in Master’s theses, but there is less evidence of EBP in nursing
degree curricula. On the other hand, in medical curricula, there has been an increase
in the number teaching EBP at the degree level with medical students exposed to
integrated evidence-based medicine in bedside teaching (Piriyasupong, 2008). The
Faculty of Medicine, Prince of Songkla University, for example, also draws on a
problem-based learning curriculum for medical students.

Although nursing literature has addressed the importance of theory and research in the
baccalaureate curriculum since the early 1970s (Rambur, 1999), the evidence in
addressing and integrating evidence-based practice has been piecemeal at best over
the last decade. There is however a current national movement of Thai nursing
profession to move towards evidence-based nursing practices, yet how this will play
out in reality is dependent, I argue, not only on the desire of the nurses themselves but
an understanding of the complex relationships that already exist and not only inform
but drive the current practice on nurses at a day-to-day level. Since the critical
relationship between evidence-based nursing practice and scientific and economic
integrity (Swanson, Albright, Steirn, Schaffner, & Costa, 1992), the economic strain
in Thailand, from the past decade to present, are another important factor requiring
Thai nurses to become evidence-based decision-makers. The current acceleration in
using evidence-based medicine as such witnessed in clinical practice, for example, the
use of fast-track multimodal model of care for patient undergoing abdominal surgery
and cardiac surgery in Songklanagarind hospital, also push Thai nurses to change some of their nursing practices for patients in these groups. However, as this thesis will show, it is difficult, given the social relationships and staff culture that exist so strongly in a ward such as the TSW, for EBP and CDM to be played out as they ought. Developing Thai nursing students understanding of the importance of evidence-based decisions in nursing care, over traditional practices, through Thai nursing curriculum is therefore needed – though again, as Mailloux, (2006) suggests difficult because of the traditional learning environment that exists. A group known as the Journal club, for example, has been held by The Faculty of Nursing, Prince of Songkla University in order to enhance the 3rd year nursing students to search and read research in English version and then exchange among their group under the supervision of the nurse educators. Also, one of the major objectives of baccalaureate degree nursing curriculum (revised 2008) is to increase awareness of the students in the significance of research in developing nursing care and health. The required subjects to serve this objective consist of statistics, basic research in nursing, issues and trends in nursing. While these are without a doubt important first steps towards altering nursing practice again, as Goopy’s (2001) study revealed, long held cultural practices and social expectations need to be understood and factored into the call for change as these are extremely influential elements. Indeed, they are implicitly powerful in determining the success or failure of any move to alter the status quo (Goopy 2001).

Presently, one of the compulsory roles of nurse educators is also to research and publish findings or develop at least one research project a year. Along with this, nurse educators are encouraged to draw on published research and theory for student lectures rather than using textbooks, in addition it is a requirement that Master’s
degree students use research to support their nursing care plan and actions. Here, it is challenging for Thai nurse educators, and scholars, to develop strategies that are both culturally sensitive to Thai tradition and encourage the understanding and practice of EBP in undergraduate Thai nursing students not only in the lecture theatre but also in the clinical area. Unfortunately often the rhetoric of EBP and in turn CDM is realized without the practice.

As discussed above, Clinical Decision Making (CDM) is seen by Thai Nursing and Thai Nurses as an important part of professional nursing and the term itself has been subsumed into Thai nursing culture. However, as is evidenced in my study, decisions made by Thai nurses are not necessarily made strictly within the accepted guidelines of evidence-based practice (which guides the accepted understanding of CDM), rather the Thai nurses have absorbed the language of CDM into their daily practice. As such CDM and EBP appears throughout this thesis primarily in this broad, cultural, usage.

**Issues and trends of professional Thai nursing and Thai nurses’ CDM in the era of information technology and evidence-based practice**

Professional nursing in Thailand operates, as in other countries, within a healthcare service characterised by advanced use of information technology and in the context of quality assurance, total quality management, accreditation and hospital re-accreditation. In the Thai community, however, healthcare clinicians and providers make patient care decisions based on traditions, clinician expertise, personal experiences, or on expert opinion rather than research findings (Pichitpornchai, Street, & Boontong, 1999). According to Gerrish and Clayton (2004), nurses depend mostly on experiential knowledge derived through their interactions with peers, medical staff and patients to inform their interventions and work-based information to inform their
practice. Also, most nursing research has been conducted by academic nurses as an academic discipline. Independent nursing care seems to be limited in its use of these research findings (Nagy, Lumby, McKinley, & Macfarlane, 2001).

The evidence-based practice, which refers to the incorporation of evidence from research, clinical expertise, client preferences and other available resources to make decisions about clients (Canadian Nurses Association, 2002; Mulhall, 1998), has as is argued in much literature coming from countries such as Australia, the USA, the UK and Canada, influenced nurses’ CDM and practices. Indeed, evidence-based decision-making has become an important element of quality care in all domains of nursing practice, aiming to optimize outcomes for patients, improve clinical practice, achieve cost-effective nursing care, and ensure accountability and transparency in CDM (Canadian Nurses Association, 2002).

Currently, the globally flourishing evidence-based practice movement has resulted in pressure for research to be incorporated into nursing practice, and there are growing demands for nursing to demonstrate the scientific basis for practice (Carroll & colleagues, 1997). Evidence-based nursing is designed to be a systematic means of combating the biases that arise from uninformed decision-making (Thompson, 2003). According to Anthony (1999), development of evidence-based practice is one of the strategies to help nurses cope with decisions about patient care under conditions of uncertainty. Appropriately applied guidelines can reduce uncertainties associated with CDM, diminish variation around usual practices, demystify unfamiliar terminology, and decrease the need to search for journals and articles (Canadian Nurses Association, 2002). Clinical guidelines are systematically developed statements that
are used to assist practitioners with decisions about appropriate healthcare for specific clinical circumstances (Renbolm, Leini-Kilpi, & Suominen, 2002).

On the other hand, a nursing culture which is still being focused on ‘doing’ rather than ‘questioning’, has low management priority given to evidence-based practice (EBP), has poor working of multi-professional teams, and has poor access to research evidence, is faced with barriers to adopting EBP into every day practice (Sitzia, 2002). A low level of nursing autonomy has been identified as one of the main barriers in using research. Therefore increased nursing autonomy has also been identified as possibly contributing to a poor uptake of EBP and in turn CDM as it is understood in the literature (Papathanassoglou et al., 2005; Parahoo, 2000). Indeed the literature in this area, while limited, suggests that nurses and midwives do not seem to incorporate the results of research routinely into clinical decisions they make and prefer resources that provide decision-specific advice, such as peers (McCaughan et al., 2002). As my research reveals, in the chapters that follow, this reality is strongly influenced by not only questions of professional autonomy and standing but by long held, culturally bound relationships.

Research utilization is therefore not easily generalized in practice by just introducing or simply copying a highly successful study from other contexts. For instance, although there has been much success in using patient control analgesia (PCA) to manage postoperative pain, the report from Songklanagarind hospital in Thailand found nurses were only moderately satisfied with this method and their likelihood to use it depended on convenient equipment use, knowledge of the method, and the
nurse’s workload (Buhachat, Chanvej, Suwuttikul, & Choom-upagarn, 2001) rather than the evidence.

In surgical nursing, the care of surgical patients requires a complex interaction of health team skills that vary in type and degree from those needed to care for patients with other health problems (Bakalis & Watson, 2005). Currently, a popularized clinical pathway to accelerate recovery after colonic resection based on a multimodal programme or ‘fast-track’ surgery generalized implemented in the Western countries has demonstrated improvements in physical performance, pulmonary function, body composition and a marked reduction of length of stay (Basse, Thorbol, Lossl, & Kehlet, 2004; Fearon et al., 2005). However, there is no evidence identified that it has been implemented in South East Asia, with the exception of Singapore in which similar outcomes were achieved (Tan, Foo, & Cheong, 2005).

Additionally, while discharge planning has been widely discussed and implemented among ward nurses in Western communities and plays an important part in ‘fast-track’, Thai literature reveals that little is known about the discharge function of hospital nurses in this country. In Thailand, the discharge process is highly informal with several factors affecting the effectiveness of nurses’ discharge functions (Pichitpornchai, Street, & Boontong, 1999). Coordination among health personnel and sectors has been shown to be unsystematic and ineffective and the collaboration between nurses and physicians on discharge planning tends to be superficial (Pichitpornchai, Street, & Boontong, 1999). The discharge discussions often occur on the discharge day, leaving insufficient time for nurses to prepare or assist the patients. It was recognised that the informal and inconsistent patterns of this care process stem
from a lack of standard guidelines, quality assurance and a hospital accreditation system to control the health provider’s practices. There are several organizational factors affecting the discharge functions of these nurses, including unplanned or early discharge due to either poor cooperation among staff or their different perceptions on the discharge events (Pichitpornchai, Street, & Boontong, 1999).

Currently, although many graduate programs are offered, including international doctoral programmes in nursing, there have been evidences of crisis of professional nursing in Thailand. The crisis of professional nursing in Thailand, according to Srisuphan (2007), is rooted from the shortage of nurses is a result of the Health Care Reform, which increased demand for registered nurses by more than 15,000 nurses. The shortfall in the nursing workforce in Thailand has been increasing continually. In 2008, nurse turnover was about 3,000 nurses or 3 percent. Nurses resigned from professional nursing because of inadequate pay and welfare, lack of progression in the profession, and lack of participation in decision-making. Nowadays, 80 percent of the nurses are in the middle age group with high workloads of 1 to 30-40 patients; as a result they develop stress and fatigue, and finally resign. According to the president of Thailand Nursing Council (interview, 2009), the following solutions are proposed to fix this problems: 1) provide the position of working for the government to replace the current worker position, 2) increase the wage and provide career advancement, 3) provide a chance to study for a higher degree (both master and PhD) and study visit, and 4) establish one-year short course training for nurse assistants (1,000 per year have participated since 2008).
Although nurse numbers have increased and there are now more acceptances of nurses as members of a multidisciplinary care team, there is still lack of a sense of a clear identity in nurses’ role and the overlap of work done by the nursing and medical profession. In response to this, nurses are confronted with a crisis in the quality of nursing care delivered; this is especially the case in nursing information systems and the relationship between nurses’ goals, their competency development in every level of nursing, and their ability to meet organizational goals. This ‘crisis of nursing’ within the profession affects the strength and capabilities of both registered nurses and nurse administrators.

In response to what in many ways presents itself as a contradictory system, wherein the ideals and rhetoric of EBP and CDM as espoused in much Anglophonic nursing literature, is adopted in Thai nursing from an official governance and educational level, my own experience and the limited Thai literature suggests that in practice there are little signs of this. It is therefore against this background that this study seeks to map and describe what CDM means at an every day level for Thai nurses. Given the aims of this study to explain the local organizational culture of Thai surgical nurses and the way culture plays out in day-to-day practices, particularly when nurses make clinical decisions about allocating care to patients, it is necessary to introduce and orient the elements of the national development of nursing profession and education in Thailand. To date, there has been a dearth of literature that looks at the unique culture of Thai nurses at hospital workplaces and its effect on care and practice. Hence, the principal focus of this study is on rectifying this situation through its mapping and description of the day-to-day practices of the Thai surgical nurses as they go about making their own clinical decisions. In so doing the study intensively
describes the cultural issues and social relations where the Thai nurses of the TSW make decisions that contribute to the development of a specific type of Thai nursing practice. As such, the study also describes the impact that workplace relations have on workplace organization and seeks to detail the role played by core Thai values on clinical decision making in the every day.

Throughout the chapters that follow I have deliberately chosen to use the term CDM or the phrase clinical decisions’ as this is the terminology used by the nurses themselves. Indeed, as the descriptions of the nurses’ day-to-day practices will reveal clinical decisions are made daily, the nurses are aware of CDM and EBP and yet they are, it seems concepts in practice at odds with reality. It is this reality that this study seeks to describe in detail with the hope of shedding light on practices and broadening the discussions on nursing culture beyond simply a question of good or bad, right or wrong nursing practices. Ethnographic research mixed with aspects derived from auto-ethnography is therefore the best fit and the most useful approach to use to address this focus of a distinct group of Thai nurses as well as to record their local culture.

The following chapter deliberately details the world of Thai surgical nursing, focusing on the context and space at the Thai surgical ward (TSW), including the significance of the space as the stage and the backdrop upon and against which all nursing activities and decisions are made. The relationship between Thai culture and how the space organised is also highlighted.
CHAPTER THREE

THE THAI SURGICAL WARD

In the previous chapter I provided an overview of the development of nursing education and the professional characteristics of Thai nursing. With this as the backdrop to nursing in Thailand, I now begin to explore how these standards and knowledge are interpreted and played out in the reality of the workplace. In this chapter I introduce you to the world of Thai surgical nursing by highlighting my entry to the field and my focus on mapping the physical space. I begin to explain and explore in detail the context and space at the Thai surgical ward (TSW), including the significance of the space against which all nursing activities and decisions take place. I also highlight the relationship between Thai cultures and how space, even within an institution, is organised.

My (re) entry to the Thai surgical ward: Be my guest at home

My interest in studying my own setting arose when I found on examination that there was no literature in the area of evidence-based nursing to support the practice of early mobilization to promote bowel function in patients following abdominal surgery even though I had strongly believed in this relationship since I was a nursing student. This realisation became a turning point and encouraged me to begin my search for what it is that drives the care given in the hospital setting. As I began to reflect on my own experiences of nursing, I realised that in my own ward area, where I worked as a nurse educator, surgical nursing care was actually determined by and allocated in
patterns that have remained the same for many years despite the acknowledgement among the staff that new global trends in surgical care were of interest and importance to the ward. For example, although my literature review highlighted the implementation of a ‘fast track’ multimodal model of care with surgical patients in other healthcare regions, there is no evidence of implementation in Thai surgical wards.

The reality of the enormous gap between what is known, what is acknowledged and what is done in my own workplace made me realise that if this situation was to be addressed within this TSW, I would have to uncover the factors underpinning or driving the continuation of traditional day-to-day practices even in the face of new scholarship and evidence-based nursing. My central aim from this point was to gain a clear understanding of current nursing practice, in particular what it meant to nurse – to care for a patient and to make decisions about care, within the TSW. Because the aim was to uncover the reality of what was occurring in practice – to see what went on in the everyday, to understand the decisions made and why – I turned to ethnography as a methodology, where the practice of participant observation and a range of formal and informal interviews and conversations are central to data collection.

My familiarity with this setting as a nurse educator meant that I needed to do all I could to assist the participants see me as a researcher, not as a staff member. As such, my first challenge on entering the field was to detach myself from the previous role I had in the setting and re-invent myself as ‘researcher’. I did this by positioning myself as ‘outsider’, by setting out to see the ward through fresh eyes – by questioning all I
saw and mapping the space in detail. This proved to be a successful way for me to re-
orient myself to the world – I now began to see the space in a new way, noticing thing
that I had previously not noticed or taken for granted. In this way I worked from the
outset to avoid the pitfalls of researcher bias (see Lipson, 1984; Gerrish, 2003),
especially within this world with which I was so familiar.

Permission was, of course, granted for this study by Songklanagarind Hospital before
I entered the field. Subsequently, a formal letter of ethical clearance approval from the
Ethical Committee of Songklanagarind Hospital and a letter of introduction from
Griffith University (from which ethical clearance was also obtained) were distributed
to the staff of the TSW. While I identified above the difficulties of researching in a
familiar setting, there were some advantages: I was familiar with the staff at the
hospital and so used personal contact with the surgical department, the directors of the
nursing department, the head nurses and the staff at the setting to ease entry. These
included key informants who served as gatekeepers and helped me to inform the other
participants, including people involved in the setting (e.g. surgeons, patients, care
givers).

Obtaining approval and informed consent, and informing the nurse participants about
the study, were of great importance given my status as a previous colleague. I needed
to be sure that their involvement was completely voluntary. This was achieved by
informing staff directly about the study and by being available to answer any
questions they had. All participants gave their informed consent. The informed
consent was developed based on the standard informed consent procedure of Griffith
University and the principle of respect for autonomy for participants to sign before
they engaged to the research. The consent form was back-translated from English to Thai version by the researcher and the external (Thai) supervisor and both versions were submitted to the ethics committee of the hospital.

To avoid false expectations from the nurse participants, I informed and identified my role as ‘researcher’ and what could be expected of the researcher’s role during data collection with the nurse participants and the ward staff. Although I did realize and keep in mind to all potential dilemmas arising from researching a familiar area, I sensed that there were occasions when the nurses expected me to respond as I would in my previous role – even to become a helping pair of hands when the staff nurse was absent, or in emergency situation or a knowledge resource when they encountered an unfamiliar problem. The nurses sometimes sought my advice on their approach to care and it seemed wholly inappropriate not to respond in such situations to demonstrate and maintain my credibility. There were also occasions when nurses consulted me while participating in hand over. In such situations, although the nurses were aware of my presence as a researcher, they also responded to me as a nurse educator, often seeking my professional advice on matters of concern, in particular during the first month of my re-entry. Fortunately, the gatekeepers and the key informants, even the head nurse, helped me to clarify and establish my role with the staff as a researcher. One of my favourite statements became: “I come to make observation not give consultation” (Field notes, 2007).

To minimise the impact of the researcher on the behaviour of the nurses, I went daily to the ward and I made a point of ‘hanging out’. In the beginning I spent time sitting at the same place (the conference table – location 4 on Map 1) opposite the entrance
to the nurses’ station. I also made a habit of undertaking activities such as using a laptop computer (a way to re-define myself as a researcher), and greeting the staff in such a way as to make the participants begin to feel at ease with me in my researcher role.

To prevent my biases from distorting my understanding or leading me to miss important data, I kept everyday field notes not only to record what I observed and discussed with staff but also to reflect on my own biases, assumptions, prejudices, opinions, and values. Additionally, the skill of maintaining naïveté recommended by Bernard (1994, p. 149) was employed in doing my field study by observing everything as if I knew nothing. According to Bernard (1994, p. 149), doing field research in one’s own culture, the researcher should try to develop skill at being a novice – ‘being someone who genuinely wants to learn a new culture’. These techniques helped me make detailed observations, allowing me to gain a broad view of the setting, its routines and rituals from the viewpoint of the researcher.

Descriptive observation began with my first entry into the setting. Initial observations were focused to gain a sense of a new familiarity with the setting: ward routines, conference areas, areas where most communications, interactions or activities take place. The surgical ward context and the activities in which informants participate as a part of culture were observed, a physical map of the setting was produced, and a portrayal of where participants are positioned over time and description of the physical surrounding were conducted. The participants’ activities and interactions that occurred in the setting were recorded and described in detail. As I participated, I made observations, and listened to communication/discussion while nurses performed daily
activities such as hand-over, pre-working conferences, meal breaks in the tea room, preparations in the treatment room and medication room, and daily interactions with each other, medical doctors and other allied health professionals. By spending 10 months in the TSW a space and culture that had before seemed so familiar to me gradually revealed many elements of its organization and functioning that I had previously either ignored or taken for granted. Gradually more and more focused observations took place, including the specific activities and questions selected or identified for later visits and observations. Overtime I built up a ‘thick’ (Geertz, 1973) description and understanding of the TSW.

During the first three weeks, I participated in the whole activities of the nurses in every shift. After that, I observed the participants at different periods of time during each shift and during different shifts. As Kawulich (2005) suggests, visiting the setting at different times of the day provided me with the opportunity to see how the ward is used differently at different times of the day and night. Importantly, I had to determine to what extent I, as the researcher, would participate in the lives of the participants and whether to intervene in the situations I witnessed. I made the sometimes difficult decision as the researcher to step back from situations in order to maintain objectivity and avoid influencing the nurses’ behaviours.

Having made these decisions, I gradually became more focused in my observations and noticed that after a few weeks the nurse participants felt comfortable with my presence. I began to gain a real sense of the unit and become familiar once more with the setting and its routines through the lens of the researcher. Importantly, I gained more understanding, and became more focused in doing participant observation. The
nursing staff became accustomed to the presence of me as an outsider and an observer.

The participants were made aware that identifying information that would attribute a particular action or comment to any one nurse would be known only to the researcher and would not be used in the writing-up of the data or the results. Observation included informal and formal interviews with general and key informants and compilation of field notes while nurses were at work. This served to assist with my understanding of aspects of the culture and to emphasize, support, and guide my observations. In-depth interviews with 16 nurse key informants were also conducted. The aims of the interviews conducted in this study were, as Taylor (2005) suggests, used to explore the ‘insider perspective’ and to capture through the participants’ own words, their thoughts, perceptions, feelings and experiences. This, as is demonstrated in the later chapters, has made it possible for me to explore the issue and meanings that the nurses hold for their everyday activities, included focusing on individuals and how their experiences both shape, and are shaped by, social and cultural processes.

I temporarily left the field for a period of two weeks (the last two weeks of August, 2007) during the last two months of my field work. The advantages of taking this break from the field were multiple: I had the opportunity to put some distance between myself and the field site. This gave me the chance to put things into perspective, to take a deep breath, to think about what data I had collected so far, and what kind of data were lacking or missing, and what data needed to be collected in the

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1 See, for additional discussion on the importance of this, Sharkey & Larsen (2005)
time remaining, including providing a chance for me to return to the field with ‘fresh eyes’. After taking the break and returning to the setting, selective observations were the major focus and undertaking additional participant observation and further in-depth interviews to collect more in-depth data.

The study was continued for ten months until no new pertinent data were being collected and I then formally informed the participants that I was exiting the field. In leaving the field I took into consideration the importance of doing so in a manner that would have positive consequences for future research, with my aim being to ensure that on leaving the field I was able to maintain both good personal and academic relationships. To this end I followed cultural practice and presented tokens of appreciation to all participants to thank them for their participation, collaboration and inspirational support for this study.

Although I had been waiting for this ‘independence’ day for ten months (since I started in the field I had been counting down), I felt in the days immediately following my exiting from the field as if something was missing from my daily life. It was only then that I realized that doing field study had become one of my vital routines as well. Doing field research study in my own setting has not only given me an enormous amount of data in accordance with my research aims, but has also given me the opportunity to develop a deeper understanding of my career culture as ‘Thai surgical nurse’ both emphatically and sympathetically. I also feel that my time in the field has led me to increase my own sense of ‘solidarity’ with the nurse participants as I shared

\[2\] See Bernard (1994) for more discussion on the benefits of taking a break from fieldwork
both happiness and distress with them through the long engagement as ‘researcher’. The surgical staff nurses in the setting are not only my participants and key informants but most of them are also my in-the-field friends. They encouraged and provided inspirational support for me to continue doing field study while I was feeling despaired, greeting with me when my data is saturated and waiting for me to back and work with them as well as wishing to hear my success (Field notes, 2007).

In this section I have highlighted my personal experience of entering a familiar field and working with familiar people in a familiar space. In the following section I will introduce a more pragmatic way to the ‘world’ in which I undertook this study. As with any new place, understanding its geography, its space, its physical layout sets the explorer in good stead to understand and to begin to know something of the world that they have entered. This section then moves to give the contextual detail of the setting in a Thai hospital in which my study took place.

**The context of the Thai surgical ward (TSW)**

This study was conducted at a university hospital in Southern Thailand. Songklanagarind Hospital, more often referred to as “Mor-or” by the local southern Thais, acquired this name from the acronym of the title of the present King’s father, Somdej Phra Mahitalathibet Adulyadejvikhrom Phra Boromarajachanok – the father of modern Thai medicine. Additionally, his monument in front of the hospital provides moral and spiritual inspiration for all university staff, students, patients and family members. The Songklanagarind Hospital has been serving the people of Thailand since 22 February 1982 but its inaugural ceremony only took place on 18
September 1986. The hospital is affiliated to the Faculty of Medicine, Prince of Songkla University, which was established through the government policy of expanding university education to the wider provinces. At present, Songklanagarind Hospital has the capacity to accommodate up to 855 beds. The hospital serves as a referral and a regional tertiary centre for the southern part of Thailand. It is a major educational facility and gives medical practice not only to the medical students and specialists but also to sub-specialists including other health sciences students such as nursing students, dental students, physiotherapy students, and pharmacy students.

The vision of the hospital is to be an internationally recognised hospital of excellence by the year 2011. The vision of the nursing and the surgical department is to be recognised as a superior nursing and surgical department nationally in the year 2111. The hospital’s values are focused on quality, customer service, teamwork, and risk and safety awareness. The hospital has six excellence centres: cardiovascular centre, gastrointestinal and hepatic diseases institute, cancer centre, trauma centre, information centre, and palliative care unit, including infectious control unit and central supply centre. In 2007, the hospital was re-accredited for national hospital reaccreditation, and claimed an award for being the first Thai hospital to receive Thailand Quality Class (TQC) in 2008.

The general surgical care unit for in-patients in this hospital consists of three adult (15-year-old and above) ‘normal/general surgical wards’ (non-private) – two male wards and one female ward. They are situated on the third, fourth, and fifth floors of the thirteen-level (central) building (the hospital consists of eight inter-connecting buildings) respectively. Each ward is organised in the same way (see Map 1).
Surgical ward mapping

1: The head nurse office
2: The tea room
3: The treatment room
4: The conference table
5: Chemotherapy preparation area
6: The isolation unit
7: Nurse’s station, nursing care Team A, B, C, D
8: Sink for (staff) hand washing
9: Patient bed 25-40; team C: Bed 25-40
10: Patient bed 1-24; team A: Bed 1-12, team B: Bed 13-24
11: The Medication room
12: Multi-purpose sinks
13: Used IV bottle storage
14: Emergency exit/fire exit
15: Instrumental storage
16: Clothes storage
17: IV stock
18: Patients’ toilet & bathroom
19: The staff’s toilet
20: Bed pan cleaning area
21: The corridor

The general surgical wards provide a forty bed unit for male and female general surgical patients separately with an isolation unit for each ward which serves for both sexes and every diagnostic group. The physical space of the TSW has been intentionally designed to support the various requirements of patients, nurses and medical doctors, and to support the varieties of actions or tasks that take place within the area.

As seen in Map 1, the head nurse (HN) office (1) is located on the left side of the main entrance in front of the ward. Its location and size reflect its function as an area for the head nurse where only very few staff enter and then only for a very specific purpose or occasionally to speak with the head nurse. It does not allow for unauthorised access by patients or visitors and is physically quite removed from the day-to-day workings and occupants of the ward.
There are two front main entrances, one between the tea room (2) and the treatment room (3) which is used daily for entering the ward. The other is located between the treatment room (3) and an isolation unit (6) and is kept closed and used only occasionally for specific purposes such as cleaning. The main entrance is opened only during the visiting time (11 am – 7 pm) and has the visiting times and prohibition sign and visiting regulations clearly posted on its door screen.

The small tea room (2) the so-called ‘break room’, is the rest area for the ward staff, and is situated at the right side of the main entrance opposite the treatment room (3). It provides a long dining table at the centre of the room, surrounded by chairs. Also, the individual personal lockers, supplied for each nurse, and the shared lockers of the orderlies and practical nurses (PNs) are located here along with a general use computer which can access the internet (the only one in the ward, excluding the head nurse’s computer) for multi-purpose use, a television (which is placed above the fridge), and a range of basic kitchen utensils provided for the nursing staff (e.g. dining sets, microwave, rice cooker, kettle). This room, as its contents suggest, is the social hub of the ward and its location at the entry to the ward, away from the heart of the unit and close to the other ‘off-limits to general patients’ areas (3, 5 and 6) indicates, as we shall see later in chapter 5, that from the outset this room holds an important place in the day-to-day running of the TSW.

While the ‘break room’ sets itself up as the hub of social activities for staff; the ‘treatment room’ (3) is set up as the first point of work/activity organization. The treatment room (3) stores used and unused medical devices, all disinfectant and antiseptic solutions, and medical treatment cards, including wound dressing and
catheterization preparation cards. This room includes a sink for washing used medical devices and also contains the infectious (red) and non-infectious (stainless steel) rubbish bins. On the other side of the treatment room is the isolation unit (6). The chemotherapy preparation area (5) is between the treatment room and the isolation unit. Chemotherapy is actually prepared in the chemotherapy unit on the first floor, but the old preparation area is still preserved in the surgical ward. Here too and perhaps most significantly, is the staffing board posted on the wall of the treatment room, with photos of the ward staff organised to reflect seniority and role within the unit. For instance, the photo of the head nurse is on top followed by the photos of the most senior to less senior registered nurses, practical nurses, orderlies, clerk, and cleaners running in descending order sequentially with the name and working position of each staff member under their photo. Here, in this ‘first room’ of nursing activity and organization we see, in contrast with the familiar space of the rather welcoming and social ‘break room’, the hierarchical order being played out.

As we begin to move into the ward area proper, there is a space between the nurse’s station (7) and the treatment room (3) where we find a multipurpose ‘conference table’ (4). This space is used primarily by medical and nursing students to place their belongings (notes, bags, etc.) and participate in clinical conferences, or by patients and visitors who sit here to chat and/or watch the television that is placed on the small shelf in front of the conference table beside the left entrance to the nurse’s station. This television, while for the use of patients and their visitors, is usually turned off during the day time and has a hand-written sign attached to it stating, ‘Do not allow patient and relatives to adjust the television’. On the wall which the conference space shares with the treatment room (3) about two metres above the floor behind the
conference table a Buddhist shelf with a Buddha image hangs. It is always adorned with lei of jasmine flowers (both fresh and wilted), two electrically powered lamps, and burning joss sticks.

The nurse’s station is a “U” shaped space located at the centre of the ward, between the parallel lines of patients’ beds (9 & 10). It is not only provided as a nurses’ desk or office, but is also used for the storage of a variety of documents, forms, protocols, the nursing standard handbooks, and specimen collecting tubes. There is also a locked drawer in this area which can be accessed only by the head nurse and an in-charge nurse and is used to keep patients’ valuable items which are not allowed to be kept with the patient at the bedside (e.g. wallet, money, necklace, and ring). The four corners of the nurse’s station (see Map 1) are allocated to the various nursing teams that make up each ward (three in the male surgical ward and four in the female ward). The nurses treat the nurses’ station and in particular each corner as the ‘team headquarters’ – from here each team manages, monitors, and decides on their care actions.

As seen in Map 1, this division and use of the nurses’ station works in the following way: Team A (Bed 1-12) is arranged beside the front entrance of the nurse’s station behind the television; Team B (Bed 13-24) is situated next to Team A on the same side, while Team C (Bed 25-40 or 25-32) and Team D (Bed 33-40) are situated at the other side of the nurse’s station opposite with Team B and Team A, respectively. For this reason, close observation and critical patients are usually admitted in front of or close to the nurse’s station of each team: for example, bed 7, 12 (Team A); bed 13, 18 (Team B), and bed 33, 36 (Team C). By contrast, stable and nearly discharged
patients, including patients waiting for surgery and patients after simple surgery, are usually admitted in the last block of each team (e.g. bed 21-24, bed 25-28, and bed 37-40).

A single computer terminal is provided for all teams to share and is used primarily to provide information and instructions to the nurses as to the orders from medical doctors that need to be carried out for patients and/or to document patient data. While there are another six computers placed around the nurse’s station, these are primarily provided for the use of medical doctors and allied health workers. In addition to the computer(s) there are two telephones provided beside the computers, which are mainly used by the staff nurses.

As seen in Map 1, there are 40 beds along both sides of the nurse’s station. Each block consists of four or six single beds with a space of only 80 cm between each bed, providing just enough room for a chair, a spittoon, a small bedside table, and a full green curtain that surrounds each bed. Instead of using a wall, a half wood screen and a white fold fibre screen provided between each block acts as a border between each block; the nursing staff use these screens to prevent exposure of patients (e.g. while performing a bed bath or perineum care). A beeper is provided on the wood screen over each patient’s bed. A ceiling fan is provided for each block (four to six beds) while the switch control is placed on the wall behind the conference table. Oxygen, air, and suction wall pipelines are provided on the wood screen at some patients’ beds – mostly the beds in front of the nurse’s station (this is another reason why critical patients are admitted in front of the nurse’s station). There is a space between the nurse’s station and the medication room (11) which has an emergency cart, IV trolley,
and a fridge for keeping medications, total parental nutrition (TPN), blood components, a clerk’s desk, and a short corridor that connects both sides of the main ward area.

The medication room (11) provides a built-in counter for keeping all patients’ medications and medication devices, which is used for preparing medications. A medication card box hangs on the wall beside the entrance and is used for keeping patients’ medication cards chronologically. A printed sticker containing patient’s name, bed, type of medication and doses is stuck on the card. The medication cards system uses different colours to classify different routes of medications (e.g. a pink card is used for injection medication and a white card is used for oral medication). The 5Rs (right drug, right dose, right patient, right route, and right time) are posted on the signboard over the preparation area and above the medication box. Other medical devices are also kept in this room; for instance, colostomy and wound care devices, and frequently use-IV fluid bottles. Consequently there is little space left in the medication room, and as a result the room is narrow and has poor ventilation. The medication nurse sometimes prepares medications on the medication trolley in front of the medication room as do the nursing students when preparing medications with a nurse educator.

Multi-purpose sinks (12) are supplied on both sides of the ward (one sink per two teams). This area is generally used to store (temporarily) patients’ food trays, used and unused bath towels and enamel basins. The emergency exit is next to this area and connects this ward to the other general surgical wards. This exit is usually used by medical doctors and other hospital staff instead of the front main entrance to enter to
the ward, as it means that they can enter the ward area without being noticed by
visitors. The bathrooms and toilets (18) for the patients are located next to the last
block of patients’ beds on both sides of the ward immediately before the back
entrance. There is a space in front of the toilets which has the fridge ‘labelled’ for
keeping patients’ food, which includes blender-diets for patients, and also holds the
drinking water which is provided for patients on the big table beside the fridge.

Next to this space, before the back entrance and the corridor (21), is the storage/
supply room which stores the medical equipment and patients’ clothes (15, 16 and
17). The female staff toilet (19) is in front of this room before the back entrance
which is always kept locked. The male staff toilet is provided in the front of the ward
next to the head nurse office while the visitors’ toilet is located on the first floor of the
hospital (visitors are not permitted to use the staff toilet). The ward is surrounded by
the long corridor (21) with entrances to each patient block, but these are usually
locked and will only be opened for specific purposes. Some equipment, such as bed
pans, urine bottles, and used clothes are kept in the back corridor.

The plan I have set out above of the surgical ward identifies the physical setting in
which my field work took place. While I was deeply familiar with the ward area, in
my previous capacity as a nurse, I had never previously thought about the significance
of the physical space and its affect on people’s activities, relations, or care. In the
following section I therefore begin to un-wrap the mysteries of this space and
consider the influence that it may have on how the ward area is viewed and used by
patients, staff, and relatives.
A number of activities of the nurses in managing their space reflect the influences, concerns, hospital policy, rules, regulations, and beliefs of the organization. The role and beliefs of Theravada Buddhism are evident in the decoration of the ward, such as a Buddhist shelf in the highest place, as mentioned previously. The ways nurses use and manage the ward space also reflect the hierarchy, power distance, and the social order that is dominant in Thai society. The dispositions of space are closely related to a hierarchical system of organization and generally related to the status associated with the person and reflecting the national and organizational culture (this is discussed further in Chapter 4).

Hierarchy and the power distance, as these terms are understood by Hofstede (1991), are visible in physical space of the TSW through the way the nurses and/or all the people who use the ward use, control, and employ the ward’s spaces and artefacts. The level of control over space, the behaviours of people and relationships reflect hierarchies based on level of education, position, and social status both in Thai society and in the healthcare system. The private spaces, for example, are only assigned for particular users, for example, the head nurse office, personal locker, the tea room, even the staff toilet.

Every space in the TSW is governed by the cultural rules relating to ‘suitable’ or ‘unsuitable’ uses of space and the equipment. People tend to learn to use each space according to the specific purpose. Privatised and personalised of space allocated by using a name on the door or a signpost, including perceived space based on experiences and interpretations as ‘symbolic identifiers’, tells others about the status, goals, interests, and other qualities of those belonging to that space and the role of
physical space in power relationships (Stewart & Kornberger, 2006). The private markers of space which are used, such as locked and labelled doors/areas indicate and limit what their purpose was and who could legitimately enter them depending on status, position, the time of day. The values of particular manners at particular places are also created, as ‘regionalisation of activity’ as a result in control over how the room/area is used, when and by whom as ‘boundary marking’ (Stewart & Kornberger, 2006).

The behaviours of people in each particular space also reflect these categories of ‘suitable’ and ‘unsuitable’. According to Triandis (1994), beliefs about correct and appropriate action in specific situations (norms), including people who hold specific positions, are developed in a particular culture and inform the way in which people live in any given society. The nurses in this study, as I discuss in the coming chapters, exercise control over patients, patients’ visitors or people entering to the ward and each particular areas (e.g. nurse’s station, tea room, medication room, staff’s toilet) as ‘gate keepers’, including control over people who used their artefacts and patients’ instruments (e.g. patient’s chart, computers, television, refrigerators) based on their status and role within the cultural space of the TSW. Obviously, people who violate the ‘cultural law’ of ‘suitable’ or ‘appropriate’ in using their spaces and artefacts are likely to be negatively looked upon as ‘strange’ or ‘non-compliant’, which can lead to the development of bad impressions and poor relationships with the nurses.

As I observed, the patients and family members rarely enter into the spaces of the nurse’s station, medication room, treatment room, or, especially the tea room (where the door is kept closed at all time). The space of the nurse (along with their activities
and associated materials) is closely guarded so it is not surprising that the nurses are unhappy or even angry when patients or family members open their chart or documents, touch their IV line or look at medical instruments, ask any questions about their environment, or even make any changes around the patient’s bed (e.g. move another chair from elsewhere) (Field notes, 2007).

The ward staffs control visitor entry to the ward by closing the front main entrance outside of visiting hours and reminding the visitors of visiting rules, even going so far as showing an unfriendly face to those who seek to challenge these rules. The main entrance is kept open only during the visiting time (11 am - 7 pm) and has visiting times and visiting regulations (e.g. not more than four visitors per patient at any one time, children fewer than 12 not allowed) posted on the screen. The waiting area for patients’ family members and visitors is provided by the long benches in front of the ward next to the HN office while only one chair is provided at each patient’s bedside to limit visitor numbers at the bedside. Visitors wanting to enter the ward outside visiting time must ask for permission from the nurses, especially while medical doctors are performing the morning service round and a cleaner is cleaning the floor (between 7.30 am and 9 am). Patients’ family members are often seen waiting in front of the door while the medical doctors and the hospital staff easily open the door to go through (Field notes, 2007).

Hierarchy is always present in Thai society and the oldest member of the group is honoured. Often, I observed that seating inside the nurse’s station and around the conference table was arranged according to the hierarchy. It is therefore better to wait until you are told where to sit. Most of them usually display ‘kreng jai’ or diffidence to each other in using the share areas such as the conference table and the computers,
especially giving priority to senior staff and medical doctors. Also, the high power distance and hierarchical relationship made each group use the spaces separately and tend to keep space between each group. For instance, although visitors, nurse educator, medical students and medical doctors sit at the conference table altogether, each group sits separately and keeps a space, such as a free chair, between each group. Even such a space is left between nurse educator and the nursing students (Field notes, 2007).

The structure of the nurse’s station, which is surrounded by the 50 centimetres high edge blue circumference, also creates the sense of ‘enclosure’ as the privacy marker or a boundary between the nurses and other parties such as patients, visitors, and the nursing students. These groups usually communicate with the nurses in front of the nurse’s station behind the circumference. However, the medical doctors can walk into inside the nurse’s station as needed. Some of the nurses’ behaviours behind the circumference such as talking telephone calls, keeping busy by using the computer and documenting data, avoid eye contact or turning the face down, inhibit the patients and visitors from approaching them. However, the nurses were sometimes interrupted since there is no information desk and the ward clerk is not responsible for giving information to patients and visitors. The nurses sitting at the nurse’s station or hanging around were therefore unintentionally working as receptionists (Field notes, 2007). The significance of the physical space to the organization and the way the space is viewed, used and shared by patients, staff, and relatives also has implications for care given or the decisions nurses actually make. The following chapter therefore begins to explain the relationships within the space of the TSW and the way the relationships influence the nurses in making decisions about care for patients.
CHAPTER FOUR

HIERARCHY

“We have been told and allowed to do it this way”

In the previous chapter I highlighted my entry to the field and my focus on mapping the physical space. I also explored in detail the significance of the space as the stage and the backdrop against which all nursing activities and decisions are made. In this chapter, I begin to focus on my observations and discussions with the nurses of the TSW. I outline a typical day in the life of the Thai surgical nurse (TSN) and begin to map the hierarchical relationships as they play out in the daily routines of the TSW, with a particular focus on how the hierarchy affects the way the nurses provide care and the way they go about making decisions. The relationships between the nurses, the medical staff, and the patients and their relatives of the TSW form the basis for the observations and discussions offered in this chapter.

Hierarchy and the medical doctors, nurses and patients of the TSW: Establishing the order

Thai society is inherently hierarchical so that familial respect and respectability is extended to the respect shown for authority and status, which is based on the existential inequality where respect is always showed by one on the lower rung of the hierarchical ladder (Klausner, 1993). For instance, in the case of the TSW and its TSN, this is especially evident in the relationship between medical doctors and nurses, medical doctors and patients, nurses and patients, and even nurses and other nurses. Within such a large-power-distance society and organization (in this case the hospital
ward), superior-inferior relationships provide ‘inequity’ within social relations (Burnard, 2004) which become evident in their reciprocation.

Medical doctors in Thai culture are traditionally held in very high regard. People are usually unwilling to criticize them (Tyson & Pongruengphant, 2004; Tangcharoensathien et al., 1999) and they are likely to be deferred to (Pichitpornchai, Street, & Boontong, 1999). Medical doctors are treated with respect and hold a socially superior position over patients. According to Orem (2001), nurse-patient/medical doctor-patient relationship at the TSW, is a complementary relationship as both nurses and physicians take a superior role in relation to their patients, in both cases the relationship is analogous to a ‘parent-child’ relationship.

In Thai society, the medical and nursing professions are identified strongly as government-regulated positions and as such are highly admired and respected by Thais, especially by rural patients and family members who see both professions as careers to which great honour is ascribed (Holmes & Tangtingtavy, 1997). The reason underpinning this value is that Thai people are not inclined to take risks – they like stable jobs such as government jobs rather than business jobs which demand risk. This way of thinking comes from teaching given by Thai parents who counsel children to become government workers (Apapirom, 1976; Soupap, 1975).

The pattern of relationship between healthcare providers and patients/family members at the TSW is underpinned by basic virtues in Thai culture, in particular *kreng jai* and bunkhun. This kind of relationship is rooted in the social relationships of Thai society as a patient who benefits being obligated to do something in return is referred to as
bunkhun, which must be repaid by showing kreng jai or not bothering (Niratpattanasai, 2002) medical doctors and nurses. Showing kreng jai when two parties interact or communicate with each other (e.g. surgeon to nurse, nurse to patient/family member) could be seen as a hierarchical chain of kreng jai, and is associated with hierarchy significantly. Medical doctors and surgeons and even medical students receive high levels of respect and kreng jai from patient and family members. For instance, patients’ requests for help are usually made to a nurse rather than directly to a medical doctor, including expressions of displeasure or disagreement rarely shown in front of medical doctors. Undoubtedly, plans of treatments are taken over or dominated by medical doctors and (good) patients and family members rarely question their plan of treatment (Field notes, 2007).

Driven by a medical model patients in the TSW are expected to cooperate and comply with the treatment process as well as in ward routines and regulations. Compliance by patients at the TSW is evident from the moment the patients walk into the ward where, through the process of admission, they are given and take on the role of the ‘sick person’. I observed that when the patients are admitted to the ward, they have to change their clothes to a white hospital uniform with a wrist name card, and take off all valuable jewellery, personal belonging, nail polish, and underwear. Also, patients and family members get less involved, less flexible in their caring and personal activities, and all their activities are controlled by ward routines and have to be finished at the expected time. The patients’ activities in daily living must be changed to conform to ward norms: meal times, bed times, or going out from the ward (but within the hospital) must be authorised by the nurses and patients are instructed to stay in bed during vital signs and medications round. Even for main meals, there is no
choice or menu for ‘ordinary patients’, that is, patients admitted to non-private wards. For example, rice porridge (khaw tom) is served to every patient for breakfast (in bed) about 7.30 am and a hospital staff member will come to bring all food trays back half an hour later regardless of whether patients have finished eating or not (Field notes, 2007).

The sick role and sick-role behaviour could be seen as the logical extension of illness behaviour to complete integration into the medical care system and accept diagnosis of the established medical care system, thus allowing the individual to take on behaviours compliant with the expectations of the medical system. Thus the function of the physician is one of social control. The individual who is sick is not only physically sick, but adheres to the specifically patterned social role of being sick based on the social norms that surround it (Parsons, 1951).

The ‘sick role’ develops from the work of Talcott Parsons (1951), who was concerned with understanding how the sick person related to the whole social system, and what the person's function is in that system. According to Parsons (1951), the ‘sick role’ has four chief characteristics. First, the sick person is freed or exempt from carrying out normal social roles. The more severe the illness, the more one is freed from normal social roles. Second, people in the sick role are not directly responsible for their plight. Third, the sick person needs to try to get well. The sick role is regarded as a temporary stage of deviance that should not be prolonged if at all possible. Finally, in the sick role the sick person or patient must seek competent help and cooperate with medical care to get well.
Because there is such a strong hierarchical structure and a large-power-distance in Thai society (Hofstede, 2001), patients are sometimes respected and treated differently, according to their status outside the hospital, reflecting the hierarchical system in which people can be ‘high’ or ‘low’ in status according to their age, family background, and occupation or profession (Vongvipanond, 2003). This reflects one of the cultural values in Thai society and can manifest, even in the ward area, as ‘inequity’. In this hierarchical system power-worship exists and there is a hierarchical tradition in which people occupy differently ranked social positions or status (Vongvipanond, 2003). Consequently, like other Thais, while nurses feel that patients should all be treated the same, very high status and very low status patients are likely to be talked to and respected differently. Many nurses, while they are uncomfortable with this apparently large power disparity, will continue to ‘obey’ customary practices. For example, although most of the nursing staff strictly controlled the visiting rule, an exception was evident in the case of patients who were family member of nurses or the other hospital and university staff (Field notes, 2007).

It is not surprising, then, that a patient’s rank (hierarchical status) is expressed during handover. For example, nurses of the TSW will alert the next shift to the presence of a high status patient, namely a ‘VIP patient’. Such an action would in turn have implications for the allocation of staff for that patient and also for interactions with that patient. For example, junior nurses or those nurses who felt less confident in their work expressed high levels of concern regarding working with a VIP patient – they expressed concern in communicating and providing care for any patient in this group. Also, work allocation was adapted to accommodate such a patient. This included avoiding assigning the nursing students/novices to performing procedures, with patients in this group most likely to be cared for by the more senior and the most
skilful nurses. The surgical nurses refer generally to such patients as ‘Case VIP’ and these include patients working in high position/high economic status jobs, parents or relatives of medical doctors, and patients transferred from private wards (Field notes, 2007).

**Hierarchy and social relations among the group of Thai surgical nurses**

While the terms nurse and nursing may conjure up images of kindness, caring and equality to the outsider, nursing is in fact, as Walsh and Ford (1989) have demonstrated, a very hierarchical profession. Even at the TSW itself with its clear lines of status between medical doctors, nurses and patients a sense of hierarchy is strongly evident among the group of nurses themselves. While the word 'nurse' at Songklanagarind Hospital, as well as across the country, is used to refer to a 'registered nurse' (RN) for administrative purposes, nurses encompass a very wide group from the head nurse down to newly graduated nurses and the staff auxiliaries (practical nurses, orderlies, clerk, and cleaners).

The hierarchy is evident in their communications, the way they use and share their space and artefacts, the way they dress, the way they socialize new comers and the way they make decisions about their actions. As mentioned in Chapter 3, the hierarchy is made clear from the moment you enter the ward: for example, the head nurse’s office is separated from the ward itself with the sign ‘head nurse’ posted on the door, which is kept closed at all times. Likewise the door to the main entrance of the ward is controlled by the nurses and is used to reinforce the hierarchy by being closed outside visiting times with the warning sign of ‘no entry’. The staffing board in front of the tea room and the staff roster are also divided clearly along hierarchical grounds with each staff member within the nursing group, as listed on the board,
divided clearly by position, rank and title – the head nurse, sub-head nurse, RNs, PN, orderlies, clerk, and cleaners. The nurses’ roster is also ranked in order from the head nurse (at the top of the list) followed by highest ranked seniors to the lesser ranked juniors and novices at the bottom (Field notes, 2007).

In Thai society, status can be determined by clothing and general appearance, age, job, education, family name, and social connections (Klausner, 1993). Clothes can reveal the social and economic status of the person and while in general, most Thai people, particularly in Bangkok and other big cities, wear clothes similar to Westerners, in some rural areas, including around the hospital region of ‘Hat-Yai’ city, elders continue to wear traditional dress (Field notes, 2007). The working clothes of the nurse create not only a sense of identity as a member of the nursing profession, they are also indicative of the rank held by the nurse within the unit and send clear and important messages to patients and co-workers. Indeed, the varieties of staff uniform reflect the hierarchy among the group of the staff at the TSW (Holland, 1993).

In the TSW, the differences of staff uniform in each group identify the status/position and hierarchy between the staff in each level. At Songklanagarind Hospital, the orderlies wear a white blouse with purple pants, a ward clerk wears a blue blouse with a blue skirt, and cleaners wear a blue blouse with a black pants or skirt. Among the staff nurses, it is the Thai nurses’ custom to wear nurse’s uniform, strictly following (traditional) rules of professional dressing. Historically, a typical nurse uniform consisted of a dress, pinafore apron and a nurse’s cap. According to Sparrow (1987), the traditional nurse uniform has been maintained because it creates identity and cleanliness rather than for the purpose of freedom of movement. Although the
traditional nurse uniforms have been replaced with the ‘new’ scrub dress in many countries (e.g. US, UK, Australia) (Sparrow, 1987), the nurses at the TSW as well as the nurses across the nation, continue to wear the traditional white-nurse uniform and a nurse’s cap (some private hospitals in Thailand allow nurses to wear alternative nurse uniform but are still in white and with a nurse’s cap). In Thailand, the white uniform is generally and traditionally used by all nurses as the identity or public image of the nursing profession. No exception is made for the surgical nurses who work with patients’ wound and discharges. This uniform is not always comfortable in the workplace as a nurse’s cap can often be stuck in the curtain and IV hanger split, and the skirt is not comfortable when climbing into a metre-high patient’s bed to transfer patients between bed and a stretcher or to perform cardiac massage (Field notes, 2007).

At the TSW, the head nurse, nurse educators, RNs and PN wear the same nurse uniform with a nurse’s cap; however, the black mark on the nurse’s cap is significant in showing status. Two strips of black mark are used for the head nurse and nurse administrators. Similarly, RNs and nurse educators use a long strip of black mark across the nurse’s cap lengthways (medical doctor sometimes cannot differentiate between RNs and nurse educators), and a vertical half strip of black mark is used for the PN. Nursing students wear a nurse uniform covered with a purple apron and without a strip black mark on the cap, and white socks. Traditionally, long-haired nursing staff have their hair covered neatly with a hair net tidily (long-pony-tailed hair is not allowed). Staff are also required to have their nails cut short without coloured-nail polish, to wear polite fully-enclosed white shoes, and not to wear jewellery other than a wrist watch and (plain) necklace (which includes the sacred white cord bracelet called sai sin, which in Theravada Buddhist belief keeps out evil spirits and protects
everyone and everything inside it). A male nurse wears a white medical T-shirt with a navy blue strip at the top of the shirt’s pocket (a green strip is used for medical student and no strip for medical doctors) with black pants. However, most of local patients and family members could not differentiate a male nurse from a medical doctor, reinforcing the fact that nurse is seen as a 'female' career in Thai society (Field notes, 2007).

At the TSW, status is linked with 'status jobs' and lines of responsibilities or certain functions seen as one more important or higher than others; it also implies a certain level of control and the expectation that people lower down in the hierarchy will obey an order without questioning. The level and status in hierarchy come with power and authority to give commands to persons below. Within the ward staff, perceived-low-prestige jobs, which are actually part of real nursing care, such as assisting patients with eating and bathing and cleaning patients after defecation or urination or serving a bed-pan, are mostly done by the auxiliary staff. When a patient asked a nurse for a bed pan, instead of walking to bring it from the back corridor, she loudly told an orderly or PN to bring it for patient. Also, the nurses (especially seniors) are sometimes aggressive in their communication with the auxiliaries, included not hesitating to blame or become angry when auxiliary staff did something incompletely or wrong – much as medical doctors do with nurses (Field notes, 2007).

As I observed, the head nurse would readily criticise work done by her subordinates (e.g. PN, orderlies, or junior RNs). These subordinates would equally readily make changes in response to her comments or commands without any attempt to negotiate their position. For example, a senior PN stopped work on a nearly finished new medication board once the head nurse told her that she did not agree with the design.
Although the nurses did not agree with new method of inter-department patient consultation launched by the surgical department, they strictly follow this new policy as the head nurse told them to do so. The novices and the nursing students tend to be placed in the lower rung or at the bottom within the hierarchical ladder of the staff nurses so that even PN and orderlies expressed sarcasm when they could not finish routine tasks on time (Field notes, 2007).

Along with the chain of hierarchy at the TSW, the social relations among the group of the staff nurses is underpinned by the key feature of ‘seniority’ as well as superior and subordinate relationships. Those with seniority refer to those with a high position who generally are older. ‘Seniority’ is important in all Thai hospitals. In a high-power-distance society such as Thailand, ‘seniority’ is an important part so that a younger person shall respect the older person (Burnard, 2004). Superior and subordinate relationships are maintained on the basis of favour reciprocity and mutual support (Manosilapakorn, 2003). Thais have very high respect for parents and the elderly as children are inculcated from very early childhood to follow the advice of their elders, not talk back or voice contrasting views (Mulder, 1996). One who is a lesser person should know his place and not disagree or argue with a senior or a superior, or even express an opinion in his presence (Manosilapakorn, 2003) as I witnessed at handover and pre-working conference.

In Thai society, seniority is highly valued so that Thai children are taught to please elders, not to argue with seniors, and not to disagree with those who have more power (Klausner, 1993). Thai youth are expected to defer to wisdom, as well as authority of elders. Even higher education does not qualify youth to question, criticize or challenge elders (Klausner, 1993). Thai proverbs exemplify the respect given to older
persons: ‘seniors took a hot shower before’, which means seniors have a lot of experience or know more; or ‘a dog does not bite you if you walk following seniors’, which means you would be safe or have less chance of doing anything wrong if you follow seniors’ guidance or instruction. So, if younger person presents as overconfident or knowing more than senior, he/she would be negatively perceived as bypassing one’s superior or ‘pass over senior’s head’ (Thai people believe that the head is the highest and purest part of the body and to touch someone on the head can be very offensive and is considered to be highly disrespectful) (Klausner, 1993).

The basic Thai virtue of ‘seniority’ shapes the behaviour of the TSN to show unusually high deference towards those of senior status in all social relationships as evidenced in the interview quotation below:

The seniors in our ward have the high feeling of seniority and superiority. They don’t want a novice and junior to offend or behave as if she is not satisfied or argue. They are disappointed with a novice who ignores or does not pay attention to their comments. In our ward, juniors are expected to take instruction and guidance; not argue or disagree with seniors; pay attention and listen to seniors’ complaints or instructions as taught (‘sorn’=teach). This includes not arguing or showing any evidence of disagreement through expression. The junior nurses have to treat seniors with respect and to pay compliments to them. Juniors who seek out rationales or explanations for what they have been told by seniors could be seen as challenging them, disputing or not paying respect to the senior (‘teang’), and could result in the junior nurse being labelled as ‘Hua khang’ (Hua=head, khang=hard) or obstinate which could have negative effects for the good relationship of the junior nurse with
her other senior colleagues. Consequently, junior nurses often say what seniors want to hear and do what seniors expect them to do rather than risk being thought of as controversial or confrontational.

(Field Notes – Interview KI 5)

As evidenced in the above quotation, like the other Thai nurses, the characteristics of the TSN reflect the status of young women, who are expected to respect the wisdom and the virtue of seniors’ role in giving instructions and consultation to their younger nurses. To consult, respect and obey their seniors are the (compulsory) roles of juniors so that they may avoid conflict in relationships with seniors. Respecting and showing *kreng jai* towards one who is higher in rank and those perceived as being in the higher position and status (social place) or age is in evidence in the TSW and in many ways overwhelms relations among the TSN.

*Kreng jai* is the notion of always thinking of the other person first; of refusing to worry another person with your own problems; of respecting those perceived as being senior to you (Burnard & Naiyapatana, 2004; Niratpattanasai, 2002; Vongvipanond, 2003). It is diffidence, deference, and consideration merged with respect, proper and appropriate behaviour or concern with offending others, and a need to respect those perceived as being senior or in a position of power. The hierarchical relationships and seniority among the group of nurses as they play out in the daily routines influence day-to-day ritual practices, the nurses’ interests, the way they go about making decisions, and relations with medical doctors as discussed in the rest of this chapter.
A typical day in the life of the Thai surgical nurses

The working system at the TSW, like other Thai government hospitals, is divided into three shifts – the morning (8 am – 4 pm), the afternoon (4 pm - 12 am), and the night shift (midnight - 8 am). There are twenty-six full-time RNs (including the head nurse) and they work approximately forty hours per week to reach the minimum of twenty to twenty-two shifts monthly. Generally, the nurses are assigned to work continually for five days, follow by two days off, for example, through two morning shifts followed by two afternoon shifts and a night shift. The nurses have the freedom to change their shifts with their colleagues; however, shift interchanges must be approved by the head nurse. Although the nurses take turns working across all shifts, the head nurse and eight months pregnant nurse work only in the morning shifts. Senior nurses are also allocated night shifts less than their junior counterparts (Field notes, 2007).

Team management is used at the TSW to divide forty patients into three nursing care teams. The nurses’ primary role is organizing the three-shift allocation of surgical patient care based on functional task assignment. The staff nurses in each shift consist of seven to eight RNs who will be assigned to adopt particular roles – one in-charge nurse, three nurse team leaders, one medication nurse, and two treatment nurses (see Table 2). As seen in Table 2, beyond the groups of the staff nurses, the staff auxiliaries in each shift consist of three to four practical nurses (PN) and/or orderlies, the clerk (only morning shift of weekdays), and a cleaner. At the TSW, the ward clerk does not have any responsibility to manage patients (or even pick up telephone calls) but rather she/he works as a messenger or the head nurse’s secretary by taking documents and medical devices back and forth between the ward and other departments.
Table 2

*The routine activities of the TSW*

<table>
<thead>
<tr>
<th>Time</th>
<th>Morning shift 8 am – 4 pm</th>
<th>Time</th>
<th>Afternoon shift 4 pm – midnight</th>
<th>Time</th>
<th>Night shift midnight – 8 am</th>
</tr>
</thead>
<tbody>
<tr>
<td>8am–4pm</td>
<td>Staff: The HN*, 2-3 Tx* nurses, 3 TL*, 3-4 TM*, a med-nurse, a clerk, 1-2 cleaner, 6-8 nursing students &amp; a nurse educator</td>
<td>4pm-12am</td>
<td>Staff: in-charge nurse, 1-2 Tx nurses, 3 TL, 3 TM, a med-nurse, a cleaner</td>
<td>12am-8am</td>
<td>Staff: in-charge nurse, 1-2 Tx nurses, 3 TL, 3 TM, a med-nurse, a cleaner</td>
</tr>
<tr>
<td>7:30 am/7:45 am</td>
<td>- Pre-working nursing round</td>
<td>3:30pm/4:45pm</td>
<td>- Pre-working nursing round (TLs)</td>
<td>11:30pm/11:45pm</td>
<td>- Pre-working nursing round (TLs)</td>
</tr>
<tr>
<td>7:45 am</td>
<td>- SCTs* perform bedside service/teaching round</td>
<td>- Checking patients’ medication cards with prescriptions in computer (med-nurse)</td>
<td>- Checking patients’ medication cards with prescriptions in computer (med-nurse)</td>
<td>- Checking patients’ medication cards with prescriptions in computer (med-nurse)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Checking patients’ medication cards with prescriptions in computer (med-nurse)</td>
<td>- Checking emergency card, narcotics stock, testing Defibrillator</td>
<td>- Checking emergency card, narcotics stock, testing Defibrillator (Tx nurse)</td>
<td>- Checking emergency card, narcotics stock, testing Defibrillator (Tx nurse)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Brief handover (the night in-charge nurse &amp; the HN)</td>
<td>- Brief handover (the HN &amp; the afternoon in-charge nurse)</td>
<td>- Ward round (SCTs)</td>
<td>- Brief handover (the afternoon &amp; the night in-charge nurse)</td>
<td></td>
</tr>
<tr>
<td>Time</td>
<td>Morning shift</td>
<td>Time</td>
<td>Afternoon shift</td>
<td>Time</td>
<td>Night shift</td>
</tr>
<tr>
<td>------</td>
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<td>-------------</td>
</tr>
<tr>
<td>8am-8:30</td>
<td>- Shift report &amp; handover by the night nurse TL &amp; all the morning staff, the HN, and/or nursing students, nurse educator</td>
<td>4pm-4:30/5pm</td>
<td>- Shift report &amp; handover by the morning nurse TL &amp; all the afternoon staff</td>
<td>12am-12:30/1am</td>
<td>- Shift report &amp; handover by the afternoon nurse TL &amp; all the night staff</td>
</tr>
<tr>
<td>/9am</td>
<td>- Ward round (SCTs)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9am-9:10am</td>
<td>- Carry-out medical doctors’ orders, send patients to OR (TLs), inter-department investigation/treatment coordination</td>
<td>5pm-6pm</td>
<td>- Carry-out medical doctors’ orders, admit patients from OR (TLs)</td>
<td>1am-2am</td>
<td>- Chart audit (TLs)</td>
</tr>
<tr>
<td></td>
<td>- Allocate prescribed and routine tasks, discharge document (Tx)</td>
<td></td>
<td>- Allocate prescribed and routine tasks (Tx)</td>
<td></td>
<td>- Check medication stocks (med-nurse)</td>
</tr>
<tr>
<td></td>
<td>- Administrator medications (med-nurse)</td>
<td></td>
<td>- Administrator medications (med-nurse)</td>
<td></td>
<td>- Check all medical devices stock (In-charge), administrator medication (med)</td>
</tr>
<tr>
<td>10am</td>
<td>- Bedside visits (TL) - Discharge, admit new patients from OPD</td>
<td>6pm-7pm</td>
<td>- First break dinner (tea room)</td>
<td>2-2:30am</td>
<td>- Vital signs, turning position of bed-ridden patients, suctioning patients altogether</td>
</tr>
<tr>
<td></td>
<td>- Take a short break (2-5 mins) at the tea room if they have free time</td>
<td></td>
<td>- Admit new patients from ER or OR</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- Visit by nurse supervisor</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Time</td>
<td>Morning shift</td>
<td>Time</td>
<td>Afternoon shift</td>
<td>Time</td>
<td>Night shift</td>
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<td>-----------------------------------------------------</td>
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<td>------------------------------------------------</td>
</tr>
<tr>
<td>12pm-1pm</td>
<td>- Second break lunch (the second half staff)</td>
<td>9pm-10pm</td>
<td>- Documentation: nursing intervention record (TLs)</td>
<td>4am-5am</td>
<td>- Documentation: nursing intervention record (TLs)</td>
</tr>
<tr>
<td></td>
<td>(tea room)</td>
<td></td>
<td>- Intake-output record, routine vital signs (TM)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1pm-4pm</td>
<td>- Admit new patients from OPD, patient back from OR</td>
<td>11pm-12pm</td>
<td>- Documentation: nursing intervention record, short handover from nursing students (TLs)</td>
<td>5am-8am</td>
<td>- Morning hygiene care (TM, family member)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- Intake-output record, routine vital signs (TM)</td>
<td></td>
<td>- Blood tests, IV indwelling for patients undergoing surgery (RN altogether)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>- Individual ‘ward round’ (medical doctor)</td>
</tr>
<tr>
<td>4-5/530pm</td>
<td>- Handover</td>
<td>12-1230/1am</td>
<td>- Handover</td>
<td>8-830/9am</td>
<td>- Handover</td>
</tr>
<tr>
<td></td>
<td>- Leave from the ward altogether</td>
<td></td>
<td>- Leave from the ward altogether</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* HN = head nurse, TL = nurse team leader, TM = team member, Tx = treatment nurse,

SCT = surgical care team (comprise surgical educator, 1st year medical doctor (intern), 2nd – 4th year surgeons, included 4th – 6th medical students)

*Inter-department co-ordination and selective cases operations will be done only during the office hours (830am-4pm) of the weekdays

*Turning position of bed-ridden patients is done every two hours

*Routine vital sign recording is done at 6am, 10am, 2pm, 6pm, 10pm, and 2am
PNs and orderlies predominantly take responsibility for recording patients’ vital signs, oxygen saturation, intake-output, included tube and drain cares, changing wound dressing and assist patients with eating, tube feeding, bathing, urination/defecation, and cleaning patients’ environment (e.g. make bed, wash jug and glass).

In the TSW, since bedside care and records are allocated to team members, RNs are at quite a distance from the patients. This can present some challenges when we consider that the nurses (RNs) are dependent on the PNs and orderlies to inform them of any deterioration or unusual patterns in a patient’s condition such as when the patient has abnormal signs and symptoms (e.g. vital signs abnormalities, decreased oxygen saturation level). In this situation the RNs are reliant on PNs and orderlies for their information and rely on the PN’s/orderly’s ability to make a decision to tell them in the first place:

We have to make decisions when the PN or orderly reported the patient’s vital signs or clinical manifestations. For example, PN told me that patient’s blood pressure was 60/40. I have to assess before making decision to notify medical doctor, in particular when getting reports from less experienced orderlies. I assessed and decided that the patient had signs and symptoms of shock. If a patient is still talking or good consciousness, I will decide to repeat a blood pressure test. However, if a patient has cold skin and loss of consciousness, I will decide to call a medical doctor urgently. Most of all, I have to assess and analyse to decide whether a patient is normal or abnormal actually after getting reports.

(Field notes – Interview KI 13)
The reliance on PNs and orderlies is indicative of three issues within the Thai health system and the TSW itself. First, the shortage of nurses in Thailand means that it is necessary that RNs are supported by less trained assistants. This itself is further complicated by the recent changes to national policy which has seen the end of the training of PNs, forcing the hospitals to hold short courses in training ‘orderlies’ to replace PN position. Finally, this is further complicated by the embedded hierarchy which determines the chain of command and type of work completed between ranks. This means that those on the lower rungs (PNs and orderlies) find themselves doing the majority of patient cares and observations. The less experienced auxiliaries, however, are mostly assigned to work with highly experienced nurses and the head nurse assigns the experienced staff in each group to work with novice staff in each shift (Field notes, 2007). The allocation of roles will vary from shift to shift; however, assignment interchange can occur (under specific conditions) if necessary. As the following extract demonstrates the roles and responsibilities of nurses are not fixed but rather changeable depending on their daily job/position allocation:

The kinds of decisions which we make in any shift are mostly dependent on the current position and job allocation. If we work as an in-charge nurse, we have to make overall decisions about administration, staff management, staff ratio, and also check supply, and be a consultant for everybody in the shift. So, we have to make most decisions regarding administration. If we work as nurse team leader, we need to make decisions about notifying medical doctors, coordination to send patient to anywhere, talking with patients’ relatives, or coordinating between patients’ relatives and doctors. Decision-making about administering medication is needed if we work as a medication nurse; for example, managing to administer medications for patients in case that
medication is running out. In short, our decision-making mostly depends on the current job description in any shift.

(Field notes – Interview KI 15)

Each role has a status attached to it thus limiting/determining who can be allocated which role. In general, the in-charge role is mainly responsible for staffing and administrative decision-making rather than supervising the nursing staff and performing tasks. Nurse team leaders have mainly responsibility to allocate and provide care for patients in each team, co-ordinate with their colleagues about patients’ plans of treatment and care, including documenting all patient data – what was/is/will happen to each patient. For this, they spend most of their time at the nurse’s station and use the computer for checking and carrying out medical doctors’ orders and documenting patients’ data (the computer has been used for documenting data and ordering instead of using chart and KARDEX since 2005); communicate with the treatment nurse, team member, and/or medication nurse about changed or new medical doctors’ orders; coordinate with the other department/s; notify medical doctors; and perform pre-working nursing round, pre-working conference, and handover. Treatment nurses mainly perform all medical and nursing treatments, routines and prescribed tasks for patients (e.g. collecting blood tests, changing wound dressing), including admission and discharge procedures. The medication nurse takes responsibility for preparing and administering medications for all (40) patients (Field notes, 2007).

Under the rubric of ‘seniority’ at the TSW, time (length of employment) acts as the measure of competence and ability and is also used as a prerequisite to allocate work in each role. For instance, the TSN has a general agreement that there are at least two
senior nurses allocated to every shift and that only one to two novices are rostered for a day shift and only one for the afternoon and the night shift (KI 1 – discussion). As one nurse commented when talking about allocating the nurses to work in the ‘in-charge’ position that: ‘we cannot easily take junior to be in-charge nurse without getting senior’s supervisory’. In general, the preliminary criterion to work as an in-charge nurse at the TSW is working experience at least five years, combined with the approval from the ward committee whose focus in determining suitability is based on their judgement of the nurses’ capability to make decisions and problem solve. Since more than 50 percent of the nurses in the TSW have clinical experience of more than ten years due to the low turnover rate, five years of clinical experience is, in the TSW, still regarded as ‘juvenile’.

This situation has itself impacted on the nurses in the ward, as one nurse with five years experience expressed it: ‘I do not feel confident to work as an in-charge nurse. I have a very strong need to continue to work under a senior nurse’. I also observed the impact of this sense that five years experience is not enough when a younger nurse was assigned to work in the position of nurse in-charge while she shared the shift with her elder senior colleague. The young in-charge nurse clearly felt the pressure of age as a marker of status and despite her position as nurse in-charge she made the point of consulting her older (and hence more senior nurse colleague) before making decisions in a complex situations or when decisions had to be made together. From the key informants’ point of view, working as an in-charge nurse is a step towards becoming a senior nurse (Field notes, 2007). However, observations suggest that social indicators of rank, such as age, continue to dominate even when professional recognition is given.
At the TSW, although the ward routines timetable is not clearly written, everything has been done at the fixed time (see Table 2). The strength of following and focusing on routine tasks at the TSW can be explained by Giddens’ (1984, p 376) idea that ‘time produce[s] a sense of order and predictability creating routines and a sense of safety as ontological security that enable[s] the nurses to go on from day-to-day’. Feeling capable and ‘fitting in’ has been created via repetitive practices and situations in everyday nursing practices. For this reason, as seen in Table 2, there are several routines/rituals related to time, depending on time-space such as medication rounds, changing wound dressing, hygiene care, pre-operative teaching and preparation, even routine post-op. care. Day-to-day nursing rituals are enacted in the three main nursing activities: pre-working nursing round, shift report and handover, and pre-working conference, which are conducted and replayed in every shift.

- Pre-working nursing round

A typical nursing day of the nurses at the TSW begins with the ritual of auditing and checking patients' documentations, including all bedside medical devices, IV infusions, and work done by the off-going staff, the so-called 'pre-working nursing round'. This activity is done at the transition between two shifts or about fifteen to thirty minutes (extend to forty-five minutes for novices) prior to working time. The nurses indicated that the significance of this activity is for auditing patients’ data (or auditing the off-going staff) of the previous shift, consistent with controlling their working standard (Field notes – discussion, 2007). The climate while the nurses perform this activity is sometimes tense since the seniors and the head nurse often made a lot of complaints about recording errors and incomplete works, especially intake/output documentations and delay of IV infusions. I wondered “how often the
similar comments and complaints have been barked to each other while performing intake-output round at the beginning of every shift” – like a (vicious) nursing cycle (Field notes, 2007).

- Handover

Following pre-working nursing round is the handover, which marks the official commencement of each shift (8 am, 4 pm, and midnight). Before performing this activity, the ward staff of both shifts gathers at the central counter of the nurse’s station (no nurses remain around or near patients’ beds at this time). A shift report is given with the intention of informing on-coming staff of the total number of patients, the number of new admissions, discharges, deaths, transfers, and patients undergoing surgery and/or investigations. The nurses also, unofficially, use this time as an opportunity to catch up with each other and discuss personal, social, and working happenings. The head nurse also takes the opportunity of having all staff gathered together to announce to her staff news, new regimes or changes to policies that will affect either the ward or the staff. Once this activity is done, the staff will move to each team according to the assignment to join in the actual handover.

Detailed information on patients’ conditions is provided during handover. It is sequentially presented in the same pattern every shift and, in this verbal format provides considerably more detail than what is written in the nursing intervention records (which are also documented in the same pattern). This is especially true of social and psychological problems – which the nurses do not document in nearly as much detail as they do the activities/works they have carried out throughout the shift (Field notes, 2007).
The information given during handover has different implications or is used differently by each group and also according to different roles among RNs. Noticeably, nurse team leaders pay more attention than others since the information given at handover allocates/assists them to make decisions about the nursing care required by each patient to ensure the continuity of patient care, and provide important information to guide RNs in making decisions about what has been done previously and what does and does not need to be carefully recorded. The information given to guide PNs and orderlies on routine tasks needs to be allocated to each patient (e.g. the frequency of vital signs recording, the amount and time of tube feeding).

Although the role and significance of handover at the TSW is similar to other hospitals, this activity is not just about transforming information – it is also about ‘socialization’ and 'enculturation'. The ‘handover' also acts to provide group support. During handover, a complex form of communication providing mutual supports to each other is generated. However, free discussion and expression tended to be rigid as a result of the ward structure and the limitation of their physical space, meaning that the handover is heartily welcomed by third parties, especially medical doctors, often using computers and hanging out in front of the nurse’s station during that time. Additionally, in considering patient confidentiality, the physical structure of the nurse's station, through its proximity to patients' beds surrounding the nurse's station, tended unintentionally to devalue patients' confidentiality. As seen in Map 1 (Chapter 3, p. 55), the 40-bed parallels lie along both sides of the nurse’s station and there is only 80 cm. space between each bed. Also, since the loud and public blaming and instructing are widespread among the group of medical doctors, nurses, and nurse educators, social embarrassment might be another issue to consider (Field notes, 2007).
- **Pre-working conference**

Every shift, once the handover is done, the nurse team leaders start a traditional pre-working conference with their team members (PNs or orderlies). This takes place at the nurse’s station and takes about five to ten minutes (although it can be extended to an hour when carried out by the novices and/or the nursing students\(^3\). The contents of this briefing (pre-working conference) are mainly focused on clarifying the routine care activities needed for each patient in accordance with the information given in the handover by the previous shift: current patients’ condition, prescriptions and medical doctors’ order. This is when the team leader asks the question, ‘what we are going to do with patients?’ this issue encompasses issues such as the frequency of recording and monitoring of vital problems and concerns.

The observational data while performing the pre-working conference confirm that the nurses hold seniority and experience as more important than formal education – knowledge is seen as secondary to experience. Since hierarchical relationships and seniority in the TSW influence the organizational system that is culturally set up to honour experience over knowledge, membership is assured when accepting

\(^3\) From Monday to Wednesday (except during the University break), the nursing students join in this activity to present care plans of their assigned patients with the nurse team leader and nurse educator. The nurses, however, are not much involved in training nursing students. Rather, they relay new medical doctors’ orders or the missing routines and prescribed tasks, included occasionally instructing while performing some prescribed and routines task; such as preparing and administrating injections to patients or collecting blood test when a nurse educator is keeping busy with other students (Field notes, 2007). Training the nursing students here is accepted as the responsibility of the nurse educators as the students render care to patients under close supervision, except when the students practice as ‘the nurse internship’ in the fourth year without the nurse educator.
experience over knowledge. This gives insight into the power of the hierarchy and indeed the importance of solidarity – and with it becomes belonging in the TSW.

How much a higher degree is valued is dependent on how it is valued by peers – in this case the TSN. For example, the long discussion of theory and evidenced-based nursing knowledge presented by Master degree students tends to be meaningless and less important for the nurses than jumping out of the nurse’s station to allocate new prescribed tasks while performing pre-working conference (Filed notes, 2007).

Communication and socialization between the seniors and the novices occur while performing handover and the pre-working conference are also a good example of the significance of ‘senior’ at the TSW. As I observed, the time spent and the handover atmosphere were profoundly different when this activity was performed by the novices as opposed to senior nurses since training and coaching new staff nurses is also done during this activity. The atmosphere is sometimes tense and stressful since the nursing staff traditionally uses this prime time for assessing and critiquing novices’ competency, giving feedback, and instructions about the novice’s weak points, including transforming the routine works, the working system and the particular details of working to the novices.

The senior nurses expect the novices to tell the patient’s story systematically and sequentially according to the priority of any problem, whereas the novice did not perform handover fluently as a result of interruptions from questions, complaints and blame from seniors. The novices, however, are not expected to argue at this stage but rather to maintain an outward appearance of ‘being 'obedient' and 'respectful' and also provide a sense of ‘novices are in control and (much) inferior than seniors’ (Field notes, 2007).
The observational data on communication and interaction during handover and the pre-working conference show that the training and learning environment, including relationships between students/novices and colleagues/nurse educators, hinder the development of self-confidence or autonomy among nursing students and the novices from being active and independent. For example, in the pre-working conference, the nursing students were standing in front of the nurse’s station and a nurse team leader and nurse educator were sitting behind the circumference inside the nurse’s station – like the accused or defendant and the prosecutors. In comparison, the training styles of the surgical nurses and nurse educators’ teaching styles are similar, which is sometimes ‘tense and unfriendly’.

As I observed, a nurse educator frequently asked negative questions and gave negative feedback to the nursing students as the nurses did with the novices and the nursing students. From this, the ‘unquestioned’ knowledge evident both between student nurses and nurse educators and between novices and the senior nurses, as witnessed in the interview extract below:

We use Betadine for changing incision wound dressings because we have been taught to use Betadine. I used to use normal saline for changing wound dressings but my teacher seriously asked me why I did not use Betadine. I negotiated that because I read from the textbook but the teacher told me to go back to the treatment room to change from saline to Betadine. I took the textbook to show to the teacher but she did not accept. We are not only confused about changing wound dressings but also about writing up the nursing diagnosis. We have to change with each teacher. While one says ‘yes’,...
the other says ‘no’ for the same nursing diagnosis and then we have to change if we want to pass the evaluation.

(Field notes – Interview KI 8)

The reason for this behaviour is rooted in traditional Thai culture, which as in most other Asian countries places a very high value on learning. Because of this, the learning environment is highly teacher-centred (Prpic & Kanjanapanyakom, 2004): and teachers are highly respected and typically considered as knowledgeable and authoritative (Hofstede & Hofstede, 2005). Out of respect, Thai students may not feel as comfortable asking questions and/or voicing their opinions as Western students. Students are not particularly required to be critical of what they learn and would certainty not openly challenge what is taught; in clinical practice, student nurses are very unlikely to challenge a teacher (Burnard, 2006). This attitude of the ‘unquestioned’ knowledge of the teacher permeates the educational system, from early schooling to university education. As a result, the manner in which nurses are trained is rigid, controlling and encouraging conformity, passivity, dependency and subordination. Currently, according to Hagbaghery, Salsali, and Ahmadi (2004), most of the nursing curriculum in Thailand seems to contain a vast range of theoretical content, mostly based on the medical model. They spend more time on theoretical education, so there will be less time for practical and student-centred learning and developing students’ decision-making skills. Consequently, clinical education in Thailand has focused on doing rather than learning and students are left to apply theory into practice by themselves.
In clinical practice, even students studying for a master’s degree tend to apply nursing knowledge and theory applied to the through their post-clinical conference with the nurse educator rather than to each patient tangibly – this is not uncommon in Thai nursing (clinical) study. While the master’s students present knowledge of evidence-based knowledge of nursing practice or previous research instead of participating, the nurses tend to keep working with computers in checking and carrying out medical doctors’ orders, consistent with telling their colleagues that ‘Master degree students do nothing, just talk with patients’ (Field notes, 2007). Also, the nurse educator and the senior nurses spent a lot of time asking nursing students and novices detailed questions about the pathology of particular diseases while performing the handover and pre-working conference rather than focusing on nursing knowledge and nursing care (Field notes, 2007).

According to McKenna and Slevin (2008), Thai nurses have been berated for basing their teaching and practice on the medical model as evidenced in their nursing curriculum. Similarly, clinical practice and teaching/learning activities of nursing students have to be managed to fit with ward routines and rituals. Also, the long time spend documenting their plan of care is overwhelmed by a task-oriented medical model and routine of practice at the TSW. For example, while at the pre-working conference nursing students offered nursing diagnosis according to care planning, the nurses kept checking current medical doctors’ orders and interrupted by telling the current plans of patient and seriously told the nursing students to finish all routinized tasks on time (Field notes, 2007).
Although their day-to-day activities, as seen in Table 2, tend simply to follow the traditional schedules throughout the traditional three shifts, decisions about which nursing activities or actions to undertake with the patients are made at all times, even in deciding to sit and talk or to do nothing. Therefore the following section attempts to explain how hierarchy and seniority relations among the group of the nurses influence when they make decisions about patient care at the TSW.

**Hierarchy, relations and decision-making rituals among the TSN**

Since most of the nursing procedures are based on and reflect routines and traditions, the TSN does not actually organise his or her day by wondering around thinking, ‘Am I making a decision and how did I arrive at it?’ The key informants in this study found it very difficult to identify or explain the meaning of decision-making and the sequential steps they took when making decisions. The TSN makes decision in ways that indicate a routine, complex, and contextually embedded phenomena. Decision-making often happens very quickly, especially in familiar situations. These decisions in turn become, or at the very least form the basis for, routines, rituals, and the usual ways of making decisions within the TSW.

According to Walsh and Ford (1989), carrying out a task without thinking it through in a problem-solving, logical way implies ritual action. So we find that most of the decisions made by the TSN in relation to patient care are probably the result of ritual rather than evidence-based decisions. From the key informants’ point of view, decision-making mostly happens in a situation that requires making a choice to notify or not notify a medical doctor:
Generally, we do routine jobs except in a situation where it is required to notify a medical doctor, such as in case of emergency when we need to make decisions beyond completing routine works. It’s very hard to tell what I was thinking before making decisions. Day-to-day nursing care is not quite automatic but it’s happened very quickly so that we don’t spent time for thinking ‘what’re we going to do?’ when we encounter each situation.

(Field notes – Interview KI 10)

The hierarchy and seniority relations at the TSW influence the nurses to make decisions in the same pattern, and most of their decisions making are made as a result of ‘general agreement’ among the group of the nurses. This has led to the development of a ward-based understanding of what is ‘right’ or ‘appropriate’ or what ‘ought to be’ in relation to patient care and the clinical actions that are taken. That is to say, in some ways ward-sanctioned clinical actions have negated the need for clinical decisions (as understood as rational and evidence-based responses to problems).

The successful outcome of decisions made by nurses is determined primarily by the level of acceptance and satisfaction that the action taken receives from colleagues and the proven safety of the action for the patient. As a result, the model of clinical decision-making followed most closely in the TSW is that of ‘we must do it this way’. Success and support from colleagues in the light of previous decisions taken enhance the nurse’s confidence and willingness to make future decisions. Through the duration of participant observations, the surgical nurses made many ‘routine’ decisions, which are the habitual nursing activities in everyday nursing practice based on the established-ward’s norms and rituals of practices: repetitive, time-scheduled and not
out of ordinary for them. I observed that they inform the patient pre-operatively, collect all patient documentation (e.g. nursing intervention records), and communicate during handover by using the same language and order (Field notes, 2007).

The system of seniority at the TSW, where younger nurses show respect to older nurses by not engaging in confrontation, impedes Thai nurses from being independent, active, and creative in making decisions rather than following ‘ritual decision-making’. ‘Routine’ decisions include pre-operative teaching or the way patients are dealt with in the night prior to surgery, changing wound dressings, daily patients’ hygiene care, handover, pre-working nursing round, and documenting patient data. Changing wound dressings, for example, is a routine decision in terms of time allocation, types of solution, and the number of gauzes, even the way to cut and seal the plasters. Consequently, the TSN usually seeks information, suggestions, and confirmation from their colleagues to support their decision-making before finalising decisions or deciding on actions to satisfy all parties (Field notes, 2007).

The act of making what are viewed in the TSW as satisfactory and suitable decisions results from a combination of socialization and enculturation. This is seen in the following extended and detailed example of the enculturation process, which acts to highlight the impact of hierarchy and solidarity (discussed in detail in Chapter 6) on decision-making. The seniors in the TSW play the major role in influencing and shaping the behaviours of nurses working in the TSW – this includes the way they make decisions which is clearly witnessed with the arrival of newly graduated nurses at the end of March for a period of six months. The arrival of graduates on the ward signals to the established staff that it is now time to begin to work with the new staff not only to familiarise them with the ward itself but also to develop within the new
staff an acceptance and understanding of the rituals of the ward and the way in which
decisions are made in the TSW. The features and patterns or methods used in the
TSW for making decisions are shared by its members who in turn set about using
various methods to encourage new ward members in conforming to the way the
decisions are made in the TSW.

According to Schein (1985), socialization plays vital role in maintaining and
strengthening norms, routines, and rituals of TSW from senior nurses to novices.
Since orientation process and procedure manual are impossible to address all cultural
expectations, including unwritten policies as well as the variety and uncertainty of
responses from medical doctors, the role of mimetic processes through mentoring are
seen important in this local culture. Here, new members mimic existing members as a
method of learning the correct ways to perceive, think, feel, act, and adapt until
become normative behaviour in order to gain acceptance and to achieve a sense of
belonging without understanding the reasons underpinning their behaviours (Kondra
& Hurst, 2009).

Theoretically, nurses’ decision-making skills have developed from simple to complex
and from patient care decisions to condition-of-work decisions. The assigned-position
and job allocation on any given shift are not only influenced by how the nurses
perform different main tasks, but also by the fact that nurses make decision at one
time, yet not at another time. From this, it’s tended to be only certain people or
‘expected/referred decision-makers’ who can make certain decisions in the particular
setting – who is/are the decision-maker in each situation naturally. For example,
highly experienced nurses are predominantly considered to make decision for
condition-of-work decisions, such as in dealing with complex, emergency, and critical
patients’ situations or difficult cases. The seniors and the head nurse take most responsibility in negotiating, including making suggestions to the surgeons and medical doctors who mostly talk to seniors or the head nurse (Field notes, 2007).

Decisions also tend to be made differently according to the level of seniority and clinical experience. Surgical nursing care at the TSW, like nursing care in the other settings, is a high demand clinical experience. The competence and responsibility afforded to the nurses by colleagues, medical doctors, and others appeared to be based upon positions and years of experiences. The key informants considered ‘clinical experiences’ to be a pre-requisite to making quality decision and also as a critical factor in providing timely and quality care. Novices and less experience nurses, on the other hand, seem to make seemingly irrational decisions. While the seniors apply more knowledge and experiences and other cues to fit the situation, the novices strictly follow established routines, relying on measurable data and medical doctor’s orders (Field notes, 2007).

The complexity of patients (e.g. surgical patients with other co-morbidities, critical patients) reinforces need for the nurses, especially less experience nurses, to depend on hierarchy and solidarity in the organization. The more experienced nurses, however, usually provide support to the junior and less experienced nurses when decisions are complexes, such as in the case of critical and emergency patients’ situation. The limitation in making decisions on complex or critical patient situations for the less experiences nurses is then perceived as inextricably linked to the clinical experiences, including that the seniors have less trust on the junior nurses’ competency in allocating care to complex patients. The junior or less experienced nurses, on the other hand, tend to avoid giving care to patients in this group and rely
mostly on seniors. Currently, the increasing number of critical and complicated surgical patients in the ‘general surgical ward’ – ventilated patients and acute post-op. open heart surgery patients, for examples – not only makes juniors rely more on seniors’ supervision hierarchically, but staying in a ‘senior’ position also makes the seniors get more involved in making decision for less experience nurses.

When a patient became critical, for example, novice and junior nurse notified a senior nurse prior notifying a medical doctor and let the seniors play a major role in managing the situation (e.g. shock, ineffective breathing). In the patient’s emergency situation, the seniors take (over) actions as leader and give commands to the ward staff and automatically perform their roles in resuscitation patient fluently whereas the novice and junior often step back as an observer and follow senior’s commands. Additionally, perceptions about the limitations of less experienced nurses make the seniors usually monitor/assess critical and complicated patients that are the responsibility of the novice’s team. As I observed, several times during the shift the head nurse and the seniors detected a patient’s deterioration under a novice’s team and (loudly) told the novices to notify a medical doctor. The seniors’ instructor/mentor role is therefore seen as assuring patients’ safety (Field notes, 2007). Undoubtedly, the senior nurses see the most important factors influencing their decision-making as high power and involvement in making good decisions based on more clinical experience:

The most important factor that helps me to detect a patient’s deterioration and decide on actions is experience. When I was novice and I saw a patient was restless with agitation, I didn’t understand why a patient presented like that, I’d no idea what’s wrong with my patient, what I should do with the patient,
whether I had to call a medical doctor or not, and felt a bit scared. Fortunately, my senior colleagues helped me to deal with the patient at that time. During the novice period, I always consulted the senior nurses and followed their suggestions and instructions. Sometimes I made different decisions from the senior but I respected and preferred following the senior’s decision-making because they have a lot of experience and they always make good decisions. I also learnt how to make decisions in each situation by observing when the seniors make decisions. When I experience each situation again and again, I can easily and quickly detect the cause and decide on my actions, including instructing my less experienced colleagues to make quality decisions. When we have worked with patients for a long time or got more experience, we can predict that what will happen with a patient in the near future – getting worse, having an oral breathing tube inserted, and can predict medical doctors’ order or prescriptions.

(Field Notes – Interview KI 5)

Our decision-making is mostly dependent on our experiences. We sometimes need to consult senior colleagues to confirm or suggest how to make decisions appropriately. I select consulting the senior nurses who have a lot of clinical experiences to make sure that I make a right decision. Although, knowledge is important, we cannot make a good decision without having clinical experience. Importantly, when we are working with junior nurses or junior medical doctors, our experiences help us to look and see beyond a current patient’s manifestation to tell us whether it will be good or not good in the
near future or we can predict what will happen by using our experiences and it always becomes true.

(Field Notes – Interview KI 14)

The above interview extracts also reflect the significance of hierarchy and clinical experiences to help the nurses predict and prepare a response to the power of medical doctors and hence this becomes a plan and driver for decision-making. Thus the following section moves to explain the relations between the nurses and medical doctors/surgeons at the TSW and how this influence when the nurses make decisions on patient care and care given and when decisions are expected to be made together since they are (expected to be) ‘multidisciplinary working teams’.

**Hierarchy and relations between nurses and medical doctors of the TSW**

It is no accident that most nurses at the TSW are women (only one male nurse) whereas the majority of surgeons are men. A famous Thai saying says that: ‘the man is the front legs of the elephant’ and ‘the woman is the back legs of the elephant’. This means that the man leads and the woman follows him. Nowadays, although most young Thai men and women are very self-confident, independent, and intelligent, professional nursing in Thailand is still given a sense of ‘female career’ since it was the first education-based occupational field for women. The current number of male nurses at the TSW supports this assumption. According to Lerdmaleeewong and Francis (1998), as the great majority of nurses are female, traditional values and customs which ascribe a subordinate position to Thai women, as followers and homemakers, may lead to gender discrimination in areas of health and this could be seen to be real at the TSW which is evidenced through the discussion in this section.
The surgical nurses and the surgeons working at the TSW mostly graduated from the same University and had performed clinical practice at the setting since they were the medical students (4\textsuperscript{th} year to 6\textsuperscript{th} year) through becoming intern medical doctors, surgeons (residents), and/or surgical educator. The relationship between these two professions through this prolonged engagement is, however, within this professional hierarchy, a friendly but with respectful one. The nurses’ feeling of inferiority towards medical doctors is evident from all key nurse informants and the nurse participants on their day-to-day conversation. According to the key informants’ point of view, the inferiority of nursing knowledge is the key feature affecting nurse status in multidisciplinary working teams. Within the multidisciplinary team, professional medicine has been put in the first rank as entry to medicine requires the highest marks in the national admission system, followed by dentistry (six-year-curriculum), pharmacy (five-year-curriculum), and nursing (four-year-curriculum).

We have a value which has been established since we were a child that the clever students will study medicine. So, medical doctors are highly proud of their profession without showing much interest in the other professions. In addition, the value of studying nursing has changed. Few people favour studying nursing. Most of the new generation study nursing because their parents wanted them to be a nurse whereas most of them favour studying multimedia, business, or accounting. They mostly think that nursing is boring since they have to work with sick people and do the disgusting jobs such as cleaning patients after defecation while some are scared of bleeding.

(Field notes – Interview KI 7)
Along with the rigid hierarchy, the respect Thais accord to professional medicine influences the male surgeons who therefore often give commands to the female surgical nurses about what to do with patients; the nurses also see it as natural to carry out those orders rather than making their own decisions, including accepting and complying with other masculine behaviours. Also, the nurses tended to be modest and compliant in interacting with the surgeons, for example, not displaying overconfidence and adopting a subordinate, inferior and humble stance. This humility in the nursing profession, as well as low levels of nursing autonomy, was regularly complained of by every nurse informant and voiced by nurse participants in everyday working:

We lack respect and acceptance from medical doctors because we lack competency to participate or make decisions with medical doctors. They are in the high position, which always looks to the stars and never looks down to the ground. We learn and know less than medical doctors so how can we suggest ideas to them. We are at the bottom of a multidisciplinary team, permanently working under medical doctors. They have a high authority in making decisions related to patients and everything. We always say holistic care or patients’ centre but the fact is medical doctors’ centre.

(Field Notes – Interview KI 3)

It is not a good surprise that as we move into the 21st century this study indicates such a low level of nursing autonomy. Such findings are congruent with the studies conducted in Australia by Street (1992) and the arguments made by Turner (1987) some 15 and 20 years ago and yet these issues are only now being raised as major concerns for Thai nurses as they strive for professional status. According to Street
(1992), the male-dominated medical profession dominates nursing profession, which values the knowledge and experiences of women. Since the privileges of the medical profession further empower them to exercise patriarchal authority and control over an occupation which is dominated by women, the activities of the nursing profession are delegated by medical doctors and involve executing decisions arrived at by medical doctors. Consequently, there is little scope for independence, autonomy, and self-regulation, which in turn impedes autonomous decisions-making by nurses (Turner, 1987). The key informants discussed the reasons underpinning the fact that medical doctors tend to believe in the inherent superiority of his or her group and feel contempt for other groups and cultures and that Thai nurses believe in their own inferiority:

Thai culture gives the great honour to professional medicine. Thais sometimes think that nurse is a subservient to the medical doctor because we always say the medical doctor gives an order and nurse has just carried out the doctor’s order or the medical doctor is a boss of the nurse. We sometimes give a suggestion to a medical doctor, but he insists on following his orders or losing temper because he did not want to lose face. So, we learnt that it’s useless to make any suggestion. Medical doctors are highly proud of medical profession without concerning on the other professions. That’s why they treat nurses as if we were in the lower position or as if we were their slaves.

(Field Notes – Interview KI 7)

The above interview extracts reveal that the value given to professional medicine in Thai society influences the hierarchical relations between nurses and surgeons at the TSW. In a country like Thailand, with the division of labour in medical services,
women continue to function as subordinate labour and this feature of female employment in medicine is forcefully illustrated by the case of nursing and midwifery. Also, nursing is subordinated within the technical divisions of labour surrounding medicine and the development of specialized educational programs for nurses has not significantly improved their status in the medical hierarchy within the hospital context (Muecke & Srisuphan, 1998). One of my key informants, a woman with 15 years clinical experience outlined in our discussions what she saw as one of the key reasons for low nurse autonomy: the majority of nurses perceive that bachelor and master degree nurses do the same work and just as routine tasks; this is evident in the small number of nurses who graduated Master degree of Nursing at the TSW:

I think nurses have to increase their competency to get more autonomy. You see, we prefer doing routine jobs than thinking of study in a higher degree. We lacked of motivation to study Master degree because we still have to do the same work after graduated. A higher degree study is for nurses who want to be a nurse educator.

(Field notes – Interview KI 11)

Medical doctors in Thai culture are traditionally held in very high regard and people are usually unwilling to criticize them, in general. It is certainly the case that traditional discussion of the doctor-nurse relationship emphasizes total obedience and nurses feel peripheral within the healthcare system, especially in relation to power, autonomy, and decision-making:

Nurse autonomy has to be under a medical doctor’s order. We are limited in making decisions or performing independent nursing care. We have just independently given basic nursing care, health education, and hygiene care.
Providing nursing care is mostly based on a prescription. Importantly, we have to do as ordered prior to giving other independent care.

(Field Notes – Interview KI 8)

Medical doctors have high authority in making decision related to patient and everything. We always say holistic care or patients’ centre but the fact is medical doctors’ centre. They have to get everything they want both from us and patients. We absolutely cannot confirm or give a suggestion with some surgeons. If he said you do as I ordered that means he doesn’t want any suggestion. I sometimes did not agree with prescription or treatment for dying patients such as high cost Antibiotics or everyday blood tests. However, I can say nothing because medical doctors always think that they have the right to cure patients whereas nurses only have the right to care accorded to his orders. Importantly, it depends on each medical doctor’s characteristics. Some medical doctors are concerned about our suggestions and the patient’s need.

(Field Notes – Interview KI 3)

The above interview extracts also support the description of the status of Thai nurses by Tyson and Pongruengphant (2004) and Tangcharoensathien and others (1999) that: along with the rigid hierarchy, nurses are subservient to medical doctors rather than co-workers, to men, and to anybody in authority. The hierarchical structure of the healthcare profession assumes medical doctors make decisions about patient treatment, while nurses assist patients and provide support for medical doctors (Tyson & Pongruengphant, 2004).
This status of professional nursing in Thailand is not surprising if we look back to the development of Thai nursing, in particular Thai nursing education. In the past, most Thai nursing educational programmes had predominantly feminine characteristics, and the public view of nursing in Thailand has emphasised technical skills more than independent decision-making (Lundberg & Boonprasabhai, 2001). This history means that nurses in Thailand have largely been subordinate executors of medical doctors’ orders. The current definition of nursing itself also reflects the dominance of the medical model underpinning professional nursing and nurses’ roles:

“Nursing” means the actions related to helping and caring for the sick for the purpose of alleviating the symptoms of illness and preventing it from deterioration, assessment of their health condition, promotion, and rehabilitation of health, diseases prevention, including providing assistance to physicians and execution of a physician’s instructions in a treatment, based on scientific principles and the art of nursing.”

(Professional Nursing and Midwifery Act B.E. 2528, A.D. 1985; emphasis added)

The medical dominance in Thai culture reflects the predominant place of that which is viewed as masculine. This in turn also shapes the behaviours and characters of the surgeons at the TSW which in turn affect relations and the way nurses make decisions. As I observed, the surgeons speak loudly, work and walk fast or look as though they are always in a hurry. They start loudly talking while they are walking around the ward entrance and emergency exit. They sometimes exhibit disruptive behaviour and adverse affect. They sometimes use bitter speech, sarcasm, and do not hesitate to present negative reactions or express negative emotion to the nurses both
by speaking and using sign language: for example, making a bang by putting thing
down on the circumference of the nurse’s station when they get dissatisfied while the
nurses mostly sit and watch or listen quietly (patiently), except sometimes in the case
of the head nurse or senior nurses in relation to a junior medical doctor (Field notes, 2007).

From the key informants’ point of views, the stereotypical characteristics of the
surgeons are masculine, bullyrag, bluster, rampage, and castigation – which has been
acknowledged as ‘the nature of the surgeons’, meaning that it is impossible to change
(KI – discussion). The jargon ‘wean’ has been developed and used at the ward and in
the hospital to refer to the behaviour of medical doctors, in particular the surgeons
when they aggressively criticize someone in a castigating manner. Also, some
behaviour which are seen as ‘inappropriate’ or ‘don’t’ respect the nurses as ‘Thai
ladies’ tended to be common for the surgeons/medical doctors. For instance, while it
is impolite for the nurses to sit on the nurse’s station or table, especially to sit higher
than more senior people, and they are not allowed to have food and drinks outside the
tea room (with some exceptions in the night shift) 4, the surgeons commonly ignore
these prohibitions without getting any warning; this behaviour was perceived as
normal and perceived as the masculine style (Field notes, 2007).

4 With the exception of the night shift who because they are not seen by visitors, and
because they are on duty when patients are asleep, are able to flout the rules by
wearing thongs or slippers instead of fully enclosed nurses’ shoes, and removing their
nurse’s cap (although they too must change back into the complete uniform early in
the morning so as not to be seen out of uniform)
The rules in the organization are tended to be built for the nurses to follow rather for medical doctors who tend to be beyond the reach of rules and regulations. While the nurses have to dress tidily in their traditional nurse uniforms, the surgeons wear private clothes or a green OR uniform with thongs while visiting patient, particularly in the night time, during weekends and holidays. Also, female medical doctors and medical students with long hair need not to keep it tied up and tidy like the nurses must. Furthermore, they mostly wear trendy fashion dress cover by short medical-gown and wear fashion shoes.

As I observed, some of medical doctors, surgeons and medical students enter the ward with a can of coke or a cup of coffee or even leave it at the nurse’s station or computer desk – my experiences as a nurse here told me that ‘nurses are never ever allowed to do so’. Medical doctors sometimes leave the used-medical devices at the patient bedside or at the nurse’s station (Field notes, 2007). Fortunately, although the nurses are dissatisfied and usually make a lot of complaints, and present as bored and angry about these surgeons’ habits, the culture of ‘femininity’ makes them put everything back in order tidily, inspect every surgeon’s works and follow the surgeons to complete their jobs again and again without presenting as tired of their routine task. For example, they will ring a medical doctor to complete a consultation document, or to look at patients’ investigation or laboratory results or give some important orders for patients – as their culture tell them to do so.

Surgical nurses and surgeons do not easily follow instructions and accept any changes or ‘Phud Yark’ (phud = talk to; yark = very difficult) or “difficult to persuade or talk to”. I think surgical nurses’ characteristics have to be like a mutinous woman because we have to forever fight with surgeons. So, we have
to be like this to survive. Surgeons are very cruel and do not listen to anybody.
You know, since HA (hospital accreditation) has been widely used in our hospital, it helps medical doctors and nurses communicating by using the same language with the exception of surgeons and surgical nurses.

(Field Notes – Interview ex-HN)

Talking about the surgeons in this organization is usually going with the reputation for character and working style shown above, which has been described by nurses over the last thirty three years as ‘the story telling of the surgeons’:

We have been fighting with surgeons for an age. When I first came here 24 years ago, every senior nurse moved out from the surgical ward because of the aggression of surgeons and they didn’t want to fight with surgeons anymore. In my view, I’m fine because everything was over after they presented their temper and aggression. I think aggression would help a surgeon to release their tension or pressure. I accept as the nature of surgical staff that we don’t speak softly or use a beautiful word in communication and use sarcasm or a bitter speech. You know, one staff member has been well known about his style since my generation which scared every nurse. However, we accept and realize that he gives the best care to patient, that’s enough, isn’t it?

(Field Notes – Interview KI 7)

The traditional story telling of the surgeons' characters and reputations influence the nurses in developing organizational ‘rules’ and patterns for contacting the surgeons, which remind the nurses to consider the dictum that 'risk outweighs benefit' before contacting medical doctors/surgeons, in particular making decision to notify or not
notify medical doctors. The example of unclear prescriptions and questions are not simply asked and confirmed with medical doctors, on the other hand, making decision to contact or notify medical doctors is perceived as high important and consideration by the TSN could be inferred that the actions taken by the TSN of the TSW are manifest expressions of the group's response to hierarchy and structure that negates the need for and ability for the TSN to make clinical decisions. Also, the working, communications, and decision-making patterns of the nurses seem to be shaped to fit with the surgeons' nature and reputation as 'performance of expectations' in order to avoid conflicts and create harmony within their workplace. Through this the hierarchy is perpetuated and also the possibility of decision-making is limited, especially in terms of the creation of nursing as an independent practice (this is further discussed in Chapter 6).

Staying in the higher position of professional hierarchy and being a topmost person in a hierarchical ladder enhance the surgeons’ status. They often need everything to be done in a twinkle without regard to the regulations or process. When the surgeons want assistance from the nurse or ask for a helping hand, he/she interrupts the nurse although they were doing documentation in the nurse’s station, talking or nursing patients. The surgeons sometimes show lack of acceptance, disrespect, or dissatisfaction when the nurses give suggestions or ask them to complete their jobs. Besides, the surgeons show the high confidence trust in their capabilities which sometimes make sense of non-respect to the nurses, especially seniors.

As I observed, they sometimes present lack of trust or ridicule the nurses’ actions. For instance, as I witnessed, they laughed at nurses when the nurses used EKG monitoring with a patient receiving KCL 60 MEQ in 5%DN/2 1000 ml according to the ‘high
alert drug protocol’. Once the medical doctors left, the nurses showed anger at their colleagues; however, they have decided to stop using the monitor since then. Thus the nurses sometimes change practice in response to medical doctors’ reaction or as expected to be done by each medical doctor rather than following the hospital policy as they mostly say (defence) that: “we don’t want to have any trouble with medical doctor” (Field notes, 2007). Here although the nurses within collectivist society socialize to conform to group norms and regulations, social relations tend to make these less important.

Currently, doctor-nurse communications at the TSW are rare, and their shared knowledge about the patient tends to be weakened. The communications between the nurses and surgeons are mostly relating to patients and sometimes looked like the communication between defendants (nurse) and prosecutor (surgeon). The nurses and the surgeons work like ‘one does one job’ and mostly communicate via medical doctor’s order or ordering style. It seemed to be that medical doctors just give orders and the ‘good nurse’ does what she was told via medical doctors’ order or words of communications –‘medical doctors’ orders are to be obeyed, not questioned’ (Field Notes, 2007).

Complying with surgeons’ working style and behaviours tended to be one of the important strategies to harmoniously work with the surgeons at the TSW. The surgical nurses seem to accept, understand, and overlook those surgeons’ reputations beyond giving good care to patients. Surprisingly, the nurses often negotiate or debate when the other persons beyond the group of nurses themselves, such as patients or patients’ relatives, criticise or talk to the surgeons negatively. Since the majority of the nurses are female, quality of life is achieved through placing greater emphasis on the
importance of relationships, feelings and harmony in feminine cultures (Hofstede, 1997; Prpic & Kanjanapanyakom, 2004). The TSNs learn the nature or limitation of particular surgeons/medical doctors and display compliance. Similarly, compliance is as counterproductive as hostile confrontation when confronted by an abusive or sarcastic doctor (Walsh & Ford, 1989). The hierarchical relations of the nurses and the surgeons at the TSW lead to explain the emphasis on task and physician-centeredness of the TSW, which in turn has implications for the ability of the nurses to make decisions about patient care.

'Functional task-oriented' and ‘physician-centeredness’ of the TSW

The medical dominance and hierarchical relations influence the nursing system at the TSW, leading to an approach that is 'functional and task-oriented'. This reinforces the prioritising of care needs and actions by the TSNs based on a task-centred working system which adheres to the medical model (McKenna & Slevin, 2008). Similarly, the cultural and professional models of illness, in particular the biomedical model, which has dominated health care for the past century (Wade & Halligan, 2004) means that the nurses make decision on individual patients mostly on the basis of pathology of diseases. The patients' conditions and medical doctors' orders become the vital factors for the nurses in making decisions about their actions and time spent with each patient. The nurses decide on their time allocation and work priority with a focus on completing ‘prescribed’ and ‘routines’ tasks, especially carrying out medical doctors’ orders and ensuring patient safety. For instance, both treatment nurses and nurse team leaders hurry to perform medical doctors' orders once they finish the pre-working conference or even while listening at the handover. The routines and prescribed tasks are also checked and/or audited to be finished in time by seniors or nurse team
leaders, especially when novices or nursing students perform those tasks (Field notes, 2007).

The dominance of the biomedical model as the driving model for nursing, over say the social model, at the TSW influences the way what skills, actions and kinds of knowledge are valued by the nurses, medical doctors, and patients at the TSW with implications for practice. How busy a nurse is depends on the number of identified ‘critical’ patients and of prescribed tasks. Also, perception of ‘finished working’ or ‘being free’ is defined when the nurses have finished allocating both ‘prescribed’ and ‘routine’ tasks whereas a number of critical patients and medical doctors’ orders to carry out are perceived as ‘being busy’ (Field notes, 2007). Nurses also praise their colleagues and nurse educators who completely and quickly finish working on/before time, quickly assess patients’ deterioration and manage emergency situations, and have high competence in indwelling IV catheter and successfully performing blood tests; they also show dissatisfaction with juniors who cannot finish work on time (Field notes, 2007).

One of the most notable habits of all team leader nurses at the TSW is that they have taken their roles in overseeing documentation and visits. The nurses spend much of their time for visiting, documenting, and highly paying attention on critical, unstable, or complicated patients, as they have a lot of medical doctors' orders and prescriptions for this kind of patient. Since the patients' conditions at the TSW vary from nearly discharged to critical, they rarely walk to visit stable or ‘non-treatment’ patients (e.g. waiting for urological surgery) whereas they usually visit critical patients, who are being admitted in front of the nurse’s station, or visit patients to perform prescribed/routines tasks. One of the key informants expressed her feeling of guilty at the end of
the busy shift that two new critical patients in her team which made her forgot to visit the other patients in the last block (bed 25-28).

Within an environment of the TSW that emphasizes ‘task and physician-centeredness’, providing assistance to physicians and execution of physician instructions in a treatment is the major concern for the TSNs as they hurry in completing medical doctors’ orders. While the actions related to promotion and rehabilitation, especially in rehabilitation post-op. patient, health education, and wound healing were mostly done sporadically when they had free time after completing medical doctors’ orders, especially with sicker patients. As I observed, the seniors usually instruct and inspect novices and the nursing students to complete medical doctors’ orders than focusing on independent nursing care (Field notes, 2007).

The non-medical needs of patients are not factored into either the activities performed or understanding of their role. For example, taking time to chat with well patients can be considered an important nursing activity yet in the TSW this activity is not allocated status and so is not defined as important. At the TSW, bedside nursing cares such as assisting patients with bathing, eating, tepid sponge, ambulating, even changing wound dressing and all recording are mostly allocated to team member (PN or orderlies). Whereas RNs spend most of their time at the nurse’s station carrying out medical doctor orders, completing prescribed tasks and huge documents, follow by (quick) routine bedside visit patients to document in nursing intervention records. Talking to good condition patients is mostly done when they have less complex patients in the ward. I wondered whether we learn a huge amount of nursing theory and knowledge through the four-year-nursing curriculum (plus two compulsory
summer courses), including participating in several courses of continuum nursing education to understand medical doctors’ decisions and their prescriptions (Field notes, 2007). These phenomena reflect the dominance of the medical model and ‘functional and task-oriented’ at the TSW underpinning their practices which are witnessed through a typical day of the nurses. An environment in the ward that emphasizes task and physician-centeredness is one of the vital factors that influences the nurses’ developed routine and ritual decision-making.

Hierarchical relations and decision-making discretion of the TSN

The pattern of behaviour between two parties in the TSW reflects symbiotic relationships such as superior-inferior, patron-client or elder-younger and influences cultural nursing practice and the way nurses make and implement decisions. The relations between the nurses and the medical doctors within the TSW influence the nurses to adopt ‘expected roles’ in the ward when they make decisions, particularly those that involve the medical doctors. There is a pervasive and socially-legitimated expectation in the TSW that decisions should be made by those in positions of authority. The hierarchical nature of relations at the TSW places a high value on seniority and professional medicine, and produces an environment where decisions are made at the discretion of the medical doctors/surgeons and the senior nurses. This finding is consistent with previous studies (Hallinger & Kantamara, 2000; Hofstede, 1991).

TSNs pointed out a physician-centred atmosphere in the ward that doesn’t respect nurses’ decision-making, which could frustrate and constrain when they make decisions and question their autonomy in making decisions. TSNs decide on their actions mostly to support the needs and prescriptions of the medical doctors. Making
decisions about what to do with the patients is therefore most influenced by medical
doctors and prescriptions telling nurses what to do rather than being involve in
patient’s plan of treatments. This poses certain questions about nurses’ autonomous
decision-making and the reality of ‘nursing care’. As I observed, although they
sometimes express distress and dissatisfaction with inappropriate prescriptions or
practices from the surgeons (e.g. weaning a high-body temperature patient or a lot of
blood tests in a dying patient), there is little chance to speak out or even ask for
reasons as the organizational culture means that it is inappropriate to speak out or
question medical doctors’ orders.

Organizational culture appears to be a more powerful driver than the imperatives of
patient health of the type of decision-making that occurs in the TSW. Decentralized
decision-making has been identified as important to the autonomy and functioning of
organizational subcultures in innovating firms since it enables members to obtain the
resources and autonomy necessary to construct and maintain a subculture (O’Reilly &
Tushman, 1997). Thus, in larger organizations with greater task differentiation, more
divisions (functional or product), more groups of professionals, more decentralized
power and decision-making subcultures are likely to emerge than in smaller
organizations with less task differentiation, fewer divisions or professional groups,
and more centralized power and decision making (Boisnier & Chatman, 2003). In the
case of the TSN, a hierarchical structure based on medical dominance clearly limits
the decision-making discretion of the TSNs.

The system used within the hospital itself, such as the patient admission system, also
enhances the decision-making power of professional medicine. According to the
admission system of the surgical department, the surgical patient will be admitted and
categorized to be a patient of a particular surgical educator, who is the so-called ‘owner of the patient’. Generally, the professional bureaucracy of medicine enables medical doctors to have significant power and authority distributed along a formal chain of command, directing those beneath them, especially nurses, at a lower level of this hierarchy to receive and execute medical doctors’ orders (Hardcastle, Usher, & Holmes, 2005). Similarly, all decisions on the patients’ plans of treatment and prescriptions are made by the medical staff. Also, since the nurses do not have the power to prescribe drugs and most of their activities are ‘prescribed tasks’, the nurses making few decisions without the medical doctor’s assent:

While medical doctors can order any medications to cure or release patient discomfort immediately, we (nurses) can only give first aid which just supports the distress and tends to be useless and worthless for the patients and have to wait for a medical doctor’s order when they are away from the ward. I encountered a situation when a patient receiving chemotherapy was developing nausea and vomiting, I supported her by giving lukewarm water to swish her mouth and massaged her softly back and forth touch along her back. She however, looked seemingly irritated with me and kept asking about antiemetic as well as telling me to call a medical doctor.

(Field Notes – Interview KI 1)

The nurses at the TSW do make decisions to administer some dependent/interdependent nursing care to patients without a medical doctor’s order. Although, most of the nurses’ decisions on their actions rely on therapeutic actions as prescribed by the medical doctors, the surgeons allow nurses to make decisions in some circumstances, especially when patients deteriorate and a medical doctor could not
come straight away. Moreover, since the critical patients have been admitted at the ‘general surgical ward', TSNs, similar to critical care nurses, make decisions in emergency situations without medical doctors’ orders on matters such as administering oxygen, stopping weaning of dyspnoea-patients from mechanical ventilator, and even performing IV indwelling and blood tests.

One of the good examples of their decision-making freedom was observed when a nurse was terminating weaning of a patient from a mechanical ventilator once the patient developed difficulty breathing prior to notifying a medical doctor and the medical doctor looking satisfied and accepting of the nurse’s decision. On the other hand, the head nurse disagreed with a nurse team leader to continue weaning a good condition patient from the mechanical ventilator beyond the duration in medical doctor’s order as she asked, ‘who’s going to take responsibility if the patient develops unexpected deterioration?', and suggested that the nurse notify the medical doctor if she wanted to continue weaning the patient (Field notes, 2007).

The differences in making decisions about the same clinical condition, however, reflect the high impact of medical doctors have on nurses’ decision-making. Making decisions without having medical doctors’ orders as back up still runs the risk of incurring medical displeasure:

We can do some dependent procedures without having a medical doctor’s order. For example, we perform DTX (dextrose level test from finger’s blood) when a patient with or without underlying DM has signs of hypoglycaemia, such as loss of consciousness, sweating or fainting before notifying medical doctor. In case of patient with GI bleeding and presenting with bloody
vomiting, we can stat (stat = statim = immediate) HEMATOCRIT and report the result when we notify. Most of the surgeons accept these patterns. We decide to do these procedures based on our knowledge and experiences from observing seniors’ actions in each particular situation and the medical doctors also accept our decisions such as by asking ‘what’s the DTX level?’ When we experience the same situation and we get acceptance again and again, we assume that we can perform those dependent-activities.

(Field Notes – Interview KI 15)

The reasons underpinning low nurse autonomy in making decisions within the hierarchical structure of the healthcare profession, in particular professional medicine at the TSW, is firstly supported by Turner (1987, p 141), who argues that occupational subordination to medical dominance characterizes both nursing and midwifery. As a result, there is little scope for independence, autonomy, and self-regulation, which in turn impedes the nurses’ autonomous decision-making. The nurses however have ways of dealing with this – their own control over each other; the ways they help out and protect each other. The hierarchy and seniority among the nurses themselves help the nurses to deal with this and as a result to maintain harmonious working at the TSW.

Under the working environment of lack of recognized specialized nursing knowledge, workloads with critical patients, and high expectations from stakeholders, the nurses here are also expected to work more effectively than ever to achieve the goals of the hospital to reach the quality of nationwide as well as preserve and conserve the image of Thai nurses and Thai ladies traditionally. The nurses, on the other hand, are mostly happy and rarely move out of this culture. The present low turnover rate and the high
retention of experienced nurses at the TSW indicates that other forces are at work to counter the nurses’ constrained decision-making constrain and inferior position on the hierarchy compared with professional medicine. Nurses want to take care of patients and are proud to be a surgical nurse. The following chapter moves to explore how the TSNs maintain and preserve the strong bonds among the group and boundaries that divide them from outsiders as well as to maintain their balance to be happy within a hierarchy and with ‘decision-making constraints’.
CHAPTER FIVE

SOLIDARITY

“Stick together and support each other”

“We always do it this way”

In the previous chapter (Chapter 4) I have shown through my discussions of the TSN and their social relations with each other in the ward, the influence of hierarchical relations among nursing staff, and the influence of this on nurses’ decision-making in the TSW. The discussions in the previous chapter also highlighted the way in which the enculturation and subsequent integration the TSN bind the members under the hierarchical relations within the context of the TSW. In this chapter, I share my direct observations of the ways in which the nurses of the TSW establish and maintain the strong boundaries surrounding their group that act to protect the members of the nursing staff in the TSW against outsiders. This is, what Douglas (1978) refers to as “group strength” (see also Chapter 1 pages 6 – 10) and like hierarchy is important in determining the way in which the members of the TSW make and employ decisions. Against the background of the physical structure with all of its implications (Chapter 3) and the pragmatic routines of the everyday and the associated hierarchy of the hospital and the ward (Chapter 4), this chapter begins to reveal the way the solidarity (group strength) influences the process and the complexities that drive the nurses of the TSW to make the decisions they do.
A ‘family-like-atmosphere’: Stick together and support each other with care and consideration

The social and professional relationships that exist among this group of TSN has a long history having been established over many years beginning at the time when they were nursing students at the same institute. The nurses (RNs) at Songklanagarind hospital as well as at the TSW, graduated from Faculty of Nursing, Prince of Songkla University (PSU, established in 1974). Close relationships were established during their freshmen years and have continued through the four years of the nursing degree program. There are a number of practices in place at the student level which assure the development and continuation of these relationships. For example, the senior students use the so-called 'SOTUS' system (S: seniority, O: order, T: tradition, U: unity, and S: spirit) to welcome new students via a ‘cheer meeting’. A group of senior students called ‘varger’, meaning seniors’ role-play various situations that the nurses may encounter – including bullying and anger. This activity and its themes act to create a tense atmosphere for the group of new students with the intention of forming among the students the basis for establishing a strong bond within the group and a ‘detachment’ from external threats. The spirit among the group of the new students is strengthened in this way – by establishing a sense of belonging and unity – to deal with threats from outsiders (Field notes, KI – discussions, 2007).

This activity also aims to preserve and maintain one of the important values of Thais: ‘showing respect to seniors’. This is achieved among nurses from the outset of their education where following the disciplines and acts of socialization set down for them by the more senior students lead to a transfer of the nurses’ culture and tradition to newcomers regardless of different social and family backgrounds. For example, the
freshmen are expected from the very beginning of their University experience to pay respect to nurse educators and students in more senior years by enacting the practice of *wai*, the traditional form of greeting, given by the person of lower status to the person of higher status.

In Thai society, non-verbal communications as manifested in Thai body language through symbolic gestures are used in daily life between individuals and groups to differentiate respective positions and reflect the basic Thai structures of the socio-cultural ladder of status, prestige, seniority, and power. ‘Social definition’ can be flagged in what to the outsider would be seen as very subtle ways such as by the way Thais stand, sit, walk past someone, and pay respect to someone. *Wai*, for instance, is used to clarify the relative status and respect accorded to parties concerned. In Thai society the use of *wai* publicly demonstrates the superiority rule. When two people meet, the socially ‘inferior’ person takes on an inferior position while the socially ‘superior’ person assumes a physically superior position. The *wai* is also common as a way to thank someone or apologize in Thai culture and used for both hello and goodbye.

The *wai* (pronounced *why*) is a gesture used to demonstrate the importance of Thai values and attitudes. Some believe that *wai* is one of the most important social customs of Thailand. The Thai greeting referred to as the *wai* consists of a slight bow, with the palms pressed together in a prayer-like fashion. The joined palms are raised to the level of the nose, the tips of the thumbs touching the tip of the nose and those of the index fingers touching between the eyebrows complied with saying *Sawasdee* (hello). Generally, this is an act of respect towards one's parents, senior family members, teachers and revered people in Thai society.
In Thai society, there are strict rules concerning who and how to wai. The status and seniority of individuals can be ascertained by the way they wai each other. Generally, the younger or junior person (within the social hierarchy) initiates the wai. It is considered unlucky by some Thais for an older or senior person to wai a younger or junior person first. The lower the head is bowed, the more respect is shown. The higher the hands are held in relation to the face and the lower the bow, the more respect/reverence the giver of the wai is showing. If the head is bowed and the fingertips are just above the tip of the nose, it means that the socially inferior person is showing respect to a socially superior person. A socially superior person will return the greeting to a socially inferior person by joining the hands and keeping them close to the body with the fingertips reaching the neck level. The head will be kept either straight or slightly inclined. When one lowers the forehead to the base of the thumbs and the body is also bent at the waist, it means that the respect is being accorded to the King, monks, temples, spirit houses and statues.

In the TSW, although there is a strong hierarchical relation among the ward staff and between professions, they rarely use wai when they meet each other. The lack of the use of wai between established members of the TSW suggests that while hierarchy remains – as a way of defining role position – some of its rules are flouted by the commonality of the membership to the group. This becomes especially apparent with the arrival of a novice on the ward. Novices perform wai to the ward staff in almost every position during their first month on the ward. However, as they become more accepted by the TSN the practice of wai decreases significantly except with nurse educators who still have a very direct role with the novice. The nurses by contrast perform wai only to more senior nurse educators, nurse supervisors, and administrators, and then only once at the beginning of each interaction (Field notes,
2007). The nurses themselves, when asked, told me that that since they meet each other almost every day, they need not to wai every time. So, wai, from my observations is used to differentiate between ‘native persons’ or to ‘prolong enculturation’ of ‘newcomers’ or ‘guest’.

This sense of closeness between the nurses of the TSW is further established through the relationship between the academic and the clinical area. The PSU nursing student undertakes their clinical learning experience at the Songklanagarind hospital. This means they are exposed to their own alumni thus reinforcing this relationship between the University and the hospital. Many of the nurses now working in the TSW performed their clinical practice as nursing students and worked as ‘nurse intern’ here. After graduation, they returned to work at the same organization, modifying the previous personal relationship of senior and junior. This practice and relationship combine to reinforce and create a low level of competition for career advancement and a highly stable workforce at Songklanagarind hospital.

The high group strength is evident among this group of the TSN in the fact that they devote most of their time to interacting with each other for both working and individual activities together, especially among the long-term staff (the ward has a very low turnover rate of about two or less nurses annually out of 28-30 nurses). This has ensured establishment of strong relationships and solidarity among the TSN and has led to a formation of a “closed group” through strong boundaries against outsiders and a conservative hierarchy within the group. Consequently, the expectant act of the individual is associated with the collective whole and normative interests of its members as such witnessed from the typical day of the TSN. According to Douglas and Wildavsky (1982), hierarchy is enacted in a ‘high group’ social environment
through influencing members to maintain hierarchy, and presenting the dominant of collectivist as well as ascribed hierarchy. From this, the individual’s behaviour is controlled and sanctioned by group membership, including providing both individual and group supports within their group. A long-term commitment is then established and a tight identification of members with one another as a cooperative entity (Douglas & Rayner, 1985).

The strong bonds among junior and senior nurses reflect a sense of reciprocation as witnessed by how members of the group communicate with each other in the TSW. The language of kinship is used by the TSN as an idiom to express both the solidarity of the nurses in the TSW and how non-kin relationships are ordered hierarchically. As I observed, the nurses use kinship terminology for non-kin work colleagues, patients and patients’ family members. Generally, Thais adopt kinship terms that can show the right degree of respect, deference and intimacy and use kinship terms depending on age to address each other, as if they were blood siblings. Kinship implies obligations that transcend the particular shared-interest situation (Keyes, 1987). The kinship relation at the TSW allows colleagues to become ‘elder sibling-younger sibling’ (*phee-nong*) to each other or ‘sibling together’ (*phee-nong-kan*), and not just ‘co-worker’.

In Thai society, kinship terminology reflects generational relationships. For example, *phee* (elder sister/brother) refers to a person who elder than the speaker, *nong* (younger sister/brother) refers to person younger than the speaker. A kinship term may also be placed before the given name in addressing when the relationship is clear as such elder-younger terminology is often substituted for ‘I’ and ‘you’. At the TSW, when two people are introduced to each other, it is important to know each person’s
age or year of (bachelor degree) graduation to set the rank of *Phee* or *Nong*. These two words help in decreasing the space and increasing the closeness of relationships between persons. However, *Phee* is sometimes used with a person younger than the speaker to show ‘respect’, especially by person in a lower rung of the hierarchy. For example, although one senior PN is older than the head nurse and senior nurses, she calls the head nurse and the seniors *Phee* whereas *Nong* is often used to call the group of ‘subordinates’ as most of the RNs call the orderlies ‘Nong orderlies’ no matter how old they are (Field notes, 2007).

**TRADITIONS, BELIEFS AND RULES**

The strong bond among the group of TSNs is also derived from the pattern of their beliefs and values since the majority of them are Buddhists and Southerners. For Southerners, cultural images of the good life are matched by lifestyles as blueprints in everyday life for the organization. Importantly, local signifiers are not replaced by Western symbols. For instance, anyone arriving around meal time is always welcome to stay and share the meal. Also, local foods are chosen to represent authentic Thai culture and traditions, indicating nostalgia of the past in the face of social change and the influx of Western lifestyles (Horstmann, 2002).

The religion of the majority of people in Southern Thailand is Theravada Buddhist. Buddhist virtues are deeply instilled in Southern Thai culture since it has been presented in the area already for centuries. Many people from this region combine Buddhism with belief in spirits in nature. Spiritual power spreads by words of mouth and quickly attracts members. The appearance of the Southern Thai is distinct and their persistence predominantly identifies them. Generally, the tone of their skin is
darker as compared to the average Thai. They have their own dialect called "Southern Thai" and it varies in seven tones. The personality of the Southern Thais is generally strong and they are more aggressive than their Thai cousins from other regions, and they really express what they think. However, aside from their persistence they are reserved, gentle and giving. It is important that visitors in this part of Thailand to stay calm always smile and show gratitude for the kindness of their hosts. From this, the distinct culture and personality of the Southern Thai people have often been misunderstood and this has even become as a source of conflict between their own fellow countrymen. It takes a deeper sense of understanding of these people to have a harmonious relationship to them.

Consequently, some of the nurses’ ritual activities are enacted from the general agreement on the stories and myths regarding their religious Thai customs, Thai festival celebrations, and supernatural believes, such as New Year celebrations and ‘annual merit-making’. From the key informants’ point of view, ‘annual merit-making’ or *tam-boon-ward* has been held at the TSW, as well as in every ward and on behalf of the hospital, reflecting their supernatural beliefs, the so-called *jao tee* (*jao = God, implies a control over natural phenomena that needs to be paid respect or homage to, ‘tee’ = place)*.

Every year, monks are invited to the ward to provide a chance for the ward staff, patients and family members to make merit by offering foods, and a set of flowers, candle and joss-sticks, and envelopes with money for their day-to-day needs to the monks. The day before the ceremony, all the furniture is moved out of the tea room and the cushions and mat prearranged neatly along the walls and floor. A bowl filled with water to be consecrated during the ceremony is placed on the floor so as to be
within the abbot's reach and around the ward. After the ceremony, the monks will walk around the ward, included the patients’ area to throw a holy water to bring the good luck and ‘khwan\(^5\) to all parties (Field notes – discussions, 2007).

The system of gaining religious merit operates almost on a point system (Leppert, 1996). A variety of misfortunes in the ward or with the ward staff, such as the sickness of three staff and their parents, or the passing away of two patients at the same time, are frequently talked about and linked with the postponement of ‘annual merit-making’ (Field notes, 2007). This is not uncommon since Thais ascribe almost all events to the will of spirits, Brahmanical ceremonies and ritual play an important role in strengthening morale, maintaining psychic balance and maintaining tensions and anxieties as well as being essential to the wellbeing of members and a stabilizing social force in organization. Holding a *tam boon* ceremony (making merit by offering food to monks) in one’s own home and workplace is something with which every Thai Buddhist is familiar. Mischievous spirits, for example, are said to cause sickness, sorrow, and pain, make people lose their way, fall out of love, and cause virtually any problem in life. From this, any odd event may be interpreted as a sign from the spirits. Thais also concentrate on gaining merit to help them achieve a better karma (or fate) for reincarnation. Failing this, some Buddhists will try to create merit to increase the joys and reduce the sorrows of this life (Leppert, 1996).

\(^5\) *Khwan* is, according to Burnard and Naiyapatana (2004), one of the important beliefs of Thais which is usually conceptualised as a form of life force or life spirit as well as it goes away when a person ill or in shock.
Thai Buddhists also believe that spirits inhabit objects. This belief predates Buddhism, and especially prevails in times of crisis when Thais rely more on spirits than merits. Spirits are the souls of departed ones and they may cause trouble unless properly supplicated with offering and prayers. For instance, it’s common for many nurses and ward staff to wear amulets (Buddha image, often gold-plated) around the neck since it’s believed to possess a variety of scared power. According to Thais’ beliefs, magic amulets ward off nefarious spirits, carry much power and protect the wearer from ghosts and demons.

I heard certain ghost stories being seriously retold among the group of the nurses and ward staff quite often, such as the story of people who saw a patient with a red rope (generally symbolising a dead body) around the wrist name card in the lift and a patient seeing a ghost at night. A delirium post-op. patient with electrolytes balance was discussed while performing handover in according to supernatural jao tee or ‘the owner of the bed’. The story of a patient admitted to the isolation unit of the ward who saw the ‘passed away-woman’ sitting in the bedside chair at night time has been told among the ward staff quite often and they all (including me) believe this story and ‘feared ghost’ (Field notes, 2007). This is not uncommon since astrology and the supernatural heavily influence the daily life and decisions of a large number of Thai people. According to Klausner (1993), while gnome mania has become an amusing fad in western world, ghosts, gods and demons are still very much reality in the rural area as well as some urban in Thailand.

In the modern and highly technological medical care context of the urban ‘Hat-Yai’ city, the world of spirits and magic is never far away. In some situations beliefs overcome the rules at the TSW. For instance, gluing gold leaf (pid-tong) to the head
of patient’s bed after getting well or being discharged by patients and family members can easily be done without getting any warning and none of the ward staff are brave enough to take them off. Since many Thais have deep-seated superstitions, they rely on ancient animistic beliefs. Buddha images, decked with flower offering and incense, are ubiquitous, including praying at ward spirit houses. As it mentioned previously, the Buddhist shelf is hung in the highest place over the conference table, which always has a garland of fresh and lei jasmines and burning joss sticks, placed to pay the respect or pledge for the wishes to the Buddha image every day by the head nurse, patients, and/or family members (Field notes, 2007).

In contrast, staff nurses and auxiliaries strictly tell the visitors not to smoke or make any flame within the ward area, especially around the oxygen wall pipelines suited over the head of each patient’s bed. However, none of the staff tell family member of deceased patients or priests to stop burning a joss stick since they believe that it helps in guiding the spirit back home (Field notes, 2007). Additionally, the TSN as the Buddhist Thais appreciate that suffering is inevitable (Klausner, 1993). Thai beliefs about death bring social unity to Thai families as distant family members return home to see a dying patient with close relatives influence the TSN to ignore the visiting rule that do not allow family member to stay overnight with the patient:

Personally, suppose we or our close relatives were undergoing surgery or are in a hopeless state, we need to stay and get support from close relatives. I think I will send a letter to the Dean and ask to break the visiting law. Our ward will allow a relative of a critical patient, hopeless patient, including immediate post-op, patient to stay with patients overnight. As you know, we don’t want lonely dying in our culture. So, it’s not good to let end stage or
hopeless patient die without family. I keep telling my junior nurses not to hesitate to allow the relatives to stay with a hopeless or dying patient regardless to the visiting policy. If a patient passed away in the night, it would be great if a relative stays beside him.

(Field notes – Interview KI 12)

The influence of Theravada Buddhism on the care given by the TSN is evident in their tendency to disagree with aggressive treatments (e.g. blood tests/interventions) to un-peaceful dying patient. Regarding the care of dying patients, Buddhists devote considerable religious practice to preparing for death as it is very important for everything possible to be done to provide as much peace and quiet for the dying person as possible. The more composed and calm the mind is at death, the greater the opportunity for a better rebirth. While Buddhists believe that it is good to continue living as long as possible, it is not believed that this should be done under all circumstances. For example, life support machines are not believed to be helpful if the person’s mind is no longer alert.

Having an alert mind and not being in excessive pain are the two primary factors that affect a Buddhist decision regarding the appropriate time of death. Once the conditions are quite difficult, it is believed that it is better to die. Allowing the person to die in a natural, peaceful manner is considered essential. A quiet and peaceful atmosphere is most beneficial when one is sick or dying. Maintaining a calm and peaceful atmosphere for the sick person is again the essential aspect while maintaining a positive, caring attitude when interacting with the patient is the traditional cultural norm (Mulder, 1996). After death, care is also accorded to Theravadas as the nursing staff would tell the patient’s family member to bring
clothes for the patient, body bed bath, allowing them to make merit (e.g. praying, burning a joss stick and walking in front of the dead body).

THE TEAROOM – THE GREAT EQUALIZER

Joining together at meal times provide another important strategy and chance for staff to strengthen their solidarity and support each other by providing a high level of comfort and less hierarchy. There tended to be less/no hierarchy and no position power in this ‘tea room’ space as a cleaner loudly argued with a senior nurse on social issues or a TV series and each person takes responsibility to clean their own eating area and kitchen utensils. According to the key informants, having meals together at the ‘tea room’ is caused not only by the hospital canteen at the basement being very crowded during the lunch time (11am – 1 pm), but also the need to get more privacy (the wood door is kept closed at all time), relax, and ‘enjoy eating’ (Field notes – discussions, 2007).

The ‘meal meeting’ is an important element in facilitating the solidarity of the TSN. During this time they congregate in the ‘tea room’ as well as sharing food to have with rice (e.g. curries, chilli paste, stir-fried, etc.). The time spent here is used to improve and establish relations and cohesion among the group of the ward staff and between new comers and old members. As I observed, most staff enjoy sharing their food with each other, talking about personal matters, telling jokes, watching TV broadcasts (the television is always turned on while they are eating), and the other activities beyond working.
The atmosphere in the tea room is relax and joyful or sanuk, which is extremely important as this is the space which provides the most support to the new comer. Here the novices become familiar with, begin to know their colleagues and start to feel more comfortable about both the ward itself, and perhaps most importantly the ward staff. The relaxed atmosphere which acts to support the nursing staff and reduce the hierarchical levels in it results in a shortcut to ‘enculturation’. Since sanuk provides welcome relief from the tensions, pressures, and frustrations it establishes an environment where respect, deference and diffidence towards seniors is somewhat relaxed, in turn helping to form harmonious, non-threatening working relations, even when clear lines of authority and hierarchy remain.

The physical distance from the ward and the privacy of the ‘tea room’ in association with the ‘home like’ furnishings of the room provides a chance for the nurses to freely express their feelings and frustrations during their ‘meal meeting’ such as to flout the system (e.g. the delay of getting extra-shift pay, the limitation in studying in higher education) as they never do in a public (professional working area) such as at the nurse’s station. The privacy of the ‘tea room’ also enhances the opportunities for the nurses to gain and/or provide supports to each other which becomes the vital tool in the TSN’s ability to maintain their harmony and increase a sense of ‘collectively’ and ‘close group’ belonging in the TSW.

An example of this can be seen in the following discussion of a ‘night meal meeting’ which took place during the night shift outside the ‘tea room’ at the central counter of the nurse’s station. In contrast with the morning and afternoon shifts, all staff join in this ‘night meal’ meeting altogether as it gives a feeling of a warm and congenial atmosphere. After recording and documenting vital signs and/or intake-output,
administrating injections around 2 am, if patients’ conditions are stable, most of the night staff joins in the night break with a light meal such as rice porridge (*khaw tom*) or instant noodle (*Mama*), which has become the popular quick meal of Thais instead of sandwiches (as one or two of PN/or orderlies cook for every staff at the tea room) or coffee (to wake them up), including hanging and sitting altogether at the central counter and at the nurse’s station (Field notes, 2007).

Having a meal and enjoying eating together additionally reflect the level of relationship between members of the group and is one of the signs of culturally denoting newcomers to be considered one of the groups. People ‘enjoy eating’ by loudly talking and laughing, while freely discussing or gossiping about the hot issues in society. From this, less talking is witnessed when the meal is shared with guess or unfamiliar persons, such as when novices join in the meal. Also, low-volume talking tends to take place when there is an unfamiliar guest or person of higher status; such as nurse supervisor or senior nurse educator come to talk to the head nurse during that time (Field notes, 2007).

On the other hand, people who have not had a close relationship with the group avoid having a meal with them. For instance, not every nurse educator working at the setting ‘joins in’ at lunch time, only ‘good relationship’ nurse educators, who make themselves available or comfortable to talk to and who allow the normal atmosphere in the tea room to be maintained. The novices/new staff prefer having lunch at the hospital canteen at the beginning. I, for example, observed the novices were reluctant to have lunch with the other staff and were uncomfortable when they joined in the tea room hurrying to finish eating and getting back to the ward earlier. The nursing students only briefly enter this room for drinking water but not having lunch while
only a few medical doctors, mostly extern (year sixth) medical student, go to this room for drinking purposes, especially in the night shift. So, 'having meals and enjoying eating' together can imply 'close relations' or 'enculturation' of persons involved with the members of the TSW, reflecting the strong bonds among the group, providing a sense of ‘group belonging’ or ‘team work’ as a result to increase job satisfaction and retention of the nurses.

**High group strength: Care and consideration**

Beyond ‘meal meeting’, the ‘high group strength’ and ‘closed group’ of the TSNs can be felt and touched and usually witnessed via their day-to-day working, activities, relations, and interactions with each other. The words ‘we’ ‘us’ and ‘our ward’ are usually used by the key informants while talking about the ward and telling their stories, as witnessed in every interview extract. Living in the collectivist Thai society, the TSNs have ways of creating family-like ties with colleagues as one’s in-group as well as thinking of themselves as part of a “we” group who belong to ‘they’ group, which is distinct from other people in society. A mutual dependence relationship and strong cohesive in-groups are then developed between the in-group and the person to secure and protect the “we” group against others.

It is not surprising if you see and hear that the TSNs all agree with one colleague’s idea/feeling, including stay on the same side when one of them has trouble with another party, in particularly medical doctors and nurses of other wards. They also take turns working with every colleague as roster changes to reflect differences in clinical experience and age. They help each other in carrying out their routines and prescribed actions, even, and perhaps most significantly, when there is a need for some form of conflict management with other groups. Indeed the nurses of the TSN
as a group enjoy eating and leaving from the ward all together. The conversation about personal/social issues are usually generated whenever they have free time or at the meal times instead of talking about working issues (Field notes, 2007). From this, harmony and loyalty are maintained and perceived as very important as a result in a smooth surface and pleasant interpersonal interactions.

The values of harmony in relationships at the TSW is underpinned by the basic Thai values of care and consideration, namely raksa nam jai, respect for others, awareness of the right time and space, namely, ru-jak-ka-la-te-sa, and not disparaging or hai kieat as it indicates the deepest reason for a smooth surface and pleasant interpersonal interactions, which is an important means to maintain or preserve one another's feelings and ego. Like Thai society in general, the atmosphere and culture at the TSW is a non-confrontational society, in which public dispute or criticism is to be avoided at all costs in accordance with the Thai belief that ‘it is better to maintain harmonious social relations’. As with other Thais, open and direct criticism is not valued by the TSN, especially when it is directed to the seniors and/or other high status persons (e.g. senior nurse educators, nurse/medical doctor administrators) who shall not be criticized at all. One should flatter the good qualities instead of offering direct criticism. They keep all their problems and feelings inside as there is little exterior sign that they are angry in front of other parties in public space (e.g. the nurse’s station) as most Thais believe that a bad situation can be avoided by not getting angry, or mai-pen-rai – “it does not matter”.

- Mai-pen-rai

When something unfortunate happens, the nurses usually say mai pen rai, a phrase meaning ‘no problem’ or ‘it doesn’t matter’. This value comes from Buddhist ideals
of peace and harmony, of avoiding conflict or displays of emotion. Since Thais are deeply religious people and the majority of the nurses at the TSW is Buddhist. It is inculcated from childhood and accounts for the mai-pen-rai responses to situations involving conflicts. For this reason, interpersonal conflicts do not lead to an open confrontation unless one is ready to take the risk of losing a relationship. Since the nurses’ value is given to avoid confrontation and even the overt expression of anti-social emotions such as anger, hatred and annoyance, conflicts seem to be avoided at all cost so that harmony can be maintained by being attentive to those one comes into contact with or mai-pen-rai. Instead of showing anger, they often say mai-pen-rai to avoid making other people feel bad and control their feelings by not allowing their face to show any frustration. Of greater importance to their position and their professional standing is their capacity to maintain a harmonious working atmosphere and good relationships – even at the expense of clinical and evidenced-based judgement and decisions.

Also, the sentence *Jai Yen Yen* (cool-heart) is often said when one starts to lose control. It means to calm down or to be patient in every situation. At all times, nurses are careful not to hurt another person's feeling, for example, not to criticize as well as not to reject another person's kindness or good intention, even though it is contrary to one's own feelings. For instance, a nurse in the ward showed appreciation and expressed gratefulness to a nurse educator who gave her an English nursing article to read even though the nurse expressed to me that she was not interested in the article and did not want it (Field notes, 2007).
Voicing complaints about the unsatisfactory behaviour of colleagues (especially medical doctors, the head nurse and the seniors) is only ever done behind the scene—thoughts, concerns or feelings are never presented directly. The hierarchical relationships make that impossible as criticising those physicians and people who are senior in age and status in front of others are not the right thing to do at the TSW and so any disagreement is talked about or discussed behind the scenes—among nurses at meal break. The solidarity that the nurses feel for each other is strongest when supported by the physical architecture and its accompanying artefacts. This is the site of safety and solidarity and so rather than critique what is said here becomes ‘gossip’. This is not uncommon for this local organization. As a result of uncertainty avoidance of the TSN as well as by other Thais, gossip is likely to be a common feature communication, as is the use of compliments to ensure that both parties are respected and made to feel comfortable (Field Notes, 2007).

- **Mee-nam-jai**

The emphasis on harmony, affiliation and team-work sets the stage for maximum involvement by the TSN which leads to a willingness to go above and beyond the job specification in order to make an effective contribution toward the organization’s goals. The working value is placed on helping and concern about each other, hospitality and kindness or mee-nam-jai, ‘offering to help others’ rather than ‘asking for help’. Underpinning this behaviour is the fact that Thais are not calculating in showing kindness and help. Showing nam jai (literally ‘water from the heart’, i.e. kindness, consideration, and sincere concerns) in being kind and helpful is something to give out without any expectation in return. While saying ‘no’, especially from juniors, would mean to destroy the harmony in the group and lack of hospitality or
mai-mee-nam-jai. This feature is inextricably linked and supported to the development of strong solidarity even in the shadow of the (high) hierarchy. The actual function of solidarity is stronger than hierarchy in the TSW.

As I observed, the nurses at the TSW usually help each other in performing nursing cares, treatments or interventions, especially in case of emergency such as indwelling IV catheter to patient, collecting blood tests, even buying foods and catering for others perceived as mee-nam-jai. Once each nurse finishes performing her prescribed/routinized job, they usually help other nurses or even staff auxiliaries in performing the ongoing job. For instance, a nurse team leader steps out from the nurse’s station after carrying out all medical doctors’ orders to help the medication nurse preparing injection medications to patients at the mediation room or even the head nurse often helps treatment nurses in collecting blood tests. They leave the ward altogether after finishing work, included going out or undertaking activities together after work. They frequently talk about exchanging the shift roster and they praise a nurse who is prepared to swap places on the shift roster (Field notes, 2007).

The eminence of our ward is our staff. They rarely have any conflict with each other. I think the evidence of low turnover rate can reflect the harmony of our ward. They are generous, caring, considerate, and provide support to each other. For example, if one has any business, they will take the great attempt to change the shift to let her free. They work double shifts within a day to make their colleagues get an extra vacation. The head nurse and the nurse supervisor sometimes postpone the formal meeting if some staff wants to take a vacation.

(Field notes – Interview KI 6)
According to Douglas (1978), high group strength, as exemplified here by the TSNs, influences individuals to act on behalf of the collective whole. Showing *mee-nam-jai* to others tends to be accompanied with the expectation that others perform *mee-nam-jai* back to each other. It seemed to be strange and a lack of hospitality if one of the nurses continues performing his/her ongoing activity or sitting at the nurse’s station while the others are busy or one of them leaves the ward before others. It becomes a big deal if one, especially juniors, performs behaviour which is perceived by the members as *mai-mee-nam-jai*. I encountered a situation in which the seniors got angry when a novice continued preparing medications in the medication room while all other nursing staff were helping to resuscitate a patient with cardiac arrest (no matter whether help is needed from every staff member or not) (Field notes, 2007).

Nurses were observed to extend their working hours to 10-12-hour shifts beyond the compulsory eight-hour shifts, included performing jobs beyond their work allocation, devoting a lot of their available time to interacting with colleagues, and sharing both nursing and social activities together, all of these showing the high group strength of the TSN. The kinship relation and shared valued through socialization and day-to-day working form the basis of solidarity among the nurses at the TSW society that bind the nurses to one another and work as the driving force to strengthen their hierarchy and then combine with hierarchy to create and reinforce routine and ritualistic practices, including decisions about allocating care to patients. From this, the milestones of a nursing journey include travelling from ‘socialization’ to ‘enculturation’ through becoming part of the culture. The outcome of their journey can be reflected via the usual characteristics of their routines, rituals, and habitual care performance and activities, and the relations with each other – which represent the realities of the TSN.
The Thai Surgical Nurses (TSN)

The likeness and similarities of the practices of the TSN is largely dependent on the commonalities they share in relation to their educational background and incorporation of beliefs, values, and regional characteristics. These are enforced with newcomers through socialization and the day-to-day practice of the TSN, which both make assumptions about and reinforce a precise set of social performances. Although as individuals the nurses hold numerous, sometimes competing, sets of cultural and political values, they develop a particular set of cultural practice that set them apart as TSN and in turn reflect the existence of a distinct professional grouping within the organization. According to Cohen (1955), subcultures are likely to form among members who interact often and who face similar problems, providing them with opportunities to exchange concerns about the existing culture. A set of norms, values, and beliefs, are then shared in the case of the TSN. These become the taken for granted actions and activities, drawn on by the group members to support and ascertain the identity. Their collective ‘typical’ characteristics or images therefore are seen as being indicative of ‘surgical nurses of the TSW’.

The realities of ‘being the TSN’, according to the arguments of Weber (1996), are determined by the cultural way of life of the TSW, where the complexity of shared concepts and patterns of learned behaviour are handed down from one generation to the next by means of language and imitation as well as the adoption by newcomers of these practices, actions, and activities. The cultural specialist and its practices created in the TSW are in turn used to ‘control their performances’: how to behave ‘appropriately’, how they create their boundary with the outsiders; such as the way they interact with each other and with stakeholders (e.g. the surgeons, the medical
doctors, the visitors or family member). So, being the same characters, behaving in the same performances, communicating in the same pattern with similar points of views, including common interests and beliefs from the head nurse through every staff nurses are good evidence of the ‘solidarity’ of the TSN subculture. According to Alvesson (2002), culture of the TSW is maintained through socialization, connecting people to strengthen interactions through networks, workshops and gathering, careful selection and recruitment of staff according to ideas and values and developing a shared sense of ‘we’ in the organization.

The experiences of the nurses can be evidenced via the reasons the nurses gave for making the decision to work at the TSW. According to the key informants, they decided to work at the TSW after graduation because of preconceived ideas and expectations about the characteristics and the realities of surgical patients, surgical nursing care, and the surgical nurse, which had been developed since when they performed their clinical practice as a ‘nursing student’:

I decided on working as a surgical nurse because my personality is similar to the major characteristics of a surgical nurse as such talking loudly, being sincere, and speaking as thinking. In contrast, medical nurses have to be bland or gentle. Surgical nursing care is challenging because a surgical patient has not only just received medication but a particular organ was ablation from their body. Some surgical conditions, especially immediate post-operative patients, change very quickly, maybe from smiley to dying in a second. So, surgical nurses have to work proficiently, detect early a patient’s deterioration and quickly make decisions to notify a medical doctor.

(Field Notes – Interview KI 13)
Such views suggest the strong solidarity of the nurses, which distinguishes the group of the TSN from others and is visible to outsider observers so that that the nurses assessed themselves as fitting in with the surgical nurses prior to entering to the TSW. For this reason, they are easily enculturated into the new culture and preserve the dominant culture. The strong boundary surrounding their group is then established as a result in providing the strong sense of ‘solidarity’ towards outsiders. The strength of their solidarity is evident in the extremely low turnover rate of staff with over 50 percent of the nurses having worked at the TSW for more than ten years. On the other hand a newcomer (nurse) who did not manage and prove herself to 'fit-in' with the group decided to leave from the culture as discussed by the 16-year experienced key informant:

It seemed to be that our nurses who continue working at our ward have the same characteristics. From my experiences, although few of us were tardy workers and characters on arrival, they have been changed to have the same characters of nurses and the working style in our culture as they could not work slowly anymore. They have to cope with our culture and adjust their own characters, even to speak faster and louder. Besides, I think surgical nurses were not only shape by ward’s culture but also our deeply habits could go well with the characters of the surgical nurses and make us stay in our culture for a long time. Few nurses decided to quit from our ward because they could not accept our culture or could not fit with the characters of nurse in our culture. They could not cope or adjust to have characters like nurses in our culture. One of them who decided to leave told me that she could not stand the surgeon’s temper and could not work in hurry. We have the same pattern of speech or conversation. As you see, we always talk loudly whereas nurses in
the other fields have tidy conversations. We work briskly, go back and forth, and sometimes make a noise or give out a loud noise or speaking by shouting, untidy. Surgical nurses have to shout or untidy, it’s maybe our old characteristics enhance with the culture that accepts the characteristics like this which contrast with good Thai lady. As I told you a nurse who has slowly or tardiness she could not fit with our culture and decided to move to the other ward.

(Field notes – Interview KI 16)

The newcomers who continue working at the TSW are able to cope and comply with the organizational culture during the metamorphosis stage until they build trust, and pass the evaluation phase. Performing the same working patterns, following/behaving accorded to group norms, including talking the same story in the same point of view empathetically tended to be the criteria of being ‘the person of our ward’ or ‘our coterie’. From this, the failure of newcomers to ‘fit in’ with the culture plays the major role in influencing newcomers to leave as well as in retaining staff that can ‘fit in’ well.

The strictness and lack of friendliness associated with the enculturation of student and novice nurses on the TSW - as seen through the process of socialization, in particular while performing handover and pre-working conference – are therefore done to maintain the status quo of the ward (the hierarchy) and encourage new members to ‘fit in’ with their culture before being accepted as one of ‘the nurses of our ward’. There are clear indications of a nurse’s acceptance into the ward: decreasing/disappearing complaints from the seniors as well as increased volume of speaking and complaining by the newcomers. As I observed one of the novices loudly told PN to repeat a
patient’s blood pressure from the nurse’s station and change the frequency of record confidently. The ability of the novice to ‘fit in’ in these ways is essential to their acceptance and survival in the TSW as the head nurse told me only one novice out of seven had displayed these characteristics and therefore satisfied all seniors and could pass the second month evaluation (Field notes, 2007).

Generally, Thai nurses are expected to exhibit competing characteristics: both to observe traditional Thai manners (e.g. respect and gratitude for parents/seniors, nation, religion, and king as a moral centre) and to respond to global trends in education and in meeting health service needs (Saksomboon, McMilllan, & Cholowski, 2002). The image of the Thai nurse is embedded within public, professional, and feminine expectations of appropriate styles of movement, which consist of good manners – politeness, softness, good relationship, enthusiasm, being knowledgeable, and high moral standing in general. Noticeably, the perceived realities of ‘the surgical nurse’ at the TSW tend to be opposed to national images of Thai nurses and feminine expectations, reflecting an aim to distinguish themselves from outsiders and to show the existence of a distinct surgical nurses grouping or ‘solidarity’ within the hospital and against outsiders (intruders). Talking with the TSN about their characters or working style often comparison with nurses in the other fields, especially medical nurses or pa-ya-bhan-med (pa-ya-bhan means nurse, med means medical ward):

I think the characters of the nurses in our ward are similar. We have the same pattern and style of speaking. If you look back to the head nurse, ex-head nurse, and the other senior nurses in our ward, they behave in the same way as being the prototype of the surgical nurses. So, the nurses who continue
Medical nurses are gentler in manner, speaking and working style. They are a tardy worker whereas the surgical nurse has to work dexterously or briskly. We talk very loudly and sometimes forget thinking before speaking, not using honeyed tongue or sugared-words and fearless speaking. Honestly, it does not have any negative meaning as we said. However, it sometimes hurts junior’s feeling or newcomers who are not familiar with us. We really want newcomers to understand our nature or habit that has been developed over more than forty years. That’s why we need a surgical nurse who is proficient, not touchy or over sensitive, not fainthearted.

(Field notes – Interview KI 7)

The TSN are easily able to articulate what it means to be ‘the surgical nurse’ or pa-ya-bhan-sun (sun means surgical ward) as performing active, dextrous, direct speaking as thinking or straightforwardness, not gentle in manner, and not displaying fussiness. They prefer working quickly and looking hurried in manner, which provides a sense of being ‘diligent’ or ‘industrious’ for them as well as they present as being dissatisfied with junior nurses and nursing students who work and even walk slowly as being ‘inactive’ or ‘lazy’ (Field notes, 2007). Walsh and Ford’s (1989) notion of ‘busy nurse syndrome’ clearly defines the TSN: “the surgical nurses often 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”.

The overall characteristics of the TSN, which tend to be opposed to those of nurses in other fields, is similar with some of those of the surgeons, as discussed in the previous chapter. The dominant characteristics are probably established as a cultural boundary
or circumference for coping with the surgeons. On the other hand, the hierarchical relation between professional nursing and medicine including the strength of seniority in the organization influence the Thai surgical nurses to be modest and comply, especially when they contact people who are perceived as in a higher rung and more senior. This is evident in the difference of the nurses’ reactions and words of communication between when they are confronting persons (especially medical doctors, the head nurse, and the seniors) who they angry with and in other situations (Field notes, 2007).

There were some situations such as the nurses keeping quiet when they encountered unwanted or unpleasant medical doctors’ orders or behaviours, which reflected that, although the interview data revealed the TSN perceive themselves to be straightforward and challenge with surgeons/medical doctors, the observational data showed that they were highly concerned, frightened and unable to converse with the surgeons/ medical doctors, and more senior nurses. The realities of the TSN also tends to be increased with years of experience, the level of seniority and status; for example, novices or newcomers rarely use loud talk and straightforwardness, especially when it is commonly used by high senior nurses and the head nurse (Field notes, 2007).

Thais as well as the TSN, place great emphasis and value on outward forms of courtesy such as politeness, respect, genial demeanour and self-control in order to maintain harmonious relations. Many of their rules of etiquette are by-products of the Buddhist religion. As discussed earlier, the TSW is a non-confrontational society, in which public dispute or criticism is to be avoided at all costs. To be openly angry with someone might attract the wrath of the spirits, which in turn could cause violence and tragedy. Openly criticizing a person is a form of violence as it hurts the person and is
viewed as a conscious attempt to offend the person being rebuked. Loss of face is a disgrace to a Thai and TSN so they try to avoid confrontations and look for compromises. If two parties disagree, one will need to have an outlet to retreat without losing face.

**The benefits of belonging**

The TSN develop deeper relations and strong bonds with each other as if they are a family member not just a co-worker, which creates the ‘family-like-atmosphere’ at the TSW. The cultural role of the seniors at the TSW protects and provides support to the junior nurses, providing a sense of acting ‘collectively’ and ‘supportively’ among the group of the nurses in the TSW. Close relationships, physical and emotional support from each other provide a sense of ‘group belonging’ or ‘being a part of the ward’ and create a feeling of surrounding by people who care, concern, and protection:

> When we have conflict with each other or encounter situations, it depends on who we are, more senior or more junior. For me I’m senior so I select to face and talk when I have a conflict with somebody, including medical doctors. In addition, our junior nurses do not make any defences with senior RN, senior PN or senior nurse assistants, especially the surgeons. It’s become a big deal in our culture if juniors do not show respect to seniors, so they mostly use avoidance. For this reason, our seniors usually help junior nurses in dealing and negotiating with the surgeons, in particularly when they start bullying. Juniors also ask for help from seniors when they get in trouble or expect to get in trouble with the surgeons since we are a big bumper.

*(Field notes – Interview KI 15)*
As seen in the above field notes extracts, the vital role of seniors in providing supports and protection to less experienced nurses, such as dealing with hierarchical situations in particularly the situations which are involved with medical doctors is clearly witnessed at the TSW. Providing a comfortable and supportive environment in the TSW workplace secures the newcomers’, allowing for the retention of newcomers as well as the maintenance of hierarchy. Interpersonal relations also play the major role in enhancing job satisfaction in creating an atmosphere conducive to retention and increasing productivity.

The strong relationship among the group of the nurses therefore aims to focus on internal maintenance with a need for stability and control within their sense and experience of ‘solidarity’. Competency and clinical experiences are important in helping the nurses to better deal with persons in higher rungs of the hierarchical ladder. The loss of personal autonomy, particularly in multidisciplinary decision-making is then compensated by the safety net of social support from their group as a result maintaining their happiness and the high retention of the nurses at the TSW. As I observed, seniors’ consultations about how to make decisions regarding to patients’ cares and care given is mostly used by the TSN, especially by less experienced nurses, to ascertain or ‘secure’ their decision-making. Senior nurses, on the other hand, do not hesitate to take responsibility in protecting junior nurses when juniors encounter problems, especially with medical doctors, and are expected by juniors to help them in dealing with trouble, resulting in increasing a sense of ‘respectfulness’ and ‘gratefulness’ to seniority.
Seniors also play a vital role in developing competency of newcomers and less experienced nurses. At the TSW, a shift roster is provided for experienced nurses to support less experienced nurses by allocating seniors in every shift (Filed notes, 2007). The survival of nursing society within the TSW therefore depends on their reliance and support of each other, in particular between novices and seniors or different rungs of experiences. The deep bond established between all individuals within the ward as a result increases the strength of their hierarchy and solidarity.

- Developing competence

Positive perceptions and pride of the nurses in the TSW were found in every key informant and the nurse participants. The key informants proudly say that the nurses of the TSW are enthusiastic, pay attention to their work and patients, walk and work fast, not reluctant to decide to call medical doctors, focused on team working, caring and considerate with each other. They say in a very proud way that they have been providing better quality of care than other wards, in particular knowledge and skills on surgical nursing care, which can build trust to the surgeons so that the surgeons prefer admitting patients at their ward. The highly competent seniors work with the active young generation, and the high degree of unity is proudly perceived by the majority of the key informants as the strength of their ward:

The nurses in our ward work quickly, detect patients’ deterioration early, and have high competency to take care of specific surgical diseases and operations like advanced practice nursing, especially our seniors. The other wards cannot do the good job as we do. As you see, the surgeons do not trust the other wards to take care surgical patients, especially after immediate operation and
in critical condition. They sometimes move the stable surgical patients to the other wards to make the vacant bed at our ward to admit post-op. patients.

(Field notes – Interview KI 5)

The interview data revealed the nurses’ satisfaction with their competency, especially from highly experienced nurses, in allocating high quality cares for patients; however, there some observational data poses questions about their actual competency. The flexibility of admitting the variety of surgical patients, including critical patients beyond general surgical patients, can fix the problem of insufficient surgical bed quota, isolating unit, and ICU space. The surgical nurses perceived themselves as ‘general surgical nurses’ but were reluctant to nurse other speciality patients in some situations.

As I witnessed the nurses often experience frustration due to lack of education and experience related to various procedures or diagnostic tests beyond common surgical care tasks such as bloodletting, monitoring blood pressure from arterial line, or ECG interpretation. There are some examples of ‘incompetence’ in nursing surgical patients with other types of problems such as post-op. cardiac surgery patient with ECG monitoring. Since nurses have to use ECG monitoring with immediate post-op. cardiac surgery patient after being transferred from ICU, some of them, especially junior nurses, thought they were not competent in interpreting ECG pacing or detecting particular abnormalities and just recorded standard nursing intervention data such as normal sinus rhythm – “we monitor because it’s compulsory to monitor” (Field notes – discussion, 2007).
Further good evidence of this issue was when nurses had to care for patients with a co-morbidity or underlying disease/s beyond general surgical problems, especially uncommon medical conditions such as Polycythemia vera – is a blood disorder in which bone marrow makes too many red blood cells that thicken the blood, also possibly resulting in production of too many of the other types of cells, white blood cells and platelets. These two situations reflect the limitation of the surgical nurses beyond allocating ‘general surgical nursing care’. This issue is increasingly significant since nowadays critical surgical patients are transferred from ICU increasingly, including the majority of surgical patients who are aging and present with other co-morbidities or chronic diseases (Field notes, 2007).

The ten surgical ICU beds are insufficient to support the increase in everyday open heart surgery patients and the other critical surgical patients due to increasing numbers of the elderly and chronic diseases, and advanced high medical technologies. As I observed and according to the key informants’ discussion, the critical surgical patients are considerably increasing whereas the surgical nurses need more skills and knowledge in caring for critical patients, ECG interpretation and ventilated patient, for examples.

Beyond the group of the TSN, as a result from the influence of medical model, they praise ICU nurses for their competency in allocating care for critical patients. From the key informants’ point of view, being competent in caring for critical patients as well as using the high technology and complex medical devices of the ICU nurses enable them to challenge and question medical doctors, in particular junior medical doctors, for example on the treatment plans.
The key informants perceived that this factor influences the surgeons or medical doctors who work with the ICU nurses to behave as ‘a good medical doctor’ by not presenting ‘bully’ or castigation manners with the ICU nurses (Field notes, 2007).

Creating working competence is therefore one of the strategies to strengthen their ‘solidarity’ against outsiders and decrease threats. Demonstrating ‘being competent’ is probably rooted in the struggle associated with low nurse autonomy in working with the surgeons and maintaining their ‘solidarity’ and ‘dignity’. Successfully dealing with hierarchical and decision-making constraints with the surgeons at the TSW is therefore perceived by the TSN as reflecting their ‘competence’ and also reflecting the vital role of hierarchy among the group of the nurses themselves in creating their ‘solidarity’.

At the top of the hierarchy are the seniors who share the role of enforcing membership rules – rules which themselves make solidarity possible. New members need to learn what to do to ‘fit in’ and only if they do so will the seniors accept newcomers. To be accepted as ‘being competent’, new graduated nurses present their capability in nursing patients and making decisions in the series of tasks that must be repeated in a certain order and manner. Successful passing of the probationary period is not, in fact, so much about the knowledge or skill of the nurse but rather their suitability to ‘fit in’ to join the group. For this reason, the nurses’ competency and decision-making capacity are enabled as they become familiar with the context, routines, rituals, and the routinization of practices as time passes.

Increasing time and experiences by prolonging enculturation at this organizational culture therefore helps the nurses to fit in with their routines and rituals, including establishing the close relations and strong bond with each other that are the key
features enhancing their competency and a sense of “being in control”. Undoubtedly, the newcomers require time to adapt to institutional norms and culture, including balancing a mismatch between their prior knowledge and contextually-embedded knowledge at the setting. Along with hierarchy in the organization, senior nurses play the vital role in maintaining their superiority by supervising newcomers to follow their cultural standard of practices.

On the other hand, juniors and less experienced nurses relied mostly on seniors in making decisions and mostly used seniors’ consultations to ascertain their decision-making. Although their prior knowledge derived through their four-year nursing educational system becomes one of the important factors underpinning how they make decisions, there were some situations which shown that the routine and rituals within the TSW are not associated with their prior knowledge but having more influence on their clinical practice and decisions. For instance, some nursing procedures which had been established by the nurse educator needed to be changed or modified to ensure congruence with the ward’s norms:

I took two years to become settled, to decrease seniors’ complaints and condemnation. I used to make seniors unhappy because I did something that was not associated with the ward norm. Once I turned patient to supine position to record CVP (central venous pressure), a senior nurse asked me, ‘you didn’t know a patient needed not to be in a supine position, did you?’ I had no idea to answer because my nurse instructors strictly taught me to turn patients to supine position when recording CVP. I also had to re-seal plasters around a patient’s oral breathing tube and IV catheter since it did not apply in the same patterns as the ward does. So, since then when I have to do any
procedures, I sometimes feel reluctant whether it’s right or wrong and if the seniors didn’t say anything that’s meant I do the right job.

(Field Note – Interview KI 8)

The senior nurses play the major role through socializing newcomers and day-to-day practice; however, sometimes less mutual support and understanding about the novices’ experience and feelings could frustrate the novices, for example, unfriendly atmosphere by giving negative feedback and making a lot of complaints while performing handover, pre-working nursing round, pre-working conference, and when working under seniors’ supervision. In contrast with other staff, directly talking and blaming in public is usually done to the novices and their knowledge, actions and decisions are usually questioned and criticized by experienced staff, especially during the first six months of the probation period.

In fulfilling their traditional role in developing novices’ competency, the seniors sometimes used sarcasm, blame, or negative feedbacks to the novices in front of third parties such as the nursing students or medical doctors, even comparing novices’ capability with nursing students. While the novices rarely give any reasons beyond smiling and saying ‘yes, sir’ or ‘yes, sister’, they sometimes stopped to cry or present sorrow in the face while continuing to perform handover activity as ‘the show must go on’ (Field notes, 2007). Thus, the new graduated nurses sometimes expressed anxiety, fear, and discontent before performing the handover with senior nurses and the head nurse and this is the reason why the less experienced nurses do not want to work as ‘nurse team leader’. However, it tended to be ‘normal’ for the ‘trainers’ at the TSW and their ‘training culture’ and as a vital tool in shaping newcomers to ‘fit in’ with their organizational culture.
The priority in developing novices’ competency between seniors and novices sometimes seems in conflicted as witnessed while performing ‘handover’. While the seniors take great attempts to push the novices to achieve the work quality, the novices require time and mutual support to cope with working under (very close) supervision of the nurse educator to work independently as ‘mature’ registered nurse during the transition period. Increasing one’s competency tended to be associated with decreasing the day-to-day complaining from seniors significantly.

To avoid being blamed and/or receiving complaints from the seniors, the novices are most concerned about performing their jobs (e.g. documenting data, giving information) in accordance with the parameters and cultural rules established by the group. The (negative) day-to-day feedback, on the other hand, is important as this negative reinforcement assists in maintaining and strengthening their cultural working patterns by shaping and controlling the members to behave in the same pattern. The novices also get psychological and inspirational support from their peers and other senior nurses through encouraging words, body language, or tell their own experiences when facing with the same training situation when they were novices (Field notes, 2007).

‘Senior supervisory’ is therefore neither inherently good nor bad. The development of novices’ competency and capabilities, however, requires time to cope and fit with the organizational culture to move from apprehension to a trusted insider co-worker. The turning point from nursing student to novice nurse needs a suitable training and supportive atmosphere to bring the novice to harmoniously work in the real clinical setting within the limits of patient safety. This would be also a good example to show how tricky it is to challenge the ritualistic practices of the TSW and just how much in
fact CDM is tied to the staff culture and social relationships in the TSW. The strong ‘solidarity’ among the group of nurses means they do not think of ‘change’ in their cultural practices or that change will be made by following their (senior) colleague – “we do the good (better) surgical nursing care already”.

Generally, the nurses in our ward do and agree about the same things and we easily make change or comply according to our colleagues’ suggestion. If anybody attended any meeting, we will share the new knowledge with our colleagues and we will change in accord with the new concept without questioning or looking for evidence. For example, we decided to stop administering one kind of antibiotic injection by using IV drip which had been done for an age, when one of our senior colleagues got the knowledge from the meeting that administering by bolus dose is better, so we have changed since then.

(Field notes – Interview KI 9)

Actually, we always make the same agreements and do the same things because we work in the same organization. We have established a high bonding and we usually agree with each other. Although I sometimes have conflicts or questions, I keep quiet because the majority of us get general agreement with that solution. As you see, most of the nursing procedures and practices have remained the same for the last twenty years, such as routine post-op. care. I don’t want to say we are out of date because we learn by telling from one generation to the next generations. We generally pay regard to senior’s instructions or copy down from senior which sometimes shows a lack of evidence or rationalization. (Field notes – Interview KI 13)
The above interview extracts confirm the solidarity of the TSN, which emphasises unity, social cohesion, collectively, and social support as influencing nurses in relying on each other for their care performances. In the following chapter, pre and post operative nursing care, as the major ritual task and decision-making of the surgical nurse, are presented to give examples of the local culture of ritual of care of Thai surgical nursing.
CHAPTER SIX

Fixed assumptions: Pre- and post-operative care in the Thai Surgical Ward

Under the care environment of surgical wards in a tertiary care hospital the importance of interdependence between nursing staff and medical staff, especially when it comes to patient care and management, is always acknowledged. Providing high quality holistic nursing care in a tertiary hospital, in an environment which values above all else the technical skills and proficiency of the nurse, is one of the biggest challenges facing Thai nurses. Undoubtedly, to be able to deliver high quality care skilfully using all appropriate technologies is essential and indicates the competency of tertiary care nurses, however, professional Thai nurses, like professional nurses in other countries and regions, requires nurses to be skilled in ways that enable them to plan and provide holistic nursing care in order to best meet the needs of patients in all aspects of care (physical, mental, social, and spiritual) with high quality and satisfaction. However, as shown in this chapter, if care is driven only by a medical model when the nurses make decisions on individual patients, they will mostly make decisions on the basis of pathology of diseases (Wade & Halligan, 2004). Consequently, the patients' conditions and medical doctors' orders become the only focus for the nurses in making decisions about their actions and time spent with each patient (Field notes, 2007).

Of course nursing does not stand alone from medicine - nor should it as of course nurses need to follow medical doctor’s orders or prescriptions, however there is also a need for balance and a need for the nurses to have some clear sense of what are
reasonable nursing actions and nursing decisions and be able to make these as required. For this reason, the examples presented in this chapter are given as a critique of nursing actions and decisions that are driven almost exclusively by the medical model. It is not done with the view to suggest that the medical model should be ignored but rather to exemplify the ways in which social and cultural relationships can shift and pervert the many and complex aspects that are required for professional nurses to provide holistic and evidence-based care to patients.

So far we have seen that while Thai nurses are well educated (four-year university degrees), have the support of professional bodies with strict regulations governing their licensing and are well recognised by government policy reform as essential healthcare providers, they are also heavily restricted in terms of how these things are played out by the rules and practices that form Thai society and govern its strict social and cultural conventions (see Chapter 2). Being a society that functions in response to status which is largely determined by family, social rank, age and gender, means that education and knowledge, while providing some access to status does so only through its links to occupation and as such is not in itself sufficient to override established power differentials.

In the case of the Thai nurse, the educational qualification and successful passing of the national exam leads to licensing as a nurse and the capacity to work in a highly sought after government job. Yet, once a member of the nursing profession their status is reasonably fixed. While experience and age can provide career enhancement within the profession, the capacity of even the most knowledgeable nurse to advance quickly within the profession will generally be restricted by core Thai values linked to experience and age. As we have seen in Chapters 4 and 5, the competence arrived at
through age and experience will position the individual nurse at the top end of the hierarchy within the group but still, in the larger picture of Thai society, nursing remains an occupation associated with female and feminine attributes, thus limiting its development. Of course, a similar situation also arises within medicine where hierarchy based on social convention determines the career trajectory of doctors. However, in contrast with nursing, medicine is a male and masculine occupation and so its general status and that of those who belong to this group will be much freer by virtue of the fact that a greater degree of power is automatically assigned to this group.

In Chapters 4 and 5 we have seen the consequences of this in the ways in which the nurses both play out their own hierarchical organization and the way in which they build strong bonds between each other as the only way open to them to deal with social and cultural conventions so strong they prevent them from advancing their own nursing practices. The creation and performance of rituals and routines around pre- and post-operative care of patients form the basis of my discussion in this chapter. Here through a number of examples, I argue that the actions taken by the TSN of the TSW are manifest expressions of the group’s response to hierarchy and structure that negate the need for and ability of the TSN to make clinical decisions. As the following discussion will show, the rituals and routines of the TSW run counter to “best practice” in the areas of patient-centred care, evidence-based practice and models of professional practice that currently dominate the international literature (Canadian Nurses Association, 2002; Mulhall, 1998).
With this in mind I will describe features of the culture of the TSN as they are played out in the day-to-day care activities for pre- and post-operative patients. The ways in which the TSN undertake ritual and routine practices, through their organization of patient care and their work with other health professionals (namely surgeons and other medical staff) are discussed in relation to the structural confines within which the TSN function. Through a series of examples I will explore the ways in which nurses mediate their dual responsibilities between patients and doctors, between care and responsibility. In this way I will demonstrate the impact that workplace relations have on workplace organization. The activities and behaviours of the TSN stem from their social unit with its own particular organization and philosophy of care. In exploring this I will highlight how the cultural implications of the pressures exerted by particular patterns of workplace relations in the nurses of the TSW are enmeshed.

In making the patient’s journey through the ward the central prism through which to view the care activities of the nurse, it is possible to highlight some of the reasons that the nurses of the TSW struggle to enact the very principles of professional practice and evidence-based practice (clinical decision making) that underpin their education and their professional formation. Pre- and post-operative examples of care presented in this chapter are therefore treated as the central elements through which to understand the relationships between rituals, routines and practice.

By examining the treatment between the patient (both pre- and post-operative) and the nurses of the TSW it becomes possible to contextualise them within the boundaries of the particular rituals, routines and practices of the TSN. It is also possible to gain understanding into why it is that these practices, routines and rituals themselves pose
challenges to the development and realisation of professional practice and clinical
decision making as it is understood in the literature (Lee, Newman, & Price, 1999;
With this in mind I now invite you, the reader, to visit the bedside of the patients of
the TSW; to explore the effect that organisational structures, cultural themes and
issues of accountability and responsibility have on the management of various pre-
and post-operative patient situations that the TSN encounters. The discussion that
follows examines both the everyday and the not-so-everyday routines and rituals of
the TSN.

The management of symbols: Proscriptions and prescriptions as artefacts of
culture

As you will see through the following discussions, the significance of hierarchy and
solidarity, as explored in Chapters 4 and 5, for action and behaviours by nurses in the
TSW becomes ever more apparent as the symbolic conditions associated with
proscriptions and prescriptions for care are actualised in accordance with the social
relations of the TSW and its nurses. Within the TSW the specific character of
medicine needs to be taken into consideration when the management of patients (by
nurses) is considered. Because of this it therefore also becomes important that the
activities carried out by those who serve both the patients’ and the doctors’
requirements (i.e. the nurses) be considered in terms of their symbolic significance.
Within the TSW there are two major types of care provided by nursing staff: pre-operative care, the care given to a patient in preparation for surgery, and post-operative care, the care given to a patient following surgery. In the TSW pre-operative care can take place over a period of one to three days while post-operative care given for uncomplicated general surgery patients is required for one day seven days. Generally, elective surgery patients are admitted one day before surgery in order for pre-operative care to given. This time is used to undertake laboratory tests and investigations, which may include complete blood count, electrolytes, prothrombin time, activated partial thromboplastin time, urinalysis, and grouping matching. In addition to this an electrocardiogram (ECG) will be performed for patients with a history of cardiac disease or who are over 50 years of age, while a chest x-ray is performed in every case. Some patients, on the other hand, will be admitted up to three days prior to surgery, for example, patients who are undergoing elective colorectal surgery for pre-operative mechanical bowel preparation, a three-day formula regimen (Field notes, 2007). As I will explain in more detail below, these activities are not only routinised and ritualised (as we have seen in the accounts of activities in earlier chapters) but reflect symbolically the carefully stabilised and elaborate hierarchy of occupations within the hospital environment (and in particular the surgical domain of this environment).

The elements of pre- and post-operative nursing care in the TSW are a combination of TSN led and Thai Medical Doctor (TMD) led initiatives. The imperatives governing these distinctions are not entirely self-evident and, as we shall see in the examples referred to here, are not necessarily linked to knowledge held by each group but reflect more precisely the special character that medicine takes in relation to the
management of nursing. It is at this point that we can begin to appreciate the complexity that lies behind the everyday activities of the nurses of the TSW, as presented in the previous chapters, and perhaps why clinical decision-making, when thought of as the professional endpoint for substantial nursing knowledge, poses such difficulties for the nurses of the TSW.

The routine orders and activities associated with pre-operative nursing care in the TSW can, in general, be said to consist of three key elements. The first ‘care’ is the physiological preparation of patients. This is carried out under the direction of the attending surgeon while the second two cares, educative and psychological support (grouped together here) fall primarily under the direction of the nurse. While at face value this may appear to be a reasonable division of authority, the symbolic significance of this arrangement becomes apparent when we consider the prestige associated with physiological health over that of preventative (education) and psychological health within the framework of hospital-based care.

The pre-operative physiological care activities undertaken by the TSN are mostly based on the pre-operative and pre-medication orders given in predictable and pragmatic ways by the surgeons and the anaesthetist. Figures 6.1 and 6.2 are examples of orders given by surgeons. These orders contain directions for the nurses on the proscriptions and prescriptions that relate to the pre-operative cares required for the specific type of surgery that the patients are to have, as I will show, in tandem.
In addition to the prescriptive nature of the nursing interventions, pre-operative orders and cares are generally carried out by the nurses in the same manner and are used as the primary guide by the nurses in their allocation of physical preparation and management for patients undergoing surgery. The hierarchical relationship between medicine and patients, which as we have seen earlier differs from that which exists between nursing and patients, means that the evaluations of types of illness and the
actions and activities associated with healthcare become intimately related to the
division of labour within the ward. In many ways the proscriptions and prescriptions
managed by medicine in the TSN and exemplified here, are an extension of the ways
in which medicine ranks specialties and accords differing status to activities.

The division of labour inherent in the identification, adoption and establishment of
TSD-led and TSN-led nursing activities, in the light of the cultural organization and
social relations that we have seen played out in the previous chapters (through
solidarity acts and hierarchy) now suggest that this division may, more than
knowledge itself, provide a symbolic and important channel for maintaining
dominance through the division of activities. In turn, as I set out below, the nurses of
the TSW also attribute prestige to those activities that are governed by (and therefore
closer to) medicine. This means, not so much that the nurses do not know and cannot
think about action and activities – clinical decision making, best practice, evidence
based care – but rather that the circumstances that the nurses on the TSW find
themselves in are not themselves conducive to being or acting professionally.

Here knowledge is not enough and status is more likely to affect the way in which
orders may, at times, go unquestioned. Alongside the written orders from the doctors
(see figures 6.1 and 6.2 above), the nurses of the TSW also document the cares that
are to be carried out. This is done in the form of the Nursing Intervention Record, an
example of which is set out below (Figure 6.3). As seen in figure 6.3, the nursing care
approach, outlined in this Nursing Intervention Record, reflects the higher status of
physiologically linked cares with little emphasis or discussion of lesser-valued health
care activities associated with education (and preventative health) and psychological
care. Rather than extending and/or embracing the possibilities of nursing care based on nursing knowledge, the Nursing Intervention Record focuses on bringing together the proscriptions and prescriptions of the TMD along with the prescribed nurse initiated educative/psychological care elements.

<table>
<thead>
<tr>
<th>Preparation for exploratory laparotomy with tumour removal</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Clear liquid diet, NSE (normal saline enema) &lt; 3 litres until clear at 5 pm</td>
</tr>
<tr>
<td>• Administering antibiotics as prescribed</td>
</tr>
<tr>
<td>• Observe weakness and start IV infusion as prescribed after enema</td>
</tr>
<tr>
<td>• Give pre-operative booklet and explain to patient about fasting, skin preparation, IV infusion, rating pain score, pain management, early ambulation, deep breathing, effective cough, post-op. medical devices and vital signs recording, including anaesthesia and reassure that safety care will be provided while undergoing surgery</td>
</tr>
</tbody>
</table>

*Figure 6.3.* Nursing intervention record (Nursing intervention record, 2007)

Here nurses use the pragmatic, physiological activity driven approach that underpins the TMD orders as a template to for their own care planning. This is further evidence of the pattern seen in the social relations and organisational culture presented in chapters 3, 4 and 5. That is to say, the knowledge of the nurses – their would-be status as educated professionals – is limited by what Hughes (1963) argues to be the dominance of circumstance over ability. In the TSW the orders, the activities and priority they are given are symbolic of the value and esteem placed on nursing
activities and the division of labour between doctors and nurse provides an important channel for devalued and discarded aspects of health work. Here, the hierarchical relationship seems to undermine educational knowledge and professional identity/capacity of nurses where the two should work together not as an either/or.

In short, as the following example taken from the TSW demonstrates, the circumstances that determine the environment of the TSW – as seen in chapter 3, 4 and 5 – have a much greater influence on the capacity of the nurses to enact their professional independence and decision-making than do their knowledge deficits. The hierarchy of relationship the nurses establish with medical staff, patients, and each other also affects pre-operative nursing practices and care administered to educate and support patients before surgery. For example, information given to patients by the nurses is performed and documented in the same pattern as the expected-information given by the surgeons. From the key informants’ point of view, the surgeons are viewed and respected as having the authority to explain in detail the operating procedure, complications/risks, and prognosis to patients. The details of surgery, post-op. indwelling medical device/s, potential risk/s and complication/s are informed to patients by the nurses in general terms. If patients and/or family members have any enquiries about the details of organ ablation, deformity, or complications from surgery, the nurses will refer enquiries to the surgeon or assess the information given by the surgeons and re-statements (Field notes, 2007). Here the nurses sometimes struggled to articulate the scope of their practice as well as to inform or identify what is good or not good for patients:
Although I may be scared by the negative results of (X) surgery because I have experienced unexpected death in several cases, I cannot tell patients and family that they should not get the operation. What I can do is just pray for patients to come back safely. Nurses can give only positive or general information to patient, can’t we? It’s a surgeon’s role or responsibility to give the information of potential risks and harm from the operation to patients. Since we do not know an exact outcome of surgery, it could be good or bad and it’s absolutely not a hundred percent failure or success. Importantly, the surgeons definitely want to perform the best surgery for patients. Importantly, if we speak about the negative outcomes from surgery, in particular permanent stoma or inability to talk, it can become a big deal if patients refuse surgery. Then we will get into big trouble with the surgeons as our seniors experienced before. The surgeons, however, sometimes do not well inform patients and family members about potential risks and complications from surgery, but just briefly explain and refrain from speaking about the negative results. I sometimes pretend to ask patients about the risk of surgery and encourage them to ask the surgeon. The patients however prefer asking us but we just tell general information.

(Field notes – Interviews KI 16)

As is evidenced in the above interview, the nurses of the TSW struggle with the boundaries of their role and the circumstances that dictate these boundaries. Their nursing cares tend to be pragmatic activities that are prescriptive and routinised hierarchically – and within these parameters there is little, if any space given over to nurse-initiated care in response to patient issues. In contrast to the broader literature
that underpins nursing theory as it is understood, the role adopted by the nurse here, in response to their circumstances, begins to reflect the highly regarded and valued habits of medicine insofar as the nurses’ actions begin to reflect traits of an occupation that is client dominating rather than the reverse – although the value of this is not directed to the same ends as it has traditionally (see for instance Jewson 1974) in the case of medicine. Rather than acting as the guide and the basis from which nursing activities can develop in response to patient needs, the status of TSD-led nursing care is such that it is the care. The influence of the group’s response to hierarchy is ascertained, here, wherein a greater degree of power is circumstantially and hence now automatically assigned to medicine, and its status which in turn negate the opportunity for (and hence the ability of) the TSN to approach their work from a position in which they have sufficient agency to act and to be regarded as acting as professionals. As highlighted here and at the very beginning of this thesis, one of the ways in which this is most clearly evidenced is through the making of clinical decisions.

When we consider this in the broader context of the Thai environment it is easy to fall into the trap of dismissing the difficulties that confront the professional advancement of nursing in the TSW as being simply reflective of Thai culture itself. After all both the culture of the TSW that we have mapped out in the preceding chapters and the social structure of Thailand itself are hierarchical. Yet, to move down this path of explanation would be to dismiss what this thesis, by focusing on mapping and understanding the social relation and staff culture of the TSW, has revealed: that while the TSN may operate as a hierarchy within a hierarchy, it is perhaps the tension surrounding the way nurses understand the relationship between knowledge and
circumstance that creates the difficulty in day-to-day practice. Of course, this is not to deny the effect that the high value given to professional medicine has on limiting and constraining the nurses’ role as autonomous decision-makers. The findings of this thesis are supported by the literature insofar as it argues that the nurse-physician relationship stems from an inequity in power relations as nurses have traditionally assumed a subordinate position to physicians in Thai healthcare professions (Gundersen, 2002). Medical doctors exert direct power in the healthcare system and I argue especially hospital medicine. The power held by hospital medicine, as so clearly evidenced in the day-to-day social relations and staff culture of the TSW, also indicates how the ascendency of specialty within medicine depends upon the success of ‘delegating stratagems which in turn undermine those opportunities within the state for the nurses’ role, (and here I refer specifically to the Thai healthcare reforms which are focused on prevention and promotion roles) to be facilitative, educative and supportive for patients.

While this thesis has not sought to present itself as sociology of nursing, there is some room here, in unpacking what has been mapped in the preceding chapters, to turn to look at some of the discussions that sit around the sociology of occupations and professions. In seeking to make some sense of what has been presented, it is necessary for us to locate the TSN as she is presented within the TSW within this perspective. As we know, from the seminal works of Parry and Parry (1976) and Jamous and Peloiille (1970) groups such as nurses have commenced as low-status occupations, defined through their involvement in support activities for doctors or surgeons, and have gradually sought to emulate traits associated with these positions. In the sociology of the professions, this is known as poaching – where responsibilities linked
to status are sought in order to enhance the value of the occupation. This activity as we have seen within the hierarchy of the nursing body of the TSW is well and truly alive (for example, the relationship between the orderlies, junior nurses and senior nurses), but circumstances – such as socially entrenched hierarchy and medical and hospital dominance – have limited the capacity of the nurses of the TSW to effectively “poach” from the TMD. As Braverman (1974) and Stacey (1988) have pointed out, the basis for work organization are the distinctions between hand and brain (Braverman) and/or male and female work (Stacey), which structure not only the value of the labour but also the course of the specialisation. Herein, I argue, on the basis of what has been presented, that despite Parsons’s (1959) emphasis on the importance of knowledge to the attainment of professional status and identity, education is not in or of itself sufficient to override the established power differentials in this local Thai nursing culture.

As discussed in Chapter 4, the 'functional and task-oriented' nursing system that we see in the TSW reinforces the prioritising of care needs and actions by the TSNs based on a hierarchy linked to activity status. Here the patients' conditions and medical doctors' orders become the vital factors for the nurses in making decisions about their actions and time spent with each patient. From this, an activity such as sitting and talking with a ‘well’ patient where the agenda for the interaction is driven by education (health promotion and prevention) or psychological support is viewed as less important than executing a medical doctor’s order or the prescribed tasks:
Even while the nurses are performing psychological support and assessing patient’s psychological status, they did not hesitate to leave the patient once a surgeon needed a hand to hold the patient while performing wound irrigation, or if another nurse asked for assistance with the insertion of an indwelling IV catheter.

(Field notes, 2007)

As we saw in the previous chapters, the more senior the nurse, the higher their rank and the further removed they are from devalued and discarded aspects of healthcare activities. The nurses present in the ward with enthusiasm and a high level of concern for the monitoring of post-operative complications while because of the lack of physiological action imperatives, the pre-surgery patient is viewed as ‘nothing to worry about’ or ‘nothing special to do’ (Field notes, 2007). Here, providing assistance to physicians and execution of physician instructions in a treatment is viewed as more important and provides the major concern for the TSNs rather than talking to and working in an educative and pre-emptive manner with the ‘well’ patient before surgery. The time allocated for educative support of patients before surgery as well as differences in priority given to each nursing practice is not merely dependent on time constraints (which tend to be the underlying rhetoric of the TSNs) but depended on what they deem and value as important or prestigious jobs. My observational data reveals that a similar amount of time is allocated to providing bedside education and support for patients the night prior to surgery irrespective of how busy or not the ward is. For instance, even when there is no critical patient or the patients are stable with no new treatments/orders the nurses of the TSW spend between 10 minutes and 20
minutes for pre-operative teaching and psychological preparation of patients (Field notes, 2007).

As discussed in Chapter 5, the high group social relation influences the way they manage cares and allocate time to each activity. As mentioned earlier, whenever patients are stable and all prescribed treatments and medical doctor orders are executed, they prefer hanging about at the nurse’s station and enjoy talking (gossiping) with each other instead of talking or assisting patients at the bedside. As with pre-operative care management, the post-operative order, which is mostly given in the same way (see Figure 6.4), provides direction for the nurses in making decisions on the lists of monitoring measures, and the therapeutic measures to be employed, such as the details of analgesia, antibiotics, wound care, IV fluid administration, and the handling of tubes, catheters, and drains.

![Post-op order for explore lap with lyses adhesion at small bowel with Appendectomy on 1/4/07:](image)

- Routine post-op care
- NPO, connected NG to IMS (intermittent suction) with pressure 20 cmH2O, record NG content and push NSS (normal saline) 20 ml q (every) 4 hr
  - Record urine output and keep > 30 ml / hr
  - 5% DN/2 1000 ml rate 80 ml / hr, NSS rate 60 ml / hr
  - Morphine (1:2) IV rate 2 mg / hr, purge 1 mg IV PRN q 30 min for pain

*Figure 6.4. Post-operative order (Field notes – Surgeon’s post-op. order 1/4/2007)*
As seen in Figure 6.4 and as witnessed from every post-operative order, routine post-operative care becomes vital ritualistic care after surgery. Here vital signs of patients after surgery are traditionally recorded every 15 minutes in the first hour since arrival, followed by every 30 minutes in the second hour, and then every hour until stable no matter what kind of surgery patient received (Field notes, 2007). This poses certain questions about the significance and benefit of this traditional approach. The workloads for staff auxiliaries are also identified since most of patients are sent back from the operating theatre during the same time.

Various tubes and associated devices (e.g. Foley catheter, NG tube, Penrose drain, Jackson Pratt, colostomy bag) have been traditionally used with patients after surgery to accurately record patients’ volume, discharges, and contents from surgical site in general. Those tube cares and records, including vital signs, are assigned to staff auxiliaries (PNs or orderlies). At the end of each shift the nurses just ask the characteristics and amount from the auxiliary staff to document in nursing intervention record and inform the on-coming staff at handover (Field notes, 2007).

Again, as with other nursing activities, deciding whether or not do some post-operative care activities depends on what they deem and value as important or high/low prestigious jobs. As discussed in Chapter 4, some real nursing cares, such as cleaning patients after defecation or urination, including skin preparation and enema, are allocated as the responsibility of the staff auxiliaries (PNs or orderlies). This practice can separate the nurse from patients as well as pose certain questions about the quality and validity of data they get.
The influence of relationships the nurses establish with each other, patients, and medical staff on the way they view and administer their nursing practices is also evidenced via the way they rehabilitate patients after surgery. Recovery of GI is believed by the nurses to depend on the level of patients’ mobilization either sitting in bed or out of bed. Telling patients to sit in bed or get out of bed to increase bowel motility as a result to shorten NPO, is endorsed by both nurses and medical doctors of the TSW as a major action in rehabilitation of patients after surgery (Field notes, 2007). However, rehabilitation and mobilization of patients after surgery has been done sporadically with inconsistency in actions such as telling patients to sit up in bed from the nurse’s station or to walk to encourage and assist patients at the bedside, or even to do nothing whenever they are busy with critical patients as well as new treatments. Even they have free time, as discussed earlier, nurses prefer hanging about at the nurse’s station talking to each other or documenting data rather than using this free time in attempting to ambulate patients. This activity is also allocated to staff auxiliaries (Field notes, 2007). Rehabilitation of patients after surgery is seen as less important and given less priority than the completion of prescribed tasks and meeting with colleagues.

The medical doctors sometimes give written orders for the nurses to ambulate or rehabilitate patients, posing certain questions about the role of the TSN in rehabilitating patients after surgery. The medical doctors’ orders such as, ‘encourage patient to perform deep breathing five times per hour’ and ‘encourage patient to get out of bed’ are still evident at the TSW. The rehabilitation orders given by medical doctors, on the other hand, provide a sense of auditing as well as encroaching on their work, resulting in the nurses becoming angry and complaining with their colleagues.
(behind the back of the medical doctors). They however tell their team members (auxiliary staff) to execute these orders (Field notes, 2007).

Rehabilitation of patients after surgery is also viewed and valued by the nurses. For instance, the nurses identify/judge the level or competency of patients in ambulating after surgery as ‘appropriate’/‘inappropriate’ or ‘good’/‘no good’. The type of surgery, the size of incision wound, the days after surgery, are generally used by the nurses to decide on the expected activities as well as the appropriateness of patients’ mobilization. Undoubtedly, well or unwell ambulation is identified by the nurses when they perform handover as well as documentation in nursing intervention records, in particular making comparison among patients undergoing the same surgery (Filed notes, 2007).

Ambulating patients after surgery is therefore a ritual or ‘what ought to’ activity. The nurses create identity and expected behaviours for patients; here, the patient has to adapt to comply with this new role of ‘patient who has undergone surgery’. The acts of patients such as strictly following pre-operative instructions of fasting without question or negotiating or following nurse’s advice by attempting to sit in bed after surgery are ritualistic ways and symbolic manifestations in responding to social relations and social order in this organization. This supports the findings of the study conducted by Burnard and Naiyapatana (2004) that patients in Thai society had to find their position in the healthcare and nursing hierarchy.
As discussed in Chapter 4, the status of medical doctors in Thai society as well as in this local nursing culture is one where medical doctors and healthcare providers are traditionally held and viewed in very high regard and hold a socially superior position over patients. Hence, patients who tend to stay at the bottom of this hierarchical relation comply and cooperate with rules, routines, and ritualised cares which are established and valued by the TSN as well as TMD, resulting in little control and participation during hospitalization. Decisions about operation time, date, and type of surgery, even type of pain management after surgery and information they should have, would be decided by the attending surgeons and nurses.

Institutional policy and guidelines also influence the way the nurses of the TSW manage and administer nursing practices and cares. Post-operative pain management at the TSW, for example, is driven by acute pain management protocol. Nowadays, post-operative pain management at the TSW is prescribed by the anaesthetists on behalf of the ‘Acute Pain Service’ by using ‘acute pain management protocol’ such as, pain assessment has been launched as the ‘fifth vital sign’ (Field notes, 2007). Consequently, the nurses follow this protocol in allocate and mange pain for patients after surgery. This tends to privilege the nurses to reach professional standards.

Beyond institutional considerations and guidelines, social relations among the groups of the nurses also create social order that controls their behaviour in implementing protocols. The nurses come to a general agreement as to whether or not to follow some regimes in standard nursing care or guidelines. Although the interview data revealed that the nurses strictly assess and document patients’ pain scores according to the protocol, they mostly made decisions to administer or stop administrating pain killer injection to patients with ‘as required’ or ‘around the clock’ prescriptions by
analysing patients’ behaviour or gestures (e.g. sleeping) rather than from analysing pain scores according to the protocol. Moreover, questions will be usually raised, in particular by senior nurses, whenever pain management has not been managed as usual. For instance, administering pain killer injections to nearly discharged patients after surgery is usually questioned, including nurses agreeing to stop administrating narcotic pain killer injection (e.g. Morphine) to a hypo-blood pressure patient even after immediate surgery. I also witnessed the nurses often saying, “Be patient wait for a minute, it does not reach the analgesic round yet” when patients asked for pain killer injections before reaching the analgesic round, rather than notifying an attending anaesthetist or medical doctor as per the protocol (Field notes, 2007). Here ritualised practices prevail over some institutional rule and policy and ascertain the inequity of social relation between nurses and patient in this society.

The unique routines and ritualised practices, such as nursing practices and cares administered to patients undergoing surgery at the TSW, are therefore established in order to maintain the integrity of the group boundaries as well as to prevent encroachment on their work by others, in particular people in the higher rungs of the hierarchy, even patients and family members. The ritualised nursing practices and cares administered to patients are seen as important and expected as a symbolic and identity reflects the quality of their care. Here the routines and ritualised practices guide and control the members’ and groups’ performance.

Culture has its basis in everyday social relations and practices (Douglas, 1978). Cultural practices reflect the role played by society and its beliefs, practices and linguistic codes, which in turn create the individual as a moral actor who is compelled to adhere to certain practices and respond in specific ways to particular objects and
actions (Goopy, 2000, p 42). As discussed so far, the culture of an organization is one of the environmental forces that influence the way people make decisions and create boundaries when they make decisions (Thomas, Wearing, & Bennett, 1991). Organizational culture shapes values and norms, is learned and transmitted between individuals and teams through social learning, role modeling and observation, and, as a result, assists organization members in dealing with external pressures that threaten organizational survival and/or internal integration (DiMaggio & Powell, 1983). A shared sense of ‘we’ is then developed in the organization (Alvesson, 2002). Here behavioural expectations, norms, and rules are communicated tacitly and explicitly to organization members to reduce ambiguity resulting in increased regularity and predictability (Louis, 1990) and reinforce what is deemed important (O’ Reilly, 1989).

For the TSN, standard achievement of their practices depending on what is deemed or valued as important reflects the quality of care by members. The routine and ritual practices in preparing patients for surgery and care given to patients after surgery discussed in this section can be seen to reflect the social relations each group has with each other unit within the TSW. The ritualised nature of these two major cares therefore represents the local culture of the TSW that governs care given by the nurses, medical doctors, as well as patient’s responses to care.

This distinct culture of the TSW, which using Douglas’s (1994) terms can be seen as the cultural bias of each particular group, allows this study to explore the solidarity of the TSN as discussed in Chapter 5 such via the everyday activities of the TSN. Douglas’s approach to ritual and social relations helps to understand the effect of local culture in underpinning and controlling the ritualised cares in this local Thai
nursing context. This insight will be used in combination with Hofstede’s four-dimensional models of the manner in which an organization deals with differences in power and hierarchy and with uncertainty and risk can also be to explicate the social relations of the TSW.

The cultural workplace of the TSW, in particular the social relations surrounding their values which created their routines and rituals, is understood by analysing on Douglas’ grid-group matrix. As discussed in Chapter 1, Mary Douglas (1970) constructed grid/group typology as a comparison tool for considering cultures and the forms of social organization that support them. Culture, according to grid/group theory, is defined as shared values and beliefs and is always closely related to particular patterns of social relations. According to Douglas (1978), daily social relations and practices are based on culture and an individual's behaviour, perception, attitudes, beliefs, and values are shaped, regulated and controlled by group commitment and grid control. The ritualised of pre- and post-operative cares given at the TSW reflect the realities of the TSN and therefore act as the vital example in understanding the local culture of the TSW. Here, the issues of pre- and post-operative cares reflect the placement of the TSN on the grid-group matrix.

The ritualised nursing practices and cares administered to patients undergoing surgery at the TSW can be explained by using Douglas’s grid-group scheme in relation to the nurses’ placement of the grid-group matrix to analyse the strength and weakness of two factors to identify the social unit of the TSW. Based on Douglas’s grid-group analysis, the TSN social relations and staff culture can be classified into the C square of the matrix as ‘high grid/high group’ or ‘hierarchist’ where the individual members
of the group are aware of their position, which is securely bounded and stratified (Goopy, 2000). The grid axis indicates the extent to which nurses of the TSW are more or less responsive and answerable to a body of formal, abstract rules which direct their daily conduct in the hospital whereas the degree of importance in daily work of solidarity with immediate colleagues was the indicator of the ‘group’ (Goopy, 2000, p 47).

TSN is within high group social organization of TSW as seen through the discussion of the ‘we always do it this way’ attitude in Chapter 5 and through the series of examples in this chapter. As discussed in the first chapter, the nurses of the TSW are driven by or restricted in thought and action by their commitment to a social unit larger than the individual or they are incorporated into bounded units. A high group way of life exhibits a high degree of collective control. Group is high when interaction between the members of a group is seen as something worth devotion of time and effort. The greater the incorporation, the more individual choice is subject to group determination. Here the collectivist Thai society privileges the high group social relation of the TSW. As discussed in Chapter 5, the organizational context of the family-like atmosphere as well as the low turnover rate of the nurses at the TSW increase the scope of interaction and emphasises the group rather than the individual.

The social relations of the TSW in term of grid control also tended to be high. As discussed in Chapter 1, ‘grid’ is the extent to which people’s behaviour is constrained or circumscribed by role differentiation either within or without membership of a group and by externally imposed prescriptions. Grid is high strength whenever roles are distributed on the basis of explicit public social classifications such as sex, colour,
and position in a hierarchy, office, descent, or point of progression through an age-grade system, including bureaucracies that base their roles on seniority (Altman & Baruch, 1998, p 772). According to Thompson, Ellis, and Wildavsky (1990), the more binding and the more extensive scope of the prescriptions, the less of life that is open to individual negotiation. Performance in hierarchies includes a large measure of following prescribed procedures.

The grid dimension will be made operational through three pairs of concepts: autonomy/ control, centralization/decentralization, and formalization/deformalization. In terms of operational definitions, the grid is low when autonomy is high and vice versa (Hampton, 1982, p 66). Autonomy, according to Hampton (1982), is based on the degree of the individual’s possibility to affect one’s own working conditions. Control is based on the degree to which the individual has control over others’ work and if the work involves decision-making or other responsibilities; when control is high then grid is low and vice versa (Hampton, 1982, p 66). The hierarchical Thai society as well as the system of seniority provides the basis for the high grid social relations of TSW. This stems from differences in position in a hierarchy both among and between each group of staff.

On the other hand, the social relations of the TSW are not merely high grid/low grid when analysed in terms of centralization and formalization. The system of seniority as well as hierarchical relations among their group tends to push this local culture in the position of high grid control but not for all aspects. According to Gaskell and Hampton (1982), the grid control in this culture is high since decisions can be made by a few top managers, whereas the grid is low when the subordinate agrees with the
supervisor on the criteria that should be used to evaluate the subordinate’s work. The amount of written instruction about how the work should be performed is a parameter of formalization and is related to centralization in that it is a substitute for direct supervision (Robbins, 1990).

According to Robbins (1990, p 82), “centralization refers to the proportion of jobs whose occupants participate in decision-making and the number of areas they participate in”. The grid is high when this proportion is low and the organization is centralized. Formalization, in other word, rules, regulations and procedures, is the extent to which an employee’s role is defined by formal documentation (Robbins, 1990, p 82). The grid is high when formalization is high. The high group is identified in this local Thai nursing culture in terms of operational concepts. These are frequency of interaction, degree of mutuality in interaction, the scope of interpersonal interactions, and the group’s boundary tightness regarding inclusion or exclusion (Mars, 1988).

The high grid/high group social relations of the TSW place the position of the TSN within the context of a hierarchical/bureaucratic social organization. Individual behaviour, group boundaries, and internal regulation are highly controlled in this context (Altman & Baruch, 1998). Personal security is valued higher than competition, and social mobility and roles are distributed on the basis of seniority and decisions on performance based on hierarchical bureaucracies.
The position of the TSW at the extreme top right, strong on grid, strong on group, reflects a cultural bias supports tradition and order, a society in which all roles are ascribed, all behaviour governed by positional rules, all the constituent groups contained within a comprehensive larger group. Roles are ascribed according to birth or gender or family, and ranked according to function and tradition. As discussed so far, the nurses in the TSW are more responsive and answerable to a body of formal, abstract rules in the organization, which direct their daily conduct in the hospital with a high degree of importance of solidarity with their colleagues in day-to-day work.

The ritualised cares given by the nurses of the TSW reflect the analysis proposed by Douglas (1973) of the relationships that exist between the status of the nurses and the type of work carried out, including the social relations that exist between nurses, medical doctors, patients, and their workplace organization. These social relations and staff culture influence what are seen as ‘important’ for the TSN as well as what it means to be the TSN, providing the basis to form the particular/unique characteristics of routines, rituals, and care given in the TSW, as discussed in Chapter 4, 5 and through the series examples of pre- and post-operative care in this chapter.

The ritualised nursing practices and cares administered to patients undergoing surgery reflect the maintenance of the social order of the TSW through their social relations. As seen, the boundary of cares is created through limitation or identified as appropriate/inappropriate in relation to both their expectation and perception to expectation from significant persons in the organization hierarchically, in particular medical doctors and senior colleagues. Showing concern for some activities such as talking to well patients is seen as less important than executing medical doctor orders,
reflecting nurses’ cultural value of what they see as significant or what actually is required for excellence or represents quality of care according to their values. Here, criteria are created as a symbol of excellence for TSN – a would-be excellent care. Members are expected to display excellent behaviours. As discussed so far, the influence of the medical model over nursing theory affects qualities and competency of cares as well as the competence to manage complicated/critical patients and medical devices. According to Raffel (2007), the ritualised nursing practices and cares administered to patients undergoing surgery amounts to a shared cultural practice.

The evidence of nurses using the pragmatic, activity-driven approach of ritualised nursing practices and cares administered to patients undergoing surgery that underpins the medical doctors’ orders, attests to the influence of culture and cultural norms in society on everyday social relations and practices. As this study’s findings and discussion demonstrate, currently, although Thai nursing has become a professional discipline, it still faces many challenges within its own cultural heritage and, more generally the cultural heritage of the Thai people. According to Burnard and Naiyapatana (2004), nurses are carriers of the culture and defend cultural norms of each country. Thai society as discussed in Chapter 1 in relation to Hofstede’s perspective has predominant social relations of high as collectivist culture (Hofstede, 2001) as well as the other dominant features of Thai culture that directly impact to form the distinct culture of the TSW, which in turn affects their culture of everyday practices which is visible by others.
The milestone development of professional nursing in Thailand, as discussed in Chapter 3, and the hierarchical relations that the nurses have with each other, medical doctors and patients, as well as the high group strength among themselves, as discussed in chapters 4 and 5, provide the basis for developing and controlling the day-to-day practices of the TSW as seen through the examples of their ritualised pre- and post-operative cares. The ritualised pre- and post-operative cares reflect the strong solidarity of their group as discussed in Chapter 5, under the culture of the Thai nursing profession as discussed in Chapter 2, and the hierarchical relations the nurses have with each other as well as have with medical doctors and patients as discussed in Chapter 4. As seen in Chapter 4 and Chapter 5, the hierarchy as played out among the nurses’ relations in term of experience and age can provide career enhancement within the profession itself. The capacity of even the most knowledgeable nurse to advance quickly within the profession will generally be restricted by core Thai values linked to experience and age. Hierarchy based on social convention also determines the career rise of medical doctors.

All Thai relationships are pervaded by hierarchy (Klausner, 1993). Hierarchies as well as occupational differences prevail as a result of differences of class, educational level, and occupation in Thai workplaces. The counter-dependent relationships between bosses and subordinates are then created so that subordinates are expected to be told what to do. As with other Thais, the nurses of the TSW were taught to please elders, not to argue with seniors, and not to disagree with those who have more power. The milestones in developing professional Thai nursing relate to the hierarchy, power distance, and the occupational differences in Thai society as a result of the medical control over the nursing profession. Here the public view of nursing has
tended to highlight and value technical skills much more than independent decision-making. By contrast, TMDs even working within a system that is called ‘multi-disciplinary’ tend to stay in a position of the boss in which they get the preference to make all decisions.

As seen through the discussions so far, the priority and time allocated to each care depend on nurses’ views about what are seen as important/not important or high/low prestige jobs. As mentioned in Chapter 2, the medical dominance in the Thai nursing workplace extends from clinical education through practice in Thailand, with a focus on ‘doing rather than learning’ meaning that concepts in the curriculum were not fully translated into practice. From this, the hospital-based nursing curriculum still remains and influences clinical nursing practice even though most nursing curricula are changing towards community-based nursing consistent with a national policy of primary health care. A focus on treatment and cure resulting from the medical model therefore affects the status of the profession.

The strength of ritualised nursing practices and cares administered to patients undergoing surgery also stems from the high group and strong solidarity within collectivist Thai society and organization. According to Hofstede’s (1991) perspective on social relations within any society, as discussed in Chapter 1, Thailand as well as other Asian countries ranks high as a collectivist culture. In collectivist Thai society as well as in Thai organizations, members have a primary concern for the group to which one belongs (Berry, Poortinga, Segall, & Dasenn, 2002). This manifests itself in concern about what others think of their actions and trying to gain respect by acting
in a way that meets the expectations of the individuals around them, including the concern for saving face.

As discussed earlier, Thais view work as a social function and want personal relationships between people, as a result creating family-like ties with persons who are socially integrated into one’s in-group. From this, newcomers, as discussed in Chapter 5, learn the new culture and the expectant results if they break the rules and norms of the organization from people who are generally ‘senior’ and thus serve as models for newcomers to imitate and form their behaviour (Hofstede & Hofstede, 2005). A mutual dependence relationship and strong cohesive in-groups are then developed between the in-group and the person. Consequently, they think of themselves as part of a “we” group who belong to something which is distinct from other groups.

Along with hierarchical relations in the organization, on the other hand, the TSN build strong bonds between each other as the only way open to them to deal with a social and cultural convention that is so strong it prevents them from advancing their own nursing practices. Hierarchy and solidarity in the TSW influence and determine the way nurses work, and decide on their actions and activities, even creating rituals and routines that govern all members’ behaviours in the organization. Here, the ritualised practices have been socialized and maintained from one generation to another as seen through the ways the nurses manage pre- and post-operative care and through the discussions in Chapter 4 about “we always do it this way”.
The collectivist culture of Thailand and high solidarity among their group influence the nurses’ response to medical doctors, and how they organize their daily works and workplace activities rather than their prior knowledge, rules and hospital policies, including current global issue and trends in nursing. Uncertainty avoidance among Thais (Hofstede & Hofstede, 2005) influences the nurses of the TSW who are strongly socialised to conform to group norms, traditions, rules and regulations, and to seek stability and view change as disruptive and disturbing. According to Goopy (2000, p. 162), the kinds of routines and rituals that nurses create and perform are mostly supported and determined by the solidarity of the group and the degree to which one is accepted by the group.

The way the staff nurses of the TSW manage and administer cares for patients before and after surgery, such as the primary focus on following medical doctors’ orders rather than talking to well patients, therefore reflects the values, social environment, social relations, and culture of the TSW. The unique pre- and post-operative cares given in the TSW are therefore created to guide and control nurses’ performance as my examples have shown in the earlier discussion. The actions taken by the TSN are manifest expressions of the group’s response to hierarchy, in which a greater degree of power is automatically assigned to the medical group, and that negates the need for and ability for the TSN to make clinical decisions.

The local distinct Thai nursing culture was viewed and described according to four-dimensional model purposed by Hofstede and grid/group matrix of Douglas. While Hofstede’s model well used describes the specifics of this Thai nursing culture in terms of the individual and the ‘group’ (individualism vs. collectivism), masculine
and feminine, and uncertainty avoidance, some similarity is detected between these two models. Importantly, both models reflect the understanding of culture as the group’s learned responses to problem of survival in its external environment and its problem of internal integration (Schein, 1985). In contrast, Hofstede’s four-dimensional model tends to focus on homogeneity while Douglas’s grid-group typology seems to better describe particular cultures as different ways of life. The Douglas’s cultural theory links social relations, biases and strategies in specific ways within each of the four cultures of individualism, fatalism, hierarchy and egalitarianism. The interconnections between these three domains make a culture coterminous with an institution. It is the explicit combination of values and social relations within the cultural type.

The maintenance and change of ritualized practices of the organizational culture can be said to stem from the support of social relations within a high grid/high group. Creating a new culture of research utilization or evidenced-base knowledge in this local Thai nursing culture, for instance, is seen as possible if organizational factors to change the group’s beliefs and values are created. As discussed earlier, the rituals and routines of the TSW run counter to “best practice” in the era of patient-centred care, evidence-based practice and models of professional practice that currently dominate the international literature. For example, the recently launched national hospital policy of from routine-to-research-to-routine or ‘R2R2R’ at the studied hospital works as external pressures for nurses and other staff to conduct research from and in relation to their day-to-day practices. Here, hospital activities such as ongoing training and workshops on R2R2R are held to create new desired values and behaviours (Field notes, 2007).
This external pressure is, however, not strong enough to overcome the ritualised practices. As seen through the series of pre and post-operative examples, care in the TSW is still based on ‘traditional surgical cares’. The current suspension in implementing research as well as evidence-based knowledge into their daily routines and practices such as pre-operative care given also supports this claim. Similarly, the study among the group of Thai healthcare providers and clinicians revealed that traditions, clinician expertise, and personal experience were used in making patient care decisions rather than research findings (Pichitpornchai, Street, & Boontong, 1999). Here the social relations as well as organizational culture tend to have more influence on day-to-day nursing practices than national and institutional policy or issues and trends in nursing. These practices, routines and rituals themselves pose challenges to the development and realisation of professional practice and clinical decision-making of Thai nurses as it is understood in the literature and the nation through institutional policy in integrating research into their daily practices and vice versa. Here, the success in implementing evidence-based knowledge as well as research utilization into this distinct Thai nursing culture is dependent on the way they see the significance of implementing global evidenced-based knowledge into their rituals.

The ritualised practices are seen by the nurses as important and as their identity, order their actions and behaviours. Here the flourishing of evidence-based knowledge in Western society tends to be less value in Thai nursing workplace. Since culture plays the major role in prescribing and proscribing individual behaviour and role expectations (Batelaan, 1993, p 28) to achieve institutional legitimacy and create cultural uniqueness (Pedersen & Dobbin, 2006), persistence and resistance to
institutional pressures in creating changes among sub-cultures while attempting to instill and maintain norms and ritualised practices is therefore not uncommon for this local Thai nursing culture.

Douglas’s notion of cultural biases as well as Hofstede’s view of the differences between Western and Asian culture provide suggest the difficulties in applying global nursing knowledge into Thai nursing. Knowledge constructed in the American context might have been formed based on the social relations of American culture, which obviously contrasts with Thai culture. Western-based knowledge cannot simply accommodate to Thai nursing culture. In order to further develop professional nursing in Thailand, the cultural biases from using knowledge developed in other cultures should be rigorously interrogated. The routines and ritualized pre and post-operative cares which are based on tradition show that although the development of the Thai nursing profession is mostly based on American nursing theory the influence of Thai nursing and associated culture remain strong.

The reasons why the nurses of the TSW give less priority or even struggle to enact the very principles of professional practice such as evidence-based practice (clinical decision making) that underpinned their education and their professional formation can be inferred from the influence of Thai society and the dominant features of Thais on the development of professional Thai nursing, organizational culture and the social relations of the TSW. As discussed so far, education is not sufficient to override established power differentials. Although the TSN are well educated through a four-year university degree with some also undertaking a Master degree and short courses training (e.g. palliative care, CVT nursing, critical care, wound care), they work under
the greater degree of medical power which has been traditionally and automatically assigned throughout the development of Thai nursing profession within organizations and social culture. The hierarchical structure of the healthcare profession, power sanctions and imbalances between the cultures of professional nursing and medicine are still evident in Thailand as well as in this distinct culture.

Low levels of nurse autonomy resulting from these social relations hinder the TSN from enacting professional principles. For example, the focus on ‘doing’ rather than ‘questioning’ as a result from physician-centred and functional task-oriented nursing system of the TSW and a low level of nursing autonomy entails the low management priority given to evidence-based practice (EBP). Consequently, the nurses adhere to the performance of set routines and ritualized tasks, and execute medical doctors’ orders. Here the gap between professional theory and the reality of practice is identified as well as the importance of increasing the ‘power decision-maker’ aspect of nurses in this local culture. Successful change among TSN within high grid/group social relations of the TSW entails developing the group members’ autonomy to run their own affairs to enhance the group’s professionalism.

The strictly hierarchical staff relations within the organization can either support or block change in this local Thai nursing workplace organization. According to Thai social and cultural norms, resulting from the system of seniority as discussed so far, nurses of the TSW have a positive attitude toward authority and expect instruction and guidance from seniors and people in higher rungs of hierarchy by not engaging in confrontation. Consequently, the positions and responsibilities of the TSN clearly mirror experience which is inextricably linked with age, meaning that it’s probably
worthless to implement new knowledge such as evidence-based knowledge if this is led by well educated junior nurses, or even nurse educators or junior medical doctors. According to Erez and Gati (2004), organizational culture is nested, each layer carrying and affected by the layers surrounding it, so a change in one layer affects all surrounding layers in both top-down and bottom-up directions. In case of the TSW, beyond the group of staff nurses, each group of other staff tends to be nested hierarchically. Here the strong hierarchy in Thai society as well as in this local culture provides further suggestions and predictions for making change. Such change in ritualised practices among the group of medical doctors will in turn influence change in ritualised nursing practice.

For example, the gradual demise of ritual skin shaving with a razor in preparing patients for surgery has occurred as a result of a protocol launched by the surgical department. The head nurse acknowledged that the reason for this change is that most of the surgeons accept that shaving skin around the surgical area has no benefit and increases the risk of incision wound infection. The nurses view the primary benefit of this change in terms of decreasing their workload (Field notes – discussion, 2007). The high group as well as collectivist feature influences the way the organization is set up and ideas about what is best for staff. Here, the benefit of not shaving hair around the operation site tends to be valued for its effect on workload rather than as a shift to ‘best practice’, or for its effect on the patient’s well being and comfort. This is an example of work changes to make their life easier, with the patient outcomes and evidenced-based further improved as a consequence.
The high group strength of the nurses in the TSN also provides the possibility of creating change in this organization by primarily focusing on peer pressure and informal sanctions. According to Fortado’s (1994) suggestions, informal and unsanctioned activities may also be undertaken by individuals or groups to encourage compliance with cultural expectations of behaviour enforced through peer pressure and informal sanctions. Failure to comply with expectations may result in peer ‘punishment’ unsanctioned or even forbidden by the organization (Kondra & Hurst, 2009). This form of social control creates self-generated discipline to conform to organizational norms to ensure a sense of belonging.

According to Parsons’s (1968) rule-following theory, people conformity to cultural rules is produced not merely by the threats and/or the rewards of external sanctions but rather because people have come to ‘internalise’ the rules by being motivated to comply with rules as a duty. Rules are understood as a moral obligation on our part: the moral obligation is to obey a rule, the voluntary adherence to it as a duty (Parsons, 1968, p 383). Parsons (1968) viewed adequate rule-followers as driven by a moral obligation, by a sense of their duty that we have come to internalise is a sort of commitment to allocating cares to patients. Pre- and post-operative cares are therefore the orderly behaviours that are perceived by the TSN as professionalise and standardise. Pre- and post-operative caring behaviours reflect the concerns of the TSN about their duty, an internalised moral obligation to pre- and post-operative care. What has been internalised is not concern for the quality of care but the moral obligation – the duty – to always be complete and do what their colleagues and other staff, in particular medical doctors, expect them to do. Importantly, the issue of power and control in the organisation, in particular who holds the power, what kind of power
it is and what implications that power has on group affected, are highly relevant (Kondra & Hurst, 2009).

Creating interested among the nurses as well as a sense of the benefits of introducing research and evidenced-base knowledge into their ritualised practices as distinct from their day-to-day practices may therefore enhance professionalisation and standardisation of care based on scientific evidence in this Thai nursing culture. Social relations through daily organisational activities such as meal meeting, handover, pre-working conference, mentoring novices or nursing students therefore provide opportunities for sharing information, transmitting behavioural norms, expectations, and ritualised practices that shape and control behaviour. Here, hospital activities such as ongoing training and workshops on quality management and R2R2R are held with the same purpose, to create new desired behaviours.

Raffel (2007) argues that the failure to disseminate and implement research as well as evidenced-based practice can imply a possible problem of members, in this case TSN and staff, do is what is expected of them – the problem of how persons follow social rules. Low turnover rates in this organisation can affect the success of an individual’s values to converge and be congruent with organisational values, a process referred to by Kelman (1958) as ‘internalisation’. This implies that the nurses’ ritualised practices stem from their values beneath the surface elements of their culture: these are the hardest to discern and change, and individuals may not even be aware of them (Sackmann, 1992). This explains why ritualised practice are always done ‘in this way’ and why the global flourishing of evidenced-based knowledge tends to less valued and acknowledged in this distinct Thai nursing culture. In order to successfully
manage and change culture, one needs to aware of the many elements that can distort or create an incomplete understanding of culture and produce resistance (Tichy, 1982).

Culture is a major force for either maintaining or changing ritualised practices. The ritualised practices stem from the shared ways and thinking that grow out of group experience and are passed from one generation to the next (Broom, Selznick, & Broom-Darrock, 1981). These also stem from the deeper level of basic assumptions and beliefs that define in a basic taken-for-granted fashion a group’s view of its practices and its environment. These assumptions and beliefs according to Schein (1985) are learned responses to the group’s problems of survival in its external environment and its problems of internal integration.

It is clear that culture and institutions guide individual actions and behaviour. Change is embedded in culture and institutional arrangements of the organization. Two existing models purposed by Geert Hofstede and Mary Douglas have been used to describe this distinct Thai nursing culture and analyse cultural conditions for reaching more professionalised and standardised nursing practice. This poses certain questions about which social conditions in particular influence access to and use of research and evidenced-base knowledge. The way nurses organise patients undergoing surgery pose certain questions about whether the institution shall draw its group boundary closer, or relax it, apply its rules more strictly, create more rules or relax them all.
CONCLUSION

In conclusion, I shall briefly summarize the reason for embarking on the kind of study that I have undertaken. The impetus for undertaking a largely descriptive ethnography of the Thai Surgical Nurses presented in this thesis arose from the relative neglect of the role played by local culture in studies of nursing. Accompanying this was my enthusiasm for promoting the importance of taking account of culture in ways that current ‘universal’ calls for changes to nursing practices (and in particular the decision making of nurses in their cultural ward settings) cannot easily accommodate. With these intentions in mind this thesis addressed the social relations and staff culture of a particular group of Surgical Ward Nurses in Thailand. In discussing the day-to-day practices of the TSW and in particular the ways that the nurses make their clinical decisions, I hope to have shown the combined significance of internal and external factors on the manifestation of certain actions and cultural themes. Moreover, through its detailed description of the TSW and the TSN this thesis has shown the readers that not only are the actions, habits, routines or rituals themselves important, but also highlighted the cultural and social elements that underlie and impel these daily occurrences. In short, both the internal and external features of a given environment, including its history, politics, economics, and institutions, determine its social relations and culture.

By highlighting the complex relationships in the TSW and how they affect daily practices through the detailed ethnography, the thesis presents future policy makers and change agents with an understanding of the complex issues that exist within the day-to-day culture of Thai nursing. This largely descriptive approach has been used throughout the thesis as a tool to help explain why the TSW nurses manage the
patients and their care as they do. Through its detailed observations, of day-to-day practices, staff and patient relationships, and routine practices, some concrete explanations are offered for those idiosyncrasies that might otherwise be viewed, reductively, as simply that. The various elements described and analysed throughout this thesis have in turn shown the numerous pressures that shape the social relations and the staff culture of the nurses of the TSW.

The history and evolution of the nursing profession and education in Thailand from the past to the present and into the future discussed in Chapter 2 has shown that hierarchy, power distance and occupation differences prevail in Thai nursing workplaces. Presently, although Thai nurses enjoy higher educational standards, strict regulation governing national licences, and an advanced career path, questions remain about nurses’ autonomy and professional status, for example, the tension between education of nurses and the practice of nurses as a reality. These issues tend to be barriers for Thai nurses in the 21st century, an era in which is nurses are expected to employ advanced use of information technology and quality assurance, and incorporate research into nursing practice. Congruent with my experience as a surgical nurse educator at the setting, the failure to accommodate evidence-based nursing practice and the new multimodal model of care in the Thai hospital context was my primary encouragement to study the local surgical ward culture. The study also arose from my curiosity about the local culture of Thai nurses and how nurses from different cultures such as that of the TSW in this case, manage care to patients and respond to global changes in the nursing profession.
Specific nursing culture works as mental rules guiding behaviour to control the way of life, actions and works in patterned ways of its members (Burnard, 2005). To date, as shown in the literature review, the unique culture of Thai nurses at hospital workplaces and its effect on care and practice has not been widely examined and discussed. The principal focus of this study was therefore on the social relation and staff culture of the TSW, aiming to explain the local organizational culture of Thai surgical nurses and the way social relations and local nursing culture plays out in their life and day-to-day practices.

Ethnographic research is therefore the best fit and useful to address this focus of a distinct group of Thai nurses as well as to record their local culture. Ethnographic study was then utilized through the lens of Douglas’s cultural theory and Hofstede’s perspectives to understand social relations and staff culture, including the way it underpins certain nursing actions of the TSN. Cultural inferences were made through observing and participating in day-to-day activities of nurses at the TSW, including interviews with 16 key informants to develop a deeper understanding of social relations and staff culture of the TSW. From this, social relations and cultural factors underpinning or driving the traditional day-to-day nursing practices at the TSW are uncovered to gain a clearer understanding on the current nursing practice in a new light, in particular what it meant to nurse – to care for a patient – to make decisions about care.

The influence of the dominant Thai cultures and Thai society underpin the social relations and organizational culture of the TSW and the everyday practices have been described and analysed throughout this thesis. The thesis addressed the social
relations of the nurses and other staff of the TSW based on the ‘gird-group’ cultural theory of Mary Doulas and Hofstede’s societal perspectives. The local Thai nursing culture is then transformed to the readers by telling a typical day in the life of the TSN through the explanations of their hierarchical relationships, the high degree of integration and its influence on the life of the TSN, including providing example of fixed assumptions, pre- and post-operative care in the TSW, to show the way these two features of the culture of the TSN influence on the way practice is organized.

As seen, the discussions on the physical space of the TSW in Chapter 3 reflect the hierarchy, the social order and the power distance between levels within Thai society and differences rungs of the professions which is visible via the way they use, control, and employ their power in relation to the ward’s spaces and artefacts. The level of control over the space, the behaviours of people and relationships were shown to relate to the level of education, position, social status based on the hierarchical level both in Thai society and in the healthcare system.

The discussions in Chapter 4 revealed the hierarchy, seniority and kinship relations among the staff nurses themselves as revealed in evidence such as the variety of uniforms used, and the way that time (length of employment and experiences) acts as the measure for competence and ability and is also used as a prerequisite to allocate work in each role. Here the cultural construction of being a nurse of the TSW is imbued through socialization as can be seen via the extended and detailed example of the ‘training newcomers’ by senior nurses during the first six months and a typical day in the life of the TSN, reflecting the impact of hierarchy and solidarity on patterned work, and the ritualized practices, and characters of the TSN.
Superior and subordinate relationships between professional nursing and medicine, including between medical doctors/nurses and patients play out in the daily routines of the TSW hierarchically. The evidence of the hierarchical relations and inferiority of nurses (e.g. the story telling of the surgeons) in relation to medical doctors and the nurses’ compliance behaviours with surgeons and communication barriers confirm that the hierarchical structure of the healthcare profession, power sanctions and imbalances between professional nursing and medicine are still ongoing in the Thai nursing organization. The dominance of the medical model over nursing theory can be evidenced in this Thai nursing culture through the functional task-oriented nursing system of the TSW, reflecting the way nurses value and see what is or is not important as a result in the way work is managed and prioritised at the TSW. Most of the actual nursing cares (e.g. patient’s comfort) are allocated by the staff auxiliaries whereas the nurses mostly spend their time at the computer at the nurse’s station to carry out medical doctors’ orders or devoting themselves to prescribed tasks.

The hierarchical relation with professional medicine, on the other hand, is apparently at odds with the warm and congenial atmosphere of the TSW as well as the low turnover rate and the high retention of the experienced nurses and other staff at the TSW. Consequently, Chapter 5 discusses how the TSN maintain and preserve the strong bonds among their group and strong boundaries with outsiders. Here utilizing ‘grid’ and ‘group’ theory of Douglas and Hofstede’s societal perspective provide the basis for analysing and identifying the social relations of the TSN.
The reality of life in the TSW arises from the strength of grid and group dimensions. The strength of grid as a result from professional and societal ethos is essential in shaping behaviours of the TSN to conform to orders, rules and regulations of the organization hierarchically. The group pressure as a result from the high group strength amongst the nurses themselves complied with the dominant Thai features and values as identified by Hofstede (1991). Their behaviours and actions are therefore based on their perception of imposed standards as well as behavioural expectations both from their nursing colleagues and other stakeholders, in particular people on a higher rung of hierarchy, in this case medical doctors/surgeons.

The commonalities that nurses share in relation to their educational background and incorporation of beliefs, values, and regional characteristics influence them to establish the likeness and similarities of the practices and a set of social performances. These become the taken-for-granted actions and activities, and are drawn on by the group members to support and ascertain the identity as being indicative of ‘surgical nurses of the TSW’. Here, the use of Douglas’s approach and Hofstede’s perspective provided explanation of the reasons underpinning the way the nurses of the TSW manage care to patients.

The discussions of hierarchy in Chapter 4 and solidarity in Chapter 5 contribute to the discussions and conclusions in this chapter via the examples of the local ‘cares’ and ‘ritualised of practices’ resulting from the social relations and staff culture of the TSW. The collectivist and the hierarchical culture, and system of seniority in Thai society, including the historical development of professional nursing culture in Thailand, provide the basis for establishing the hierarchical relations and the high group strength of the Thai nursing organizational culture.
The TSN make and employ their clinical decisions mostly based on medical doctors’ orders and prescriptions. The struggle of nurses to articulate the scope of their practice as a result impedes the nurses’ autonomous decision-making. Here the nurses of the TSW struggle to enact the very principles of professional practice such as evidence-based practice (clinical decision making), that underpinned their education and their professional formation. As seen previously, the specific pre- and post-operative cares offered by the nurses of the TSW are routinis ed, almost ritualised, and reflect fixed assumptions about the way cares ought to be delivered. So, while national healthcare policy and current nursing curriculum are shifting from the medical model to run counter to nursing theory and evidence-based nursing practices, the practices of the TSW are driven by medical doctors’ prescription under the environment of functional task-oriented nursing system. Here the tension between education of nurses and the practice of nursing as a reality can be diagnosed.

Although rituals illustrate the realities of life and the unity of nurses as a social group, according to Walsh and Ford (1989), carrying out a task without thinking it through in a problem-solving, logical way implies ritual action rather than decision-making. Presently, incorporation of the research or ‘evidence-based regime’ into the Thai surgical nursing practice is still suspended even under the era of establishing the nationwide culture ‘from routine to research to routine’ within the Thai hospital and healthcare context. Here, ritualised practices, including the dominance of the medical model are consistent with the (negative) attitudes to doing research among the group of the TSN, with negative implications for encouraging a culture of ‘from routine to research to routine’ as well as inhibiting the atmosphere of evidenced-based practice.
In the era of global evidence-based nursing practice, particular nursing rituals such as routine post-op. care should be further explored by utilizing ethnographic study to seek a scientific explanation.

A change in surgical nursing culture is needed in order to promote the application of evidence-based practice, in particular consideration to factors such as the impact of ritualised practice, medical dominance and the medical model over Thai nursing practice and education as well as the locus of power and decision-making. Implementing evidence-based surgical knowledge and establishing the value of ‘from routine to research to routine’ in the general surgical wards under total quality management hospital also requires the TSN to improve their CDM skills to enhance patient outcomes and meet the optimal goals of the organization under nursing culture and the context of multidisciplinary teams. The strategies for refining and developing the valued aspects of CDM of the TSN to best fit with the Thai hospital culture is vital to developing a workplace culture to enhance CDM.

The evidence generated from this study on the social relations and staff culture of one Thai surgical nursing context as it represents the hierarchy and the high group strength and practices and the way they make clinical decisions establishes that organizational culture is particularly important when attempting to manage wide change in nursing organizations. It involves not only changing structures and processes, but also changing the corporate culture. Here nursing theory as well as evidence-based nursing practice cannot overwhelm day-to-day nursing practice without concerning a particular distinct nursing culture. Organizational culture plays the major role in both inhibiting and facilitating nursing practice and education. From
this, there is no one single method or package to instantly make any changes. This does not mean that any changes or technologies cannot be implemented or accommodated in the Thai nursing culture. The changes, however, can be cultivated based on some western-based knowledge with a need for congruence with the context of Thai nursing culture.

According to Gerrish and Clayton (2004), implementing evidence-based practice in a Thai healthcare organization should be concerned not only with the nature of the evidence, but also to the methods of facilitation and the Thai healthcare context. A positive research culture is therefore required to create in the Thai nursing organization the recommendation of Le May, Mulhall and Alexander (1998, p. 429) to “create a whole system where research is perceived as more favourable and used more proactively by the majority of practitioners”. For this reason, prior to gaining success in applying the value ‘from routine to research to routine’ in Thai hospital context, it is necessary to promote a change in Thai nursing culture. To create ‘research culture’ in the Thai nursing organization, for instance, the future research should attempt to answer the question, “How can we harmoniously change from traditional to critical or evidence-based approach?”

The study’s finding about the inadequacy of autonomous decision-making and the inferior role that the nurses’ play in multidisciplinary decision-making results from medical dominance as well as the prevalence of the medical model over nursing theory, suggesting that maintaining professional autonomy needs to become a priority for Thai nurses. In order to increase autonomy in professional nursing, professional
nursing power to enhance nurses’ autonomy is should be prioritized by nurse administrators and nurse educators.

A major concern should be for Thai nurses to become proud of their professions and create professional identity and autonomy rather than humbling and complaining atmosphere in the nursing profession. Developing a nursing workplace culture to empower each other as well as to establish assertive behaviour from the nursing students should provide the possibility to solve this cultural issue. Increasing nurses’ autonomy in making-decision, for example, can be done from within the nursing profession. Studies should be conducted to answer the question: **How can we improve the status, autonomy of professional nursing, consistent with developing high quality nursing care?** Also, strategy refining compassion, empathy, mutuality, respect for other autonomy and separateness, in particular norms, believes, values, and cultures should be also explored in future studies.

Allowing nurses to focus and prioritise on real nursing cares rather than functional task-oriented nursing system is also important. Future research can answer the question: **How can we shift the nurses’ value from medical model to real nursing cares?** Significant improvement in career advancement of professional nursing in Thailand also provides the opportunity to balance the difference of the professional power between nursing and medicine. This improvement however, poses to certain question: **How to create the curiosity of the nurses to primary focus to achieve the career advancement?**
The study also brings broad recommendations to Thai nursing education as the vital agent in producing graduated nurses who become the input of the nursing culture.

The impacts of organizational culture, in particular through enculturation and socialization of nursing students and novices, need both actions and mutual corporations between nurse practitioners and nurse educators.

To increase evidence-based practice in Thai nursing, we (both practitioners and nurse educators) should start looking at the evidences or factors underpinning our traditional surgical nursing practices, in particular the ‘routine post-op. care’, including the other ritualised practices. Establishing nursing culture as entailing evidence-based or research utilization in making decisions in everyday nursing practice should be done from the undergraduate nursing students (e.g. in writing patients’ care planning) through to developing the standard of nursing care or clinical nursing guidelines. Systemic review regarding the surgical nursing concepts, such as nursing care for patients undergoing surgery, requires sustained attention, both in surgical nursing textbooks, research, and utilization in practice. Nurse educators, nurse administrators and the head nurse are well positioned to leverage their teaching and clinical organizational culture to enhance Thai nursing professionals to conduct their studies and employ evidence-based practice in day-to-day nursing cares.

The application of evidence-based practices needs to be reinterpreted or reorganized in the Thai hospital context. To develop Thai nursing, a model of nursing care needs to be developed which can harmoniously integrate evidence-based practice with Thai value and cultural way of Thai life. To make the nationwide change of professional nursing in Thailand, a holistic approach to nursing organizational culture needs to be considered. From this, a local culture of Thai nursing across the nation needs to be
examined. The further studies to explore a local culture of nursing in each Thai region can be cultivated based on the method and knowledge on the local nursing culture constructed and derived from this study. This also provides further recommendations in utilizing ethnography to study the commonalities or likeness and differences in national Thai nursing culture.

Utilizing ethnographic study by using participant observation was the major method in conducting this study. LeCompte (1999, p. 91) that participant observation is “the process of learning through exposure to or involvement in the day-to-day or routine activities of participants in the research setting”. The social relations of the nurses and other staff of the TSW are addressed based on the ‘gird-group’ cultural theory of Mary Doulas and Hofstede's societal perspectives. Here my research question and major goal were to study social relations and staff culture of one distinct Thai nursing culture, what happens in Thai nursing culture, and how this can be problematic when looking at or wanting to develop a workplace culture in which western models of nursing and health care such as evidence-based knowledge can flourish – as it is meant to, including what aspects of knowledge and practices are valued and how could these be re-worked to fit with the Thai nursing culture. A number of questions arise from this study to be further researched to push Thai nursing profession to meet international ‘excellence’.

Being a nurse ethnographer in my own nursing setting is valuable in that I see the culture of my clinical nursing practice in a new light, in particular what it means to nurse – to care for a patient – to make decisions about care that I never have a chance to view and learn as a nurse educator. Here the useful insight for promoting and
creating culturally sensitive change to run counter to professional excellence can be yielded.

The occupational structure of nursing in the TSW as presented in this thesis is of interest as it offers insight into both the wider processes of professionalisation within Thailand and also highlights its pattern of development through its juxtaposition of the educational level afforded nursing in Thailand on one hand and the day-to-day reality of ward work within, in this case, a Thai surgical ward on the other. Added to this, as we have seen throughout the thesis, the elaborate hierarchy among the nurses of the TSW themselves but also, and perhaps more significantly as highlighted in my discussion has been the development of a carefully stabilised and elaborate hierarchy of occupations – in particular medicine over nursing – which with the support of the state holds a virtual monopoly on formal health care – especially within hospital medicine.

This thesis further raises the question: How does the relationship of the education of nurses in Thailand and the ways in which activities are undertaken on a daily basis and clinical decisions are made at the ward level (in the workplace) provide a measure of progress in specific instances of occupational change? From this then arises too the question, following on from the work of Everett Hughes (1963): Under what circumstances would the nurses of the TSW seek to turn their occupation into a professional practice in which clear trait and functionalist perspectives can be identified? And, in turn to what extent does/would the profession of medicine in Thailand influence the similarly aimed stratagems of nursing in Thailand?
By posing these questions as points for further investigation the material uncovered in this thesis points to a need for us to revisit, at least in part, the question of what is it that creates and forms the professional and what is required of this. Parsons (1959: 547) closely identified professionalism with modern scholarship: ‘I conceive a profession to be a category of occupational role which is organized about the mastery of, and fiduciary responsibility for, any important segment of cultural history. In addition a profession may have the responsibility for the application of knowledge in practical situations.’ With his heavy emphasis on knowledge Parson’s differs significantly from Hughes (1963) who places great stress on the service and trust components of professional performance over the knowledge component. The professional role that Hughes (1963) highlights in his work is that of the professional who is uniquely identified with service to the client: the professional/client role relationships is at the core of this understanding of the profession with service and trust reciprocation (which is the assumption of autonomy) at the very heart of the realisation of professional conduct and status.

While this study generates evidence about the social relations and staff culture of one Thai surgical nursing context, I am mindful of its limitations in terms of the things that it does not address. The understanding on the reasons underpinning the everyday work life of the TSN has been proposed by utilizing Douglas’ two dimensional grid-group approaches which combine well with Hofstede’s societal perspective. With this in mind, the thesis discussions have been drawn within these two paradigms as a result in limiting its scope to particularly focus on investigating the other impact cultural factors of the TSW.
Since the majority of nurses in this culture are women whereas most of the surgeons are men, the study results revealing how the dominant feature of male and female underpin their relations and behaviours, this thesis could have taken a much more feminist approach to reading the nursing workplace situation under the ‘patriarchal dominance’ of male medical doctor. A feminist approach, however, was not taken because this study aims to describe TSW organizational culture in all aspects, in particular in terms of local Thai and Thai nursing culture – not only the impact of femininity on the majority of nurses in their everyday life.

The pervasive hierarchy of collectivist Thai society underpins unequal social relations rather than gender differences. The equality of the sexes and the social inequalities in current Thai society are not based on gender as much as unequal distribution of wealth and opportunities between men and women as well as the dominance of both male and female medical doctors. Importantly, being a female researcher myself, I decided to avoid using feminist theory as the major tool to read the distinct Thai nursing culture and examine the experience of the majority of female nurses and their relation with the majority of male surgeons. Gender biases as well as discrimination against masculine male doctors can be claimed to decrease through the framework for discussion I used.

The other limitation is that given the ethnographic value of context preservation, this study is not a complete picture of Thai nursing culture. Since the thesis discussion is drawn from field notes about a group of Thai surgical nurses in one particular setting, the findings cannot be generalized to Thai surgical nursing as a whole. The
information drawn from this study, however, can provide information that may inform policy in the new era of Thai nursing.

The better results from this study may be claimed according to Orb, Eisenhauer, and Wynaden (2001) as a result from my previous involvement with this culture as ‘native researcher’ in knowing the setting and getting the trust of participants. Participant observation depends on the help of the culture’s members to give me as a privileged status to capture cultural context. Utilizing these two methods also ensures the validity of data, consistent with Germain’s (1993) statement that the group informant is essential to grasp the native’s point of view as well as to clarify discrepancies between participants’ and researcher’s perceptions. The majority of interviewed data deriving from experienced and expert participants as well as the long-term direct and repeated engagement and involvement in participants’ day-to-day activities in the scene can be used to claim the trustworthiness of this study. External validity or “fittingness” of this study is also claimed from the likeness of the study results such as in term of communication in Thai nursing (Burnard & Naiyapatana, 2004); hierarchy in Thai society (Hofstede, 2001) and Thai nursing culture (Tyson & Pongruengphant, 2004).

In utilizing the tools of ethnography to study the culture of the institution of the TSW and borrowing in part from the techniques of auto-ethnography both the importance of local culture and my relationship within, and to, this has been made clear. The successful alternative presentation and use of a largely descriptive (and in part interpretive) ethnography has been strongly supported by both Douglas’s and Hofstede’s understanding of culture and suggests that there is much scope, in many
areas of nursing, medicine and health, for similar studies. By presenting the literature and investigating local culture from a largely descriptive position, I have been able to avoid the tendency to produce trans-cultural findings or generalities and as such this investigation broadens the discussions of nursing culture beyond a question of good or bad, right or wrong practices.

These findings that nursing culture at the local level is so influential in the day-to-day practices and decision making of the TSN challenge the notion of professionalism as a universal reality and, in turn, suggest some alternatives for the development of nursing. Where institutions and their rules fall short in their provision of sufficient resources, there is little room for the development of a ‘professional’ ethos. The nature of professional identity requires that certain elements be present if professional attributes such as accountability and responsibility, mediated through practice that is evidence-based, are to be realized. In the case of the TSW nurses, as shown in Chapters 3, 4 and 5, these elements are largely missing. It therefore becomes ever more difficult to speak of professionalization (as understood through the tenets of ‘clinical decision-making’ based on ‘evidence-based practice’) in the sense that is promoted in the wider literature in either the TSW or, I suggest broader Thailand. In seeking to promote nursing in Thailand, the findings of this thesis suggest that attempts to adopt the current universal practices associated with ‘clinical decision making’ and ‘evidence-based practice’ will be fraught with many obstacles. It is therefore suggested that, at least initially, alternatives which promote nursing and draw on the already present strengths of the Thai nurses, be sought. This will, I argue, not in itself be easy and I argue that the findings of this thesis all point to the need for
further investigation of the way culture is created and for a wider appreciation of the social factors which underlie its particular forms.

Nursing in Thailand and its continuing development at the practice level will benefit from further research into the impact that local culture has on nursing practice and interpersonal relations. My research has produced some initial conclusions regarding the importance of local culture in understanding social relations and the impetus behind workplace management and organization. Naturally these conclusions must be provisional insofar as their extension to other areas of nursing in Thailand, and comparable units elsewhere, is concerned. Although the nurses who participated in my study in the TSW area view their world as unique, it will be an analytical task for the future to determine how unique it actually is.

I finally end my thesis with my expectation, actually my dream, to see the implementation of a strategy for refining Thai nursing culture so that nurses have high professional autonomy in a workplace where nursing theory prevails over the medical model, and evidence-based practice and research into day-to-day nursing practice are valued and given high priority by Thai nurses across the nation while preserving and maintaining the beautiful manners and features of Thais.

This however, does not mean that the carrying out of medical activities is not important but rather this thesis attempts to suggest that it appears to be the only driver in the TSW. According to Smith (2003); the capacity for decision-making is an indicator of professional autonomy and accountability is a consequence of autonomy. Here if Thai nurses can develop their ability as a group to formulate professional
policy and control professional activity, professional Thai nursing autonomy may be increased. Additionally, the evidence-based practice movement can have a positive influence on career advancement in terms of enhancing evidence-based decision-making and nursing practices as a result increasing quality care in all domains of nursing practice – optimising outcomes for patients, improving clinical practice, achieving cost-effective nursing care, and ensuring accountability and transparency in clinical decision-making.

From this it can be argued that a higher emphasis on the value and importance of nursing care that is holistic, and not only technically accomplished, within the increasingly highly technical healthcare environment, is crucial if healthcare services are to best meet patient needs and both the collective and individual level. In order to develop career advancement and achieve a high level of professional status, which can be recognised in Thai society, nurses need to develop competent decision-making abilities that are holistic in their approach and firmly situated in evidence-based knowledge. In this way it may be possible for Thai nursing practice to be viewed as both empirical and rational and, as a result, be recognised more broadly for the significant contribution it can make to the health and well-being of Thai people and from this position it may be possible for nursing as a profession to derive greater societal value.
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Consent Form for Participant Observations

Khomapak Maneewat, RN, Ms, a doctoral student at Griffith University, School of Nursing and Midwifery, is conducting a study entitled “Nursing Care Practices and Workplace Relations in a Thai Surgical Ward: An Exploration of Clinical Decision-making”. The purpose of the study is being to explore clinical decision-making in the care of surgical patients within the Thai healthcare system organizational culture. I understand that I am being asked to participate in this study and have the option to refuse at any time. If I agree to participate, my involvement will include giving permission for student researcher to stay near me, make observation, and listen to communication/discussion while I am performing hand-over activity, pre-post conferences, while I am spending time at tea room, treatment room, medication room, and bed-side, including while I am communicating with medical doctors and other allied health. In addition, student researcher may ask questions relating to action observed with an unobtrusive as possible. I understand that I am free to refuse to answer specific questions that I may be asked and free to withdraw my participation at any time without penalty.

I understand that there will be no physical risks, social risks, legal risks, and psychological risks to me resulting from my participation in this study. There may be no direct benefits to me as participant engaged in this study, however, there may be improved in surgical nursing and nursing education following completion of this study. I understand that the information will be published, but my name will not be
associated with the study. I understand that I am free to withdraw my consent and to
discontinue participation in this study at any time without affecting my present
employment. Miss Maneewat has offered to answer my questions I might have.
Additionally, I understand that if I wish further information regarding my rights as a
research participant, I may contact and ask her advisor, Prof. Marianne Wallis, in the
school of nursing.

__________________________________________

PRINT NAME

I agree to participate as a participant in the above described study.
APPENDIX 2

Consent Form for In-depth Interview

Khomapak Maneewat, RN, Ms, a doctoral student at Griffith University, School of Nursing and Midwifery, is conducting a study entitled “Nursing Care Practices and Workplace Relations in a Thai Surgical Ward: An Exploration of Clinical Decision-making”. The purpose of the study is being to explore clinical decision-making in the care of surgical patients within the Thai healthcare system organizational culture. I understand that only the researcher will know about the selection process and the list of participants. I understand that I am being asked to participate in this study and have the right to freely decide whether to participate in a study, and the right to withdraw any time without penalty. If I agree to participate, I understand that I will be asked to participate in a 1 hour individual in-depth interviews and will be tape recorded. I understand that information disclosed in this study will be protected and can only be given to the third party with the consent of me.

I understand that data will be kept in locked cabinet in locked office. Tape transcripts, field notes, consent form, and patient data document will be erased and destroyed after finishing data analysis. This recording will be used only for data analysis according to research’s questions. The recording will be destroyed after their contents have been transcribed by the student researcher. I understand that anonymity will be used in presenting my information and my name will not be located near the tape, named will not be disclosed, my identities must be disguised. Also, quotations used in publications will be approved by me. A comprehensive summary of thematic and
pattern analyses will be returned to me for asking permission in publication. I understand that there will be no physical risks, social risks, legal risks, and psychological risks to me resulting from my participation in this study. There may be no direct benefits to me as participant engaged in this study, however, there may be improved in surgical nursing and nursing education following completion of this study. I understand that I am free to withdraw my consent and to discontinue participation in this study at any time without affecting my present employment. Miss Maneewat has offered to answer my questions I might have. Additionally, I understand that if I wish further information regarding my rights as a research participant, I may contact and ask her advisor, Prof. Marianne Wallis, in the school of nursing. The consent form will be kept in a secure place and will be destroyed.

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PRINT NAME

I agree to participate in interviews in the above described study.