

## Structure of nursing care

### — Analysis of the structure and process of nursing care in the primary nurse support system —

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#### Abstract

**Aim :** The purpose of this study was to clarify the structure and process of nursing care in actual practice in the “primary nurse support system” a systematized nursing care resource that can be used by nurses for patients in their charge, based on the concept of “caring”.

**Methods :** This study was carried out using symbolic interaction theory, as follows. The study made use of the grounded theory. The subjects of this study consisted of nurses in a general hospital in Tokyo. After the study was explained to them, informed consent for participation in this study was obtained from all the nurses involved. Data were collected by the interview method and continuously analyzed until no new category was obtained. Data collection was continued until the purpose of this study was realized, in 1999. A total of 34 nurses were interviewed. Their length of nursing experience ranged from 1 to 11 years (mean : 3.9 years).

**Results :** As a result of the evaluation of associations among the major nursing care concepts of “creation of situations”, “creation of nursing care places (community)” and the “emergence of persons”, nursing care could be structured and defined as “symbiotic nursing care”.

**Conclusion :** Based on the results of this study, symbiosis could be defined as “a process involving the generation of individuals in the space formed by the creation of situations after establishing subjects and sharing meanings between the participants and other people, and by the creation of places allowing connections to be made with the feelings of others present”. “Symbiotic” nursing care can therefore be seen as a social act involving a process of socialization that mutually creates multiple “situations” between nurses and patients and multiple “nursing care places (community)” among nurses, where patients’ daily life patterns gradually emerge, and nurses cooperate and become independent.

**Key words :** Nursing care ; Caring ; Primary nurse support system ; Grounded Theory ;  
Symbolic Interaction ; Symbiosis

## Introduction

The nursing situation in Japan at present is very serious, as shown by the steep rise in medical costs. Therefore, the health care system has been seeking to increase efficiency, focusing on the provision of intensive medical care in order to achieve the early discharge of patients. As a result, hospitals have been classified into special functioning hospitals which provide highly advanced medical care and regional medical care support hospitals which provide medical care, including home care. In conjunction with this approach, medical care policies designed to cope with the steep increase in medical costs and meet the needs of the public have been adopted. However, modern society (comprising families, communities and schools) has been gradually disintegrating in some areas, causing increasing difficulties in daily life. In such a society, it has become increasingly important for hospitals to provide ongoing nursing care for the elderly and those people living with illness or still in the process of recuperating from illness. An evaluation of the value of hospitals in providing nursing care in the form of this type of "caring" may help clarify the role of nursing care as a social resource as well as its social function.

In the 1980s, several nursing theories based on the idea of "care" were published (Leininger<sup>1)</sup>, 1980 ; Watson<sup>2)</sup>, 1979 ; Benner<sup>3)</sup>, 1989). Subsequently, from the 1980s to the 1990s, many studies were carried out in order to evaluate the characteristics and categories of caring, caring behavior, caring processes (in the context of the nurse-patient relationship), and the results of caring (Gaut<sup>4)</sup>, 1986 ; Valentine<sup>5)</sup>, 1989 ; Wolf<sup>6)</sup>, 1994 ; Lea<sup>7)</sup>, 1996 ; etc.). However, no studies have yet been carried out on care or caring in order to clarify exactly how nursing care is practiced within the complicated health system currently responsible for actually providing such care.

## 1 . Purpose of the study

The purpose of this study was to clarify the structure and process of nursing care in actual practice within the "primary nurse support system" a systematized nursing resource that can be used by nurses to care for the patients in their charge.

## 2 . Theoretical premise of the study

This study was performed in accordance with a series of theoretical premises based on symbolic interaction theory. Symbolic interaction theory views social action as consisting of both the individual and the collective activities of people who are engaged in social interaction. Thus, "human beings interact with one another and interpret these interactions in the light of the situation in which they are acting" (Blumer<sup>8) 9)</sup>, 1969). Applying this to the topic of nursing care, the following assumptions can then be made :

- 1 ) Nursing care is formed by a process of "interaction with the self (indications given to the self)".
- 2 ) Nursing care is formed by a process of social interaction.
- 3 ) Nursing care is formulated by individuals or groups.
- 4 ) The structure and process of nursing care are integrated.
- 5 ) The nursing care group consists of the nurses and the patients who participate.

In the formation of nurses' "ego", which occurs when nurses regard themselves as "subjects", become aware of their own feelings, develop their own beliefs and communicate amongst themselves, the presence of other nurses is indispensable. Nurses become "social beings" through their interactions within nurse groups and can then form their ego and work with others in nurse-patient interactions.

### 3. Definitions of terms

The primary nurse support system : A systematized nursing resource (human resource) that can be used by the primary nurse to care for patients in their charge (Figure 1).

## Methods

### 1. Topics to be addressed in this study

- 1) The contents of nurses' nurse-patient interaction experiences and the importance of these interactions for nurses in the "primary nurse support system"
- 2) The contents of nurses' nurse-nurse interaction experiences and the importance of these interactions for nurses in the "primary nurse support system"
- 3) The contents of nurses' nursing care experiences in the "primary nurse support system" and its importance in practical nursing care
- 4) Structurization of nursing care in the "primary nurse support system"

### 2. Location of the study, and selection of subjects taking part in the study

The subjects of this study consisted of nurses in 3 nursing teams in a ward making use of the

"primary nurse support system" in a general hospital in Tokyo. After explaining the purpose of the study, informed consent for participation in this study was obtained from all 34 nurses contacted.

### 3. Data collection and analysis

The study made use of the grounded theory formulated by Strauss and Glasser<sup>10) 11)</sup>. Data were collected by the interview method and continuously analyzed until no new category was obtained. Data collection was continued until the purpose of this study was realized (from the beginning of June through to the end of September in 1999). Researcher interviewed recording permission in one hour. A total of 34 nurses were interviewed. Their nursing experience ranged from 1 to 11 years (mean : 3.9 years).

## Results

The importance of the nurse-patient interaction experience in nursing care practice was evaluated, and nursing care was structured in terms of the "creation of situations". Subsequently, the importance of the nurse-nurse interaction experience in nursing care practice was also evaluated and structured in terms of the "creation of nursing care

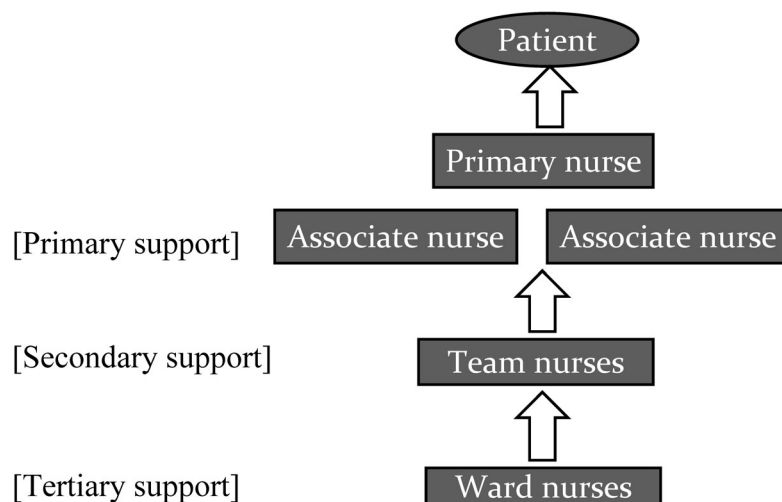


Figure 1 The primary nurse support system

places (community)". In addition, the importance of nurses' nursing care experience was evaluated and structured in terms of the "emergence of persons".

### 1. Creation of situations

Regarding the actual nature of patient-nurse interactions in nursing care practice, "getting to know each other", "developing a bond", and "being able to live" were extracted as study categories. The evaluation of associations among the categories showed that nurses experienced interaction with patients as a process in the "creation of situations". The structure of this "creation of situations" comprised intellect, emotion, volition and care as its various component strata (Figure 2).

#### 1) The intellect stratum and the creation of situations for "getting to know each other"

The interaction processes for "getting to know each other" ranged from "being" to "thinking", from "feeling" to "intuiting", from "staying" to "existing", and from "seeing" to "caring". This interaction facilitating "getting to know each other" formed the basis of people's recognition of an object (person) and also a basis of nursing care. In particular,

"existing" and "caring" were acts that were characteristic of nursing care practice.

Among the various "getting to know each other" interactions, "existing" and "caring" were specific to nursing care practice. The process involved in the creation of situations for "getting to know each other" was present at the most personal level for both nurses and patients, forming an intellect stratum in the structure described for the "creation of situations". In this process, "reliable" and "relieving" situations were created between nurses and patients.

<From "being" to "thinking" >

Nurses intuitively grasp that "there is something in the person" whenever they meet a patient and this involves the development of their awareness. For example, in one case when nurses met a patient they "thought" that "they would like the patient to under go treatment until the fever falls". In another example, when nurses "wanted to get to know the patient" and "thought that there is something special about the patient", their desire to provide care was raised. When patients understood the nurses' actions of "trying to get to know the person" and responded, the nurses experienced a

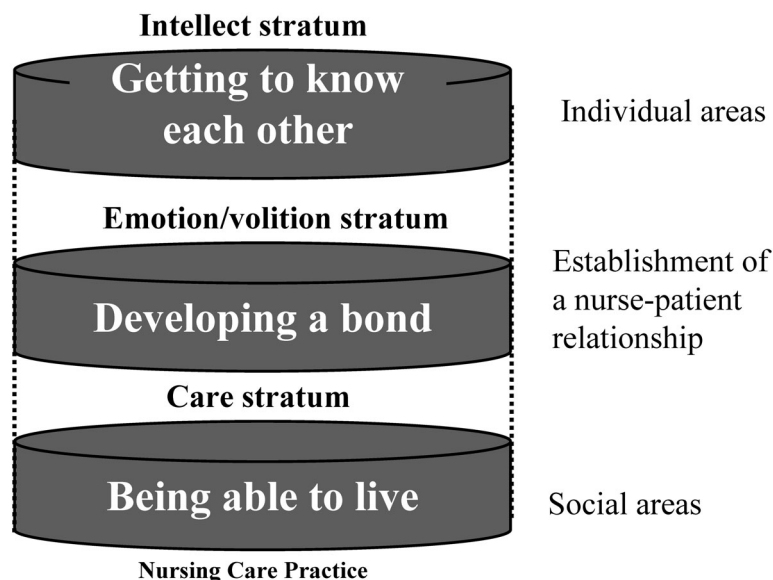


Figure 2 The structure and process involved in the "Creation of situations"

sense of pleasure at being trusted. Nurses experienced instances of the “creation of situations” between nurses and patients in which they were “friendly”, “easy to become involved with”, “easy to talk to”, “easy to open up with”, and “easy to express feelings to” which, in turn, “rapidly facilitated care”.

In this process, nurse determined whether something was “present” or “absent” in the patient and then thought about the patient more, as a result. By means of these acts, nurse experienced shared feelings and acts such as being in the mind “nurses’ own feelings toward the patient and the patients’ own feelings”.

#### <From “feeling” to “intuiting” >

Nurses could also intuitively sense some things based on information obtained by simply “moving and observing” every day, as part of their routine activities. When nurses felt certain responses from something they had observed, they instantly reacted, resulting in the act of “sensing”. They “sensed” something while carrying out their own “movements” such as observing, listening, and responding. In other words, they used their senses by “moving”. Actions such as “measuring body temperature” and “taking a pulse” meant that the nurses then objectively “felt” the patients’ actions they had sensed. The nurses intuited changes in patients’ actions, which were 3-dimensional rather than 2-dimensional, and could not otherwise be sensed by the nurses but were known by the patients themselves. In addition, while nurses did not consciously “try to see patient’s actions” they unconsciously experienced these actions as they entered their visual field when they moved about every day, as part of their normal routine. While nurses did not always actively direct their attention to something, trying to see it, they still found that they could detect daily changes early by means of their everyday observations. The nurses intuited

daily changes in their patients by the act of “observing” rather than by the act of “listening”. Thus, they carried out all their daily actions by intuition, taking their next action by “responding” to subconscious clues from the patient.

This process represented “intuiting”, in which nurses sensed the patient’s own sensations in some way, such as by unconsciously observing behavioral changes in their daily life.

#### <From “staying” to “existing” >

Nurses’ staying with their patients allowed “talking”, “speaking”, and “listening” to occur. The nurses found that patients were “relieved” or became “composed” by “talking” and “staying together”. In addition, the act of “listening to the patients talk” meant that the nurses’ physical presence and feelings were directed toward the patients due to their “staying” and their “attitude of listening”. The nurses found that their sharing the same “place” with the patients had a slight therapeutic effect, in itself. The ways in which the nurses carried out “staying” varied: “sitting at the bedside and making eye contact with patients by adjusting their eye level to that of the patients”, “looking at the patients beside them”, “staying beside the patient while talking”, “staying beside patients while holding or stroking their hand”, and “staying beside patients in a way that enabled them to forget the pain”. In addition, when nurses “wished to listen” or were “interested in the patient”, they were able to select the time and place and take the initiative in “asking the patients about their thoughts” or asking them to “talk about their feelings”. When nurses wished to make time to talk to patients, they deliberately created something to do that required them to visit patients or they created many things to do so that they could repeatedly visit patients, thereby allowing more time for talking. The nurses would then listen to patients and tried to understand

their feelings.

In this process, nurses' physical presence and feelings were directed towards the patients as they stayed beside them and the patients were more relieved, became more relaxed, and recovered from illness faster. Both nurses and patients realized the value of each other's "staying".

#### <From "seeing" to "caring" >

When patients "said the same thing twice", "casually said something", or even just "casually acted" in some way, the nurses would often look at their patients and wonder "what does this mean?". Likewise, the nurses looked at their patients' surroundings, they would often be "trying to know" or "trying to see" into their patients' daily lives based on the "objects around them" and their "positions".

Nurses intuitively thought "why" when patients talked or complained of the same thing twice, or thought "What is this?" when they saw patients saying or casually acting the same way repeatedly. Thus, nurses caught a glimpse of the "daily life of patients" when patients repeated these types of behavior. Nurses also "cared" patients directly, themselves, and noted changes in their feelings, their physical well-being, and their responses (all based on signals given off by the patients).

In this process, nurses were present throughout patients' daily life and experienced their daily life by caring their "patients and their surroundings". Patients understood this and would reveal aspects of their daily life in this situation, for the benefit of patients and nurses, alike.

#### 2) Emotion/volition strata and the situation leading to "developing a bond"

The processes leading to "developing a bond" involved the "establishment of a nurse-patient relationship", "further involvement by nurses", and

"the appearance of a person providing nursing care".

As a result of these processes, situations were generated in which nurses and patients "develop feelings" and become more motivated.

The process of forming the interaction of "developing/revealing feelings" between nurses and patients comprises the core of the "establishment of a nurse-patient relationship" in the emotion/volition stratum of the "creation of situations".

#### < "Establishment of a nurse-patient relationship" >

In this process, situations develop in which attitudes and feelings are revealed, and information is exchanged between nurses and patients. For example, the nurses might express their "respect for their patients' wishes" by means of their attitude, or patients might try to influence nurses' feelings by touching, complaining, or by attracting the nurses' attention.

#### < "Further involvement by nurses" >

Once a nurse-patient relationship was established, the nurses performed the interactions of "directing their attention to patients", "accepting their own conflicts", and "developing thoughts". These independent acts carried out by the nurses were not inherently required of them but constituted exploration/search processes in the established nurse-patient relationship. Nurses experienced the act of further involvement as the acceptance of pressure (stress). To help overcome this stress, nurses needed access to nursing care places (community) where they could, for example, talk with other nurses involved.

#### < "The appearance of a person providing nursing care" >

In this process, "further involvement by nurses" induced acts such as "developing feelings", "becoming motivated", and "imagining the personality of patients", and involved the persons who provided

nursing care appearing in front of their patients and dealing with them directly and personally. In this process, the nurses experienced “developing feelings” for their patients and reported wanting to grant their patients’ wishes. Since the “development of persons who provide nursing care” is closely involved in nursing care practice, the nurses interviewed were very eager to have access to nursing care places (community).

### 3) The care stratum and the creation of situations facilitating “being able to live”

The interaction processes involved in “being able to live” were the “creation of situations in which persons can be themselves” and the “creation of situations enabling patients to live with their illness”. To “live” is an extremely independent act, led by “being able to live” interactions between the nurse and patient.

In this process, nurses who appeared as persons providing care in front of their patients created “situations in which patients can be themselves” and “situations enabling patients to live with their illness”. The process for the creation of situations facilitating “being able to live” constituted a care stratum in the “creation of situations”.

< “Creation of situations in which patients can be themselves” >

In this process, nurses understood the patients’ original circumstances, (i.e., their environment, what they are doing now and what they have done in the past, their original lifestyle, and their inherent problem-solving ability) and provided nursing care that took these characteristics into consideration and helped create situations in which their patients could look after themselves.

< “Creation of situations enabling patients to live with their illness” >

In this process, nurses “made up for those things that patients could not do for themselves”, “gave patients information on their illness”, “were close to patients while they learned to live with their illness”, and “overcame suffering with their patients”. Nurses “supplemented” and “linked” things and parts, “were close to patients”, “overcame suffering with their patients”, and “evaluated timing” with regard to their “illness”, the “process of living with their illness”, and the matter of “what patients cannot do because of their illness”. As a result, nurses found that patients could adjust by adopting their own specific ways of coping and became more composed once they were satisfied with their diet and lifestyle, after which they would then begin to associate with others.

## 2. “Creation of places for nursing care (community)”

As regards the interactions experienced by nurses in nursing care practice, the categories extracted from the study were the “unification” of nurses in a small group (consisting of a primary nurse and associate nurses), the “socialization of nursing care” by the small group, and the organic “connection” of nurses in the team. Evaluation of the associations among these categories showed that nurses experienced interactions as a process facilitating the “creation of a place of nursing care (community)”. The structure of “nursing care places” consisted of the “peer (partner)” stratum and “the community (everyone)” stratum (Figure 3).

### 1) The peer (partner) stratum and the generation of “unification” and “socialization”

Nurses in each small group shared tacit knowledge by “talking about patients”. Associate nurses who understood “situations between the primary nurse

and patients” began to think about patients and worry about patients just as the primary nurse did, which led to the “unification” of associate and primary nurses. In each small group, there was a peer (partner) stratum among nurses that allowed them to talk at ease amongst themselves, even when their ideas had not yet firmly taken shape. In addition, the small groups in which the unification of nurses occurred formed places of “socialization” for nursing care to ensure the “completion of the day” by patients, i.e., the result was the creation of “being able to live” situations between nurses and patients.

## 2) The community (everyone) stratum and the creation of places of “connection”

When the small group comprising unified nurses socialized patients’ nursing care, team members noted the eagerness and attitude of the primary nurse and created places where nursing care for each patient could “spread to all members”. In addition, independent nurses created stable places where “all members with their own feelings were connected”. Thus, the primary nurse created places where patients could complete their day and 24-hour nursing care was connected in order to create “being able to live” situations between nurses and patients. Primary nurses found that “observing

all members” was also possible in these places of connection.

These places of organic “connection” for all team members were present in the social area and formed a community (everyone) stratum within the structure of “nursing care places (community)”.

## 3. “Emergence of persons”

In terms of the nurses’ experience in nursing care practice, the extracted categories identified in the study were “cooperation/independence”, “accumulation of experience”, the “development of nurses who acquired a nursing care form (independent nurses)”, the “emergence of patients’ daily life”, and the “emergence of persons (individuals) who care about themselves”. An evaluation of associations among these categories showed that nurses experienced nursing care practice as a process involving the “emergence of persons”, which consisted of the “development of persons (individuals) providing nursing care” and the “emergence of persons (individuals) who care about themselves (Figure 4).”

### 1) Development of “persons (individuals) providing nursing care”

The nurses experienced cooperation/independence during the “cooperation of all nurses in developing

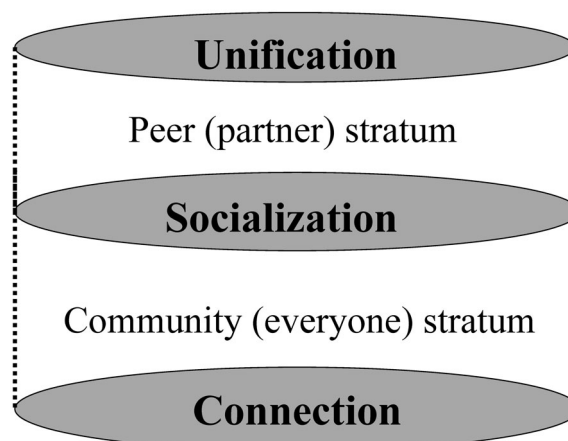


Figure 3 The structure and process involved in the “Creation of places for nursing care (community)”



the nursing form of each nurse”, “accumulation of experience”, and “sharing the thinking process among all nurses” as processes of interaction. In addition, the personality of each nurse became more noticeable and independent nurses developed their own nursing care style, which included “staying” and “caring”. Independent nurses taught the other nurses their thinking process, supplementing their own way of thinking and “demanded thinking from them” while also experiencing the “spontaneous development of acts and attitudes as humans” in them. In addition, independent nurses shared their thinking process with other members of the group so that they could also become independent and serve as primary nurses. Nurses developed into persons who could provide nursing care themselves, after and accumulating experience based on their own feelings (including any painful feelings) as part of the “accumulation of experience” process involving self-interaction.

2) “Emergence of persons (individuals) who care about themselves”

In the process of interaction regarding the “emergence of patients’ daily life”, nurses acted so that patients could “actively contribute to their

relationship with nurses” and “show their personality in daily life”, which resulted in the “emergence of patients who care about themselves”.

The nurses experienced the patients’ independent acts of “talking”, “eating”, and “moving” as the processes of an interaction involving the “emergence of patients’ daily life”. During this experience, patients who acted independently “talked”, “moved”, and “ate”.

Nurses who began to evaluate patients in daily life created situations which facilitated “patients’ independent acts” and found that patients could “actively contribute to their relationship with nurses”. This means that each nurse, patient, and the other nurses could “actively contribute in that space”, i.e., experience the emergence of individuals. In addition, the nurses found that “their personality is shown in daily life”, in those situations where both the patients (individuals) who cared about themselves started to show their personality, and persons (individuals) who provided their nursing care gradually started to show their personality and develop, also.

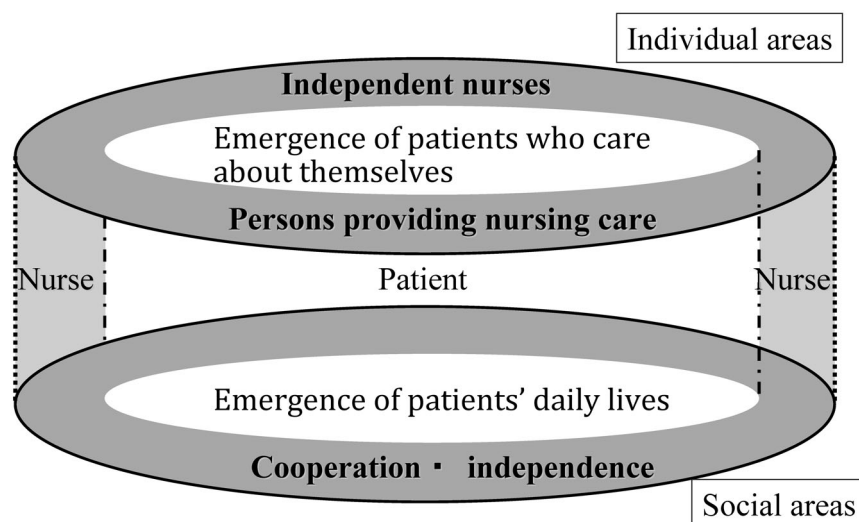


Figure 4 The structure and process involved in the “Emergence of persons”

## Discussion

As a result of the evaluation of associations among the major concepts of “creation of situations”, “creation of nursing care places (community)” and the “emergence of persons” constituting nursing care, nursing care could be redefined and described as part of a new structure entitled “symbiotic nursing care”.

### 1. Definition of nursing care

Nursing care is a process involving the creation of multiple “situations” between a nurse and a patient who are independent of each other. Thus, situations, not relations, are created between nurses and patients. “Situations” are not the natural environments of humans but are artificially created between humans. As Blumer<sup>8)</sup> (1991, p.88) points out “subjects are all the things that human beings indicate or refer to, and human beings are prepared to act toward subjects on the basis of the meanings that those subjects have for them”. Thus, nurses and patients mutually identify subjects and share specific meanings in the process of presenting these meanings and responding to them. This allows “the construction of definitions for various situations and the sharing of specific meanings among the people concerned”, as Strauss described it (Hogetsu<sup>12)</sup>, 1995, p.141). “Situations” are created by the establishment of subjects and the sharing of meanings. Thus, nursing care is an interaction that creates situations between nurses and patients in which “patients can live as they are” and “can live with their illness” and also creates “persons (individuals) who care about themselves” such as those who “act independently” or “trust themselves (including their body)”.

Nursing care is also a process that involves the creation of multiple “nursing care places (community)” among nurses themselves. As Mead described it,

“social behaviorism is concerned with the generation of conscious subjects derived from associations between the actual acts of multiple individuals, i.e., the dynamics of generated subjects and the social process”, paying attention to social acts that mutually affect multiple individuals (Ito<sup>13)</sup>, 1995). Nursing care is a social act, for which nurses create multiple “nursing care places (community)” for their own use and well-being. Thus, nursing care is an interaction involving the creation of places where “all nurses with their own feelings are connected” due to the presence of individual patients, where patients can complete their day, and where 24-hour nursing care creates “being able to live” situations between nurses and patients.

In addition, nursing care is a process involving the “emergence of persons” and consisting of the “development of persons (individuals) who provide nursing care” and the “emergence of persons (individuals) who care about themselves”. However, previously published results on “caring” have sometimes differed. In Lea<sup>7)</sup>, (1996) caring was reported to affect “both patients and nurses” (Watson<sup>2)</sup>), “nurses alone” (Forrest), or “patients alone” (Gaut<sup>4)</sup>). Mayeroff<sup>14)</sup> (1993) stated that “Care for another person, in the most significant sense, is designed to help him grow and actualize himself. Caregivers follow the growth of cared-for persons, while enhancing their responsiveness to their own movements. Care is the involvement with others that develops after a relatively long period and indicates changes in both caregivers and cared-for persons, and in their relationship that grows and develops”. Nursing care is a process involving the development of persons (individuals) who provide nursing care by means of interactions such as the “cooperation of all nurses in developing the nursing form of each nurse” or “sharing the thinking process among all nurses”. In addition, the personality of nurses becomes clear over time, especially through

the act of “getting to know” the patient, which in turn leads to the creation of independent nurses. The patterns of the act of “getting to know” people include “existing” and “observing” and show how nursing care is directed towards the “induction of independent acts by patients” and the development of “patients that can trust themselves (including their body)”. In addition, nursing care is a process involving the development of persons (individuals) who care about themselves. This involves an interaction “between the patient and the self”, bringing about the “emergence of patients’ daily life”, along with other interactions such as “actively contributing to their relationship with nurses” and “showing their personality in daily life”. Nursing care is an interaction in which both nurses and patients live fully in each other’s place, showing themselves how to “live” or “be able to live” in order to facilitate their everyday life, with dignity.

## 2. Structure of “Symbiotic nursing care”

The structure outlined above for “Symbiotic’ nursing care” comprises the “emergence of persons”

as its central focus, along with the “creation of situations” and the “creation of nursing care places (community)” (Figure 5).

The multi-layered structure of the “creation of situations” comprises distinct intellect, emotion/volition, and care strata, all of which are involved in the creation processes for the situations of “getting to know”, “developing/revealing feelings”, and “being able to live”. The intellect stratum is the most personal area involved in the “creation of situations” while the emotion/volition stratum is at the center of the “establishment of the nurse-patient relationship”.

The “creation of nursing care places (community)” consists of both the “peer (partner)” stratum and the “community (everyone)” stratum, both of which are involved in the processes needed to create places of “unification” among nurses, the “socialization of nursing care by the unified nurses”, and the organic “connection” of all nurses. These “nursing care places (community)” are organic because they only last until the discharge of the patients. “Nursing care places (community)” created among nurses consist

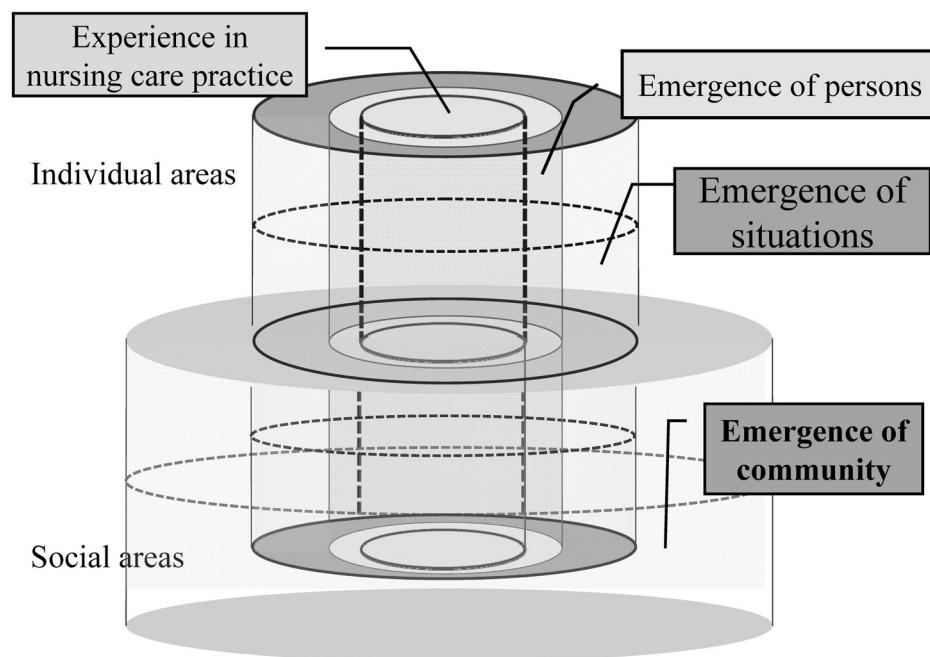


Figure 5 The structure of “Symbiotic nursing care”

of a “peer (partner)” stratum where paradigms are tacitly shared and a “community (everyone)” stratum where paradigms are explicitly shared.

The “emergence of persons” comprises the “development of persons (individuals) who provide nursing care” and the “emergence of persons (individuals) who care about themselves”. The former process involves the development of nurses who “are cooperative and independent”, “accumulate experience”, and “have acquired the nursing care style (independent nurses)” while the latter process involves the emergence of patients who “reveal their daily life” and “care about themselves”.

Nursing care can be seen as a process of interactions allowing various “persons” to “live together”, and can be structured as a process that results in the development of persons (individuals) who care about themselves and nurses (individuals) who provide nursing care. These results are consistent with the definition of “symbiosis”, whereby there is “cooperation between two or more organisms in a large multi-dimensional structure in order to facilitate their mutual growth and development”

(Karimata<sup>15)</sup>, 2000, p.212). Therefore, the nursing care process can be structured and described as “symbiotic nursing care”. The term symbiosis is frequently used in many fields, but there is a “danger that the term is sometimes used without a clear definition, or that incorrect meanings are sometimes attributed to the term”, as suggested by Ozeki<sup>16)</sup> (1995, p.139). Symbiosis was originally a biological term categorized as being either mutualistic or commensalistic. Symbiosis is now generally defined as the “cooperation of two or more organisms living together in a large multi-dimensional structure in order to facilitate their mutual growth and development” (Karimata<sup>15)</sup>, 2000, p.212). The term “symbiosis” is derived from the Greek (sum = with, bios = living). Inoue classified the

Japanese term “kyosei” as roughly equivalent to symbiosis in terms of “conviviality”. Symbiosis is thus “characteristic of closed co-existence co-prosperity systems, and there is a close cooperative relationship between symbiotic organisms based on a stable community of interests” (Karimata<sup>15)</sup>, 2000, p.212). Conviviality is “a social bond pattern within a heterogeneous group of people where different people with different lifestyles freely take part in shared activities and make use of shared opportunities to actively establish and participate in mutual relationships” (Karimata<sup>15)</sup>, 2000, p.212).

Based on the results of the study, symbiosis could be defined as “a process involving the generation of individuals in the space formed by the creation of situations after establishing subjects and sharing meanings between the participants and other people, and by the creation of places allowing connections to be made with the feelings of others present”.

“Symbiotic’ nursing care” is a social act and can be seen as a process of socialization that mutually creates multiple “situations” between nurses and patients and multiple “nursing care places (community)” among nurses themselves, where the patterns of the patients’ daily life emerge, and where nurses cooperate and become independent. On the other hand, “symbiotic nursing care” can also be seen as a process that results in the development of nurses “who provide care in individual areas” as well as patients “who care about themselves” by means of the socialization process generated and experienced by both nurses and patients.

Among the various aspects of nursing care, the act of “getting to know each other” is the most personal. This act is intimately associated with the practical knowledge acquired by nurses through their accumulation of life experiences. At the center of “symbiotic nursing care”, situations in which feelings are exchanged between nurses and patients are generated, and the development of places where

the “feelings of all nurses are connected” is then facilitated by these situations. Thus, nursing care can be described as consisting of various interactions such as the development of “feelings” between persons or the connection of “feelings” among nurses. The most sociable area of “symbiotic nursing care” consists of the care stratum and the community stratum where nurses connect with everyone. Therefore, in order to create “allowing persons to live” situations, “nursing care places (community)” are needed where everyone lives together and their feelings are all interconnected.

As a result, in order to achieve the “living

together” of “persons” and the emergence of individuals who are “able to live”, nurses and patients also need to be able to interact with the community and others (individuals) involved in nursing care practice.

“Symbiotic nursing care” is a process that facilitates the expression of personality and the exchange of feelings between nurses and patients, and among nurses themselves, while also encouraging the “emergence of individuals” and the creation of situations where everyone “can live together”.

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## 看護ケアの構造化

—— プライマリナース・サポートシステムにおける看護ケアの構造とプロセスの分析 ——

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### 要 旨

#### 〔研究の目的〕

本研究では、ケアリングとしての看護ケアを基軸として、看護師が担当患者の看護実践に使うことができる看護資源を組織化した「プライマリナース・サポートシステム」において、どのように看護ケアが行われているのか、その看護ケアの実践のグラウンドで看護ケアの構造とプロセスを明らかにすることを目的とした。

#### 〔研究方法〕

本研究は、シンボリック相互作用論の考え方を理論的前提とし、グラウンデッドセオリー法を用いた。データ収集は、インタビュー法を用い、継続的な比較分析を行い、新しいカテゴリーが出なくなるまで行った。データ収集は、1999年6月上旬から9月下旬にかけて研究の目的が達するまで行った。本研究は、研究への参加に同意を得た、東京都内の総合病院の看護師を対象とした。インタビューを実施した看護師は、34人で、看護の経験年数は平均3.9年、1年目から11年目までと幅があった。

#### 〔結果〕

「プライマリナース・サポートシステム」における看護ケアの構造とプロセスを検討した。その結果、「状況の生成」、「看護ケアの場（コミュニティ）の生成」、「人の生成」の主要な概念が抽出された。その主要な概念の関連を検討した結果、看護ケアは、『共生』の看護ケアというように構造化できた。

#### 〔結論〕

本研究の結果から共生は、「人が他者との間に対象の形成と意味の共有によって生成する状況と、人の存在によって他者間に気持ちが繋がる場の生成によってつくられる空間に個人が生成されるプロセスである」として定義することができた。『共生』の看護ケアは、看護師と患者の間に相互に多重な「状況」を生成し、看護師間に多重な「看護ケアの場（コミュニティ）」を生成し、その空間に患者が日常生活を現し、看護師が共同・自律するという社会的行為であり、社会化のプロセスであった。

キーワード：看護ケア、プライマリナース・サポートシステム、グラウンデッドセオリー、シンボリック相互作用論、共生

