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The Poetics of Professionalism Among Dialysis Technicians

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RUNNING HEAD: Professionalism in Dialysis

The Poetics of Professionalism among Dialysis Technicians

Abstract

The vast majority of care for end-stage-renal-disease (ESRD) patients is provided by skilled (but not formally educated) paraprofessional technicians. Using Goffman's (1959) framing of the performance of self in everyday discourse, this study examines discourse from dialysis technicians and technical aides to explore these paraprofessionals' construction and performance of professional identity and professional communication within the context of an outpatient dialysis clinic. Themes of professionalism—individualized care, vigilance, teamwork, and emotion management—are illustrated via poetic transcription of interviews with technicians. I contend that such representation offers validity equal to that of traditional research accounts while embodying alternative representational strengths.

Key Words: Dialysis, Professionalism, Technicians, Paraprofessionals, Caregiving

The display of professionalism by health care providers is widely perceived as integral to health care delivery (e.g., Morgan & Krone, 2001). Even low status workers such as technicians, aides, and assistants receive instruction in and report embracing an ethic or attitude of professionalism, despite their being accorded organizational and social status far below that of most professionals (Barley, 1996). Within the field of dialysis, which provides life-sustaining treatment for patients with chronic kidney failure (i.e., end stage renal disease [ESRD]), patient care technicians (PCTs) provide much direct care that used to be performed by nurses before that became economically unfeasible (Polaschek, 2003). Advances in biomedical technology both make the trend towards technicians and other paraprofessionals providing care to patients possible and arguably necessary, and at the same time make this class of workers conceptually aberrant within the traditional disciplinary hierarchy and philosophical underpinnings of the U.S. health care system. Communication between paraprofessionals and patients has been dismissed as unimportant and neglected in health communication research in favor of research between professionals (e.g., physicians, registered nurses) and patients (Anderson, Ammarell, Bailey, Colon-Emeric, Corazzini, Lillie, et al., 2005; Ellingson, 2008).

In this study, I explore the meanings of professionalism for PCTs in an outpatient dialysis clinic. Based upon interviews and fieldnotes, I developed themes that emerged as central to PCTs' self-understanding of exhibiting professionalism. I illustrated each theme through poetic transcription rather than with traditional, brief transcript excerpts (Carr, 2003; Furman, 2006). In this way, I provide readers with a richly nuanced view of PCTs' perspectives. I begin by outlining a performative theoretical framework, followed by an overview of the role of technicians in health care and their status as paraprofessionals.

Theoretical Framework

A performative lens proves useful for examining communication and professionalism in health care because it focuses attention on the constitutive role of individual interactions in creating communication norms of a space and troubles the taken-for-grantedness of the concept of professionalism.

In popular and academic parlance, professional has been a taken-for-granted term—widely invoked and readily recognized but rarely interrogated or deeply understood... Despite the term's varied connotations, we apply it decisively in everyday talk—as if it were a neutral, self-evident descriptor. Yet, to invoke the professional is to put into conversational play a set of unacknowledged cultural assumptions. (Cheney & Ashcraft, 2007, pp. 146-147).

Scholars have investigated how organizational roles and norms are performed and constructed via day-to-day communication within medical settings (e.g., Ellingson, 2003, 2007; Morgan & Krone, 2001). Turner (1988) suggests that humans are in essence performers who co-create cultures and perform, challenge, and transform the roles and norms of those cultures through daily interaction. A performance is

all the activity of a given participant on a given occasion which serves to influence in any way any of the other participants. . . . The pre-established pattern of action which is unfolded during a performance and which may be presented or played through on other occasions may be called a “part” or a “routine” (Goffman, 1959, pp. 15-16).

Goffman suggests that we are always playing one or more roles, which are aspects of who we understand ourselves to be; we perform our selves in interaction with others, whose responses also shape our performances of self, particularly when those roles are part of a team performance. A team consists of “any set of individuals who co-operate in staging a single

routine” such as the PCTs do in providing routine dialysis care (Goffman, 1959, p. 79). This is not to say that PCTs’ performances are somehow false or merely for show, but that all people exemplify specific aspects of their identities in different situations, and that those aspects become solidified through repeated performances into identities (Butler, 1993). Hence in observing the presentation of PCTs’ selves in the dialysis unit and their articulation of their roles in interviews, we can understand their perspective on professionalism as an identity that paraprofessionals embody and perform as they communicate within health care contexts.

Health Care Professionalism

Professions include those occupations in which workers “are relatively privileged, self-regulating, knowledge-based and service oriented” (Evetts, 1999, p. 119). While precise definitions of professionalism remain elusive (Beckett-Tharp & Schatell, 2001), they generally include civility or politeness, emotional control, confidence, and “an emphasis on rational appearances and technological displays of competency as appropriate behavior” (Morgan & Krone, 2001, p. 327). The relatively recent “Charter on Medical Professionalism,” generated by an international consortium of medical foundations, specifies three principles underlying health care professionalism—primacy of patient welfare, patient autonomy, and social justice—along with ten commitments: professional competence, honesty with patients, patient confidentiality, maintaining appropriate relations with patients, improving quality of care, improving access to care, a just distribution of finite resources, scientific knowledge, maintaining trust by managing conflicts of interest, and professional responsibilities (American Board of Internal Medicine [ABIM], 2002).

With increasing reliance on interdisciplinary teams in health care (e.g., Opie, 2000), the performance of professionalism increasingly includes skills in collaboration, negotiation, and

problem-solving across disciplines. Indeed, McNair (2005) called for a shift in definitions of professionalism away from “uni-professionalism,” or “the pursuit of goals for single health care professional disciplines to the exclusion of other disciplines,” toward one of “interprofessionalism” that takes seriously the differences in values, norms, status, and power among health care disciplines as barriers to improving patient care (p. 458). The field of nursing in particular advocates for the necessity of interdisciplinary education to instill a sense of professionalism that encompasses a respect for the contribution of all health care disciplines and seeks to minimize “abuse of power, arrogance, greed, misrepresentation, impairment, lack of conscientiousness and conflicts of interest” among health care professionals as they collaborate across disciplines (McNair, 2005, p. 458). Moreover, health communication research must begin to include technicians and other paraprofessionals as part of interdisciplinary and interprofessional collaborations, rather than focusing exclusively on the experience of professionals (Ellingson, 2008). Yet some warn that with increased bureaucratization and specialization of medicine, professionalism can become too focused on the mechanistic at the expense of the humane. Indeed “professional training, the professional mind-set, and professional ‘systems’ environments tend to work against and undermine or devalue what is human, and subvert opportunities for achieving a shared understanding of our humanity” (Hunt, 2004, p. 193; see also Frank, 2004).

Technicians in patient care

Increased reliance on paraprofessionals and “semiskilled” workers to provide the vast majority of direct care further complexifies the enactment of professionalism in health care (Anderson et al., 2005). According to the U.S. National Kidney Foundation, a patient care technician is the “primary direct care giver” for dialysis patients and works with registered

nurses “as an important member of the patient care team” (www.kidney.org). Technicians are a relatively recent (post WWII) workplace category, and the growth in technology since the 1970s led to a rapid increase of technicians in scientific workplaces: U.S. companies have long employed more than two technicians for each engineer, scientist, or physician (Barley, 1996). Technicians exist betwixt and between traditional levels and “violate the alignment of those attributes that have long distinguished manual, blue-collar work from mental, white-collar work” (Barley, 1996, p. 412). Technicians resemble professionals in their socialized, analytic skills and artisans in their on-the-job training, manual skills, and operation of equipment. Their knowledge is contextual rather than formal or abstract. Although the details vary by state, requirements typically include a high school diploma or an equivalency, 10 weeks of classroom instruction, a licensing exam, and on-the-job training. PCTs resemble certified nursing assistants and other types of aides and technicians in health care (Colon-Emeric et al., 2006).

Because physicians are not present during routine treatments to gather patient information directly, PCTs act as an intermediary between professionals—physicians and to a lesser extent nurses—and those over whom the professionals purportedly are most knowledgeable, i.e. patients. This reflects a partial decoupling of expertise and knowledge from authority (Barley, 1996). An under class of technicians has emerged that occupies a paradoxical organizational position: they are experts in operating and maintaining technologically sophisticated dialysis machinery and are responsible for performing risky procedures on which patients’ lives depend, but they hold little authority within the organizations that employ them (Ellingson, 2008). This difficult positioning directly impacts communication between technicians and patients, warranting further study.

Understanding technicians as paraprofessionals who collaborate with professionals is

hampered in part by the notion that nurses in dialysis often are “reduced” to being technicians, suggesting focus on biotechnology detracts from nurses’ ability to provide compassionate, holistic care for patients (e.g., Polaschek, 2003; Ran & Hyde, 1999). Such discourse implies a false dichotomy between caregiving and use of technology, devaluing the role of technicians by using their role as a synonym for a lack of caring, while reifying the status of professionals: “professional practice has always depended on feminized adjunct labor in ill-defined, non- or semiprofessional support roles” (Cheney & Ashcraft, 2007, p. 165). Moreover, even PCTs are not “purely” technicians. They do not just monitor technology; they provide direct patient care. Antiquated notions of medical care assume that knowledge created and held by physicians, nurses simply carry out physicians’ orders, and PCTs perform purely technical tasks to operate machines. These historical legacies are no longer (if ever) applicable but continue to support harmful hierarchies. Both technicians’ and nurses’ roles involve direct use of technology with patients’ bodies *and* caregiving tasks involving interpersonal interactions. We must think beyond the tendency to devalue the contributions of paraprofessionals and instead embrace them as complementing professionals.

Health care organizations discipline PCTs with a discourse of professionalism to encourage them to obey state and federal regulations, optimize patient care, and perform organizational loyalty (Ellingson, 2008). At the same time, PCTs internalize an ethic of professionalism that they claim to uphold. Given the prevalence of PCTs in providing direct patient care, understanding their perspectives on professionalism could provide practical and theoretical insights into collaboration among professionals and paraprofessionals. Thus this study asked the question: What meanings of professionalism do patient care technicians in a dialysis clinic co-construct?

The Need for Complementary Forms of Representation

I proposed not only a research question that focuses on dialysis technicians' conceptualizations of professionalism, but also to push the boundaries of mainstream health communication research conventions by contending that this question is optimally addressed using poetic transcription—a nonstandard form of representation—to report results (Faulkner, 2010). I do not offer an attack on mainstream qualitative analysis and its standard forms of representation; indeed, the majority of my publications utilize these forms, and I developed both a passionate defense of conventional report forms (Ellingson, 2009, pp. 59-60) and an aesthetics of conventional qualitative research writing (Ellingson, 2009, pp. 151-154). Instead, I enhance this study's focus on technicians with a form of representation that enables their voices to emerge more aesthetically and holistically than a traditional research report allows. While these representations are still decontextualized from lengthy transcripts and edited by myself, poetic representation nonetheless invite audiences to consider data from a different mode of sense making than do traditional writing conventions. I will explain in the methods section how I constructed poetic accounts; for now, I articulate the epistemological and methodological underpinnings of this strategic choice.

An integral goal of this research project is to provide a space for technician's organizationally marginalized voices (e.g., Fine, Weis, Weseen, & Wong, 2000). Their voices were so fragmented in my grounded theory analytic memos (Charmaz, 2000) that the account no longer conveyed much of the sense making that I appreciated about this group of participants. The traditional research reporting process “impos[es] a researcher-perceived order on things. It requires data reduction and segregation of thoughts” (Glesne, 1997, p. 206). Complementing traditional reports that use excerpts of data from different participants woven together to support

a theme, aesthetic practices push the boundaries of traditional social science by retaining the rigor of qualitative analysis while offering more interpretive modes of presentation that embrace both rational and aesthetic modes of sense making (Ellingson, 2009). Interpretive forms engage readers by inviting them to think *with* PCTs' stories of their work, in addition to (or instead of) breaking them apart into analytical bits for categorization (Frank, 1995).

We argue for the theoretical and practical incorporation of aesthetic rationalities in engaged scholarship—logics of possibility that cultivate individuals' capacities to imagine otherwise. . . [W]e can enlarge the realm of possibilities for what counts as accepted research practices and advance methods for studying the aesthetic nature of communal life (Harter, Ellingson, Dutta, & Norander, 2009, p. 34).

To be able to imagine otherwise is the beginning of social change. Thus inviting the imagination of researchers and readers into journal articles may help promote the application of findings to health care settings.

Many researchers who situate themselves closer to the post-positivist end (middle-right) than to the interpretive end (middle-left) of the methodological continuum (see Ellingson, 2009) contend that such complementary forms of representation, while valuable, are necessarily supplemental to—never constitutive of—the authoritative research account. Morse (2004) cautions that “alternative” forms of representation “cannot, and must not, be the first or the only results emanating from a qualitative project; the refereed article first produced then provides the criterion to evaluate the message or the adequacy of the alternative arts-based ‘publication’” (p. 887). I have chosen consciously not to conform to this widely held standard herein.

The order in which researchers produce accounts does not demonstrate nor ensure rigor. Researchers can engage in rigorous data analysis processes that we then express in creative

genres, or produce interpretive work that then leads to systematic analyses, and researchers can enact multiple modes of sense making concurrently. While artistic representations cannot fully capture the meaning of any phenomenon, neither can conventional reports. The tendency to romanticize traditional analysis as the primary and hence only authoritative account obscures its limitations as an inherently partial account embedded in relations of power (Ellingson, 2009; Ferguson, 1993; Haraway, 1988). Qualitative (and quantitative) reports require readers' faith that the authors conducted rigorous analyses and that they have offered a fair, thorough, and nuanced account. Invocation of the report genre does not automatically ensure such rigor, anymore than adopting a more aesthetic genre necessarily precludes or casts doubt on it. The rhetorical advantage of the report genre manifests in its explicit discussion of procedures, which enhances perceptions of accountability, affording it more surface credibility than an artistic/interpretive account. Yet authors should be trustworthy to the highest standards of analytical rigor regardless of the genres they select for representation or the order in which they produce representations.

Interpretive representations of qualitative data require us to reason in different ways; alternative rationalities bring fresh perspectives to illuminate the complexities and cultural contexts of health communication. Thus the account I present below is different from and equal to more traditional representations of grounded theory analyses. First, it offers the benefit of creative representation that is contextualized with a literature review, methodological explication, and discussion, thus providing background in which to interpret the meanings inherent in the poetic transcriptions. I maintained the form and most of the content of the research report genre while adding the benefits from more aesthetic representation. Such benefits include evoking more readily reader's emotional connection to the topic (Ellis & Bochner, 2000), and inviting aesthetic and imaginative reasoning (Harter et al., 2009). Second, the

account highlights marginalized participants' voices more holistically, inviting more empathy than typically brief excerpts of data (albeit not purely or perfectly). Third, the poetic form is "exquisitely appropriate" (Riessman, 1987, p. 188) to the PCTs' ideas about their identities, roles, and position within dialysis culture because it retains rhythms of individuals' speech, providing a deeper portrayal of participants' ways of knowing.

Heidegger does not see a separation between truth and beauty when talking of poetic discourse. Poetic language with regard to experience is "truthful" in that it attempts to retain the prereflective qualities of experiential structures—concrete, embodied, mooded, sensed, interrelated, and always full of the imagination gathered from other times and places. (Todres, 1998, p. 125)

Here beauty is not a judgment of something as beautiful or ugly but of an aesthetic experience of being able to breathe in or take in the truth of an experience into oneself. Hence, poetic representations enable readers to more closely inhabit the world of dialysis PCTs, complementing—rather than challenging or replacing—the traditional report genre (Ellingson, 2009).

Method

The data analyzed here are part of a larger ethnographic study of communication within a dialysis unit (e.g., Ellingson, 2007, 2008).

Participants

I employed ethnographic methods in order to investigate how workers "do professionalism" in everyday interaction (Cheney & Ashcraft, 2007). Western Valley Dialysis (a pseudonym) owns and operates 14 units in the Western U. S. I secured entry to one unit through the organization's director of social work services, with the consent of the unit's nurse manager.

The unit employed about 25 people, including registered nurses, licensed vocational nurses, PCTs, technical aides (TAs), clinical social worker, registered dietitian, head technician, unit secretary, and nurse manager, with per diem nurses and PCTs augmenting the staff. At the time of observation, the patient census fluctuated between 91 and 100 patients. The unit operated from 6:30am to roughly 6:30pm, with 3 staggered shifts of 3 hours each, with additional time for connection and disconnection. The clinic had one isolation unit; the other 24 chairs were arranged around the perimeter of an open room, with a nurses' station in the middle that housed computers, records, phone, and supplies, as well as medication and lab preparation areas. A reception area occupied the front of the unit, and at the rear were staff restrooms, break/conference room, examination room, locker room, storage, and water treatment facilities.

Data Collection

I engaged in participant observation for two to three hours per session, approximately twice per week, from October 2003 to June 2004, culminating in over 100 hours of observation. I adopted the observer-as-participant role (Lindlof & Taylor, 2002). That is, both staff and patients were aware of my identity as a researcherⁱ, and I observed and conversed with patients and staff, while assisting in minor tasks (e.g., lowering patients' recliner position). When time permitted, I asked staff members questions in informal interviews. While in the treatment room, I took notes and transcribed brief conversations on a palmtop computer; these notes were expanded into fieldnotes, for a total of 191 single-spaced, typed pages.

After my period of fieldwork, I conducted semi-structured interviews exploring professionalism, collaboration, perceptions of power and hierarchy, patient care, and meanings of work with 17 staff members, including the social worker, registered dietitian, nurse manager, head technician, two TAs, unit secretary, two registered nurses, and eight PCTS. Participants

completed a Human Subject Board-approved informed consent form, provided demographic data, and were given a \$40 gift certificate for participation. With the exception of the nurse manager, I conducted interviews in the unit's examination room, which averaged 60 minutes in length. Interviews were audio-recorded and transcribed following Waitzkin's (1990) protocol, yielding 226 single-spaced, typed pages of transcription. Next, I solicited patient participation in a structured oral questionnaire on perceptions of staff communication. I recruited twenty patients by asking if they were interested in participating, briefly explaining the procedure, and offering a \$20 gift certificate for participation. I recorded patient responses, which averaged about 10 minutes. Questions and responses were transcribed, totaling 68 typed pages. Finally, I collected documents produced by the dialysis company to gain insight into how the organization represented its practices and policies, including a nutritional guide, patient handbook, and PCT training manual.

Data Analysis

Initially, I conducted a grounded theory analysis of fieldnotes, interview transcripts, oral questionnaire transcripts, and organizational documents. For the purposes of this study, I focused primarily on the interview transcripts of the eight PCTs, using the other data to contextualize the PCTs' experience. Charmaz (2000) revised Glaser and Strauss' (1967) classic method of grounded theory, placing it within a social constructivist framework and enabling researchers to "form a revised, more open-ended practice of grounded theory that stresses its emergent, constructivist elements" (p. 510). I followed the steps of traditional grounded theory analysis outlined by Strauss and Corbin (1990) and Charmaz (2000): coding data, developing inductive categories, revising the categories, writing memos to explore preliminary ideas, continually comparing parts of the data to other parts and to literature, collecting more data, fitting it into

categories, noting where it did not fit, and revising the categories using constant comparative analysis (see also Corbin & Strauss, 2008). I engaged in reflexive consideration of my own role in data gathering and analysis to enhance “theoretical sensitivity,” or “an awareness of the subtleties of meaning of data” (Strauss & Corbin, 1990, p. 41). I reflected upon issues that influenced my sensemaking, such as differences between my education attainment and that of the paraprofessionals, my freedom to come and go freely from the clinic, my white privilege in an incredibly diverse group of patients and staff that often included people of eight or more ethnicities at any one time in the clinic, and my own limping, scarred, cancer-survivor body as a part of my interactions with patients and staff. After determining a preliminary typology, I solicited feedback from staff, which informed the final results (Reinharz, 1992).

At this point, I felt unusually frustrated by attempts to break up interview transcripts and fieldnotes into manageable exemplars for a traditional findings presentation, for the reasons described above. I turned to the practice of poetic transcription of interview transcripts in order to illuminate the emergent themes of professionalism in a manner that better reflected my perceptions of the technicians’ experience, expertise, and identity (Richardson, 1992a, 1992b, 2000). Poetic transcription departs from the typical representation of grounded theory findings, adding a valuable alternative that shares the goals of grounded theory analysis and fulfills the additional goal of highlighting marginalized voices : “the poems reclaim the individual experiences that recede in the generalized theory (Kennedy 2009, p. 1419). Poetic representations of research use artful phrases and arrangement of words to convey meaning and emotion (Faulkner, 2010; for exemplars see Austin, 1996; Carless & Douglas, 2009; Chawla, 2006; González, 1998; Hartnett, 2003; Prendergast, 2007). My combination of grounded theory analysis and poetic representation represents a merging of aesthetic and empirical rationalities

that is intended to question this dichotomy through inclusion of both meaningful categories and unique experiences of individuals within the same text (Todres, 1998).

Of course, these poetic representations are no less my construction than are excerpts of data interwoven into analytic explanations (Glesne, 1997). Researchers follow a variety of rules when engaging in poetic transcription. While Richardson stated only that she retained her participant's words, syntax, and grammar while editing a transcript (Richardson, 1992a), Glesne (1997) and Kennedy (2009) elaborated on more detailed processes. I selected bounded, chronologically ordered excerpts from interview transcripts. I reviewed each of the coded phrases for a particular theme, then selected one that offered a rich statement that clearly reflected a central point or illustration of the theme. I also made choices on the basis of aesthetics, selecting excerpts that seemed eloquent, contained telling details, and were particularly compelling. I then condensed the prose by editing out words and phrases that did not directly serve the theme or were redundant. Finally, I physically arranged (i.e., line breaks, spacing) each poetic transcript on the page to artistic effect. I did not reorder comments, nor combine discussions from different segments of the transcript. As much as possible, I sought to artistically render each coherent thought in the form offered by a participant, rather like a sculptor who chips away at the block of stone to reveal a form contained within (see Faulkner, 2007, 2010). I repeated this process for each of the four themes. The selected transcript excerpts came from four participants (see Kennedy, 2009), in contrast to other researchers whose poetic transcriptions were grounded in a single participant's transcript (e.g., Carr, 2003; Furman, 2006; Glesne, 1997).

While my poetic transcriptions are informed by an aesthetic, interpretive sensibility, this process produces texts that “move in the direction of poetry but [are] not necessarily poetry”

(Glesne, 1997, p. 213) and “tended to be more elaborated and lacked the implicit and oblique character of more developed poems” (Willis, 2002, p. 4). Nonetheless, poetic transcriptions in their more elaborated form offer a compelling view of PCTs’ perspectives, as well as a refreshing angle from which to view clinical interactions. Moreover, they reflect a performative perspective (Goffman, 1959) as each of them more closely embodies an individual performance of self than would a collection of briefer excerpts from across a larger number of participants.

Results

The grounded theory analysis yielded four themes: individualized care, vigilance, teamwork, and emotion management. For each theme, I provide an explanation and illustrate with a poetic transcription from an interview with a PCT. Of course, by relying on an exemplar from one participant per theme, I forego the opportunity to showcase more fully the varieties of experience across PCTs. I endeavor to explain the diversity of experiences reflected in each theme and balance that limitation with the advantageous depth of insight provided by the poetic transcriptions.

Individualized care

Individualized care refers to the technicians’ practice of accommodating patients’ physical, mental, and emotional quirks, as well as individual needs and preferences. PCTs framed such adaptations to individual patients as a way of demonstrating care for patients as whole persons, rather than just bodies to be worked on. PCTs articulated that adapting to patients was a skill learned over time, one that they took great pride in and felt demonstrated their caring and compassion for patients.

Joking Around

Patients vary.
Some patients, you talk about sports.

Some patients, you talk about the stock market,
even though I don't know much about it,
but you mention it and they start talking. And then
you turn around and you say,
you know, joking around:
"You don't wanna add more weight to yourself with all that money."ⁱⁱ

It depends on the person.
Some people deserve nothing but the utmost respect:
"Yes ma'am, yes sir. No ma'am, no sir."
Some patients want to be called by their last name.
Which, outside of asking them
"How are you feeling...any pains, any problems?"
That's all they want to hear from you
'cause they believe that if you're talking to them
you're not concentrating on what you're doing.

I talk a lot when it comes to patients.
Believe you me, I talk a lot.
That eases me.
When I'm getting ready to insert the needles, that's when I shut up.
Put one needle in.
Then I ask, "Does it feel OK?"
Yeah, yeah, yeah OK
Then I shut up and do it again and
once I get 'em on, my mouth starts a-running—
depending on who it is.

Yeah, you joke around with *him*, 'cause I remember
when he first came to this clinic
he was—well to me he still *is*—
a grumpy old man.
OK, but he was worse.
He had a really bad case of hemorrhoids
and he couldn't sit down long times
and he would cuss you
and yell at you
and everybody he would treat wrong.

It took me a week or so until I figured
him out.
Give him a bad time, argue with him
and it makes him happy. That's him.
I hate to say it.
You got to be, kind of like,
disrespectful towards him

and speak to him in his own language
 in order for him to be happy.
 And he has to complain
 to be happy ha ha.
 Oh I love that old man.
 He's one of those patients that when it's time
 for him to go -- it's gonna hurt.

And other patients it's "Yes ma'am, No ma'am"
 'cause that's the way they want it
 and with no joking around.

This PCT's explanation of learning patients' preferred interaction style reflects his skill in reading patients' affect. In the poetic transcription, the PCT's sense making is evident. For example, he frames his explanation with beginning and ending references to the "yes, ma'am, no ma'am" style to contrast with his portrayal of the patient with whom he joked around. His repetition of the phrase "it depends," indicated his awareness of variability among patients and his willingness to adapt to different exigencies. In addition, his explicit acknowledgment that it took him awhile to figure out how to adapt to a new patient reflects his awareness of patient care as an ongoing process of adjustment.

This PCT learned which patients wanted him to talk and which did not, which preferred a serious tone and which enjoyed light-hearted banter; in essence, the PCT described how he adapted his performance of professionalism to each patient (Goffman, 1959). While such adaptations may seem unremarkable, they affect patients directly and meaningfully. Dialysis is a difficult way of life for many people; the vast majority of the patients in outpatient dialysis clinics have moderate to poor quality of life (e.g., USRDS, 2009). Dialysis can be exhausting, painful, frustrating, and fraught with near constant complications (Bevan, 2000). For these patients, having a PCT who respected and accommodated their interaction preferences during the 12 hours a week they spent in the unit was deeply appreciated. Indeed, several of the patients

who lived alone reported to me that they actually enjoyed coming to dialysis because it gave them social interaction with staff and other patients. I witnessed and participated in many playful sessions between PCTs and patients, and also saw the gratitude of patients who were made comfortable and left alone to rest quietly as they preferred. PCTs also observed each other in the unit as they interacted with patients. PCTs' professionalism thus involved watching, learning, and intuiting how best to adapt to individual patients -- "depending on who it is." PCTs described caring about their patients' needs as part of being good at their jobs. Thus professionalism for PCTs was more than technical competence; it also included caring, an aspect of health care generally thought of as the province of nurses (Bevan, 1998). They also endeavored to share their knowledge of how to adapt to a particular patient with other PCTs to ease their colleagues' processes of adapting their performances, similar to the "local idiosyncrasies" form of contextual knowledge sharing identified in Barley's (1996) study of technicians.

Vigilance

This theme refers to technicians' focus on their responsibility for ensuring all patients' well being while in the dialysis unit. To be professional is to take seriously the need for attending to signs and symptoms of patients and signals from dialysis machines that indicate a patient may be at risk—whether or not a patient was one of those assigned to a particular PCT on a given day. Patients regularly fainted, had heart failure or difficulty breathing, or in other ways were critically ill, requiring the summoning of an ambulance and emergency personnel. Even when all went smoothly, patients take great risk in undergoing dialysis; because of the complexity of the process and the requirement for significant amounts of patients' blood to be outside their bodies and circulating at a relatively rapid rate, great care must be taken to ensure that the

treatment goes as planned (e.g., Beckett-Tharp & Schatell, 2001). Quite simply, errors in dialysis can quickly become fatal. In this poetic transcription, one PCT explains the responsibilities of PCTs for constantly watching for clues that indicate a threat to patients' safety.

Make Sure

What I'm supposed to do is
to make sure the patient's comfortable,
alive,
safe.

Make sure they're stable before they get on a machine.
You ask certain questions because
the patients just don't outright tell you—
"Oh you know I had diarrhea"
Or
"Oh you know I was throwing up."
You have to ask questions
because if you put them on
a machine—it can make it worse.
So I'm supposed to make sure they're OK
or at least stable enough to get on the machine.

Put the needles in their access
and get them started,
make sure they're stable while they're on the machine—
anything irregular or not normal or just irritates,
or just the patient wants me to tell someone,
let the nurse know or the clinical manager know.

And make sure they get off.
They're not bleeding,
they're stable before they leave,
enough to go home and drive
or what not.
And that's it.

This aspect of the performance of professionalism by the PCTs includes being watchful and attentive. Again, the stylistic repetition of a key phrase— "make sure"—indicates a way of making sense of responsibility for patient care that involves being vigilant and continually re-checking information and perceptions about patients' well-being. The description also delineates

three phases of the process – preparation for the treatment, connection to the machine (“putting the patient on”) and disconnection (“taking the patient off)—to clarify what he is responsible for during treatment. Vigilance is part of each treatment phase as the PCT “makes sure” by looking for specific clues, such as bleeding and stability of vital signs (e.g., blood pressure). Moreover, the PCT reports a willingness to pass on information to his supervisors if a patient requests it, reflecting a respect for patients’ self-knowledge and an openness to collaboration with professional colleagues. Training manuals and comments in the clinic’s communication log further reinforced the internalized message that watching patients to keep them safe from harm is the responsibility of professionals (e.g., Beckett-Tharp & Schatell, 2001). Professionalism clearly linked in PCTs minds as reflecting their competence and vigilance in treating patients.

Teamwork

PCTs expressed appreciation for those PCTs who worked as a team, helping others without being asked. PCTs explained that PCTs who regularly assisted others voluntarily were valued as colleagues, while those who focused on their own work load without assisting others were criticized (Ellingson, 2007). To be a professional was to both give and receive assistance as needed for the good of patients, staff morale, and efficiency. Much of this performance of professionalism—referred to as “pitching in” within the clinic—was as simple as pushing a button to reset a patients’ machine while the patient’s assigned PCT was involved in another task, such as helping another patient or entering records into the computer. In this poetic transcription, a PCT explained the rhythms of supporting colleagues.

Getting the Job Done

Teammates need help, and they got
two machines that are not cleaned,
so I figure
“Nope. The day’s not done.”

Got these—not finished.
 I'll clean that up.
 What I figure is
 OK, just if I'm done,
 I see my partner has to get
 what we call bleeders—like for prolonged bleeding.
 I just tell 'em
 “You just deal with that. I'll take care of this.”
 That way, when they're done bleeding,
 take 'em out,
 do their paperwork.
 Yeah, it really makes a difference when you just help and
 not just do your own thing 'cause
 I've been taught ever since I started
 to work as a team,
 not just “me, me, me.”
 I was never taught to work like that.

This PCT invokes his training as an appeal to authority – he remembers how he was taught to work and takes pride in following his supervisors' teachings. In addition to the value he places on helping other PCTs, this PCT acknowledged his training and socialization, how he was “taught to work,” or to perform. PCTs discussed their previous or current work at other units (picking up per diem shifts to supplement salaries was common) and described the varying cultures of the units in regards to teamwork. They also identified particular individuals they believed were especially apt to “pitch in” or conversely were thought to be selfish and disinclined to assist others. The PCT's words in the poetic transcription imply a disparagement of those who chose not to work as a team. Professionalism was thus not limited to one's own assigned tasks but to collaboration with colleagues in ways that benefited the overall performance of the clinic staff in providing high quality patient care (see McNair, 2005).

Working as a team was also crucial to supporting another of PCTs' key priorities as professionals: to maintain a smooth flow of patients through the unit. A steady turn-over of patients was important because any deviation from the routine could lead to a cascading series of

problems. Patients were tightly scheduled in staggered shifts, and maintaining the routine was paramount to being able to treat all patients in a timely manner. In the poetic transcription, the awareness of schedule is reflected in references to the end of the shift, to needing to get the patients who are having difficulty stopping blood flow from their access points following treatment (a frequent occurrence) out of the treatment chairs, and to logging the necessary paperwork for each patient which occurs at the change of each shift as one patient leaves and another arrives. In addition, the necessity of working as a team imbued throughout the poetic transcription underscores the PCT's awareness of the extraordinarily complex coordination needed to shift patients around as necessary whenever obstacles arise. Extraordinary efforts and constant minor adjustments were made to coordinate carefully among PCTs, nurses, technical aides, and the nurse manager to enable the schedule to continue (Ellingson, 2007). PCTs continually multi-tasked and became skilled observers who could detect and respond to abnormalities quickly and effectively. Professionalism was reflected in both PCTs' level of concerted effort toward this goal and their impressive skill at performing it.

Emotion Management

PCTs perceived emotion management as a key aspect of professionalism in a position that involved performing difficult emotional labor on a daily basis (Morgan & Krone, 2001). PCTs, along with nurses and other staff, articulated that one of the most difficult aspects of their job was coping with stressful emotions that accompany working so closely with ill patients. Thus the ability to accomplish this management well was heralded as indicative of professionalism. Some of the emotional stress was due to the frequent loss of patients. The mortality rate of dialysis patients is quite high (e.g., USRDS, 2009), and coping with patients' deaths involved intense emotional labor for PCTs (Kelly, Ross, Gray, & Smith, 2000). At the same time that the

loss of some patients was painful, other patients induced emotional distress by being unlikable or frustrating. Uncooperative patients were a common complaint among PCTs, and the capacity to manage such patients in a calm, pragmatic, and diplomatic manner reflected professionalism.

Venting

You just let them vent
and say what they want to say,
and I try not to get angry
and I try to use the proper words.
If it's a threat or anything like that
we don't even address it back,
like in an angry way.

We just let the social worker handle it,
let the RN handle it.
I personally just let them just vent and
don't do anything different.
I mean I'm still gonna do my job,
and I'm still gonna treat them with respect.

You get a couple of them that come in—
they're just angry.
They're just angry about their situation,
they're angry about having to be there,
they're angry about having to—so to speak—
give up their life.
And you just be loving,
you just be caring,
and just be willing to listen.

We have one and
he comes in angry all the time.
You try to say something nice
and he doesn't have nothing nice to say back,
but you just, kind of, just deal with it.
Do your job
still treat them with respect
and still ask them
“Oh, how's your family”
and things like that,
and sometimes that breaks it.

Disruptive and even abusive patients must receive treatment despite the inordinate stress they may bring to staff and other patients (Friedman, 2001)ⁱⁱⁱ. PCTs often found that providing patients the opportunity to vent helped to diffuse patients' animosity, as in the above example. This PCT's repetition of "they are angry" emphasizes that she listened carefully to her patients and paid attention to their emotional displays. She also endeavored to give concrete examples of the many ways in which she tried to adapt her performance of professionalism to provide as much emotional support as possible to her patients, such as listening, saying something nice, and being respectful. PCTs did not engage in angry or hostile communication with patients during any of my observations, although on several occasions PCTs grew increasingly tense and frustrated and excused themselves, leaving the floor and going to a backstage area in order to calm down, as they perceived that their performance of a professional affect was in danger of failing (Goffman, 1959). PCTs reported venting to sympathetic colleagues as a way to maintain a professional demeanor in front of patients while exorcising pent up anger and resentment. The invocation of a verbally abusive patient by the PCT reflects the strength of her ideals; that is, by invoking the most extreme example of a challenge to her performance of professionalism, she communicated how strongly she felt about the importance of performing emotional management when interacting with patients. PCTs took pride in and respected others' abilities to remain calm when verbally harassed by patients, and they considered expressing anger to patients to be a breach of professionalism.

Discussion

This study illuminated the concept of professionalism from the point of view of dialysis PCTs in order to reveal its meanings for these paraprofessional, direct care providers. Four themes of individualized care, vigilance, teamwork, and emotion management emerged. Poetic

transcription of participants' speech provided an opportunity for exploration of the meanings of these themes on both rational/analytic and aesthetic levels. I offer three important implications of this study for health communication literature and for future research on professionalism, paraprofessionals, and communication within dialysis contexts.

First, communication of paraprofessionals is an understudied area that reflects researchers' bias toward honoring and interrogating communication of professionals such as nurses and physicians at the expense of the large and growing group of paraprofessionals providing direct caregiving to patients. Yet the findings of this study clearly indicate that much about how paraprofessionals engage in reasoning, provider-patient communication, and collaboration with their co-workers of all status levels is significant to health care delivery and worthy of investigation. PCTs' (and other paraprofessionals') perspectives needs to be incorporated overtly into discussions of cultures of medical care, interdisciplinary and interprofessional communication, and provider-patient communication along with medical, allied health, and social service perspectives. PCTs reported internalizing specific ideals of professionalism and offered rich examples of how they seek to perform a professional identity as they provide patient care. Exemplars such as those reported here are ideal for training and socialization of new PCTs as they explore how to perform their complex identity as a direct patient caregiver with paraprofessional status. In addition, exemplars of PCTs' sense making surrounding professionalism also offer rich possibilities for training of nurses, dietitians, social workers, and others who work closely with paraprofessionals.

Second, the themes reflecting PCTs' understanding of professionalism—individualized care, vigilance, and emotion management, and teamwork—overlap significantly with formal definitions of professionalism. For example, Morgan and Krone's (2001) concept of technical

competence was reflected in the themes of individualized care and vigilance, as was the medical principle of the primacy of patient welfare (ABIM, 2002). The professional concept of emotional restraint (Morgan & Krone, 2001) was evidenced in the PCT's articulation of emotion management. Likewise, the teamwork theme includes the importance of collegial and effective collaboration with other providers, or "interprofessionalism" (McNair, 2005). The more abstract values and commitments contained in professionalism codes (e.g., social justice, access to resources) were not articulated by PCTs. This absence can be considered part of the PCTs' performance (Goffman, 1959); that is, in making sense of professionalism within our interviews, PCTs articulated four embodied, performative strategies that contrast in their specificity with the broader, more institutional and social level principles not stated. Thus PCTs' beliefs about professionalism were in accord with, but not exhaustively inclusive of, professionalism codes of those providers accorded professional status (e.g., physicians). This study adds to the health communication literature by documenting similarities and differences between paraprofessionals' and professionals' articulations of professionalism. This raises questions for future research that focus on how similarities and differences between conceptualizations of professionalism intersect with differences in status, training, and socialization as professionals and paraprofessionals work together to provide patient care.

Finally, this study demonstrated that employing poetic transcription to illuminate participants' point of view constitutes a viable complement to more traditional forms of representation of qualitative data. The engagement with aesthetic rationalities enables researchers to "engage with the social worlds of others, defamiliarize the ordinary, break through the crusts of conventionalized and routine consciousness, and co-construct more fulfilling social orders... [and] to enlarge citizens' potentialities and capacities" (Harter, Norander, & Quinlan,

2007, p. 112). The poetic transcriptions do more to let us imagine PCTs as individuals, not merely as sources of information fragments that researchers use to make “our” analytical points (Fine et al., 2000). At the same time, I did fragment PCTs’ experiences into categories through grounded theory analysis that forms the foundation of these findings. In conducting a constructivist grounded theory analysis and representing the findings in a nonconventional manner, I unsettled the assumption that poetic discourse and rigorous inductive analysis may only contrast and conflict on an epistemological level and instead showed how they can complement each other to co-construct a richly nuanced report.

Conclusion

In conclusion, the meanings of professionalism to lower-status health care workers encompass a range of desirable values and modes of behavior. Ideally, a balance should be found that enables paraprofessionals to feel empowered by their own sense of professionalism and take pride in their work while also encouraging health care organizations to treat paraprofessionals as valued members of health care teams and to recognize their contributions to patient care. Of course, the ideas presented herein are derived from an ethnographic study of staff and patients of a single dialysis unit, and hence further research should explore the roles of technicians and other paraprofessionals across a variety of health care settings. As paraprofessionals continue to play vital roles in health care delivery, health communication researchers must increasingly take into account how their perspectives shape and are shaped by communication surrounding professionalism at interpersonal, organizational, and systemic levels.

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Endnotes

i. Most of the staff and patients were aware of far more of my identity than merely my status as a researcher. Staff and patients asked me many questions about my position as a university professor and about my personal life, including my marriage, pets, and leisure activities, and I answered them freely. In addition, because I walk with a limp and my right leg was disfigured (due to several operations), staff and patients asked me questions about my health, and I disclosed my status as a cancer survivor (see Author, 1998). My personal disclosures appeared to enhance my rapport with my participants and facilitated the development of trust between us. Moreover, I felt an ethical obligation to reciprocate with personal information when I ask my participants to share their lives with me. However, I did avoid discussing the research questions of my study, and explained only that I was interested in documenting mundane communication in the unit (which I often referred to as “what you do all day”).

ii. This joke refers to the fact that patients are required to radically limit their fluid intake in between dialysis treatments. Patients are weighed before and after treatment, with the difference in their weights attributed to the amount of fluid removed during dialysis. Hence, this PCT is joking that having a lot of money in the patient’s pocket would make the patient falsely appear to have gained excessive weight between dialysis treatments. While the premise of the humor may not work well for those outside the world of dialysis, this comment generally would be considered appropriate and effective humor by the staff and patients of the unit I observed.

iii. Unfortunately, unpleasant patients are not uncommon within dialysis care. ESRD is most prevalent among minority and economically disadvantaged populations who lack health

insurance; hence, they often are often angry about the previous lack of treatment that contributed to the onset of ESRD. In addition, ESRD is a side effect of substance abuse, and people with addictions to illicit substances tend to be noncompliant, difficult patients. Finally, life on dialysis is not easy; it involves many side effects, drastically restricted diet and fluid intake, and the loss of much independence. Such limitations may induce normally pleasant patients to act out in anger and frustration (Friedman, 2001).