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University of Southampton
Faculty of Health Sciences

Thinking about patients and talking about persons
in critical care nursing.

by

Christopher Duncan McLean

Thesis submitted for the Degree of Doctor of Philosophy
September 2012

UNIVERSITY OF SOUTHAMPTON

ABSTRACT

FACULTY OF HEALTH SCIENCES

Doctor of Philosophy

THINKING ABOUT PATIENTS AND TALKING ABOUT PERSONS IN CRITICAL CARE NURSING.

By Christopher Duncan McLean

Nursing scholarship and healthcare policy set an expectation that nurses should think about patients as persons. Nevertheless, the literature reveals that critical care nurses can struggle to perceive patients as persons, and thus suggests they may think about patients in different ways. This thesis presents the findings of an ethnographic study undertaken within one critical care unit in the United Kingdom which examined how critical care nurses *do* think about patients.

A purposive sampling strategy recruited 7 participants representing both experienced and inexperienced critical care nurses. Data were collected over a period of 8 months during 2006 to 2007, and primarily comprised the field notes from 92 hours of participant observation supplemented by 13 tape recorded interviews. Data analysis was influenced by Foucault and Goffman and adopted the perspective of linguistic ethnography. Analysis revealed that all participants thought about patients in seven distinct ways: as 'social beings', as 'valued individuals', as 'routine work', as a 'set of needs', as a 'body', as '(un)stable' or as a 'medical case'.

Accounts of participants' practice revealed that they had a tacit understanding that these different ways of thinking related to aspects of one coherent whole, but no one way of thinking could be characterised as thinking about this 'whole person'. Nurses could only think about one aspect of the patient at a time. Nurses' practice was not guided or explained by their thinking about patients as persons, but rather expert practice was characterised by nurses' fluid and appropriate movement between different ways of thinking about patients.

When participants talked *about* their practice it was evident that these nurses could only legitimately talk about themselves as giving care to *persons*. Participants characterised some of the ways in which they had to think about patients as impersonal, and this actively hindered these nurses from describing or reflecting upon elements of their practice. There is therefore conflict and dissonance between nurses' expectation that they should think about patients as persons, and the fact that delivering nursing care requires them to think about patients in different ways.

The development of future critical care nurses will require practitioners and educators to recognise that nurses think about patients in different ways, and that expert practice is characterised by the clinical wisdom which enables nurses to think about patients in ways which are appropriate to the moment. Nurse scholars and educationalists should therefore avoid claims to a unique professional knowledge base which suggest to nurses that some ways of thinking are *always* inappropriate or *inherently* reductionist. Instead, there is a need for scholars and policy makers to articulate a vision of person centred care clearly, and in ways which avoid constructing dissonance between nurses' ideals, and the ways in which they do and must think about patients.

List of Contents

Title page.....	1
Abstract.....	3
List of Contents	5
List of tables and figures	9
Academic Thesis: Declaration Of Authorship	11
Acknowledgements.....	13
1.0 Introduction	15
1.1 Different ways of thinking about patients in critical care nursing	17
1.1.1 A personal background and perspective.....	17
1.1.2 The culture of critical care and challenges to person focussed care	18
1.2 The wider context of “person-focussed” practice.....	20
1.3 The aim of the study and structure of the thesis	21
2.0 Literature review.....	25
2.1 Factors potentially influencing how critical care nurses may think about patients.....	27
2.2 Person focussed and person centred care	31
2.3 Differentiating and recognising different ways of thinking.....	34
2.4 Thinking and related concepts	36
3.0 Methodology and Methods	41
3.1 Study objectives.....	41
3.2 Methodological considerations	42
3.2.1 Characterising the ethnography.....	43
3.2.2 Operationalising ways of thinking.....	45
3.2.3 Criteria for successful completion of the study	48
3.3 Data Collection	49
3.3.1 Site selection and negotiating access.....	50
3.3.2 Defining the field	51
3.3.3 Sampling.....	52
3.3.4 Field / researcher role and fieldwork considerations	54
3.3.5 Observation.....	57
3.3.6 Recording Data	58
3.3.7 Leaving the field	62
3.3.8 Interviews.....	63

3.4 Data Analysis	66
3.4.1 Data Management and Coding	68
3.4.2 Qualitative description.....	69
3.4.3 Establishing patterns.....	70
3.4.4 Incorporating the interview data.....	71
3.4.5 Identifying the Discourses.....	73
3.4.6 Saturation and negative cases	78
3.5 Interpretation and writing the ethnography.....	79
4.0 Overview of findings.....	81
4.1 The ethnographic context	81
4.1.1 Overview	81
4.1.2 The environment.....	82
4.1.3 The Nursing shift.....	84
4.2 Individual accounts of participants	86
4.2.2 Nurse A.....	87
4.2.3 Nurse B.....	89
4.2.4 Nurse C.....	91
4.2.5 Nurse D	94
4.2.6 Nurse E	97
4.2.7 Nurse F	100
4.2.8 Nurse G	103
5.0 Seven ways of thinking about patients.....	107
5.1 Thinking about the patient as routine work	108
5.2 Thinking about the patient as (un)stable	115
5.3 Thinking about the patient as a body.....	121
5.4 Thinking about the patient as a set of needs.....	127
5.5 Thinking about the patient as a medical case	134
5.6 Thinking about the patient as a social being.....	142
5.7 Thinking about the patient as a valued individual	149
6.0 Moving between ways of thinking and “clinical wisdom”	157
6.1 Different ways of thinking are distinct.....	159
6.1.1 Humour	160
6.1.2 The Big picture	162
6.1.3 The fluency of expert practice	166
6.1.4 Implications of the finding that ways of thinking are distinct	167

6.2 Expertise and ways of thinking	169
6.2.1 Individual participants ways of thinking about patients	169
6.2.2 Differences between novice and experienced participants.....	170
6.3 Moving between ways of thinking about patients.....	173
6.3.1 Appropriate and inappropriate ways of thinking.....	174
6.3.2 Correct perception and Clinical wisdom	177
7.0 Thinking about patients and talking about persons	181
7.1 Practice associated with ‘impersonal’ ways of thinking.....	182
7.1.1 Routine	183
7.1.2 Nursing an (un)stable set of systems	185
7.1.3 Nursing the body.....	187
7.1.4 Understanding the medical case.....	188
7.2 Practice associated with ‘personal’ ways of thinking about patients.	190
7.2.1 Nursing the valued individual.....	190
7.2.2 Nursing the set of needs	191
7.2.3 Nursing the social being	192
7.3 Talking about persons.....	194
7.4 A central tension: Thinking about patients and talking about persons.....	199
8.0 Conclusions and recommendations.....	201
8.1 Trustworthiness of the study and transferability of findings	201
8.2 The contribution of the study to nursing scholarship	205
8.3 Recommendations.....	208
8.3.1 Critical care practice and education.....	209
8.3.2 Education.....	211
8.3.3 Future research	212
8.3.4 Policy	214
9.0 Summarising the study	217
Appendix 1: Search Strategy	221
Appendix 2: Confirmation of ethical approval.....	225
Appendix 3: Information to unit staff	227
Appendix 4: Managers confirmation of access to study site	231
Appendix 5: Participant information sheet.....	233
Appendix 6: Managing risks to patients in the field	237
Appendix 7: Revision of field notes	239
Appendix 8: Questions / prompts to guide interviewing.....	241

Appendix 9: Jeffersonian transcription symbols	243
Appendix 10: Illustration of Content Coding	245
Appendix 11: Content Codes	249
Appendix 12: Extended example of linguistic analysis	251
Appendix 13: Completed proforma characterizing one Discursive formation / Discourse.....	255
Appendix 14: Unit Guidelines for “safety checks and handover”	259
Appendix 15: Practice background of the participants	261
List of References	263
Bibliography.....	281

List of tables and figures

Figure 1: Operationalising 'Ways of thinking'	p. 45
Figure 2: Levels of Care (Department of Health, 2000)	p. 50
Figure 3: Inclusion / exclusion criteria for selection of participants	p. 52
Figure 4: Revision of field notes	p. 61
Figure 5: Key conventions in Jeffersonian transcription	p. 64
Figure 6: Brewer's (2000) stages in Data Analysis	p. 67
Figure 7: Characterising the Discursive Formation / Discourse	p. 74
Figure 8: Extract from the unit 'Guidelines for Bed Safety checks'	p. 108
Figure 9: Thinking about the patient as routine work	p. 115
Figure 10: Thinking about the patients as (un)stable	p. 121
Figure 11: Thinking about the patient as body	p. 126
Figure 12: Thinking about patients as a set of needs	p. 134
Figure 13: Thinking about the patient as a medical case	p. 142
Figure 14: Thinking about the patient as a social being	p.149
Figure 15: Thinking about the patient as a valued individual	p.154
Figure 16: Summary of the different ways of thinking about patients identified	p.155

Academic Thesis: Declaration Of Authorship

I, **CHRISTOPHER DUNCAN MCLEAN** declare that this thesis and the work presented in it are my own and has been generated by me as the result of my own original research.

Title of thesis: **Thinking about patients and talking about persons in critical care nursing.**

I confirm that:

1. This work was done wholly or mainly while in candidature for a research degree at this University;
2. Where any part of this thesis has previously been submitted for a degree or any other qualification at this University or any other institution, this has been clearly stated;
3. Where I have consulted the published work of others, this is always clearly attributed;
4. Where I have quoted from the work of others, the source is always given. With the exception of such quotations, this thesis is entirely my own work;
5. I have acknowledged all main sources of help;
6. Where the thesis is based on work done by myself jointly with others, I have made clear exactly what was done by others and what I have contributed myself;
7. None of this work has been published before submission

Signed:

Date:

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1.0 Introduction

Within the United Kingdom (UK) the Department of Health (DH) expects that healthcare should be person-focussed or person centred (DH 2008a; DH 2009; DH 2010a; DH 2010b), and a focus on the whole person is argued to be particularly characteristic of nursing (Royal College of Nursing: RCN 2004). Within this political and professional context, critical care nurses care for patients who require intensive monitoring or intervention in a curatively focussed and highly technological environment (DH 2005). Nursing literature suggests that this environment can be inherently dehumanising, and also makes evident that the delivery of person centred care can be a challenge for critical care nurses. Whilst healthcare policy and nursing scholarship suggest that nurses *should* think about patients as persons, and there are clear reasons to believe that critical care nurses may have difficulty in doing so, no previous research has explored how nurses do *in fact* think about patients. This thesis reports on an ethnographic study which explores how critical care nurses think about patients.

Critical care nursing is the “specialised nursing care of critically ill patients who have manifest or potential disturbances of vital organ functions” (World Federation of Critical Care Nurses: WFCCN 2007). Critical care nurses have responsibility for continuous monitoring and assessment of critically ill patients, delivering and evaluating high-intensity therapies, and responding promptly to sudden changes in a patient's condition (British Association of Critical Care Nurses: BACCN 2009). The critical care unit is therefore a curatively focussed environment characterised by the heavy presence of technology, both of which are features suggested to be inherently dehumanising and at odds with nurses’ traditional focus on care rather than cure (Gadow 1985; Locsin 1995; Christensen & Hewitt-Taylor 2006; O’Keefe-McCarthy 2009).

Whilst working within this highly technological environment, critical care nurses are also required to establish therapeutic relationships with patients and their relatives (WFCCN 2007), and to care about patients as well as to care for them (DH, 2008b). Nursing is frequently characterised as having a distinctive concern with caring for the whole person (Watson 1998; Barker 2001; McCormack & Titchen 2001; RCN 2004; McCance et al. 2011), yet critical care nurses seem to be required to adopt a biomedical focus which is argued to be inherently “dehumanising” (Christensen & Hewitt-Taylor 2006). Although it has been suggested that these perspectives can be reconciled by characterising critical care nursing as a ‘caring science’ (Galvin, 2010), they appear to imply that critical care nurses may think about patients in different ways. The imperative to deliver person centred care appears to suggest that critical care nurses should think about patients as persons, yet adopting a “dehumanising” biomedical focus suggests that critical

care nurses may think about patients as something other than (or less than) a person. The professional expectation of delivering 'care' and the culture of 'cure' therefore appear to require critical care nurses to think about patients in different ways.

Literature searches have not revealed prior research giving overt consideration to the different ways in which nurses may think about patients in the sense outlined here. It is known that nurses draw upon different forms of knowledge (Carper 1978; Liaschenko & Fisher 1999), and nurses' thinking has been examined through the exploration of intuition, reflection-in-action or thinking-in-action (Benner 1984; Dreyfus & Dreyfus 1985; Effken 2001; Gobbi 1998 & 2005; Tanner 2006; Green 2012). Nonetheless, no previous scholarship has been identified which examined nurses' thinking from a perspective which aimed to characterise the kind(s) of being that nurses consider patients to be (whether a person or otherwise).

An understanding of whether, and how, nurses think about patients in different ways is important. Critical care nurses are known to experience frustrations or moral distress as they attempt to care for the 'whole person' whilst also managing their other work responsibilities (Beeby 2000; Cronqvist et al. 2001; Cronqvist et al. 2004; Cronqvist et al. 2006; Lawrence 2011; McAndrew et al. 2011). In healthcare more widely the NHS Constitution (DH 2009) mandates that health care practitioners should value people as individuals, yet recent reports within the United Kingdom (UK) have made clear that this ideal is not always achieved in a range of healthcare environments (Kings Fund 2009; DH 2010c; Care Quality Commission 2011; Parliamentary and Health Service Ombudsman 2011). An understanding of the way(s) in which nurses think about patients may clearly play a role in understanding why there is such a stark contrast between these values and the reality of care delivery.

This study therefore examines the ways in which critical care nurses think about patients, and also investigates whether critical care nurses do in fact experience any tension or dissonance between the ways they do think about patients and the expectation that they should think about patients as persons. Given that the culture of critical care emerges as likely to be a primary influence on the way in which critical care nurses think and behave, the study takes the form of an ethnographic enquiry conducted in one critical care unit in the UK.

In the context of a study exploring how nurses think, it needs to be noted that the term 'patient' may itself be considered to reflect a particular a way of thinking about the recipient of care which contrasts with terms such as 'client', 'service user' or simply 'person'. Given that nuances of

language are often the basis for analysis within this study it is important to be consistent on this terminological point. Whilst 'patient' can carry connotations of dependency, people receiving critical care clearly *are* dependent and this term is generally used by critical care practitioners themselves. For these reasons, and for the sake of clarity, the term patient is used to refer to the recipient of care throughout this thesis.

This study will now begin to elaborate upon this background in order to clarify the aim of the study, and focus upon the two sides to the above dilemma or tension. Reasons to believe critical care nurses may think about patients in different ways are set out in section 1.1, whilst section 1.2 outlines how nursing scholarship sets an expectation that nurses should think about patients as persons.

1.1 Different ways of thinking about patients in critical care nursing

This section elaborates upon the premise that critical care nurses may think about patients in different ways. Given that my own practice background as a critical care nurse has been an influence on all stages of this research, the section opens with a personal account of what brought me to conduct the study (section 1.1.1). Section 1.1.2 then introduces some of the existing literature which makes clear that other critical care nurses can face challenges in thinking about patients as persons, and thus suggests that they may in fact think about patients in different ways.

1.1.1 A personal background and perspective

This ethnographic enquiry adopts participant observation as a primary means of data collection, and the analysis of these data also draws upon my prior experience as a practicing critical care nurse. Methodological reflexivity therefore requires an acknowledgement of my own role as an active producer and interpreter of these data (Kvale 1996; Denzin 1997; Davies 1999), and requires that I set out my own perspective or 'where I was coming from' at the commencement of the study.

Although I now have an academic role, during my clinical career I took pride and satisfaction in developing a wide range of knowledge and skills in critical care nursing. Despite the conviction that all these knowledge and skills were necessary, the expectation that nurses should always think about patients as persons appeared to me as a commentary or criticism of aspects of my practice. Key messages which had been reinforced to me throughout my nurse training and my early exposure to the nursing literature appeared to imply that my ability to draw upon

knowledge from biomedicine was to adopt a 'medical model' that was antithetical to 'nursing'; that the high technology environment within which I practiced was intrinsically objectifying and impersonal, and that it was inappropriate to take pride in 'technical skills' rather than in the more 'holistic' or affective aspects of caring.

I developed a sense that if the ideal of always thinking about the patient as a 'whole person' were somehow set aside, then this opened up the possibility that a 'medical' view, or a focus upon 'technical' aspects of care, could in some way be considered appropriate and fitting to specific situations. These tentative speculations therefore led me to question whether there could be one 'right' way in which nurses should think about patients and to recognise the possibility that critical care nurses may in fact think about patients in many different ways. I also recognised that in the absence of one 'right' way in which nurses should think about patients, it would only be possible to judge whether the way a nurse was thinking about a patient was appropriate to a particular moment. Although it could potentially be seen as a preconception brought to the study, my belief that there was not necessarily one 'right' way of thinking about patients enabled me to undertake the research free from judgments about what *ought* to be the case.

Prior to my nurse training I had undertaken a first degree in philosophy and a personal fascination with conceptual and philosophical issues thus pre-dates my nursing practice career. Whilst this background undoubtedly influenced the above early speculations, training in philosophy also left me acutely sensitive to and frustrated by ambiguous or 'fuzzy' concepts. This study was therefore stimulated by my sense that whilst it was potentially important, the concept of 'different ways of thinking' about patients was vaguely expressed, personally unsatisfying, and in need of clarification.

1.1.2 The culture of critical care and challenges to person focussed care

Critical care units exist in order to facilitate the monitoring and treatment which critically ill patients require, and thus the prevailing culture of critical care units may influence critical care nurses to think about patients in certain ways. Chapter two will explore these issues in detail, but setting the context for this study requires an overview of how the culture of critical care may influence the way that nurses think about patients.

Critical care nursing is the care of patients who have "manifest or potential disturbances of vital organ functions" (WFCCN 2007), and critically ill patients can have unpredictable and changing needs. In order to manage this unpredictability, critical care nurses often express a need to be 'in

control' (Pretorius and Klopper 2011; Boström et al. 2012) and are required to respond particularly rapidly to changing situations (Chaboyer & Creamer 1999). The critical care environment is often busy with unpredictable work patterns and high patient turnover, and can be characterised by a "tyranny of busyness" (Manias and Street 2000a). Critical care units place a high premium upon ensuring physiological safety and stability and can therefore be perceived as "dangerous" places in which there is a need to maintain tidiness, neatness and order (Manias and Street 2000a; Philpin 2007). Furthermore, critically unwell patients are often limited in their ability to communicate, and numerous studies report patterns of communication between nurses and patients in critical care to be restricted and problematic (Leathart 1994a & b; Baker & Melby 1996; Llenore & Ogle 1999; Usher and Monkley 2001; Alasad & Ahmad 2005).

While all of the above factors influence or reflect the work which critical care nurses do, little is known about how they relate to the way(s) that nurses think about patients. The 'busyness' of critical care units suggests that nurses *may* think primarily about the work that they have to do or about how they may manage their time; the need to maintain safety through imposing order and tidiness suggests that nurses *may* think primarily about the need to maintain order and control; and the failure of nurses to talk to the patients they care for *may* be taken to reflect their failure to think about patients as persons. These observations are highly speculative, and the potential 'explanation' that nurses may not always think about patients as persons only begs the question of what it may be to think about a patient as a 'person' in the first place. Nonetheless these considerations serve to highlight the need to understand how critical care nurses *do* think about patients.

One phenomenon identified within previous studies suggests that there may be a number of different ways in which critical care nurses think about patients. Writers such as Timmermans (1997) or Benner et al. (1999) describe complete and abrupt transformations in nurses' practice in response to perceived changes of context. These instances are discussed further in chapter two, but the identification of these phenomena in prior observational studies suggests not only that nurses may move between different ways of thinking about patients, but also that these different ways of thinking may be amenable to discovery through empirical research.

There are then reasons to believe that nurses may think about patients in a number of different ways whilst they are engaged in nursing practice. This emphasis on *practice* is important given that a clear distinction can be made between how nurses do think about patients, and the ways in which nurses' *talk* about their practice. It has been claimed that "humanized care" is something

about which a lot is said, but little is experienced, in critical care units (Vila and Rossi 2002). In this context, it is notable that it is in *interview* based studies that critical care nurses have described the struggle against “forgetting there is a person” (Villanueva 1999), or suggested they need to “focus” in order to appreciate the patient as a being with an identity (Walters 1994). Nurses express such difficulties whilst talking about their practice, but the relationship between how nurses *talk* about delivering care, and the ways in which they *do in fact* think about patients cannot be presumed to be straightforward. In this study, the way(s) in which nurses think about patients is taken to relate to what nurses do and say whilst actually engaged in practice.

1.2 The wider context of “person-focussed” practice

Critical care nurses practice within a wider context of nursing scholarship, nursing theory and healthcare policy which sets out strong expectations that nursing practice involves caring for (and therefore thinking about) patients as *persons* (Gadow 1985; Watson 1988; Morse et al. 1990; Lawler 1991; Barker 2001; McCormack & Titchen 2001; Melia 2004; Holland et al 2008; McCormack 2010).

The expectation that nurses should think about patients as persons is reinforced throughout nurses’ careers. Ensuring that registrants deliver care which is “person-centred” is central to the Nursing and Midwifery Council standards for pre-registration education (NMC 2010), and student nurses are exposed to nursing models and other concepts of holistic or whole person care throughout their programmes. As members of the healthcare workforce nurses are expected to care “from one human to another” (DH 2006, RCN 2010), or to respond to people with “humanity” (DH 2009). These expectations may be particularly strong for nurses whose professional identity is aligned to a discipline which has a distinctive focus on the “whole person” (RCN 2004) and which has historically attempted to define itself through constructing a difference between ‘nursing’ and ‘medicine’ (May & Fleming 1997).

As well as suggesting that nursing care is uniquely focussed on the person, the nursing literature also particularly foregrounds the “altruistic and emotional aspects of caring” (O’Connell and Landers, 2008). The expectation that caring must have an emotional component thus means that emotional detachment can carry negative connotations of objectification or dehumanisation which have been understood as coping strategies or nurses’ responses to anxiety (Menziess-Lyth 1959; Benner et al. 1999). By affirming that caring must involve an emotional involvement with a

person, this literature therefore implies that it is wrong for nurses to think about patients as objects.

Influences from education, practice and policy therefore consistently emphasise that nurses are expected to see, treat or think about patients as persons. Nonetheless, asserting that nurses *should* think about patients as persons opens up the possibility that nurses may *in fact* think about patients as something else. Despite the prominence of these debates within the nursing literature, no previous research has been identified which set out to explore how nurses do in fact think about patients, or whether the way(s) in which nurses think about patients has an impact on the care they give.

1.3 The aim of the study and structure of the thesis

The above discussion makes clear that whilst there are strong expectations that nurses should think about patients as persons, there are also reasons to believe that critical care nurses may think about patients in different ways. An understanding of how critical care nurses do in fact think about patients is therefore important.

It is known that the challenges involved in thinking about and caring for patients as persons can be a source of frustration or moral distress for critical care nurses (Beeby 2000; Cronqvist et al. 2001; Cronqvist et al. 2004; Cronqvist et al. 2006; Lawrence 2011; McAndrew et al. 2011). Whilst some studies have found that critical care nurses are not significantly stressed (Burgess et al. 2010), others have found that critical care staff are amongst the most vulnerable to suffering from emotional exhaustion or burnout (Bakker et al. 2005; Poncet et al. 2007; Lederer et al. 2008). The development of burnout is made more likely by any incongruence between idealised professional philosophies and the realities of care delivery (Maben et al. 2007; Sabo 2011). Given that burnout is associated with avoidance, withdrawal and low levels of professional performance (Iglesias et al. 2009; Goetz et al. 2011) these concerns may ultimately be of significance for patient outcome and experience. It is therefore necessary to understand whether the stress and distress which critical care nurses experience relates to any dissonance between the expectation that nurses *should* think about patients as persons and the ways in which they *do in fact* think about patients.

This study therefore aims to answer the research question “how do critical care nurses think about patients?” There are two intended areas of focus in asking this question. Firstly, determining *how* critical care nurses think about patients will require clarifying the concepts of

'thinking about' or 'a way of thinking about' patients. This will involve exploring the relationship between the ways in which critical care nurses think about, talk about, and behave towards patients. Secondly, asking *how* critical care nurses think about patients conveys a concern to identify and examine the different ways in which critical care nurses may think about patients. Seeking to identify 'different ways of thinking about patients' reflects an understanding that nurses must think about patients as some kind of being (whether a person or something else). This study seeks to characterise what these different kinds of being may be.

An examination of how critical care nurses think about patients is of no relevance unless there is a clear relationship between the way(s) in which nurses think and their nursing practice. There is therefore a need to make clear how the ways in which nurses think about patients impacts upon patient care. It is also of central importance to examine how nurses think about patients whilst they are actually engaged in nursing practice given that a straightforward relationship between the ways in which nurses *talk about* and *think about* patients cannot be presumed. From the outset of this study it was understood that naïve questioning of nurses could simply reveal their "espoused theory" (Argyris et.al. 1985), whereas this study was initially conceived as seeking to uncover nurses' "theory in use" (Argyris and Schön 1974; Argyris et.al. 1985). This study therefore aims to identify the ways in which nurses think about patients through analysis of what they do and say in clinical practice.

For reasons made clear in the chapters which follow, this thesis is also an examination of the nature of nursing expertise. Expertise in nursing practice has been extensively theorised, notably by Benner and her co-workers (Benner 1984; Benner and Wrubel 1989; Benner et al. 1992; Benner et al. 1996; Benner et al. 1999), and it is therefore important to be clear about the way in which these terms are utilised from the outset. Although Benner (1984) defines expert practice as the last of five stages of development from novice to expert, expertise may nonetheless be viewed as a continuum. This thesis therefore refers to 'increasing expertise', or participants becoming 'more expert', but such references should not be taken to characterise participants as definitively "expert" rather than "competent" or "proficient" in Benner's (1984) terms. Participants were recruited to the study on an understanding that increasing expertise is dependent upon experience, whilst recognising that experience itself was not a guarantee of increasing expertise. The term 'experienced' is therefore used to refer to participants who were recruited as such through the sampling criteria set out in chapter three.

In order to examine how critical care nurses think about patients this thesis is presented in nine chapters. Chapter two is constituted by an examination of relevant literature in order to make clear what was known at the outset of the study about the way(s) in which critical care nurses may think about patients. This review of the literature sought to identify how the way(s) in which critical care nurses think about patients may be influenced, characterised or recognised, and was therefore essential in gaining sensitivity to factors which needed to be considered in study design. Chapter two also expands upon the above discussion in order to clarify how different 'ways of thinking' about patients was conceptualised in relation to other extant literature at the outset of the study.

Chapter three sets out the methods adopted in undertaking the study, and begins (section 3.1) by setting out how the overall aim of the study was translated into specific objectives which informed study design. Section 3.2 then introduces the methodological perspective of linguistic ethnography adopted which was adopted in undertaking the study, and incorporates an exposition of how the work of discourse theorists such as Goffman (1959, 1961, 1974, 1981) and Foucault (1969, 1973, 1977) enabled *thinking* to be operationalized as the focus of an empirical study. The remainder of chapter three is devoted to a detailed exposition of the ways in which data were gathered through participant observation and interview (section 3.3), and the means by which approaches from discourse analysis informed the analysis of these data (section 3.4). The chapter concludes by giving considerations to issues raised by the interpretation of these data and writing the ethnography (section 3.5).

The primary findings of the study are presented in the next two chapters. Chapter four serves to give a broad ethnographic overview of the work of the nurses on the critical care unit where the study was conducted (section 4.1), and introduces the seven primary participants in the study (section 4.2). Chapter five then draws on examples from these data in order to set out seven different ways in which all of the critical care nurses in this study were found to think about patients.

Chapters six and seven discuss these findings from two distinct perspectives. Chapter six maintains a focus on how critical care nurses think about patients, and particularly examines how these data demonstrate the ways in which expert practitioners move between different ways of thinking about patients. Chapter seven turns to re-appraise the relationships between nursing *practice* and the ways in which nurses *think about* and *talk about* patients. These considerations

lead to an evaluation of the contribution of study and recommendations which are presented in chapter eight before chapter nine summarises and concludes the thesis overall.

2.0 Literature review

The literature searches set out below have identified no previous study which examined how nurses think about patients from the perspective outlined above. Several areas of the literature needed to be examined prior to undertaking the study and this review of the literature is therefore presented in four sections.

This study explores abstract and conceptually complex and disputed phenomena such that comprehensive search terms could not be identified with confidence at the outset of the study. The presentation of a linear search strategy is problematic given that the identification of literature was often incremental, and dependent upon following up secondary references as papers, concepts, or authors of particular relevance and importance were identified.

Nonetheless, in order to develop 'theoretical sensitivity' (Strauss & Corbin 1990) to factors which may have informed study design and data collection it was important to be aware of potential influences on how critical care nurses think about patients. Literature identifying what was known about these factors is presented in section 2.1. Chapter one has highlighted that critical care nursing practice takes place within a wider context in which there are strong expectations that nurses should think about patients as *persons*. This literature is reviewed in section 2.2 in order to situate this study within a wider body of nursing scholarship. Sections 2.3 and 2.4 then turn to a review of topics underpinning study design and the operationalization of concepts. Section 2.3 reviews that literature which enabled different ways of thinking about patients to be distinguished and differentiated from one another. Finally, section 2.4 draws upon existing literature to begin to clarify and operationalise the complex, abstract and potentially disputed concepts of 'thinking' that are the focus of this study.

Initial scoping literature searches were informed by the recognition that thinking of the patient as a 'person' could be problematised, and consequently early search strategies were derived from terms such as 'personhood' or 'person centred care'. These searches enabled the clarification of key topics or themes so as to enable more systematic searching which was undertaken primarily through the CINAHL, MEDLINE and Psycinfo databases.

The literature review was last updated in May 2012 and full details of the final search strategy are given within Appendix 1. This search was based upon the utilisation of key words selected to enable the identification of:

- Qualitative studies exploring critical care nurses' experience of providing care and the nurse patient relationship in critical care.
(Search terms included: "critical care" (and synonyms) AND "qualitative" OR "naturalistic" OR "grounded theory" OR "phenomenology")
- Relevant findings from previous nursing ethnographies
(Search terms included: "nursing" AND "ethnography")
- Literature relating to personhood and person centred care
(Search terms included "personhood" OR "person-centred" OR "care" OR "nursing models")
- Literature relating to 'thinking' and its potential synonyms
(Search terms included: "knowing" OR "perception" OR "intuition")
- Additional searches relating to specific factors which may impact on how nurses may think about patients (e.g. expertise; technology; culture)

In order to identify the literature relating to the wider political and practice context of critical care nursing, searches were also made on the websites of the following organisations:

World Federation of Critical Care Nurses (WFCCN)

British Association of Critical Care Nurses (BACCN)

Intensive Care Society (ICS)

National Institute for Health and Clinical Excellence (NICE)

Royal College of Nursing (RCN) (including RCN Critical Care and In-Flight Forum)

The Cochrane Library

Department of Health

The Kings Fund

Section 2.3 of this review makes reference to philosophers whose primary work was not identified through the above search strategy. Additional searches were undertaken using the term "personhood" (and synonyms) in the 'Philosophers Index' database.

In parallel with the identification of substantive literature, on-going research training exposed me to a range of methodological scholarship which is incorporated in the discussion in section 2.4 of this chapter. My understanding of key issues was particularly influenced by participation in a five day residential training programme entitled "Ethnography, Language and Communication" organised by the Economic and Social Research Council (ESRC) in 2008. This immersion in the field

of discourse analysis was a significant turning point in developing my understanding of theorists who have subsequently been major influences upon the study including Goffman (1959, 1961, 1974, 1981) and Foucault (1969, 1973, 1977).

2.1 Factors potentially influencing how critical care nurses may think about patients

Although no prior literature was identified which explicitly examined how nurses do think about patients, a range of factors could be identified from the literature as potential influences on how they may do so. These included the culture of critical care units, the potentially 'dehumanising' influence of technology, and other influences upon patterns of nurses - patient communication in critical care. Features of individual patients and the nurses' levels of expertise were also identified as likely to be significant factors in how nurses may think about patients. This section sets out what was known about these potential influences on the ways in which critical care nurses think about patients at the outset of the study.

Studies finding that new critical care nurses experience challenges in adapting to the culture of critical care units make clear that this culture is distinctive (Reising 2002; Farnell & Dawson 2006; O'Kane 2012). Previous ethnographic studies conducted solely or primarily within critical care units offer a range of insights into this culture, although (unsurprisingly) such studies often have a discreet focus. Previous ethnographies in critical care have explored topics such as patterns of interdisciplinary working (e.g. Manias & Street 2000a; Manias & Street 2000b; Coombs 2004), or specific clinical issues such as the management of death in the ITU (Seymour 2001) or weaning from ventilation (Crocker & Timmons 2009; Crocker & Scholes, 2009). With exceptions such as Scholes (1996) or Benner et al. (1999) discussed below, few previous ethnographic studies within critical care have focussed primarily on individual nurse-patient interactions, and thus give only restricted insights the different ways in which critical care nurses may think about patients.

Critical care nurses operate within a wider hospital culture, and ethnographic studies conducted in acute hospital care considered more broadly were also included within this review (e.g. Benner 1984; Lawler 1991; Street 1992; Chambliss 1996; Ersser 1997; Hardy et al 2000; Allan 2001). Some concepts emerging from this work such as Lawler's (1991) 'somological' practice, or Street's (1992) 'power/knowledge' and 'nurturance' grids appeared as potential candidates for different ways of thinking about patients. However, these concepts emerged as second order constructs from the analysis of data gathered in the course of studies with a wider overall focus, and which

were not collected within a critical care environment. Both of these factors will have influenced the nature and transferability of the resulting analyses.

The influence of healthcare culture on the way that nurses think about patients is often suggested to be problematic. Since the work of Menzies-Lyth (1959) it has been noted that hospital cultures may lead nurses to 'objectify' patients as a means of managing and coping with the anxiety and stress provoked by their work. Mechanisms such as the use of humour have also been analysed as means of releasing stress and tension amongst staff (Moran & Massam 1997; Scott 2007).

Working cultures also encourage nurses to adopt 'routine' or 'ritual' ways of working which Walsh & Ford (1989) have dismissed as "irrational and unscientific", although other authors have, more sympathetically, examined such routine ways of working as 'rituals' in an anthropological sense (Strange 1996; Philpin 2002). All of the above considerations made clear that any exploration of how critical care nurses think about patients would need to fully account for the influence and impact of the culture within which critical care nurses practice.

Critical care units are characteristically high technology environments. Although critical care nurses can be complacent about the use of technology (Browne & Cooke 2011), it has been claimed that technologic competence epitomizes critical care nursing (Locsin 1998; Kongsuwan & Locsin 2011). Technology has been suggested to "meld" patient and machinery into one clinical picture (Almerud et al. 2008), and many authors have suggested that technology has an intrinsically objectifying and dehumanizing impact (Gadow 1985; Locsin 1995; Barnard and Sandelowski 2001; O'Keefe-McCarthy 2009). In this context authors such as Timmins (2011) have argued that there is a need to remember the *art* of nursing in a technological age.

Despite the technology with which they are constantly monitored, critically ill patients may express a view that they feel invisible (Almerud 2008). Although patient experiences support the observation that the use of technology can be problematic, the critique of technology as depersonalising or objectifying is often advanced on purely philosophical or conceptual grounds. Although some observational studies reported that nurses find technology to render person centred interactions problematic (Alliex & Irurita 2004), a more nuanced picture generally emerges from empirical studies in critical care. Studies have found that nurses can adapt or transform technologies in ways which preserve the "essence of nursing" (Crocker & Timmons, 2009); that technology may serve to bring patients and nurses closer (Locsin 1995; McGrath 2008), or that the potentially objectifying impact of technology is not independent of its use in specific contexts (Cussins 1996; Locsin 1998; Barnard & Sandelowski 2001).

These (disputed and complex) claims about the “dehumanising” or “objectifying” impact of technology suggest that nurses may think about patients as something less or other than human, or as an ‘object’. Sandelowski (2002) argues that there is a clear link between technology and the way in which nurses may think about patients by proposing that a “virtual” body may come into being through the use of high technology monitoring. Whilst this literature therefore highlights that the use of technology may lead nurses to think about patients in different and complex ways, no papers retrieved in this search have fully articulated the influence of technology on how nurses think about patients.

Patterns of communication between nurses and patients in critical care are often characterised as problematic or restricted to patterns such as one way information giving (Leathart 1994a & b; Baker & Melby 1996; Llenore & Ogle 1999; Usher and Monkley 2001; Alasad & Ahmad 2005). Communication and information giving during critical illness is central to avoiding sequelae of critical illness such as delirium and future cognitive impairment (National Institute for Health and Clinical Excellence 2009), and although the reduced ability of critically ill patients to communicate verbally is one factor influencing these patterns of communication, there are also suggestions that the socialization of nurses to the critical care environment may be a significant factor (Leathart 1994a & b).

Although communication between nurses and patients in critical care can be problematic, research has also identified more positive aspects of communication such as those studies which report on the use and value of humour in humanising relationships (Harries 1995; Pierlot & Warelow 1999; Astedt-Kurki & Isola 2001; Dean & Major 2008; McCreaddie & Wiggins 2008). These contradictory findings suggest that nurses may communicate with patients in different ways at different times, and thus at least suggest a possibility that nurses may think about patients in different ways at different times. Again however, no research has been identified which directly addresses the relationship between these patterns of communication and the ways in which nurses think about patients. An exploration of how critical care nurses think about patients should therefore also account for the ways in which critical care nurses talk to (as well as talk about) patients.

Since the seminal work by Stockwell (1984) it has been recognised that some patients may be considered ‘unpopular’. Critical care nurses can be challenged by caring for patients from culturally diverse backgrounds (Høye & Severinsson 2010), and groups of patients such as the

elderly, mentally ill and suicidal patients may be negatively perceived by nurses (Herdman 2004). Patients' levels of physical and psychological dependency are a further factor which may impact upon the way in which they are perceived by nurses. Crocker & Scholes (2009) report that critical care nurses can prefer patients who are "stimulating or exciting", whilst Williams (2007) observes that patients who are being weaned from ventilation or otherwise receiving high dependency rather than intensive care can be viewed as 'unpopular' patients in critical care units. Such evaluative 'labels' are not predictable given that 'unpopular' patients are socially constructed within a particular context (Johnson & Webb 1995). An examination of how critical care nurses think about patients will therefore need to account for how nurses construct patients as 'unpopular' as well as how they behave towards such patients.

A final potential influence on how critical care nurses may think about patients was identified as the expertise of individual nurses. Although the nature of nursing expertise is widely discussed and debated, nursing is often characterised as uniquely responsive to the experience of the individual (e.g. Benner & Wrubel 1989; Bishop & Scudder 1997; McGrath 2008; Vouzavali et al. 2011). Tanner (2006) for example argues that an "engagement with the patient and his or her concerns" (p.206) is pivotal to expert clinical judgement, and in a recent review of the literature on nursing expertise Morrison & Symes (2011) observe that nurses' "emotional involvement" with patients continues to be viewed as the common grounding of expert nursing practice. This focus upon an involvement or engagement with the lived experience of the patient leads Gobet & Chassy (2008) to observe that the nursing literature on expertise is often based upon a phenomenological perspective which differs markedly from research on expertise within the natural sciences. This distinction is even more clearly apparent in the critique of Paley (2005) or Paley et al. (2007) who conclude that models of expertise which privilege intuition and a phenomenological perspective can constitute "a rhetoric that resists the discourse of science" (Paley 2005: p.113). Through invoking such a contrast between 'science' and an involvement or engagement in the lived experience of the patient, such arguments again suggest the possibility that nursing expertise may be better understood as depending upon an ability to think about patients in a range of different ways.

The literature relating to nursing expertise is dominated by the work of Patricia Benner and her co-workers who make strong claims about the significance of expertise in influencing nurses' worldview, and clinical 'grasp' of situations (Benner 1984; Benner and Wrubel 1989; Benner et al. 1992; Benner et al. 1996; Benner et al. 1999). However, within a 'grasp' of a situation overall it appears that a nurse must see, conceptualise or think about the patient as a certain kind of being.

Benner et al. (1992: p.14) argue that "practitioners at different levels of skill literally live in different clinical worlds", and yet whilst Benner suggests that expert nurses may think about the patient as a person, she is less clear about how the way in which non-experts think about patients may be characterised. Novices and experts may therefore have a different understanding or 'grasp' of the situations they face, but it is not clear from Benner's work how this grasp of the situation may involve thinking about patients as particular kinds of being.

Much of the above body of work develops the skill acquisition model developed by Dreyfus & Dreyfus (1985) and adopted by Benner (1984) which emphasises the ways in which experts are more likely to recognise and respond to complex patterns than to engage in simple rule following behaviour. More recent literature continues to echo Benner's (1984) findings by observing that expert nurses collect a wider range of cues than novice nurses, and are more proactive in doing so (Hoffman et al. 2009). Expert nurses therefore respond to situations in part through recognising patterns and by responding to cues that are salient, and yet it is not clear how these different patterns of perception may relate to different ways in which expert nurses think about patients. The design of this study therefore takes account of the strong reasons to suppose that expert nurses may think about patients in ways which are different to non-experts.

2.2 Person focussed and person centred care

This study examines the practice of critical care nurses, but is situated within a wider context of nursing scholarship characterised by a view that nurses ought to think of patients as persons. This section outlines how this view is sustained within the literature through discussing concepts of 'person centred care' or 'care', and through considering the role of theoretical models of nursing practice.

Considering the nature of personhood has led to the development of 'person centred care' which is often strongly tied to a practice development agenda (E.g. Barker 2001; McCormack 2010). Studies such as that by Manley et al. (2005) or Slater et al. (2009) conceptualise 'person centred care' such that nursing practice has attributes which are facilitated by identified factors, and has outcomes which may be examined using appropriate and valid outcome measures. To describe these approaches as 'person centred care' appears to imply or claim a change in the way that nurses think about, see and/or treat patients, yet despite identifying the factors which lead to, and the outcomes of, these ways of working the identified literature on person-centred care does not describe the *nature* of this apparent change in the way that nurses think about patients.

Concepts of 'care' are prominent in the nursing literature, and often form the basis of distinguishing nursing from medicine through a contrast in which nursing focuses on care rather than cure (Christensen & Hewitt-Taylor 2006). Despite this, concepts of care and caring are used with widely differing meanings between authors (Gadow 1985; Roach 1987; Watson 1988; Benner & Wrubel 1989; Morse et al. 1990; Clarke and Wheeler 1992; Savage 1995; Scott 1995; Chambliss 1996; Kendrick & Robinson 2002; Von Dietze & Orb 2004). In a noted historical review of the concept, Morse et al. (1990) found that caring tended to be depicted as a human trait, as relational or as a moral imperative. More recent literature continues to affirm that the literature relating to caring tends to highlight the "altruistic and emotional aspects of caring" (O'Connell and Landers 2008).

The literature on 'caring' therefore broadly continues to affirm that nursing care involves "emotional involvement" with patients (Morrison & Symes 2011), although a more nuanced picture emerges from studies undertaken in critical care. Critical care nurses emphasise that caring also involves what nurses do (Bush & Barr 1997; O'Connell & Landers 2008); physical and technical labour (Beeby 2000); and requires 'head' and 'hand' as well as 'heart' (Galvin 2010). Technical competence and "knowing what you are doing" are highly valued as caring behaviours by both critical care nurses and patients' relatives (O'Connell & Landers 2008). This literature emphasises a need for this study to focus upon the totality of what critical care nurses do, and to remain alert to the possibility that the above "emotional involvement" or its absence may be important in determining how critical care nurses think about patients.

A large body of nursing scholarship which may be traced back to the work of Nightingale (1860/1969) seeks to understand what nursing is or to define "the unique function of the nurse" (Henderson 1966: p.3). As a part of this endeavour, models of nursing have developed which "make assumptions about how the world of nursing is viewed" (Holland et al. 2008: p.9), offer a "way of thinking about nursing" (Walsh 1998: p.26) and which seek to offer a unique perspective on the patient (Marrimer-Tomey & Alligood 2006). Theorists such as Parse (1992) or Rogers (1990) argue that patients must be seen as "unitary" or "irreducible", whilst other models have been criticised for 'dehumanising' patients into a series of biological systems (Walsh 1998), or are open to criticism for "viewing the patient as a set of needs and the nurse as a set of functions" (Endacott 1998: p.69). Despite this variance it is nevertheless broadly acknowledged that theoretical models of nursing invariably set out a concept of the patient as a person (McKenna & Slevin 2008).

The relationship between such models and the ways in which nurses do think about patients is complex. Many models were initially developed as educational tools (Holland et al. 2008) and given that models such as those of Roper, Logan and Tierney (2000) or Orem (2001) have been prominent in UK nurse education they may dictate or influence (rather than reflect) the ways in which nurses think about patients. Models of nursing practice are also often based upon philosophical or abstract conceptions of personhood rather than upon evidence relating to the ways in which practicing nurses do in fact think about patients. Walsh (1998) observes that theorists who construct such models ignore reality at their peril, and it therefore follows that understanding the ways in which nurses *do* think about patients could play an important role in the development of nursing theory.

Only one study was identified in this review which explicitly attempted to explore nurses' views of patients' personhood. Merrill (1998) conducted a questionnaire based study which asked respondents (nurses, physicians and patients) to rate the importance of various "distinctive features" in determining personhood. As a questionnaire based study, this methodology fails to consider issues of context and does not explore how these expressed views related to nurses' practice. Such a study is also further limited by an underlying presumption that nurses may only think of patients in one way. No work identified in this review has remained open to the idea that nurses may think about different patients in different ways at different times.

Overall the literature reviewed sets an expectation that nurses should think about patients as persons, whilst neglecting to examine how nurses do in fact think about patients. Hall et al (2010: p.307) have described nursing practice as "walking the line between the possible and the ideal", yet whilst writers such as Melia (1987) and Scott (2006) have observed that student nurses learn to balance the "ideal" and the "real" way of nursing, few studies have explored how registered critical care practitioners manage these same concerns. As noted in chapter one, this is a significant omission given that incongruence between idealistic professional expectations and the work which nurses do can influence the onset of burnout (Sabo 2011). These first two sections of this review have made this clear given that the factors outlined in section 2.1 may influence critical care nurses to think about patients in ways which are not congruent with the broad expectation of a focus on the whole person set out in section 2.2.

It is therefore important to understand how critical care nurses do think about patients, and to know whether critical care nurses themselves experience dissonance or tension between the

different ways that their job requires them to think about patients, and a perception that there are only some legitimate ways in which nurses should think about patients. The sections above have therefore set out the background to and justification for this study. This review now turns to a consideration of literature which informed an understanding of how different ways of thinking about patients may be recognised, and distinguished.

2.3 Differentiating and recognising different ways of thinking

The above discussion has considered factors which may influence how critical care nurses think about patients, but prior to conducting a study into how nurses think about patients it was necessary to consider how different ways of thinking about patients could be recognised and differentiated.

In attempting to identify observable behaviours or features of nursing practice which may relate to how critical care nurses think about patients there was a notable paucity of observational studies. The fact that the majority of studies identified in this review based their findings on what nurses said during interviews is highly significant and problematic for a range of reasons. Most straightforwardly there is a risk that nurses' responses may reflect the expectation that they should think about patients as persons. Perhaps more significantly, there is little reason to presume that nurses would be aware of themselves as thinking about patients in different ways, or if so whether they would be able to articulate these different ways of thinking about patients.

It was therefore recognised early in this study that identifying the ways in which nurses think about patients would be dependent on observing what they did and said in practice rather than through analysis of how nurses talked about that practice. Finding only a limited amount of previous observational research made it difficult to identify practice behaviours which may reflect different ways in which nurses may think about patients. There were exceptions to this such as the distinction between "instrumental" and "affectional" touch described by Schoenhofer (1989), and many interview based studies suggested observable features of behaviour which may relate to how nurses think about patients and which could form a focus for observation. These included: using humour or closing physical distance (Morse 1991); giving hope (Golberg 1998); "Being firm" with distressed patients who were not comprehending a particular situation (Clarke & Wheeler 1992); or tone of voice and giving patients time (Baillie 1996).

Despite the lack of detail in respect to specific observable characteristics, prior studies strongly suggested that changes in the way in which critical care nurses think about patients could be observable. Hirschauer (1991), Timmermans (1997) and Benner et al. (1999) all offer descriptions of “a kind of gestalt switch” (Hirschauer 1991: p. 287) or “flipping the switch” (Benner et al 1999: p. 113) as nurses ‘objectified’ patients at identifiable moments such as the induction of anaesthesia. The identification of these phenomena gave confidence prior to the study that different ways of thinking about patients could be observed, whilst the review of this literature overall highlights that there are very few observational studies which touch on the relationship between the reality of critical care nursing practice, and way(s) in which nurses think about patients.

Prior to the study it was clear that it would be necessary to differentiate and describe the different ways in which nurses may think about patients. In considering how this may be achieved it was recognised that whilst the nursing literature tends to suggest that nurses should think about patients as a “person”, personhood is a highly disputed philosophical term. Olson (1997) argues that a person is simply an embodied human animal, whilst the work of Buber (1937) describes the “I-thou” relationship as occurring on an inexpressible and mystical plane such that personhood lies essentially within the mind or soul. Philosophers have argued that rationality (Descartes 1641/ 1998; Locke 1689 /1996; Kant 1785/1997); consciousness (Locke 1689 /1996; Singer 1995), having a point of view or experience (Heidegger 1927/ 1996; Taylor 1985), or having autonomy and intentionality (Dennett 1976; Taylor 1985) are necessary or sufficient conditions for attributions of personhood. ‘Persons’ have further been conceptualised as having a continued existence over time (Parfit 1984), psychological continuity (Edwards 2001), or as “the unity of a narrative which links birth to life to death” (MacIntyre 1985: p.205). Yet other viewpoints emphasise that a person is a political or legal entity who exists within a network of relationships and obligations to others (Rousseau 1762/ 1998) or as a creature of culture that is “constituted by relationships, meanings and memberships” (Merleau-Ponty 1962, cited in Edwards, 2001: p. 82).

The debate over whether these criteria are appropriate for attributing ‘personhood’ is a philosophical one, but nonetheless these debates point to potential means by which different ways of thinking about patients may be uniquely distinguished. This philosophical literature enabled a recognition that whether nurses *do* think about patients as conscious, having an experience, having a continued identity over time, or as embedded in relationships with others (and so on) were potential means of describing and differentiating different ways of thinking

about patients. Consequently these distinctions contribute towards enabling differentiation between the different 'kinds of being' that critical care nurses may think about patients as being.

2.4 Thinking and related concepts

This study aims to explore how critical care nurses think about patients. Whilst the way(s) in which nurses 'think about' patients is a concept with some initial resonance, at the outset of the study it was little more than a "signpost pointing to phenomena worth examining" (Bourdieu 1994: p.40). The review of the literature therefore also needed to recognise the need to clarify the concept of thinking, particularly so as to distinguish "thinking" about patients from terms such as ways of "seeing", "perceiving" or "knowing" patients.

It has been noted that exploring how critical care nurses think about patients will require clarifying the concept of 'thinking' itself, and the way in which this concept has been operationalized within a methodological framework is fully considered in chapter three. Nonetheless, some further discussion is necessary in order to introduce a discussion of how 'thinking about patients' relates to prior literature. It has been observed that identifying the different ways in which nurses may think about patients will primarily relate to *the kind of being* that the nurse considers the patient to be (whether a person or something else). The above discussion has also made clear that there are reasons to believe that nurses may think about patients in more than one way. It was therefore recognised that if nurses DO think about patients in different ways at different times then there must also be a sense in which nurses *move between* thinking about patients in these different ways. Whilst this study primarily set out to characterise these "different ways of thinking", it was also recognised that a full examination of how critical care nurses think about patients must also account for this "moving between" these different ways of thinking.

Within the existing literature, discussion about how nurses may 'see' or 'perceive' patients comes close to how nurses may think about patients. Ethicists such as Tschudin (2002) have suggested that "the way we see and approach the human being in need matters" (Tschudin 2002: p.124). Concepts of 'perception' (Scott, 2000; Niven & Scott 2003) or perceptual 'grasp' (Benner et al. 1999) often suggest that nurses see or acknowledgment the patients' personhood, whilst Foucault's (1973) use of 'gaze' offers an understanding that there may be other ways of seeing patients. Crudely and speculatively it may appear that thinking about (or seeing) a patient as a person may lead to the nurse treating the patient as a person, but the literature reviewed often

fails to make clear the distinctions and relationships between these terms. Whilst the literature on nurses' perception does not characterise the different ways in which nurses may "see" patients, authors such as Benner (2000) Polansky (2000), Pask (2003) Sellman (2003) and Chan (2005) frequently draw upon the Aristotelian notion of *phronesis*. Though complex, an understanding of *phronesis* must incorporate a sense of 'correct perception' (Aristotle 1984), and this literature therefore offers a means of understanding how the ways in which nurses see or think about patients may be considered 'correct' or appropriate. Overall, this literature makes clear that there is a need to clearly differentiate and understand the relationships between concepts of 'seeing', 'perceiving' and 'thinking about' patients.

The concept of 'knowing the patient' arises in a wide range of literature (Radwin 1996; Tanner et al. 1993; Benner et al. 1999; McCormack & Titchen 2001; RCN 2004; Wilkin & Slevin 2004) but is generally associated either with knowing patients' patterns of responses, or with the sum of the knowledge that the nurse knows about a patient. Within the literature reviewed, the concept of 'knowing the patient' has not been linked to a consideration of what kind of being the nurse knew the patient to be. In other literature on 'knowing', typologies of knowledge have been a feature of nursing scholarship since the seminal work of Carper (1978). More recently, Liaschenko & Fisher (1999) have proposed a typology of nursing knowledge which incorporates concepts of case knowledge, patient knowledge and person knowledge. Whilst Liaschenko & Fisher (1999) emphasise that these labels represent types of knowledge rather than the "actual recipient of care", they do not fully explore the interplay between these various forms of knowledge and nurses thinking about the patient as a 'case', 'patient' or 'person' respectively. There is therefore an uncertain and contested relationship between the forms of knowledge which nurses draw upon and the way(s) in which they may think about patients.

Further areas of the literature relating to "knowing" are those which examine the use of intuition, reflection in action and thinking-in-action (Benner 1984; Dreyfus & Dreyfus 1985; Effken 2001; Gobbi 1998 & 2005; Tanner 2006; Green 2012). Given that intuition may be considered a form of "precognitive or non-discursive awareness of or understanding of some situation" (Green 2012: p.100) an important feature of this literature is to highlight that it cannot be presumed that nurses are aware of themselves (or able to talk about themselves) as thinking about patients in different ways. Any examination of how nurses think about patients will need to account for the fact that knowledge can often be tacit and personal (Polanyi 1958, 1966). It is of interest that the ways in which people may come to understand one another *as* persons is a central concern for Polanyi (1966) in "The Tacit Dimension" where Polanyi is explicit that different forms of discourse

allow for an understanding of people as different kinds of beings. Despite the influence of Polanyi on the nursing literature, no subsequent scholarship has been identified which related this work to the ways in which nurses do in fact think about patients.

It was noted in section 2.1 that within an intuitive awareness or understanding of a situation overall, a nurse must see, conceptualise or think about the patient as a certain kind of being. Articulating what these 'kinds of being' may be has not been a central consideration in work exploring intuition or reflection / thinking in action. Gobbi (2005) for example has examined the "messy" and "idiosyncratic" knowledge and practice of nurses in order to offer an understanding that nurses work as "bricoleurs" who draw upon multiple forms of knowledge / discourses, but does not explicitly examine the relationship between these different forms of knowledge and the ways that nurses think about patients as particular 'kinds of beings'.

'Thinking' may be taken to refer to internal mental events which are not observable or discernible to others. The challenges in studying such a phenomenon are made clearer by the above recognition that nurses need not be aware of themselves as thinking in different ways or able to articulate these different ways of thinking. It is therefore appropriate to consider a final body of literature which provides the bridge between the background to the study and the consideration of the methodology and methods which follow in chapter 3. Many discourse theorists argue that meaning making is a fundamentally social practice and that it is therefore meaningless to suggest that there is such a thing as what a particular individual 'thinks'. Billig for example argues strongly against "cognitivist" models which posit "thinking" as "a silent and mysterious process, occurring in a private world inaccessible to others" (Billig 1987: p. 140), whilst Lemke notes that

"Mentalist discourses, by creating a separate mental realm and locating meanings there, are not useful for understanding the material and social aspects of meaning making"

(Lemke 1995: p.9)

This literature served to highlight the challenges inherent in situating 'thinking' within a coherent methodological perspective, yet also offers a means of understanding that this may be possible given that 'thinking' need *not* be conceptualised as a private, inaccessible mental phenomenon.

Chapter one has outlined the need to understand how critical care nurses think about patients, whilst this chapter has outlined what is already known about potential influences on the ways that critical care nurses may think about patients, and has located this study within a wider body

of literature. Chapter three will now turn to setting out the methods adopted in undertaking the study.

3.0 Methodology and Methods

In order to conduct this study into how critical care nurses think about patients, specific objectives were established which guided study design. These objectives are set out within section 3.1, whilst section 3.2 gives consideration to the methodological perspective which needed to be adopted in order to achieve these objectives. This discussion gives particular consideration to the way in which “ways of thinking” were operationalized (section 3.2.2), and to the criteria by which the successful completion of the study may be judged (section 3.2.3). The later sections in this chapter then provide detailed accounts of the methods utilised in the collection (section 3.3) and analysis (section 3.4) of data, and to the writing of the ethnography (section 3.5).

3.1 Study objectives

Clearly it is not possible to directly observe how nurses think about patients. Given this fact the conduct of the study required setting clear objectives at an early stage so as to ensure that appropriate methods were adopted for the collection and analysis of data. These objectives were to:

1. Identify critical care nurses’ different ways of thinking about patients.
2. Articulate these ways of thinking about patients as the features or characteristics of patients which are of primary significance in the discourse of critical care nurses.
3. Identify patterns of nurses’ practice that may be associated with the different ways of thinking identified.

Objective (1) served to highlight that exploring how critical care nurses think about patients primarily involved the identification of ‘different ways of thinking’ together with clarifying this concept as will be outlined in section 3.2. Objective (2) made clear not only that there was a need to develop sensitivity to potential means of differentiating “ways of thinking” (outlined in section 2.3), but also that the ways in which nurses think about patients would be determined from data which related to what nurses did and said. (The implicit claim within this objective that the totality of what nurses say and do can be considered as ‘discourse’ is addressed in section 3.2). Finally, objective (3) addresses the relationship between the different ways in which critical care nurses *think* about patients and the ways in which nurses *treat* or *behave towards* patients.

The above aims and objectives of the study led to the identification of a methodological perspective which was commensurate with these aims and which enabled key concepts to be operationalised for empirical study.

3.2 Methodological considerations

This thesis therefore now turns to introduce the overall methodological perspective adopted in this study into how critical care nurses think about patients. The study overall is characterised within section 3.2.1, and this discussion itself then serves as a background to section 3.2.2 which sets out how concepts from a range of discourse theorists have been considered and incorporated into the study so as to operationalize the concept of “different ways of thinking”.

The above objectives recognise that nurses not only have different views of the world, but also of other people within it. The implication that social reality is constructed by or between individuals places the study firmly within the naturalistic paradigm and therefore in a qualitative research tradition (Polit et al. 2001). The preceding discussion has also made clear that the ways in which nurses think about patients would be identified from what they said and did whilst engaged in clinical practice. Data were therefore collected utilising the methods of participant observation as well as by interview, and for authors such as Burgess (1982), Jorgensen (1989) or Hammersley & Atkinson (1995) these data collection methods themselves are either synonymous with, or the primary feature of, an ethnographic approach. The study examines the culture of critical care as a key influence on the ways that critical care nurses think about patients (see section 2.3.2), and adopts an emic perspective in trying to examine the ‘routine ways’ (Hammersley & Atkinson 1995) in which individuals make sense of the world and others in it. For all of these reasons it is clear that the study may be characterised as ethnography.

Although some authors may define ethnography through its utilisation of the methods of participant observation and interview, writers such as Spradley (1980) make a clear distinction between ethnography and participant observation, and “observational research can vary considerably in its character among different practitioners” (Adler & Adler 1998: p83). It is therefore appropriate to open with further comments on the ways in which this ethnographic study may be characterised.

3.2.1 Characterising the ethnography

All aspects of the design and conduct of the study have been influenced by my own practice and academic background (introduced in section 1.1.1). Whilst a view exists that ‘practitioner research’ is not academically respectable, this view has been challenged by writers such as Reed & Proctor (1995). Throughout this study my identity as a critical care nurse has enabled data to be collected and analysed in ways which would not have been possible to an ‘outsider’. Following Spradley (1980) and Jorgensen (1989), a research journal was maintained in which key decisions and impressions were recorded throughout all stages of the study in an attempt to remain reflexively aware of, and record, the influence of this practice background. In writing field notes based upon my observations, I also had a role as an active producer of data (Kvale 1996; Denzin 1997; Davies 1999). Aspects of data analysis therefore required me to adopt a position of “radical reflexivity” (Davies 1999) which recognised my own role as the author of those texts which constitute data.

The research objectives have intimated that the study may be characterised as a study of discourse. Patterns of verbal communication between nurses and patients in critical care can often be limited, and therefore a view of discourse limited to verbal communication and language would not facilitate the study of critical care nursing practice. It is therefore important to note that discourse theorists promote a view of discourse as:

“a general mode of semiosis, i.e. meaningful symbolic behaviour”

(Blommaert 2005: p.2).

Or alternatively as:

“The social activity of making meanings with language and other symbolic systems in some particular kind of situation or setting” (Lemke 1995: p.6)

The study is therefore shaped by an understanding that critical care nurses make and interpret meaning from a wide range of behaviours. Not only may non-verbal behaviour and other ‘paralinguistic’ cues such as changes in intonation suggest how speech is intended to be contextualised (Gumperz 1999), but “meaningful symbolic behaviour” (Blommaert 2005) extends well beyond speech. Critical care nurses may be anticipated to derive meaning from “other symbolic systems” (Lemke 1995) or alternative “modes of discourse” (Kress & Van Leeuwen 1996)

such as monitoring equipment which may be associated with particular ways of thinking about patients.

Research approaches which analyse discourse may be understood as lying on a continuum between two perspectives. Researchers may utilise a “micro” perspective which focuses on the linguistic features of individual utterances and turn by turn talk as exemplified by a Conversational Analytical approach (e.g. Heritage 1997; Schegloff 1988). At the other end of this continuum lies a “macro” perspective exemplified by Foucault (1969, 1973, 1977) which enables the identification of those Discourses¹ (further discussed below) which reflect and sustain broader social structures. Whilst broad ‘macro’ Discourses may clearly influence how nurses think about patients, the recognition that nurses may move between different ways of thinking about patients requires that close attention be paid to changes in d(D)iscourse from moment to moment.

In order to balance these two opposing perspectives this study adopts the orientation of Linguistic Ethnography (LE). Debates about how LE may be distinctively characterised remain current, though the term may be considered to designate “a particular configuration of interests within the broader field of socio- and applied linguistics” (Creese 2008: p. 229). Consequently LE suggests that ethnography may benefit from paying close attention to the analysis of discourse and situated language use, whilst linguistic analysis is enhanced through a deeper appreciation of ethnographic context and the reflexive sensitivity required by ethnography. Rampton et al (2004:p.4) therefore argue that LE has a role in “tying ethnography down and opening linguistics up”. Above all, by recognising that “that language and social life are mutually shaping” (Rampton et al. 2004: p.2) LE is characterised by the aim of balancing the ‘micro’ and ‘macro’ approaches outlined above.

Although adopting the outlook of Linguistic Ethnography, the methods adopted within this study differ from those which are characteristic of work in an LE tradition. Creese (2008) notes that an authoritative analysis of language use is not *typically* facilitated through participant observation and taking of field notes, and for LE researchers the close analysis of language usually involves the audio or video recording of interactions. Such methods of data collection were not possible within the critical care environment.

¹Throughout the remainder of this thesis a capitalised Discourse is used to refer to discursive formations in this Foucauldian sense. Lower case ‘discourse’ is used for general reference to discourse as “meaningful symbolic behaviour” (Blommaert, 2005). The formulation ‘d(D)iscourse’ is used on occasions where either or both senses may be appropriate.

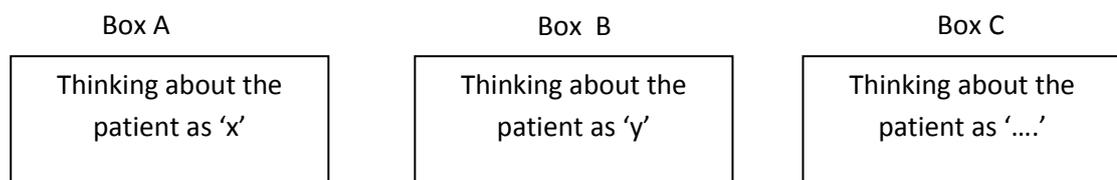
Overall this study can be characterised as adopting the perspective, but not the methods, of linguistic ethnography, and as having required a reflexive stance towards the conduct of the research and the analysis of data.

3.2.2 Operationalising ways of thinking

The above introduction to the nature of d(D)iscourse and the perspective of Linguistic Ethnography enabled the clarification of what may be meant by a ‘way of thinking’ about a patient. As a first step it is important to distinguish different ways in which nurses may think about patients from what they may know about patients. It was noted in section 2.4 that knowledge can be tacit, and that we can know more than we are able to say (Polanyi 1966). Whilst it has been observed what nurses do and say may be considered as discourse, in what follows it will be argued that the different ways in which nurses think about patients may also be conceptualised as a facet of d(D)iscourse. In later sections of this thesis it will be important to note the consequence that nurses may know more about patients than they are able to *think*, as well as that they know more than they can *say*.

It may be noted that suggesting a nurse *should* “think about patients as x” (such as a person) implies that they may actually “think about the patient as y” (such as a body). There are therefore potentially a number of mutually contradictory different ways in which the nurse may think about the patients. This idea is simply expressed in figure 1.

Figure 1: Operationalising ‘Ways of thinking’



Drawing on this model, four elements explain how ‘ways of thinking’ about patients may be conceptualised and are introduced below.

1. *All* of what nurses do and say may be considered as carrying meaning, the totality of which may be considered as “discourse” (Lemke 1995; Potter 1996; Wetherell et al. 2001; Blommaert 2005).

2. The ways in which people use discourse within any context tend to develop into relatively stable patterns (Bahktin 1986) which may be known as discursive formations or Discourses (Foucault 1969, 1973, 1977). In relation to figure 1 above, different ways of thinking about patients are associated with the different Discourses represented by “Box A”, “Box B” etc.

3. These patterns in the way that people talk and communicate (Discourses) set up the way in which nurses “frame” their sense of ‘what it is that is going on’ in any particular interaction (Goffman 1974). Consequently the Discourse represented by Box A may be understood as framing what is going on as involving ‘x’; the Discourse represented by Box B frames what is going on as involving ‘y’.

4. Discourse is intimately connected with identity (Goffman 1959, 1963, 1974; Lemke 1995; Potter 1996; Wetherell et al. 2001; Fairclough 2003; Blommaert 2005). The Discourse represented by Box A not only frames what is going on as involving ‘x’, but ascribes the patient an identity as ‘x’. A nurse who adopts the Discourse represented by Box B may be understood as ascribing the patient an identity as ‘y’.

In summary, patterns in what nurses do and say may be recognised as Discourses, each of which frames the patient in such a way as to ascribe them an identity as a particular kind of being. A nurse who frames their sense of what is going on as involving ‘x’ may therefore be said to be thinking about the patient as ‘x’ and this may be inferred from patterns in what nurses do and say. The notions of ‘frame’ and ‘identity’ which underpin this conceptualisation of different ways of thinking about patients are expanded upon below.

Goffman (1974) sets out the concept of “frame” which may be broadly considered as a persons’ sense of ‘what it is that is going on’ within a particular interaction. For Goffman all talk can therefore be seen as a “shifting stream of differently framed strips” (Goffman 1974: p. 544). The relationship between ‘frame’ and ‘Discourse’ can be seen to be primarily a matter of perspective. From a ‘micro’ (Goffmanian) perspective, in any one interaction a nurse will frame their sense of what it is that is going on and this will involve thinking of the patient as a particular kind of being. From a ‘macro’ (Foucauldian) perspective, recurring patterns in what nurses say and do may be recognised as Discourses which construct the patient as a these particular kinds of being. The practice of critical care nurses may therefore be conceptualised as reflecting Discourses which

they may move between in every interaction, and each of which 'frames' the patient in a particular way.

Discourse theorists (e.g. Goffman 1959, Lemke 1995, Potter 1996, Wetherell et al. 2001, Fairclough 2003, Blommaert 2005) highlight that identity is central to concepts of discourse and that:

"People don't have an identity, but ... identities are constructed in practices that produce, enact, or perform identity" (Blommaert 2005: p205)

A further distinction can be made between the identity which people achieve or inhabit, and the identity which is ascribed to them by others (Blommaert 2005). All discourse therefore reflects the ways in which people both assert their own identity and ascribe a particular identity to others. The ways in which critical care nurses think about patients may therefore be understood as being the identities or roles which nurses *ascribe* to patients through their d(D)iscourse.

The aims of this study include an exploration of whether critical care nurses think of patients as persons, and it is important to therefore recognise that an 'identity' need not be an identity as a person. Lemke (1995) notes that our "common sense" notion of a human individual is itself constructed through discourse, and it must therefore be recognised that discourse is itself the site at which personhood (or a patients' identity as something other than a person) is constructed. This point is significant given that an exploration of how critical care nurses think about patients clearly cannot begin with any prior understanding of what may count as thinking about the patient. To assume that nurses are *not* thinking about patients when they are engaged in apparently routine activity, discussing a medical case on a ward round, or making judgments solely on the basis of technology and information from monitoring equipment is to make assumptions about what counts as thinking about the patient in the first place.

It was noted in section 2.4 that discourse theorists generally eschew cognitivist models of 'thinking', and yet the suggestion that a nurse may think about a patient as 'x' rather than as 'y' is one which has an initial simplicity and resonance. In referring to this phenomenon it is recognised that linguistic purists may prefer references to "the identity ascribed to or constructed for the patient through the nurses' d(D)iscourse" or to "the 'kind of being' constructed by the way in which the nurse frames a particular situated interaction". For simplicity, and recognising that the study is written for an audience of practitioners, the term 'ways of thinking' about patients is retained throughout the remainder of this thesis except where context demands absolute clarity.

3.2.3 Criteria for successful completion of the study

Prior to presenting the methods adopted for the collection and analysis of data, it is necessary to outline the criteria against which the findings of the study may be considered trustworthy in the sense of “being worth paying attention to” (Lincoln & Guba 1985: p.290). It is against these criteria that the adequacy of these methods (and other aspects of the study) may be judged.

Hammersley (1990) notes qualitative research should be evaluated against criteria which are dependent both upon the aims of the research and its intended audience. The value of this study lies in its potential to inform individual critical care practitioners and those who educate them; nurse leaders and policy makers who seek to understand, articulate and promote ideals of person focussed or person centred care, and nurse theorists and scholars with an interest in articulating the nature of nursing practice and nursing expertise.

Hammersley (1992) further argues that importance implies relevance. In order to be worth paying attention to this study must itself make clear that the way(s) in which critical care nurses think about patients is of relevance to the concerns of practicing critical care nurses. In order to be relevant to nursing scholars it will also be important to situate the findings and conclusions of the study within an appropriate body of literature, whilst relevance to the concerns of nurse leaders and policy requires that the study draw conclusions which may be clearly articulated and translated into pragmatic recommendations.

Given that this study seeks to explore highly abstract and novel concepts, the credibility of the study is particularly dependent upon its epistemological and methodological adequacy (Gómez 2009). Whilst the above discussion has addressed the methodological coherence between the aims of the research and the operationalization of key concepts, “epistemological and methodological adequacy” requires that this coherence be sustained throughout data collection and analysis. Following Lincoln & Guba (1985), the credibility of the study also rests upon demonstrating that the data gathered is sufficient to support the analysis presented and this point is discussed in relation to the issue of saturation in section 3.3.

The trustworthiness of a study is also dependent upon its confirmability which may be taken to refer to the objectivity or neutrality of the data (Polit et al. 2001). Although the need for ‘objectivity’ may be disputed, this criterion highlights the need to remain reflexively aware of and make explicit my own influence on all aspects of the study. In the context of a study investigating

the abstract and contestable phenomena of 'different ways of thinking', confirmability may also be enhanced by maintaining clear distinctions between the results of data analysis, and the interpretations which may be made of these findings.

Trustworthiness also requires that the data and analysis presented are dependable (Lincoln & Guba 1985). It is therefore important that this report itself establishes my own credibility as a researcher, and a clear audit trail documents all key decisions and processes in undertaking the research. The aim in doing so must be to enable the reader to form an overall judgement of the quality of the processes of data collection, data analysis, and integration of the findings with existing theory. As a final criterion, the study must consider the transferability of these findings to other settings (Lincoln & Guba 1985). This will require providing sufficient rich description of the study setting for readers themselves to make judgements about whether findings are transferable. The transferability of these findings to other nursing contexts also requires that explicit consideration be given to differentiating those findings which emerge from the epistemological and methodological grounding of the study, and those which arise due to the substantive focus on critical care practice.

3.3 Data Collection

Having considered the methodological approach adopted to the study, this section opens with a broad overview of the methods by which data were collected and analysed prior to discussing particular aspects of data collection in greater detail.

The study was conducted on a single critical care unit and data collection lasted for a period of 8 months between 2006 and 2007. During this time field notes were generated from a total of approximately 92 hours of participant observation over 23 occasions. Due to the recognition that expertise or experience may be a significant factor in the way that critical nurses think about patients participants were selected from 'experienced' and 'inexperienced' groups. Saturation in these data was reached after spending three or four occasions (each lasting 3-6 hours) observing the practice of seven different participants. Tape recorded interviews were also conducted with each participant on two occasions during which participants were asked to comment upon and discuss episodes of care that had been observed.

Ethical approval for the study was sought and given by a local Research Ethics Committee (see Appendix 2 for LREC confirmation letter). After discussion with the Trust Caldicott guardian it was determined that written consent from patients was not necessary. A poster explaining the nature

of the research was placed within the relatives' waiting room, and the purpose for my presence was explained to all patients or their next of kin. Verbal consent was sought from patients, or (where this was not possible) verbal assent from their next of kin, none of whom raised any objection to taking part in the study. All patient related data captured within the field notes were fully anonymised.

Each participant gave written consent to take part in the study. It was also acknowledged throughout the study that the processes of observation and interview carried a risk of causing distress to participants if sensitive or painful issues were raised. I remained sensitive to these potential issues throughout data collection, and referral channels to appropriate support services were established prior to commencing the study. Other ethical considerations are incorporated within the discussion below.

3.3.1 Site selection and negotiating access

Given the potentially complex interplay between the ways in which individual nurses may think about patients and the culture of a critical care unit, it was decided to restrict the focus of the study to a single study site given that comparative study designs carry inherent risks of undertaking a less complete analysis (Wolcott 1994). In order to capture different ways in which critical care nurses may think about patients it was important to select a site with a heterogenous group of patients. Tertiary specialist critical care units (e.g. cardiothoracic or neurological speciality units) were therefore discounted, and the selected unit accepted patients with both level 2 and level 3 critical care needs (a mixed high dependency and intensive care unit. See figure 2).

Figure 2: Levels of Care (Department of Health 2000)	
LEVEL 0	Patients whose needs can be met through normal ward care
LEVEL 1	Patients at risk of their condition deteriorating. Enhanced ward care
LEVEL 2	Patients requiring close observation, including support for a single organ system.
LEVEL 3	Patients requiring advanced respiratory support, or basic respiratory support together with support of at least two organ systems.

Pragmatic considerations required that the study site was accessible for daily travel from my home base, and that I was not already well known to participants in a non-research capacity. The study site selected was a 10 bedded mixed adult critical care unit (henceforth referred to as 'The Unit') located in a District General Hospital in England.

Initial access to the Unit was negotiated through the lead nurse. This facilitated a series of discussions with groups of nursing staff, the medical director of the unit and senior members of the nursing team in order to explain the nature and purpose of the research prior to commencing fieldwork, and to gain the support of staff for undertaking the study. Written information explaining the nature of the study was made available to all staff working on the unit who were not able to attend these discussions (Appendix 3). Final written approval to access the site was obtained from the unit manager (Appendix 4).

3.3.2 Defining the field

The focus of the study was upon how critical care nurses think about patients whilst engaged in any form of activity relating to patient care. The field of study was therefore limited to the practice of nurses involved in the direct delivery of care and no attempt was made to explore how nurses acting in leadership, management or educational roles may think about patients. Nursing practice relating to the care of a particular patient was considered to include any verbal or physical interactions with a patient, and any discussion about patients anywhere within the unit environment (e.g. handover, ward rounds or coffee room conversations). Participants were made aware of these issues during the process of gaining consent.

Within these constraints, no limit was set to what counted as the 'field' prior to commencing data collection. My research journal records two occasions on which I had doubt about whether to include a particular interaction. My reflections on one such incident were recorded within my research journal as follows:

One informant made a comment to me in what appeared as a conscious attempt to demonstrate her grasp of 'proper words'. Unfortunately the comment she made was a malapropism which at the time I noted in the field log as interesting. On writing up notes however, I feel that this record only serves to make this nurse look stupid. I would not be happy to draw publicly on this as to do so would betray the trust of this informant.

Research Journal: 22/11/2006

Although my research journal contains some reflection on the appropriateness of including some data, the above extract represents the only retrospective limiting of the field.

3.3.3 Sampling

The review of the literature strongly suggests that expert nurses may think about patients in different ways to non-experts, and it was also recognised that nurses who are new to critical care experience challenges in adapting to the culture of critical care (Reising 2002; Farnell & Dawson 2006; O’Kane 2012). These factors were therefore reflected in the recruitment strategy and it was planned to recruit both experienced critical care nurses, and nurses who were new to the speciality as participants.

The initial aim was to recruit three experienced nurses and three ‘inexperienced’ nurses according to predetermined inclusion / exclusion criteria set out in figure 3 below.

Figure 3 : Inclusion / exclusion criteria for selection of participants	
Group	Criteria
‘Experienced’ Nurses	<p>More than two years’ experience working within the unit under study.</p> <p>Possession of a qualification in intensive care nursing (ENB 100 or recognised equivalent²).</p> <p><i>In addition to ensuring substantial experience in caring for the critically ill, the requirement for two years’ experience on the unit reflected an understanding that participants needed to be in a position to understand and articulate the local culture and explain ‘how things are done here’.</i></p>
‘Inexperienced’ Nurses	<p>No previous experience of working within a critical care setting.</p> <p>Less than six months experience within the unit at the commencement of the study.</p>

² Prior to 2002, the English National Board (ENB) validated post-registration nursing courses within the UK and the ENB 100 course was the recognised training for Intensive Care Nursing. In the years immediately after 2002, many Higher Education Institutions continued to offer educational courses which were widely recognised as being equivalent in content to the previously existing ENB 100.

Initial participants were selected from volunteers who offered to take part in the study, and later participants were directly approached during the course of field work. All participants were given a written participant information sheet (Appendix 5) prior to giving written consent for their participation in the study. Participants have been fully anonymised in the field notes and in the presentation of this thesis.

This planned recruitment strategy was successful in enabling the identification of staff with differing levels of experience (and hence potentially differing levels of expertise) within critical care. Due to the small numbers of new staff beginning employment within the unit, only three nurses were encountered who met the criteria for the 'inexperienced' group, and all three agreed to participate (Nurses 2, 3 and 6).

Serendipitously one nurse meeting the criteria for the 'experienced' group approached me on the first day of field work volunteering to take part in the study. In order to recruit further participants, I purposefully sought out nurses who demonstrated apparently differing approaches to nursing practice. This was in part achieved through asking other staff on the unit if they themselves could suggest nurses whose practice was distinctively different to that of the participants already recruited. This strategy led me to approach one nurse who declined to take part in the study, but who was nonetheless able to suggest that the nurse eventually recruited as Nurse 7 was "just like me". Other participants were recruited when my own observations led to the identification of individuals who appeared to talk about or behave towards patients in ways which were distinctive. This included one participant who, whilst having worked on the unit for 27 years, had not undertaken an academic qualification in intensive care nursing and who went out of her way to present herself as "not academic" and therefore different to others. Although this participant did not formally meet the predetermined inclusion criteria, I was able to recognise that this reflected my own assumption that experienced nurses would have undertaken such training. This participant was recruited in part because I considered that she might think about patients differently as a result of not having had this exposure to academic and theorized understandings of care (as ultimately proved to be the case). One participant unfortunately left employment on the unit part-way through the study, and therefore four experienced nurses were finally recruited to the study (Nurses 1, 4, 5 and 7).

Each participant was observed caring for a range of patients at different times and in different situations. This was achieved through liaising with both the participants and with the senior nurses responsible for patient allocation prior to each period of observation. Early in data collection it became clear that nurses' practice could appear different in different circumstances,

and was particularly dependent upon whether patients were receiving level 3 care or level 2 care (see Figure 2 above). Other factors included taking account of whether or not the patients was being cared for in a side room, whether patients were previously known to nurses, or the fact that later in the day nurses would typically spent more time interacting with visiting patient relatives. Periods of observation were therefore planned to ensure that any potential influence of such factors on the way in which nurses thought about patients were captured within the data. These considerations demonstrate that both the selection of participants and the situations in which they were observed were informed by the principles of theoretical sampling in response to early findings in the field.

3.3.4 Field / researcher role and fieldwork considerations

The seminal work of Gold (1958) highlights that any observation requires some degree of participation. This raises the question of my own identity in the field although in terms of the roles set out by Gold (1958) I was neither “complete observer” nor “complete participant”, but oscillated between the positions of “participant as observer” and “observer as participant” whilst engaged in data collection. Given that field roles are “played” (Gold 1958) the sections below give consideration to the ways in which I managed my own identity in the field.

My ‘field role’ was explained to other participants as being that of a ‘Research Nurse’. This had the benefits of openness and honesty over the primary purpose of visiting the field, and highlighted my identity as researcher (thus legitimizing an observational stance and asking of naïve questions). Claiming this role also highlighted my identity as a registered nurse and thus asserted a degree of expertise or familiarity within the setting. It was notable that my being a nurse was considered by the unit staff to be a pre-requisite for my gaining access to situations where intimate nursing care was being delivered. In addition to legitimising my participation in care delivery, my identity as a registered nurse also meant that I retained professional responsibilities under the Nursing and Midwifery Council Code (NMC, 2008). These responsibilities led to the development of guidelines relating to how I would ensure patients safety which are set out in Appendix 6 and further discussed below. The operationalization of these guidelines also made it necessary for me to negotiate and agree the scope of my own practice with the unit manager prior to commencing data collection.

My being a nurse was not the only identity which was of concern to participants. As a ‘research nurse’ it was clear that I was present in the unit as a researcher, but on occasion other identities became relevant. At times it was highlighted that I was a man (for example through comments

about the 'tidiness' or otherwise of male nurses), and my identity as an educationalist could also become an issue as I was asked to 'teach' or 'explain' to others. A key challenge throughout fieldwork thus related to 'identity management' (Ten Have 2004) or the 'identity work' which Allen (2004) notes as a key challenge for nurse ethnographers. Although I was transparent and open about all of these roles, the primarily observational nature of my role was highlighted to both participants and to other staff (particularly to shift leaders to emphasise that the role did not involve any degree of supervision of participants' practice). There were a occasions when I considered that it would be more awkward to avoid "explaining" than to briefly slip into the role of "educator", although these were all within group situations rather than during the direct delivery of one to one patient care.

Due to my prior knowledge of Critical Care environments I was aware that critical care nurses may be used to being shadowed. Depending on their own level of experience nurses will often work directly alongside others such as students, other novice nurses, or clinical educators. As the research nurse I therefore shadowed participants and invited them to consider me as a nurse who had some knowledge of critical care nursing, but who did not 'know how things are done here'. Working alongside nurses in this way enabled some degree of direct participation in care (such as assisting with washing or turning patients), without requiring me to assume primary responsibility for patient care. The role could thus therefore be characterised as a "peripheral membership role" (Adler & Adler 1998) within the unit culture.

These strategies were generally successful in enabling me to participate in the delivery of nursing care sufficiently to gain access to the immediate bedside whilst maintaining a primarily observational role. I was accepted as an 'insider' quite readily by unit staff, and my research journal highlights my surprise that I was trusted to 'watch' a patient whilst Nurse B ran short errands on only the second day in the field. This sense of acceptance was important to me in gaining confidence within the field, and in feeling that I (as a novice researcher) had a right to be present in the practice environment in this new capacity.

Once in the field the balance between participation and observation needed to be actively managed. On the second occasion I worked with Nurse 6 she appeared to be stressed by how 'busy' the shift was, and my research journal recorded that:

She was quite conscious of my presence and in order to manage her slight discomfort and the anxiety provoked by other circumstances in the shift I found it necessary to

adopt a more participatory stance. This included running ABG's³; administering fluids for her patient; and initiating some actions such as giving oxygen breaths⁴.

Research Journal: 15/12/06

On this occasion I felt that my presence as an observer was contributing to Nurse 6's anxiety, and I stepped into a role of assistant or guide for short periods of time until her anxiety abated sufficiently for me to step back into a more observational role.

A final challenge in balancing my role as an observer was ensuring that patient safety was not compromised by the research. It was recognised that the close observation of nursing practice could have led to the witnessing of situations where patients were put at some risk, particularly when observing the practice of less experienced nurses. In order to maintain a balance between the need to protect the confidentiality of participants and the need to maintain patient safety, principles were agreed between myself and the lead nurse for the unit prior to the commencement of the study (see Appendix 6). These principles set guidelines relating to how I would respond in the event of clinical emergencies, and differentiated how I would manage encountering "sub-optimal practice", "professional misconduct or incompetence" or "embedded poor practice". Participants were made aware of these principles and of the potential limits of confidentiality as part of the process of gaining informed consent.

Although the field notes do record occasions on which I drew on these principles, these issues were not generally problematic, and occasions when the practice of less experienced nurses could have compromised patient care (for example through failing to respond to deterioration such as hypotension and / or oliguria) were usually resolved by questioning the nurse about what she was doing which would prompt her to seek advice.

The most troubling aspects of maintaining a field role did not relate to patient safety, but to some nurses' patterns of communication with patients. This was captured in the following journal entry

Some difficult balancing issues again. {Participant} does not often talk to sedated patients when she is with them, even when undertaking procedures. Whilst my own

³ Arterial Blood Gas samples which needed to be analysed by a machine situated on the unit, but away from the immediate bedside.

⁴ Oxygen breaths. Delivering 100% oxygen via the ventilator as an initial response to a deterioration in the patients' condition.

inclination is to engage with patients much more, I am also aware that my doing so could have a profound effect in refocusing her and alter her own behaviour. I therefore make a conscious decision to try to mirror the level of interaction she is making with the patient. This feels uncomfortable, it is a way of practicing with which I am familiar as it is easy to 'fall in to', but in my own practice I would make conscious efforts to resist this and to remain focused on the patient. I try to ensure that I am interacting at least a little more than she is, as it is equally possible that she could follow my lead and talk less if I did not.

Research Journal 01/02/07

This led to a sense of discomfort which I had to learn to live with for much of the time in the field. These issues were particularly significant given that nurses patterns of communication were a major focus of observation, and (as the above passage indicates) I was aware that any effort on my part to 'role model' what I saw as good practice would be likely to dramatically alter the practice of participants.

3.3.5 Observation

Periods of observation varied in length from 3 to 6 hours whilst participants were engaged in the care of a specific patient (or occasionally 2 patients). Periods of observation covered at all times of day between 07.00 and midnight, and were planned to include observation of key activities such as handover, the initial meeting of a nurse and patient, ward rounds, and family visits. The suggestion of Clifford (1990) that observation cannot be effectively maintained for longer than around 4 hours was used as the basis for planning periods of observation, and this was found to be a reasonably accurate rule of thumb. Individual decisions to end each period of observation were influenced by factors such as the need to stay and observe a particular nurse giving handover, or through gaining a sense that no new patterns of practice were being observed in the interactions between that participant and patient.

During early periods of observation a broad focus was maintained in order to gain wider knowledge about the study site, although this focus soon narrowed toward the observation of participants' individual interactions with patients. The features of nurse-patient interactions identified as potentially salient in section 2.3 served as a valuable means of establishing an appropriate initial focus for observation. An additional constant focus of observation was to try to capture those changes or breaks in practice which may indicate a change of frame or d(D)iscourse which was associated with a different ways of thinking about patients.

The focus of observation was also informed by issues and themes which emerged whilst in the field. One example of such an issue involves the use of technical or medical terms:

Nurse 3 comments to me ... that she had not been able to prove that Mr Langden was 'well-filled' before, as she had not been able to aspirate on the central line in order to get an "SvO₂". I am struck once again by the fact that SvO₂⁵ is only ever referred to on the unit as an indicator of a patients' fluid status.

Field Notes: Nurse 3

My own familiarity with terms such as SvO₂ here led to a recognition that Nurse 3's understanding of this term was not the same as mine, and so to a heightened awareness that 'technical' or medical terms did not always have single or stable meanings for nurses. An observational focus on these issues gained greater significance in relation to other data. Chapter six will discuss one such incident in these data when the meaning of an abnormal 'Ejection Fraction' extended beyond a 'technical' definition⁶ to construct a patient as a person who was unlikely to survive.

3.3.6 Recording Data

Field notes were initially recorded in an A5 booklet which had been prepared for the purpose, and which could be fitted into a pocket of the 'scrubs' worn by nurses on the unit. Separate entries were made for discrete episodes of care which were usually delineated in time and marked by the nurse physically moving away from the patient, or by some other clear change of activity.

Although I often felt self-conscious in taking notes at the bedside, this was rarely a concern for participants except on a very few occasions when I considered it appropriate to share what I was writing in order to reassure participants when they appeared disconcerted or perplexed by the process. During activities such as handover, note taking is a legitimate and expected activity and I could take absolutely contemporaneous notes with ease. Similarly, when nurses were particularly 'busy' with their patients (e.g. during physiotherapy; talking with patients; responding to alarms) it was generally possible to withdraw to a position where both observation and unobtrusive note taking was possible. Where writing notes was not possible without being intrusive, I would find means of withdrawing after an episode of care by volunteering to undertake minor errands (e.g.

⁵ SvO₂ Mixed venous oxygen saturation.

⁶ Ejection Fraction. The percentage of the contents of the left ventricle ejected during systole. An important determinant of cardiac function established by echocardiogram.

taking linen to the sluice; taking blood gas samples for analysis) thus giving me time away from the bedside to make notes.

During the initial recording of field notes patients were referred to solely by letter (Mrs Z, Mr X and so on) using letters from the end of the alphabet in order to clearly distinguish them from nursing participants who were initially referred to as Nurses A to G within the field notes. (With the exception of Chapter 4 where these participants are introduced, data extracts in this thesis are attributed to Nurses 1-7 as an additional means of ensuring participant anonymity). In the full write up of notes patients were given synonyms by which they are referred to throughout this thesis. Patients are referred to by surname (Mr Norton; Mrs Green) except where staff themselves referred to patients by first name where synonyms are used (e.g. "Lance").

There was a strongly reflexive element to the writing of notes in the field. As I recognised specific exchanges or incidents as being significant, I was forced to reflect upon which features of the interaction had stood out to me. Adopting Spradley's (1980) 'concrete principle' which emphasizes the need for specificity in language, this required maintaining a reflexive awareness of my own immediate interpretations so as to ensure these were recorded alongside 'objectively' observable features of those interactions. The identification of these observable features was facilitated by a prompt list within the booklet in which data were recorded. This provided a constant reminder to record features of discourse (e.g. tone of voice, positioning, gaze, use of humour, physical or psychological intimacy or use of technology) which would form the basis of later analysis.

Initial field notes were used as the basis for writing an expanded account within 24 hours of completing each period of observation. In order to avoid a perceived false dichotomy between 'objective' and 'subjective' observations, personal feelings, emotions and other reflections which were recorded as arising contemporaneously with observation were included within the expanded field notes. The following field note extract illustrates this as it highlights the same discomfort with some aspects of one participant's patterns of communication mentioned above in relation to my field role in section 3.3.5.

Nurse 7 asks me to roll Mr Norton towards me slightly so that she can see better, and I feel awkward at the limited communication to the patient in all of this although I feel that I should follow her lead rather than influence the way in which she is practicing. I roll him over with only a superficial comment about his coming onto his side directed

to Mr Norton himself. Once he is on his side, Nurse 7 prods and probes once more at Mr Norton's side. Her only commentary is to me as she tries to highlight to me the extent of his cellulitis.

Field notes: Nurse 7

The note that "I feel awkward" was recorded contemporaneously and therefore retained within the field notes, whereas my subsequent reflections on the reasons for and significance of this issue were recorded in the Research journal (as discussed above in section 3.3.5). This approach both enabled impressions gained in the field to be revisited during analysis, and helped minimize any post-hoc rationalization of my own feelings and impressions.

Despite attempts to remain aware of my personal interpretations of interactions, it became clear during data analysis that the status of some field notes entries remained ambivalent. On occasion my initial field notes appeared to make claims about the mental states of others, or utilise 'fuzzy' concepts emerging from early analysis. The analysis of these data required that care was taken to make clear which 'identity' or 'voice' these comments were spoken from and to make the constructed nature of this text more explicit. In the later stages of data analysis key passages of text were reviewed and re-written in order to remove such ambiguities. The highlighted changes in figure 4 overleaf illustrate this process, and are further discussed and explored in Appendix 7.

Figure 4: Revision of field notes

Original

As his breathing settles once more Nurse 5 begins speaking to him again but there is a clear change in her voice. She is speaking quieter now and her tone appears to convey some sympathy for the distress this is causing. She explains that she will need to perform suction again, and does so. The focus of her gaze has narrowed further now, and she is intently focussed looking to Mr Young's face and the movements of his chest.

Revised (changes highlighted)

As his breathing settles once more Nurse 5 begins speaking to him again but there is a clear change in her voice. I note that she is speaking quieter now and that there are changes in her intonation. It is my feeling that this procedure has been distressing for Mr Young and I interpret these changes in {participant}'s intonation as conveying sympathy for this. She explains that she will need to perform suction again, and does so looking only at Mr Young's face and the movements of his chest. I gain an impression that this more restricted gaze represents a narrowing of focus which may be significant to the study.

Field Notes: Nurse 5

Within each days' field note entry I also recorded 'general impressions' of that shift (usually based upon notes made on the train home). These impressions summarised features of that period of observation which I considered particularly significant to the aims of the study, and included elements of reflection as well as some initial analytical insights. As such these impressions formed a bridge between the contemporaneous observation recorded in the field notes, and the more extended reflections recorded within the research journal. These 'general impressions' also recorded information I had gathered about the unit more widely and were of particular value in developing the overview of the unit presented in chapter four.

Several references have been made to the research Journal which was maintained as a single electronic document to which dated additions were made. Entries within the journal recorded both early analytical insights, and reflections on many aspects of the research process in note form. The following extract illustrates the value of these notes in preparing this section of the thesis.

Taking field notes is generally unproblematic. I can often take absolutely contemporaneous and detailed notes whilst nurses are concentrating. At other times I leave to make notes at the end of an episode. Nonetheless I occasionally receive comments from participants about “there you go again”. I received one such comment from {participant} today who was wondering what on earth I could be finding to write about during a particular episode⁷. I made the judgement at this time that I would share this with her.

Research Journal 28th Feb 2007

3.3.7 Leaving the field

Data collection lasted for approximately 8 months, and each participant was observed caring for a range of patients until no new patterns of behaviour were observed in that nurse’s practice. Although full analysis of these patterns was not complete I nevertheless had a very clear sense of when it would be possible to stop working with a particular participant. This is demonstrated by the following reflection on the final period of observation with one participant.

I felt a fairly clear sense again that I was not seeing anything new in Nurse 6’s practice during this shift than I had seen in previous episodes, and felt reassured that I would have no need to conduct further periods of observation with this participant.

Field Notes: Nurse 6 (Shift General impressions)

As I spent time with the final study participants I also gained a sense that no new patterns were emerging within the study overall. The following Research Journal entry was recorded a month before completion of data collection during my second period of observation with the last participant to be recruited.

I found this shift to be very difficult in that I felt like I was seeing nothing new, and sometimes that I was seeing nothing at all.

There are several possibilities that spring to mind in this regard

⁷ This episode in fact highlighted her quite peripheral level of participation in the ward round discussions.

- Not a lot was happening during the shift. This made it difficult to adopt an appropriate stance at times as opportunities for participation were limited.
- Have reached saturation in data. This is possible.
- Have gone 'native'. It is certainly difficult to see some of this practice as 'anthropologically strange', and I find myself accepting aspects of practice as less problematic but this may simply be my becoming more comfortable in the participant observer role.
- Have lost a focus for observation in regard to the aims of the study. Losing focus does not seem to be particularly likely. I have experienced this before, know what it feels like, and have always managed to bring myself back to an appropriate focus in the past.

Research Journal: 5th July 2007

This record demonstrates the consideration given to issues of data saturation whilst in the field, and my consideration of other potential explanations for my sense that I was not seeing anything new. Following this Journal entry, no new apparent patterns of practice or new analytical insights were gained in the final periods of observation before making the decision to leave the field.

3.3.8 Interviews

In addition to the methods of participant observation discussed above, data were also obtained through audio recorded interviews with each of the seven primary participants. The aim of these interviews was to elicit participants' understandings and descriptions of episodes of care which had been observed.

Nurse 1 left employment on the unit midway through her participation in the study and gave only one interview. Other participants were interviewed both immediately after the first period of observation, and on a second occasion at a mutually convenient time soon after the final period of observation with that participant. During these second interviews participants' recall of events was often prompted by asking them to read and comment upon extracts from the field notes. Participants were encouraged to reflect upon the way they may have been thinking about patients and upon their goals and motivations during these episodes. Although these accounts were not naively understood to reflect what participants were 'really thinking', they offered an additional means of studying discourse and the ways in which nurses talked about their practice as discussed below in section 3.4.4.

Each interview began with initial ‘broad survey’ questions inviting participants to comment upon issues which they felt were of significance. After this the first interview with each participant simply ‘talked through’ events of the preceding shift chronologically. In the second interview participants were asked to comment upon selected episodes of care which appeared particularly significant to the aims of the study, often by asking participants to read the field note entries in which incidents were described. Following Fetterman (1998), interviews were conducted in a relatively informal style which aimed to mimic the form of a conversation in which questions are embedded. A schedule of questions / prompts was devised in order to guide questioning about specific interactions (see Appendix 8) although the usage, phrasing and sequencing of questions and prompts was varied in order to maintain a natural flow in the conversation during interviews. I soon noted that participants would often address me as a fellow critical care nurse during these interviews. Intuitively feeling this to be important I encouraged this by wearing ‘scrubs’ when conducting interviews regardless of whether or not I had actually been directly observing practice on the unit at that time.

Interviews were audio recorded and transcribed utilizing the primary conventions of standard Jeffersonian transcription as set out by Wetherell et al. (2001). Figure 5 sets out some of the most common conventions whilst Appendix 9 provides a complete list of all transcriptions symbols used within this thesis.

Figure 5 : Key conventions in Jeffersonian transcription

(2)	Number in brackets indicates a pause in seconds
(.)	Short (untimed) pause
((<i>italics</i>))	Double bracketed italicised text indicates nonverbal activity or other commentary
(guess)	Words in a single bracket indicate a “best guess” at an unclear fragment of speech
<u>Under</u>	Underlining indicates speaker emphasis
[]	Onset and end of overlapping talk
[[Double left bracket indicates speakers start a turn simultaneously

From Wetherall et al (2001).

After this ‘first pass’ transcription the primary audio records were retained and listened to during the stages of analysis. Where necessary to inform analysis of key passages these were subjected to more detailed transcription and annotation.

The aim during interviews was to maintain a supportive environment in which participants would feel free to talk about and reflect upon their practice. Avoiding implicit criticism of informants was challenging at times, and the following extract illustrates how 'difficult' questions were typically handled. The length of the extract is itself an illustration of a somewhat oblique approach as I inquire about problematic aspects of the incident in question.

[Int = Interviewer: N=Nurse / participant]

Int Do you remember what happened whilst you were actually helping clean her up when she had been on the commode? Was there anything about that how were you focussing on the patient at that point (.) do you remember?

(3)

N I think I was just explaining how cold the wipes were ((*laughs*)) [I can't] remember (.) er

Int [OK]

(3)

N I can't remember

Int I think you did do (.) you did do some of that you did make some comments about the wipes. But at that point you turned to me and you were talking to me about the teaching job that you

N [[O yes

Int [[that you may have. And I just thought that struck struck (1) struck me. I wondered how it was so normal for you to be doing something that was a pretty personal act that you were actually doing at the time.

N [[Hmmm

Int [[And yet you were having a conversation with me about a potential future career at the same time as you were actually cleaning up y'know (.) the faeces. Do you remember doing that?

N I did actually. I did. I really did not think about it (.) if I've (0.6) affected .hhh the way of thinking about the situation

Int Ok. You don't remember doing How does it feel for me to point that out to you now? Do you think that is something that [everybody here would do?]

N [Now?]

Now I feel like (1)] I have done something a bit (1.2) ((*shakes head*))

Int I'm sure (.) I don't think you should (.) I'm not putting this to you to make you sort of beat yourself up. I'm just asking you to reflect. What was it that (1) why

did you (.) do you know what it was that made you take your eye off the patient in that sense?

N ((*Tone drops and voice slows*)) Well I guess I was just used to this kind of thing. You know that sometimes you forget that you are with a person

Int Right. Ok

N Now you have made me realise.

Nurse 3: First interview

Within this transcript from an interview on the first day in the field it is clear that the admission or realization of this participant that she could “forget that you are with a person” is of direct relevance to the aims of this study. This episode also demonstrates the nature of the data obtained through these methods given that this data could not have been obtained without prior direct observation of this nurse’s practice. It is also clear that this participant talks about her practice in ways which conflict with the behaviour which I had observed, although it is only retrospectively (and in the context of an interview) that she constructs her earlier behaviour to have been problematic. The relationship between the practice of critical care nurses and the ways in which they talk about that practice are therefore complex, and are considered further in relation to the approaches taken to the analysis of these data.

The presentation of the above extract makes use of Jeffersonian transcription in order to make clear the hesitant and incremental way in which ‘difficult’ topics were sometimes broached in interview. This was a necessary step in the analysis of these data but does not always add clarity in presenting these findings. Throughout the remainder of this thesis such notation is retained only where it adds to the reading or interpretation of the data presented or illustrates a significant aspect of data analysis. In ensuring that findings are presented clearly the majority of interview data are presented without such notation, and with redaction of minor repetitions or indications of hesitancy which characterise normal speech.

3.4 Data Analysis

A key purpose of presenting these methods is to provide a clear audit trail of processes and decisions made so as to enhance the dependability of the study (Lincoln & Guba 1985). In order to describe the approaches taken to data analysis it is necessary to acknowledge that the full research design emerged during the course of the research (Polit et al. 2001). The status of the interview data, and the conceptualisation of ‘different ways of thinking’ presented in section 3.2 were not fully clarified at the outset of the study. Consequently the analysis of data began with

the aim of identifying patterns of practice within the field note data that may be associated with different ways of thinking about patients (referred to in objective 3 of the study).

Data analysis began with analytical insights that occurred in the field and which served to guide my focus in subsequent observation. The writing up of field notes and transcription of interviews, together with subsequent reading and re-reading of these data led to an immersion in the data prior to adopting more formal analytical approaches. These more formal early approaches to analysis were informed by the understandings gained from a wide range of ethnographers (Spradley 1980; Burgess 1982; Devons & Gluckman 1982; Geertz 1983; Jorgensen 1989; Adler & Adler 1998; Baszanger & Dodier 1997; Denzin 1997; Fetterman 1998; Davies 1999; Hammersley 1992; Hammersley & Atkinson 1995; Tedlock 2000). Whilst ethnographers resist the notion that analysis may be broken into discreet stages and highlight that ethnographic analysis is "iterative and often cyclical" (Fetterman 1998), a clear exposition of the methods adopted nevertheless needs to proceed in some linear fashion. Brewer (2000) offers a relatively straightforward framework, and the early stages Brewer describes in figure 6 offered a valuable initial 'way in' to a novice researcher. Although distinction between these 'stages' of analysis is in part an artefact imposed by the need to set out a linear account, Brewer's framework also offers a suitable means of providing some order and structure to a retrospective account.

Figure 6: Brewer's (2000) stages in Data Analysis

Data management
Coding
Qualitative description
Establishing patterns
Developing a classification system of 'open codes'
Examining negative cases

The sections which follow therefore broadly follow the stages identified by Brewer (2000), although before considering these 'formal' stages of analysis it is necessary to recognise that analysis began in the field.

Insights in the field often took the form of loosely defined concepts which were recognised as potentially significant to the study, and which were recorded within the Research Journal. I would then attempt to remain open to, and look for, further examples of these phenomena. As these

concepts were recognised, they were often utilised within analytical memos relating to specific incidents. An example is the concept of the 'big picture' which became a significant focus within the study given that it appeared as a negative case to an evolving analysis (and as such is explored further within Chapter 6). The phrase 'the big picture' was originally noted to be casually utilised by a participant, and yet early research journal entries mark my recognition that this term was both unclearly defined and potentially important. This recognition itself then led to the insertion of a comment (utilising Microsoft Word reviewing function) whilst writing up field notes that the following extract could be an example of "seeing the big picture"

Nurse 7 looks him up and down as she repositions the bedsheets then comments to me that
"Basically he just needs a trache⁸ doesn't he?"

Field Notes: Nurse 7

In this way, early insights gained within the field were recorded and made available to inform the more formal stages of data analysis which followed.

3.4.1 Data Management and Coding

During the first 'formal' stages of analysis the data was initially broken into manageable sections. So as to enable the comparison of data extracts which related to superficially similar activity, field notes were content coded according to the type of activity that the nurse was undertaking. Coding was undertaken by hand, and hard copies of each data extract were sorted according to the code to which they were allocated. At this stage no particular effort was made to consider the relevance of the emerging codes to the overall goals of the study.

Despite the simplicity of these aims content coding was not always straightforward. Many field notes entries related to analytical themes which arose during the course of fieldwork, and as in the following example, did not clearly relate to any specific activity or episode of care with a patient.

Nurse 7 comments to me that she is not feeling very organised today, and that as a consequence she is "writing lists like mad". She is also aware that she keeps having to leave the room to fetch bits of equipment that she has forgotten and that this is not like her. She tells me that this is in part because she is frustrated by the doctors who

⁸ Tracheostomy

have not responded to her requests in a timely way. I have the impression that she feels that she knows what needs to happen (and what will enable her to stay organised), but that this has been frustrated by the fact that the medical team on that day have not 'done their bit'.

Field notes: Nurse 7

The phenomenon of nurses getting or staying 'organised' was recognised early in fieldwork, and were terms commonly used by participants. Given that this entry was recorded due to a focus on the meaning of these terms this data extract was coded as an illustration of "Being organised" at the content coding stage.

As data collection and coding progressed the codes utilised were condensed and expanded. These processes were informed by the need to sort data into manageable sections and to achieve a coding which would facilitate useful analytical comparison between sections of the data (either due to similarity or contrast between coded sections). As an example of expanding a code, only two data extracts were initially coded as 'dealing with sickness' (i.e. responding to a patient who had vomited). Recoding these instances with the broader 'dealing with distress' enabled the comparison of these extracts with other examples of nurses dealing with patients who were overtly distressed for other reasons.

A set of coded extracts from the field notes is provided in Appendix 10 in order to illustrate the results of this stage of analysis, and a full list of content codes used is provided in Appendix 11

3.4.2 Qualitative description

Following this initial content coding, qualitative descriptors were developed for each strip of activity within the field notes. Each section of data identified in the above process was examined, and descriptive words or short phrases for this activity were developed. Where possible descriptors were derived from the language of the original field notes as in the example below:

Once the X-ray has been performed Nurse 6 seems to take great care in helping Mrs Green get back into a comfortable position. Nurse 6 takes a lot of care ensuring the ET tube⁹ does not move unpredictably as Nurse 6 negotiates every movement with Mrs Green who is clearly able to indicate the position she wishes to take through gestures

⁹ Endotracheal tube

and nods. I am struck that this communication between the two looks to be easy but requires Nurse 6 to maintain very focused on Mrs Green. Once Mrs Green has found a comfortable position, Nurse 6 asks if she can take her temperature and then turns back to chart the observations.

Field Notes: Nurse 6

Descriptors for the above extract:

Close; focused; Gives care and attention; easy communication; negotiated

The comparison of data extracts with others describing nominally the same activity often served to produce additional qualitative distinctions. Where there was an immediately apparent change in activity described within a section of the notes, two or more sets of qualitative descriptors were developed to describe each aspect of the interaction. These descriptors, together with a note of the field note extracts they related to, were recorded by hand on separate sheets of paper until patterns began to emerge as discussed in section 3.4.3 below.

3.4.3 Establishing patterns

The above approach enabled the identification of patterns within these data, but was limited by the fact that this method of analysis both took each data extract out of context and failed to recognise the unique nature of each participants' practice. In order to fully explore the patterns within these data a second strand of analysis was therefore commenced with the aim of developing an individual account of the practice of each participant.

The writing of each of these accounts began by summarising my impressions of what had appeared to me as unique to each participant's practice. Once these ideas had been captured, the interview and field note data relating to each participant were interrogated in order to either confirm or refute these impressions. An account therefore developed which articulated those elements of each nurse's practice which these data demonstrated were distinctive or unique. In order to preserve the anonymity of participants the results of this stage of analysis are not illustrated here, although these individual accounts largely informed the findings presented in Chapter 4 and the exploration of the nature of participants' practice discussed within Chapter 6.

Sections within the above accounts were given headings which often (but not always) related to emerging patterns or themes in the overall data, and this approach enabled comparison between participants which itself developed further qualitative descriptions of practice. As all of the above

processes progressed, patterns began to emerge within the data as a result of both the deductive approaches described in section 3.4.1-3.4.2, and the more inductive processes described above. Qualitative descriptors were compared and similarities and differences were noted until patterns began to coalesce and merge.

Parts of these data reflected themes (such as the effects of power relations amongst staff) which are well recognised and described elsewhere, and which were not directly relevant to the aims of the study. As these strands of analysis were combined the aims of the study informed the degree to which emerging patterns were distinguished from one another. Section 3.1 made clear that one objective was “to articulate critical care nurses ways of thinking about patients as the features or characteristics of patients which are of primary significance in the discourse of critical care nurses”. Emerging patterns were therefore considered as unique only to the degree that they were based upon or constructed as significant particular “features or characteristics” of patients.

These processes enabled the identification of seven ‘Patterns of Practice’ through oscillation between the above deductive and inductive approaches, and between decontextualised and contextualised views of the data. Adopting these approaches to preliminary analysis thus gave confidence that key data extracts could be identified which could form the focus of this further analysis as outlined in section 3.4.5 below.

3.4.4 Incorporating the interview data

It has been noted in chapters one and two that there are reasons to question the status of the way in which nurses *talk about* their practice in the context of a study which seeks to explore how nurses *think*. In order to consider how the interview data were incorporated into the analysis it is therefore necessary to make some initial observations about the status of the interview data within this study.

The aim of the study was to study how critical care nurses thought about patients whilst in practice. As Hammersley & Atkinson (1995) note, interviews occur within a distinct setting, and the understandings elicited in this setting may not be those which underlie behaviour in other contexts. It was acknowledged that nurses’ talk about their practice could reflect views that there were some legitimate, valued or ‘right’ ways in which nurses may think about patients, or that nurses may simply be unaware of or unable to articulate the ways in which they do think about patients. Although interviews were therefore a valuable way of determining the ways in which nurses talked about their practice, no presumption was made that interviews simply reflected

what participants were 'really thinking'. The ambiguous nature of the interview data, and the perspective necessary to analyse it, may be illustrated with reference to two short data extracts:

Extract 1

This extract was previously introduced in section 3.3.8 and relates to the questioning of a participant who had been talking to me whilst in the process of delivering intimate care to a patient:

Int ...do you know what it was that made you take your eye off the patient in that sense?

N ((*Tone drops and voice slows*)) Well I guess I was just used to this kind of thing. You know that sometimes you forget that you are with a person

Int Right. Ok

N Now you have made me realise.

Nurse 3: First interview

It is significant that the participant is responding to questioning about a particular moment in their practice which I had directly observed only a couple of hours previously. This context, together with the intonation as she comments that she could "forget that you are with a person" suggest that this is a moment of reflection in which the nurse recognises that she has done something 'wrong'. Nonetheless it is very difficult to see exactly what may be gleaned from this passage about how she was really thinking about the patient at the time.

Extract 2

This second extract comes from the end of an interview with another participant, and starts with a question intended to inform my decisions about the patients I would observe this nurse caring for in the future:

Int Can you think now of any particular kinds of patients where your thinking would be completely different to the way you were thinking about {Mr Smith} today?

N Well yeah your - the sickest ICU patient

Int Yes

N You are - unfortunately focusing more on their observations. I mean you are obviously caring for them as a person but in quite a different way.

Nurse 7: First interview

In this instance the nurse is talking in the abstract and the comments do not relate to any directly observed behaviour. It is even more difficult to determine what may be gathered about the ways that this nurse thinks about any particular patient at any moment in time.

The analysis of such data was facilitated by a realisation that in both of these extracts the nurses *recognised* patterns of behaviour. The comment that “I was just used to this kind of thing” implies recognition of a pattern of behaviour which may in some way be described as routine or ‘just doing what you are used to’. In the second extract the nurse clearly recognises a pattern of behaviour which may be characterised as “focussing more on their observations”. It can also be seen in these extracts that participants characterise these Discourses in particular ways: ‘just doing what you are used to’ is apparently characterised as ‘wrong’ through the admission that it involves ““forgetting you are with a person”; “focussing more on their observations” is defended as “caring for them as a person but in quite a different way”.

In summary, interviews were not conceptualised as offering direct insight into what participants ‘really’ thought about patients and their practice, but rather were considered as *talk about* practice. Analysis of these data therefore sought to characterise the institutional Discourses which participants utilised, and also to identify the ways in which nurses adopted a particular stance towards these Discourses.

3.4.5 Identifying the Discourses

As set out within section 3.2.2, a ‘way of thinking about a patient’ was understood as being the identity which a nurse ascribed to or constructed for the patient through adopting a particular Discourse or discursive formation. The identification of different ways of thinking was therefore dependent upon identifying these Discourses.

The processes described within sections 3.4.1- 3.4.3 enabled the selection of key data extracts within the field notes which exemplified particular ‘patterns of practice’, and section 3.4.5 has outlined a perspective from which the interview data could inform further analysis. The identification of distinct Discourses was achieved by considering episodes within the field note data together with extracts from interviews in which participants talked about those episodes from practice. The field notes and interview transcripts were thus considered as co-texts without making any presumption that the ways in which nurses talked about practice bore a necessary relationship with their nursing practice itself.

The ways in which critical care nurses think about patients were understood to be the identities or roles which nurses *ascribed* to patients through adopting distinct Discourses. Drawing primarily upon Foucault (1969) and Lemke (1995) a proforma was therefore developed which identified the key elements of a Discourse or discursive formation. These elements or characteristics of a Discourse are shown within figure 7 (shown below and overleaf) which incorporates an indication of how these elements relate to the work of key theorists. Within the stages of analysis described in what follows, features of discourse which were typically used together (Lemke 1995) or were ‘co-located’ (Fairclough 2003) were clustered under the headings shown within this proforma, thus enabling the identification and characterisation of Discourse.

Figure 7: Characterising the Discursive Formation / Discourse	
<i>Element of Discourse</i>	<i>Related concepts</i>
The topic, entity or process constructed	A Discourse constructs a particular topic, entity or process (Lemke 1995); or alternatively constructs and stabilizes versions of the world (Potter 2004). This topic constitutes a representation of social events (Fairclough 2003) which may be taken to reflect the ‘what it is that is going on’ encapsulated in Goffman’s (1974) concept of Frame. Foucault talks about this entity or topic in terms of the “unity” of Discourse, such that the Discourse itself is “the space in which various objects emerge” (Foucault 1969: p36).
Identity or roles available to the nurse and to the patient	Meaning making is “orientational” (Lemke 1995) in the sense that meaning is dependent upon the participants’ attitude or orientation to what is being said. This orientation is itself dependent upon the ‘subject positions’ available to participants within the Discourse (Foucault 1969; Lemke 1995), and these subject positions reflect the identity (Blommaert 2005), or social identity (Fairclough 2003), which participants may adopt. This distinction between personal and social identity is also acknowledged by Goffman (1974) who notes that “the nature of a particular frame will ... be linked to the person-role formula it sustains” (Goffman 1974: p. 269).

<i>Figure 7 continued.</i>	
Element of Discourse	Related concepts
Function of the Discourse and relationships between its elements	All discourse is “action orientated” (Potter 2004) and a Discourse can therefore be understood as serving (a) particular function(s) or purpose(s). This gives cohesion to a Discourse such that there is a regularity, order or correlation between elements of a Discourse, types of statement or thematic choices (Foucault 1969). A Discursive formation itself determines “the group of relations that discourse must establish in order to speak of this or that object” (Foucault 1969: p.51). The functioning of the Discourse may be therefore be revealed through examination of its “organisational meaning” (Lemke 1995) which reflects the relations of meanings among statements and thus gives structure and meaning to a Discourse.
Ideological functioning and relations to other Discourses	Whilst all Discourse performs an ideological function (Foucault 1969, Lemke 1995), this needs to be understood alongside an understanding that there are always many Discourses circulating within any social context and that discourse is therefore always “heteroglossic” (Bahktin 1986). Discourses therefore have ideological relations with one another, and participants may experience “ideological dilemmas” (Wetherell et al. 2001; Billig 1991) as they move between or adopt differing Discourses.
Context or Activities typically involving the discursive practices constituting the Discourse	All discourse is situated and occasioned within a particular context (Potter 2004) and therefore Discourse has a “specificity of occurrence” (Foucault 1969).
Specific linguistic features of the Discourse	Specific linguistic features of a Discourse are identifiable as they are often found together or ‘co-located’ (Fairclough 2003). Discourses are systems in which certain elements of <u>d</u> iscourse are typically used together (Lemke 1995)

Following Lemke (1995) the initially selected data extracts were subjected to both ‘synoptic’ readings (in which each part of the text was interpreted in relation to the whole) and ‘dynamic’

readings (to see how the text unfolds linearly). Specific attention was paid to moments within the texts where there was apparent conflict or tension between Discourses, or signs of “ideological dilemmas” (Billig 1991). Such moments were often identified by features such as laughter (expressing tension); doubt / hesitancy and pauses; overt acknowledgements of dissonance within the account; significant repairs / reformulations or changes in lexical patterns (e.g. moving from “I” to “we”). This stage of analysis thus drew upon a wide range of ‘analytical levers’ from within the traditions of linguistic ethnography and discourse analysis. In order to illustrate this stage of analysis, an extended commentary and analysis of a data extract is provided in Appendix 12.

This form of analysis presented several challenges. As one example, one participant was not originally from the UK and had moved to the country only 4 years previously. Analysis of data relating to this participant was complicated by features of her speech which appeared to reflect her unique linguistic background. The following example illustrates the typical difficulties faced in analysis of data relating to this participant.

N I guess what I was thinking prior to the ward round is (.) You know if if (.) I would not compromise her having an NG tube again inserted if her nutritional needs is compromised

Participant: First Interview

From other participants, talk of patients being “compromised” or of having theorised “needs” emerged as significant and as representative of a particular Discourse, yet in relation to this participant it was sometimes difficult to determine whether these lexical choices were simply idiomatic products of her own linguistic background.

A further challenge related to the need for a reflexive approach in adopting these relatively ‘micro’ methods of analysis to the field note data and may be explained with reference to the following data extract:

The second nurse gives the handover quickly and smoothly. After summarising Mr Richards’ reason for admission and his past medical history, she is talking through his current condition when her voice drops as she tells Nurse 4 that Mr Richards has recently had an echocardiogram. She reports that this found him to have a septal defect and an ejection fraction of 15%. As the second nurse mentions the ejection

fraction she holds Nurse 4's gaze for a few seconds and pauses as though to emphasise the significance of the information she is giving.

Field Notes: Nurse 4

This account obviously refers to one fleeting moment which I recognised as meaningful as an observer. Having recognised this moment as significant, reflexivity in the field required that I try to recall and record the features of the interaction which had led me to recognise it as such (e.g. the pause and the gaze). A more radical reflexivity also requires recognising that this text has been *constructed* for the purpose of analysis. Discourse (and thus the above text) may be seen not so much a "mirror" to reality, but may be seen as the "construction yard" in which our sense of 'how things are' is constructed (Potter 1996). The account records that this gaze and pause appeared to "emphasise the significance of the information she is giving". Although this was clearly my impression, it cannot be straightforwardly presumed that the gaze and pause were intended to emphasise this significance.

In handling such data it was necessary to acknowledge the legitimacy of my own 'practitioner knowledge' (Meerabeau 1995). As a critical care nurse I recognise this pattern of communication, and understand this nurse to be implying that an ejection fraction of 15% is indicative of a very poor prognosis. However, to rest the analysis there is to depend broadly upon a simple claim that "I know because I was there", whilst researchers within a linguistic ethnography tradition seek to "tie ethnography down" by:

"pushing ethnography towards the analysis of clearly delimitable processes, increasing the amount of reported data that is open to falsification," (Rampton et al. 2004: p.4)

The ways through these complexities was to recognise both that features such as the gaze, pause and change in intonation referred to in the above extract are clear "contextualization cues" (Gumperz 1986, 1999), and that "speech communities" share expectations about how such cues indicate meaning (Gumperz 1986, 1999). This recognition made it possible to search these data for evidence that my own interpretation of such cues was shared by others. This could be achieved in part by comparison with other episodes (such as by examining these data for examples of other nurses responding to hearing a similar ejection fraction). The legitimacy of analysis which draws on my knowledge as a critical care nurse could also be enhanced by finding support for claims that I was a member of this same "speech community". The analysis of such data therefore required searching for evidence as to whether or not I was accorded "insider

status” at that time. Such evidence could often be found where my interpretations could be shown to be shared by other participants, or in remarks / asides or jokes that were directed specifically to me.

This linguistic and reflexive analysis enabled the identification of ‘co-located’ (Fairclough 2003) features of Discourses. These features were recorded on proforma identifying the elements of a Discourse (based upon figure 7) and using the initial patterns in the data discussed within section 3.4.3 as a starting point were clustered as patterns were recognised. Discourses were distinguished or merged as new factors emerged or initial distinctions could not be maintained, and as previously were only considered as distinct if they constructed a distinctive and different identity or role to the patient. Although seven Discourses emerged from this process, these were considerably developed from the original seven patterns identified in ways outlined in section 3.4.3. Appendix 13 provides an illustration of how the proforma detailing these Discourses appeared on completion of this stage of analysis.

3.4.6 Saturation and negative cases

An initial 45 extracts from the field notes and associated interview transcripts were closely examined using the above approaches, although no new Discourses / discursive formations were identified after the first 30 such extracts had been examined. This was then followed by a re-reading of the entirety of the data as a preliminary search for negative cases and to facilitate further characterisation of these Discourses. During this process, the field note data were also examined in order to identify moments in practice where there was a distinct change in participants’ Discourse.

With the exception of the 37 episodes discussed below, the descriptions of the Discourses identified were found to be adequate to characterise all of these data. Apparent breaks or ‘gestalt’ changes in discourse were a primary focus for observation in the field, and 262 episodes were identified where there was a clear change from one Discourse to another, and a further 155 episodes were identified in which the field notes suggested that I was framing a situation differently to the nurse whose practice I was observing . These episodes were subjected to further analysis in order to examine the ways in which nurses would move between Discourses as will be discussed in section 6.3.

A further 37 episodes were identified which did not clearly present themselves as examples of any one Discourse and which thus appeared as potential negative cases. These episodes all involved

either the use of humour, nurses having a sense of the 'big picture', or represented a form of practice which appeared as particularly 'fluid'. All of the data were therefore re-examined in order to explore the nature of these apparent negative cases as reported in section 6.1.

The identification of these seven distinct discourses was itself sufficient to achieve the study objectives as set out in section 3.1. Section 3.5 sets out the reasons for making this claim, and outlines the approaches taken to the interpretation and presentation of these findings so as to present an account of how critical care nurses think about patients.

3.5 Interpretation and writing the ethnography

The identification of seven distinct Discourses was itself sufficient to achieve the objectives of the study. These were to:

1. Identify critical care nurses' different ways of thinking about patients.
2. Articulate these ways of thinking about patients as the features or characteristics of patients which are of primary significance in the discourse of critical care nurses.
3. Identify patterns of nurses' practice that may be associated with the different ways of thinking identified.

The different ways in which critical care nurses think about patients may be considered as the identities which these seven Discourses ascribe to patients (Objective 1). These ways of thinking are articulated as features or characteristics of patients which are significant in the d(D)iscourse of critical care nurses (Objective 2). Finally, because discourse relates to what nurses do and say, the Discourses themselves represent the patterns in critical care nurses practice that are associated with these ways of thinking (Objective 3).

The discussion of these findings draws upon the work of a number of writers whose work has facilitated the interpretation of these data in ways which clarify their meaning and significance. These key influences include Foucault (1969, 1973, 1977), Goffman (1959, 1974, 1981), Aristotle (1984) and Polanyi (1958, 1966). Although this interpretation is a key means of providing cohesion to aspects of this account it must be noted that:

"to come down fully on the side of plausible interpretation is to give up some of the comforting undeniability of analysis" (Wolcott 1994: p.257).

The presentation and discussion of these findings in the later chapters of this thesis therefore aims to ensure that key findings are presented as clearly derived from 'undeniable' analysis, whilst offering plausible and coherent traditions within which these findings may be interpreted.

Interpretation of these data has also influenced the process of writing this thesis. Inevitably, some findings have been given greater prominence than others in order to ensure a cohesive narrative and argument to the overall thesis. Furthermore, ethnography may itself be considered as a form of writing, and the aim in writing this ethnography has been to present a "realist tale" which

"permits readers to hold the attitude that whatever the fieldworker saw and heard during a stay in the studied culture is more -or-less what any similarly well-placed and well-trained participant-observer would see and hear." (Van Maanen 1988: p46)

The need to ensure that findings appear 'real' and relevant to an intended audience of critical care practitioners has also influenced the selection of data extracts presented. Clearly data has been selected for presentation which demonstrates key findings and analytical points, yet avoids unusual or extreme examples so as to ensure that the ethnography presented remains representative of the day to day reality of critical care nursing. Care has also been taken to ensure sufficient detail is provided within descriptions of nursing practice for other critical care nurses to make judgements about the credibility of analysis and interpretation, and to evaluate the relevance and transferability of these findings to their own practice.

This chapter has set out a clear audit trail of those processes and decisions which enable a research community to make judgements regarding the trustworthiness (Lincoln & Guba, 1985) of this research. The findings of the study are presented and discussed in the chapters which follow.

4.0 Overview of findings

The next two chapters of this thesis present the main findings which emerged from the analysis of these data. The data collected within this study comprise:

- Field notes from a total of approximately 92 hours of participant observation over 23 occasions.
- Transcriptions and audio records of 13 interviews each lasting 45-70 minutes.
- Research journal.
- Miscellaneous artefacts / texts obtained during fieldwork (E.g. unit map; examples of documentation; unit guidelines).

The analysis of these data has enabled the development of a rich description of the critical care environment as well as exploring how nurses think about patients in this context. Chapter four presents an overview of the critical care setting and culture (section 4.1), and an introduction to the seven participants who were the primary informants in this study (section 4.2). Chapter five introduces the seven distinct Discourses identified and sets out how these Discourses constitute seven different ways in which these participants were found to think about patients.

4.1 The ethnographic context

The study was conducted on a 10 bedded mixed critical care unit within a District General Hospital (DGH) of approximately 400 beds in the UK (henceforth “the unit”). The hospital in which the unit was situated provided a range of general hospital services, including accident and emergency, general and some specialist surgery (both inpatient and day-case) and general medical facilities. Two large teaching hospitals with a wide range of tertiary specialist facilities were accessible within 25 mile vicinity of the DGH.

4.1.1 Overview

Patient admissions to the unit included a case mix of unplanned admissions from medical and surgical wards, planned admissions following major surgery (e.g. major vascular surgery), transfers from other critical care departments, and admissions from the Emergency Department which included some patients with trauma. These differences in case mix were rarely mentioned by staff on the unit who instead made a primarily distinction between ‘ITU’ patients, ‘HDU’ patient, and patients who were deemed ‘wardable’. From the outset it was clear that the level of

observation and physiological support patients required was a major factor in how critical care nurses thought about these patients.

Although the unit physically holds 10 beds, critical care bed capacity was primarily determined by nursing staffing levels. Typically 7 nurses would be on duty for each shift, one of whom would be a supernumerary shift leader. Other nurses would be allocated either one 'ITU' (level 3) patient, or up to two 'HDU' (level 2) patients, and thus the unit would be considered full with 6 level 3 patients. Although work load pressures were recognised as potentially influencing how critical care nurses may think about patients, the unit was never considered particularly 'busy' during the occasions when I visited and these staff patient ratios were adhered to without apparent difficulty or 'bed pressures' on every occasion I was present.

4.1.2 The environment

Geographically the unit was split into two areas referred to as the 'HDU' and 'ITU' sides, although these titles appeared purely nominal rather than reflecting any clear relationship to where patients with differing care needs were located. One bedspace on each side of the unit was a purpose built side room, though otherwise the boundaries of each bedspace were defined by a mixture of curtains, storage lockers and stud walls. Each bedspace was laid out in a similar fashion with emergency equipment at the head of the bed, a monitor mounted on the wall to one side, and a documentation chart (together with folders containing patient notes, unit policies etc.) placed a metre or so away from the foot of the bed which often served as a good position from which to observe and take notes. Other than this chart table (which was vertical) there was no form of desk or seating within the bedspace, and when nurses needed to sit down for purposes such as writing notes they were required to use the nurses' station. The two nurses' stations (one on each side of the unit) were positioned such that they maintained clear sight of every bedspace on that side of the unit, and each had a central monitoring console to further aid the observation of patients. These stations were the focus for much other activity as medical staff and other professionals would use the desk whilst writing or reading notes, or to use the adjacent X-ray viewers.

After a tour of the unit on my first day in the field I was taken by one of the sisters to complete aspects of my orientation. This 'orientation' consisted in highlighting three specific issues: the location of the fire exits, the location of hand gel next to the unit doors that visitors were asked to use; and to stress that "we all wear gloves and aprons for all patient contact here". This first experience in the field served to highlight that the unit was a place of work in which overt

consideration was given to the “Health and Safety” concerns which exist to protect staff and patients.

The distinctions made by staff between ‘ITU’, ‘HDU’ and ‘wardable’ patients were particularly significant. These labels broadly reflected the levels of critical care which patients were categorised as requiring (DH, 2000: see also figure 2 in section 3.3.1). ‘ITU patients’ and ‘HDU’ patients were those requiring level 3 and level 2 care respectively. ‘Wardable’ patients were those patients with level 1 or level 0 critical care needs who staff considered to no longer need critical care. ‘Wardable’ patients could be a cause of some apparent frustration to staff given that the need for such patients to stay on the unit was usually attributed to bed pressures elsewhere in the hospital. ‘Wardable’ patients were also clearly treated differently to other patients for reasons which were not always readily apparent to a novice or outsider. An inexperienced nurse in critical care commented to me in an interview that:

N So there is definitely a sense that if they are wardable they don’t really care for them in the same way. They don’t set themselves the same strict parameters, and they’ll tend to be a bit more kind of laissez-faire about the whole thing.

Nurse 2 : First Interview

I was frequently told that the unit was “quiet” due to there only being a small number of ‘ITU’ patients present. In part this again highlights the degree to which nurses would think about patients. These early impressions also served to confirm that the care of “ITU” patients was seen as the most legitimate or most valued work for the staff on the unit.

Nurses would physically locate themselves so as to maintain a degree of direct observation of the patients they care for that was determined by how ‘stable’ the patient was. The need to observe patients and keep them safe meant that ‘sick’ patients needed to be watched continually, and when caring for such patients nurses would not run even the shortest of errands without ensuring that another nurse was ‘watching’. Patients who were deemed less sick (those who were ‘wardable’ or ‘stable’) tend to be watched less closely, and when this was the case many nurses would take the opportunity to gather at the nurses’ station.

These first impressions thus served to highlight that the primary focus of work on the unit was the monitoring and support the physiology of critically unwell patients. This was achieved within a

physical environment which ensured that patients were wholly visible to staff at all times both physically and through technological monitoring. This constant need to observe and manage patients highlighted that this was an environment in which patients were seen as unstable and at risk.

4.1.3 The Nursing shift

In addition to the registered nurses who are the focus of this study, the unit had 24 hour cover from a dedicated ITU consultant supported by a medical team of registrars and more junior doctors of SHO (Senior House Officer) grade. Physiotherapists covered the unit on a rota basis and had a regular presence. In addition to the registered nursing staff the unit employed two staff in the role of 'general assistants' who assisted with some nursing tasks such as manual handling or helping to meet patients' hygiene needs. This study takes nurses as its focus and so it is appropriate to give an introduction to the work on the unit through outlining the work undertaken during a nursing shift.

The nursing staff would begin their shift with a unit handover in the staff room which was led by the nurse in charge of the outgoing shift. Patients were generally presented as being 'ITU', 'HDU' or 'wardable', and further differentiated only by reference to their medical condition(s). Handover would end with the process of patient allocation where nurses negotiated which patient they would be caring for during the shift. More often than not, nurses would be allocated to a bed by number rather than to a patient by name.

On entering the unit itself, nurses received a full handover from the outgoing nurse about the patient they would be caring for. Typically the handover was highly structured and followed the pattern set out within the unit guidelines very closely (see Appendix 14). This structure was in two clear parts. Firstly the patient was introduced (usually by name, age and the number of days they had been on the unit) before the outgoing nurse gave a summary of the patients' medical condition in the form of a narrative or story. This 'telling the story' was noticeably more fluid for experienced nurses, and would outline how the patients' medical problems developed, necessitated admission to the ITU and their treatment whilst in the ITU. The second part of the handover was clearly marked by a change of focus onto the patients' current condition, usually clearly highlighted by a phrase such as "so today". This second part of the handover would then summarise the current status of the patient in relation to individual body systems which were

again usually clearly highlighted (e.g. “respiratory wise”: “CVS¹⁰ wise”; “GI¹¹ wise”). The clarity with which this break in handover could be perceived itself suggests a contrast between at least two ways in which critical care nurses think about patients: these being thinking about the patient as a part of an ongoing narrative or story, and simply knowing patients as they are in the here and now or ‘today’.

Information given in handover was generally precise and quantifiable, and highlighted the ‘parameters’ or ‘targets’ that were the current aims of treatment. During handover the outgoing nurse would generally speak without interruption (other than for clarification) whilst the nurse receiving the handover concentrated upon making notes about issues that they needed to address during their shift. In this it was again clear that the unit was a place of work where nurses may be held to account for doing jobs which need to be done.

At the beginning of every shift nurses conducted safety checks in order to ensure that emergency equipment was immediately available and that other equipment such as infusion pumps or ventilators were functioning correctly. The need for these checks was also formally stated within unit guidelines (Appendix 14). These routine elements of the working day again reflected the high priority given to observing patients and recognition that critically ill patients may be unstable and at risk.

Much of nurses’ activity during their work was structured around other clear ‘routine’ practices. Drugs were administered at set times, and patients were turned, or given eye care and mouth care at regular intervals. Nurses also managed their time by anticipating and working around the more or less regular activities of other health professionals such as ward rounds or physiotherapist visits. The clearest routine demand of all was the need to record patient observations given that all patients who were not considered ‘wardable’ would have physiological observations recorded hourly, and so far as practicable, on the hour. The rigidity of this expectation was recognised by, and an occasional source of humour to, participants in the study as the following extract demonstrates:

Whilst we are sat at the desk, the sister approaches to ask Nurse 1 when she wants to take her break. Nurse 1 jokes that of course she cannot go at six o’clock “on the dot”

¹⁰ Cardiovascular system

¹¹ Gastro-Intestinal system

because she will need to get her obs done at that time. She is evidently joking and we all laugh, but as we do the sister interjects to tell me that “Lots of people really are like that”.

Field Notes: Nurse 1

The hourly observations served as the key means by which nurses would structure their shift as nurses would often manage their time so as to fit in other tasks between sets of ‘obs’. Other than the hourly observations and other ‘routine’ aspects of work, the most marked feature of the nurse’s activity was its episodic nature. Rather than staying close to, or with, patients at all times, critical care nurses would often enter the area immediately around the patient’s bed for a specific purpose and then withdraw. This physical withdrawal could involve moving back to the nurses’ station, moving back to the chart table to make records, turning to talk to other staff or simply stepping away from the immediate bedside. The result of this periodic physical withdrawal was that a somewhat episodic nature of critical care nurses’ work was clearly reflected within the field notes.

The patterns in nurses’ practice and the different ways in which nurses would think about patients during this episodic care delivery are the subject of the discussions which follow.

4.2 Individual accounts of participants

Seven nurses were recruited as participants in the study and these participants are introduced here through a series of individual accounts. These accounts set out the distinctive or unique aspects features of practice of these participants, and are often articulated in terms of my own impressions where these are supported by patterns within these data.

Presenting the unique and individual nature of the practice of each participant must be balanced with the need to preserve their anonymity. In order to achieve this, participants are introduced within this chapter as Nurse A to Nurse G, whilst data extracts throughout the remainder of the thesis are attributed to participants by number (e.g. as “Nurse 1”). No correlation can be presumed between these different ways of identification; therefore data abstracts throughout the thesis cannot be readily attributed to the practice of the seven individuals as described in this chapter. Whilst serving to protect the anonymity of participants, this approach serves to maintain an audit trail by demonstrating that analysis draws on findings from all participants. As a further safeguard to avoid the identification of individuals, key sociodemographic details are presented separately from the unique characteristics of the practice of these participants.

Six of the seven participants were women, with only one male nurse taking part as a participant in the study. Whilst issues of gender were potentially significant and were considered during the analysis of these data, the gender of this participant was not felt to be a significant factor in relation to any of the key findings or data extracts presented. In order to preserve the anonymity of this individual, all participants are therefore referred to in the female gender throughout this thesis. Participants ranged in age from early twenties to late forties, but as with issues of gender, age was not felt to be a significant factor in presenting findings. Participants had a range of practice experience backgrounds, although the most relevant distinction in terms of analysis was whether they fell into the 'experienced' or 'inexperienced' group. Further details of the practice and educational backgrounds of the seven primary participants are given within Appendix 15.

4.2.2 Nurse A

Nurse A was rotating to the Critical Care unit for a four month secondment and I first worked with her three weeks into this time. Nurse A did not appear to identify herself as a critical care nurse and was always clear that she would not wish to pursue a full time career within the speciality. In the final interview I conducted with Nurse A she was ambivalent over whether she had enjoyed her time on the unit, although she was keen to stress that she had learned a lot.

Clearly there was a limit to the amount of experience Nurse A could gain in a short secondment, and she frequently came across issues which she did not fully understand. Despite this inexperience, her approach to learning was distinctive compared to other inexperienced participants. Nurse A appeared to make a particularly clear differentiation between 'nursing' and 'medicine', and tended to construct 'medical' issues as none of her concern. This was illustrated on an occasion when I asked her why she disassociated herself from a discussion between two doctors about a particular patient's abnormal clotting results. Nurse A replied that

A They were trying to make a decision at that point which has nothing to do with me.

((lines omitted))

From my point of view as a nurse to make a decision I - I have nothing to do with it really. Because I have no power to order this medication, I have no power to stop them you know.

Nurse A: First Interview

Her transient status within the team and her dissociation from 'medical' concerns led me to an impression that Nurse A concentrated primarily upon just doing her job. In our final discussions she commented to me that "routine is the most significant factor" in critical care, and that she experienced each day as being "almost the same thing happening all over, over and over". My impression was that Nurse A did not come to identify herself as a critical care nurse, and therefore did not seek to adopt the knowledge, skills or worldview that would constitute "thinking like an ITU nurse".

This focus on the routine and doing the 'work' meant that Nurse A was rarely pro-active in troubleshooting issues. Although her inexperience was clearly a factor in seeking help in the episode below, the incident was notable for the fact that she made no personal effort to investigate the issue:

...I hear the ventilator alarm briefly before stopping spontaneously. Nurse A pauses and says quietly under her breath

"Is he awake?"

I do not feel that this is a question directed to me, and do not reply. She pauses to look to the ventilator and to the patient, then turns back to finish preparing the nasogastric drugs. A minute later she puts the drugs down and leaves the bedspace, commenting that she will get the Sister to have a look. I have not seen Nurse A herself make any efforts of her own to investigate the cause of the alarm

Field Notes: Nurse A

This failure to investigate or troubleshoot issues herself could not be solely attributed to Nurse A having anxiety or concerns about the complexity of critical care needs. During the shift that the above was recorded, Nurse A characterised the patient in question as "not really complicated". This characterisation appeared to me to reflect her own understanding of the limits of her role given that this patient was the only 'ITU' patient on the unit at that time, and Nurse A had spent most the shift being supervised or coached by two senior members of staff.

Nurse A always seemed happiest (in a literal sense) when caring for 'HDU' or 'wardable' patients. The following episode describes Nurse A beginning a shift caring for Mr Langden who was a 'HDU' patient who was awake and alert and awaiting surgery. Nurse A approached him as follows:

Nurse A has taken over the care of Mr Langden and immediately walks around the bed to face him. Nurse A is smiling broadly, and says hello adding that

“I know you”

Mr Langden looks up and greets Nurse A by name and he too is smiling. It is clear that Mr Langden remembers being cared for by Nurse A previously on the ward. The two chat for some minutes as Nurse A asks Mr Langden how he has been and what has been happening to him.

Field notes: Nurse A

This was not only one of the few occasions when I saw Nurse A chatting naturally with patients, but more significantly was one of the relatively few such apparently everyday social encounters recorded within these data overall. This ‘chatty’ style of interaction was unusual between patients and nurses on the unit, and appeared to be a particularly valued aspect of Nurse A’s practice. The limited opportunities for such ‘chat’ within a critical care environment appeared as another potential reason that she was not keen to stay within the speciality.

4.2.3 Nurse B

Though considered as one of the ‘experienced’ group of participants, Nurse B professed herself to be “in the middle” rather than an expert practitioner. Although she had the confidence and respect of other nurses, Nurse B was beginning to develop into a role of shift leader and this changing level of responsibility may have been the cause of some anxiety about her perceived expertise:

Int In terms of your delivery of patient care do you feel confident? Reasonably expert?

B Yeah. I feel fairly confident with my care being safe. I think that’s true

Nurse B: First Interview

Nurse B’s reply in this extract displays not only a degree of ambivalence on the subject of her own expertise, but also highlights how keeping patients ‘safe’ is intimately associated with expertise in critical care nursing practice.

Earlier in her career, Nurse B had spent some time undertaking voluntary work abroad and it was clear from our first meeting that this experience had had a very significant personal impact on her. During the course of the study Nurse B left employment on the unit in order to return to voluntary work in this environment. In our last discussion Nurse B told me that the voluntary work which she was undertaking was associated with a religious organisation, although she

downplayed this factor (or avoided discussion) by acknowledging that this may “put some people off”. I had no further opportunity to discuss her religious or spiritual beliefs and any impact they may have had on her practice, and in any case sensed that Nurse B considered such beliefs to be a private issue. Nonetheless, I had a strong impression that her motivation for undertaking this work (whether driven by religious belief or humanitarian commitment) reflected a personal ethic which also underpinned her nursing practice on the unit.

Nurse B appeared to demonstrate a genuine investment in and concern for the welfare of the patients for whom she cared. The example below illustrates this, together with a sense of her being slightly self-conscious about, or having difficulty in expressing, these feelings.

Nurse B returns from fetching an air mattress. She is smiling broadly and explains this by telling me that she had just walked past a lady patient in the adjacent bay. This patient had been very unwell and had “had the works”, which had included complex ventilatory and inotropic support. Nurse B appears clearly delighted to have seen this patient now “sat out” of the bed and commented that

“She looks so good!”

She gives a satisfied sigh, catches my eye, laughs, then looks away.

Field Notes: Nurse B

Nurse B’s personal investment in the welfare of patients appeared to be associated with a high awareness of the patients’ experience, and suggested a way of thinking about patients which required some emotional involvement on her part. Nurse B could present these issues as rather straightforward and obvious as illustrated by her comments on the following incident:

Nurse B and I are about to assist Mr Field onto the bedpan when the SHO enters the bedspace through the curtains. Nurse B and I are stood on either side of the patients’ bed, with Nurse B holding the bedpan. The doctor simply says “Hi” and walks towards the notes / chart table. Nurse B looks to me, and then says

“Um . Going on bedpan?”

The SHO looks towards her with the patients’ notes in his hand. His face looks blank and I have the impression that he genuinely does not know what he is expected to make of this information. Nurse B nods towards the notes

“Could you take them outside?”

He replies “Oh” and walks around the curtains to leave the bedspace

Field Notes: Nurse B

When asked later about the episode, Nurse B first commented that the doctors' behaviour was "unfair" and that "I personally wouldn't be able to go to the toilet with someone watching me". When pushed to elaborate, she struggled to fully explain her reaction in anything other than common sense terms

B The doctor shouldn't have been annoyed by the fact that I asked him to do something just –
It didn't make sense to me actually. I wasn't angry with him I just thought
(*sighs*) You know you're not thinking straight

Nurse B: First Interview

Although she presents her responses as simply common sense and 'thinking straight', this straightforward recognition of the patient as a person who would wish to be treated the same way as herself was not always a universal finding in the practice of all participants.

4.2.4 Nurse C

Although new to critical care at the beginning of the study Nurse C was clear that she planned for a career within the speciality. During the study Nurse C was undertaking a rotation to critical care, and at the completion of this rotation Nurse C left employment with the Trust in order to take a full time post in the Intensive Care Unit at another hospital.

Nurse C was keen to gain knowledge and skills, and frequently spoke of her experiences in terms of how much she was learning. Her practice often appeared self-consciously meticulous and 'rule following', and she appeared to have difficulty in 'multi-tasking' (such as maintaining communication with the patient when focussed on technical or technologically orientated aspects of care). These features meant that her practice was characterised by clear 'breaks': there were clear changes in her practice as she moved from appearing to focus entirely on undertaking a task, to thinking and reasoning about the patients' physiology, to simply talking to the person in the bed.

I needed to prompt Nurse C to address urgent patient problems more than with any other participant. On occasion these were problems which she had clearly observed but had not responded to as illustrated by the following extract. The patient in question (Mr Turner) had a low

blood pressure and a low urine output. I was aware that the sister had asked Nurse C to administer some Gelofusine¹² but nevertheless:

She stands for a moment, and then pulls her handover sheet from her pocket to study her 'to do' list for the shift. The first two items on this list are to commence a new observation chart for the day, and 'drugs', and I know both of these have been done. Nurse C runs her finger down the list and passes over the third item where she has written 'gelo' and down to consider a fourth item before simply folding and putting away the sheet.

((and later))

...She admits to me that she deliberately avoided the 'Gelo' item on her 'to do' list. When I ask why, she tells me that she finds the way it is prescribed confusing and that she is uncertain of what to do. The observation charts on the unit incorporate a standard prescription a doctor may sign for 100-250ml Gelofusine to be delivered over 10-60 minutes. Nurse C appeared to me to have been almost paralysed by her uncertainty over how much to give and over how long.

Field Notes: Nurse C

Elsewhere in the field notes I record my sense that Nurse C was struggling at this time, and in order to manage her anxiety and to ensure that appropriate and timely care was given I offered to administer the fluid myself (an offer that was willingly accepted). This episode marked one of the few instances in these data when I needed to intervene in order to protect patient safety and was required to draw upon the principles articulated in Appendix Six as a response to 'sub-optimal practice'.

Examining the actions of Nurse C herself during this episode makes clear that, even though she was aware of and continued to silence an alarm signalling low blood pressure for some minutes Nurse C here continued with other 'routine' jobs to do. Rather than lacking awareness that a patient with a low blood pressure may be 'unstable', this episode appears to reflect her failure to think about the patient as 'unstable' rather than continuing to think about the 'routine' work she is required to do.

Nurse C was quick to develop her own sense of what was core to critical care practice. Whilst other novices were often concerned to try to reconcile 'what they would do on the ward' with the

¹² Gelofusine – a colloid fluid commonly used to maintain intravascular fluid volume

care delivered in the unit, Nurse C gave an impression of not knowing any other way of thinking about her practice. She very quickly came to ways of speaking and thinking about patients in terms of their 'system support', and particularly in relation to whether patients' respiratory and cardiovascular systems were 'stable'.

Nurse C carried a sense of good humour into her interactions with both staff and patients. 'Mick' was a HDU patient with a tracheostomy who had been eating a meal when he had begun coughing and needed endotracheal suction.

As the suction catheter is removed she studies it closely then gives her verdict
"Sputum – but no ice cream!"

Both she and Mick laugh at this which sets Mick off on another bout of coughing.

Field Notes: Nurse C

Whilst some participants could often appear awkward or stilted in their communication with sedated or unresponsive patients, or fall back on using 'stock phrases' which were not particularly meaningful, Nurse C appeared as relatively unique in her ability to maintain the above illustrated easy and relaxed social manner in her interactions with all patients. The following extract notes how I was particularly struck by the way in which she introduced herself to a patient who was deeply unconscious.

Nurse C says "Hi" before introducing herself as a new nurse and explaining to Mrs Venn that "you'll notice the change in our voices" I note at the time that I am struck by the fact that the content of her speech would be meaningful from Mrs Venns' perspective.

Field Notes: Nurse C

Similarly to Nurse B, Nurse C frequently demonstrated an awareness of the patient's own experience and likely current concerns. Although she could become 'task focussed' when undertaking unfamiliar procedures, thinking about the patient as *having* a current experience seemed at the least to represent an ideal towards which she would aim, even when pressures of time, inexperience, or unfamiliarity with procedures may mean that it was not always achieved.

4.2.5 Nurse D

Nurse D was clearly a capable and expert nurse in regard to many aspects of clinical care, and was beginning to move into a more senior role such that she would regularly take charge of the unit. Even when caring for the most 'unstable' ITU patients Nurse D showed confidence in managing complex situations to a degree that she commented to me that she sometimes worried about being too "complacent". The following extract illustrates this point, and relates to her assisting with giving chest physiotherapy to Mr Norton who had been diagnosed with sepsis and Acute Respiratory Distress Syndrome (ARDS).

Having completed the physiotherapy treatment, Nurse D wants to reposition Mr Norton one more time so that he returns to a right sided lying position. His blood pressure is still low as he is turned onto his back, and the monitor is alarming with a BP of 73/20. At the same time the ventilator begins to alarm constantly, as does an infusion pump from the other side of the bedspace. There are therefore three alarms sounding simultaneously, Mr Norton's blood pressure remains low, and the oxygen saturations on the monitor are reading at 80%. Nurse D looks to the ventilator to check what is alarming. She tweaks the 100% oxygen button as she looks and then turns back to Mr Norton commenting that it is the apnoea alarm and that "He doesn't look apnoeic to me"

She then moves quickly around the bed, silences the alarming infusion pump and immediately checks the position of the transducer and rezeroes it. I later learn that she transiently recommenced the noradrenaline¹³ infusion at this time.

Field Notes: Nurse D

Such moments would be familiar to any experienced critical care nurse, and illustrates the skills which critical care nurses possess in relation to understanding and controlling patients' rapidly changing and abnormal physiology. In such moments Nurse D demonstrated a clear ability to think about and respond to patients who were unstable.

Nurse D had an outgoing and sociable personality which could frequently be seen in a degree of good humoured banter with patients who were awake, though when caring for unresponsive patients her sociable nature was more clearly seen in her relations with other staff. Often she

¹³ Noradrenaline is a powerful vasoconstricting drug used to which is delivered by a continuous infusion in order to maintain blood pressure.

would not display any awkwardness about talking to other staff across the bed of the patient for whom she was caring, suggesting that she did not think about unresponsive patients as social beings in the same way as the staff whom she could engage in such chat.

This good humour led Nurse D to comment to me on one occasion that she believed that this study may characterise her as the “Nurse with the Antlers and the OCD” (although it would probably amuse rather than alarm her to learn that this phrase made it into the final thesis). The fear that she would be characterised as the “Nurse with the Antlers” refers to the first occasion we met which had been a few days before Christmas and she had been wearing blue tinsel antlers. As well as wearing these antlers, Nurse D engaged in a degree of banter or repartee with her patient throughout the shift (discussed later in section 5.6) although this joking good humour was balanced by a clear desire to maintain a “professional” approach. Nurse D’s good humour never appeared to me as flippancy, and throughout this first shift I observed the ways in which she made constant and nuanced judgements about when it was and was not “appropriate” to wear the tinsel antlers.

Nurse D’s concerns about being characterised as having ‘OCD’ refers to her tendency to constantly arrange and tidy the environment and to present patients ‘neatly’ (straightening bedsheets, untangling intravenous lines, ensuring the bedspace and working surfaces were clear and so on). This constant tidying and ordering of the environment (and the patient) was a prominent feature of the practice of many nurses on the unit, although Nurse D’s joking reference to this as a form of obsessive compulsive disorder is particularly characteristic of her humour. Although it was often expressed through such humour Nurse D was a particularly valuable informant in respect to her ability to articulate the characteristic behaviour, role and worldview of critical care nurses on the unit.

It was noted above that Nurse D did not always communicate with patients who were unconscious or otherwise unable to respond to the same degree as other participants. In interview, she acknowledged that she had perhaps become ‘blasé’ about this aspect of her practice, but also made the following observations about the learned or rote comments to patients which were typical of the patterns of communication of many of her colleagues.

D I think a lot of the times we say things that patients are not gonna understand - like I’m just gonna suction you. Well that doesn’t actually make any sense ((*lines omitted*))

I'm just going to - there's just going to be a break in your breathing - and I think, well bloody hell what does that mean? Are you gonna actually asphyxiate me for a minute?

Nurse D: Second Interview

In these comments Nurse D positions herself as resisting the common unthinking and routine ways of practice which she sees in others and accord with my own general impression that for Nurse D, nursing practice was an expression of her individuality or it was nothing. Although at times her communication with patients was limited I felt that this was balanced by a sense in which there was an authenticity in all the comments and interactions with patients which she *did* make.

This sense of personal authenticity and the individual nature of Nurse D's practice was further reinforced by the way that she had the confidence to 'break rules'. She could characterise her activity as 'rule breaking' in regard to relatively trivial matters such as giving nebulisers earlier than they were prescribed, or as in the following example, allowing a patient with type two diabetes to have sugar in a cup of tea. Whilst other nurses may have refused to do this, Nurse D's responses to my questioning appeared simply to respect the patient's choices and autonomy:

D I know the information and I know he knows it 'cos I was talking about it to him yesterday

Int Right ok

D And he'd look at me and say 'oh I should have a sweetener but I don't want a sweetener' and I think - he's been educated. He's a well-educated man.

Nurse D: First Interview

Nurse D's presentation of her practice as individualised appeared as a reaction to a clearly perceived rigid and prescriptive approach which she felt was expected on the unit as a whole. By presenting this as 'breaking rules', she conveys a sense that thinking about the patient as a self-determining adult was to somehow resist expectations from within the unit culture.

Despite her occasional limited communication *with* patients, Nurse D would nevertheless talk *about* patients in ways which did demonstrate a clear regard for their overall welfare. This struck me as a central paradox in Nurse D's practice and may be illustrated by a further example. This incident occurred in the same shift as I noted that "her direct communication with the patient

was very limited”, and yet Nurse D nonetheless demonstrated an emotional response which conveyed a sense that she did care about Mr Norton in the interaction below:

Nurse D returns from analysing the blood gas, and is pulling a sad face as she comes back towards me outside Mr Norton’s cubicle. She comments to the SHO that the blood gases are no better and the SHO notes that

“We’re going to have to paralyse¹⁴”

Nurse D nods her agreement, then turns to me in exasperation and frustration

“Oooo – I’ve broken him!”

She momentarily catches my eye and then shrugs as she looks away in a way which suggests to me that despite her somewhat jokey turn of phrase she feels a genuine regret at this turn of events which is hard to articulate.

Field Notes: Nurse D

The paradox becomes apparent in the way that Nurse D showed herself to be particularly orientated towards thinking about the patient in terms of a long term trajectory towards recovery or deterioration, whilst her practice also often suggested a sense of detachment from patients’ minute to minute lived experience.

4.2.6 Nurse E

Although a novice to the critical care environment, Nurse E perceived herself as a relatively experienced nurse. She appeared keenly aware of the loss of status which accompanied her move to the critical care unit and thus placed her at the bottom of a new hierarchy, and in an interview compared her experience to “suddenly being practically a student again like a total novice”. Of all the participants in the study, Nurse E appeared most keenly sensitive to the influences of hierarchy and power structure within the unit.

Nurse E was keen to learn and was quick to seek advice or assistance when she needed it, but experienced frustration or annoyance when she was questioned, corrected or guided by the unsolicited comments of others:

E And I do have - in the back of my mind - that this is what I’m going to do next and this is how. You know what I need to have done in the next hour or something. And then you have someone that’s coming along that’s

¹⁴ ‘Paralyse’ – indicates the use of muscle relaxants to facilitate the modes of ventilation that are required by Mr Norton’s deteriorating condition.

supervising you and saying well - this hasn't been done and this hasn't been done, do you want me to give you a hand? And it's like, I'm perfectly capable of doing it myself

Nurse E: First Interview

Whilst Nurse E would occasionally attribute such tensions to a clash of personalities with senior staff, I considered that the 'personalities' (or at least the behaviour) of these senior staff were fairly typical of my own experiences in other critical care units. As the above passage demonstrates, such hierarchical supervisory relationships with senior nursing staff were clearly associated with getting the work "done" and could be a profound influence on the way that junior critical care nurses think about their practice.

In what at times appeared a considered reaction against the attempts of others to control her practice, Nurse E's practice was notable for her slow and unhurried pace and the degree to which she made the patient the sole focus of her attention. Something of the distinctive nature of this practice (and an implied contrast with that of others) is captured in the following extract

There is a cup in the bedspace which has some water and mouth sponges left in it and Nurse E picks these up, tuts, and then leaves the bedspace saying she will get some fresh water to give mouth care. She returns and helps Mr Langden with the mouth sponges until she is satisfied that he is comfortable, and then asks if there is anything else. There is no sense that she is rushing or has other things to be doing, and she waits until Mr Langden is very clear that there is nothing else he needs before closing the encounter by saying that she needs to check a few things and see her other patient.

Field Notes: Nurse E

This incident is notable given that this occurred in the very first minutes of her shift. In general, participants were strongly influenced by expectations of what should routinely be achieved at the beginning of a shift such as undertaking safety checks and assessing patients. In this regard the behaviour described above was unusual, and Nurse E's behaviour is remarkable for the way in which she would resist these aspects of her role in order to devote time to the patient.

The attentiveness which Nurse E displayed towards patients was balanced by an apparent respect for their need for privacy and a strong awareness of their personal boundaries. She would often

imply that other nurses on the unit would do too much for their patients (or “mollycoddle” them) in ways which reinforced patients’ dependency. In the following exchange Nurse E was discussing the tendency of other nurses to constantly “badger” patients with questions or interventions in a way which contrasted with her own practice.

Int So is it a sort of deliberate strategy of just not to hassle or - I don’t know if hassling is the word

E Yeah. Well I think I might - I’m like that with people in real life as well not just patients.

Int Right

E Until they - you know - I feel that they are kind of reciprocating.

Nurse E: First Interview

I associated this sense that patients should be seen and treated in the same way as “people in real life” with the way in which Nurse E appeared to construct boundaries to the nursing relationships she had with patients. Whilst she did not have particularly close or intimate relationships, she could display frustration with the way that other staff could think about patients as having constant nursing needs. In the following extract, she is commenting on an experience during her early weeks on the Unit whilst she was working with another nurse.

E And {the patient} was just, you know, absolutely knackered and you could tell she was like on the verge of just having a kind of a breakdown and the nurse that I was with kept wanting to do things to her. I said well can’t it just hang on for a bit, can’t we just let her sleep? And she said well, I know she needs to sleep, we also need to do this and we need to get it done and things and I’m just thinking - sometimes you can compromise

Nurse E: First Interview

Nurse E struck me as a relatively experienced nurse who had thrived on the hustle and busyness of managing multiple patients within a high acuity ward environment. Nurse E struggled to adapt to a slower pace of practice in the unit and expressed a sense that the critically ill patients on the unit were (perhaps unnecessarily) ‘micro managed’. Nurse E therefore appeared to resist adopting some of the values and behaviours which may be considered as typical or constitutive of critical care nursing, which she would characterise as ‘obsessive’ or nitpicking. For these reasons I was not surprised to learn later that after leaving work on the Unit she left intensive care as a

speciality and gained employment in the Accident and Emergency department of another local trust.

4.2.7 Nurse F

Nurse F came across as an experienced and confident practitioner who appeared able to cope with any eventuality arising in the clinical care of individual patients. More uniquely, her interactions with patients and their families always appeared more considered and deliberate than those of other participants. This somewhat 'straightforward' manner is illustrated by the following:

Nurse F walks up and talks directly to Mrs Williams. She remains standing and stoops slightly without making physical contact with Mrs Williams as she speaks..

"Hello my name is [Nurse F] and I'm going to be looking after you".

Nurse F goes on to explain briefly what the physiotherapy will entail. Her speech is in a normal conversational tone and volume. I do not consider it to be either quiet and intimate nor the loud and impersonal tones I have heard in others. Although she does not rush, neither does Nurse F pause after giving the explanation as there is clearly no expectation that Mrs Williams will reply.

Field Notes: Nurse F

The above extract contrasts Nurse F's practice with that of other nurses who could be either "loud or impersonal", or would make more physical contact and address patients in a quieter and more intimate tone. Nurse F's discussion of the above episode below reflects her unproblematic approach towards interacting with unresponsive patients.

F Well I mean I always- If someone is able to respond you've obviously got to give them a chance to do so

Int Mm

F Whereas obviously I'm not going to get a response out of her so I'm not going to wait for a yes or no ((*laughs*))

Int Mm

F I mean I- sadly I am just going to go ahead and do it ((*laughs*))

Nurse F: First Interview

Nurse F did not therefore appear to think about patients in such a way as to get caught up in a concern for the minute to minute experience of patients. Whilst on occasion she would engage in

social chat with patients who were awake for extended periods of time, she always appeared to control the timing and pace of these encounters such that she could withdraw from the conversation if other concerns or jobs became pressing.

This slightly detached approach was also evident in some aspects of the ways that Nurse F would deliver physical elements of care. As an example, for some nurses (particularly Nurse B and Nurse E), giving mouthcare was often associated with a slow pace of practice and particularly quiet and intimate speech, whereas for Nurse F it was achieved very straightforwardly:

Nurse F approaches Mrs Williams once more to give her eye and mouth care. She explains quietly what she is going to do, and then swiftly moves to insert a mouth sponge into Mrs William's mouth. Although she watches Mrs Williams intently whilst she works and explains her movements continuously, my interpretation is that her movements are expert, swift and 'clinical' as she does so.

Field Notes: Nurse F

Although I had an impression of this as a somewhat "swift and clinical" pattern of practice, I also gained an overall impression that Nurse F appeared to undertake activity associated with such fundamental nursing needs (e.g. eye and mouthcare; turning patients) more frequently than did those nurses for whom these were slower and more intimate interventions. Ultimately I gained an impression that Nurse F was particularly able to strike a 'balance' between expressing an empathic concern for the patients' experience at any moment, with a recognition that she needed to manage time in order to get work done and meet the patients nursing needs.

Nurse F had a clear interest in and fascination with the human body, and never displayed any form of concern regarding her interaction with the body. Other participants would at least on occasion display some kind of reaction to aspects of patients' bodies (such as occasional "yeuch" comments regarding wound drains), whilst Nurse F took some pride in never making any such response. In discussing these issues she once recounted a story of assisting a surgeon assess a patient with facial trauma which had required the exploration of the inside of the patients' face and eye socket with his finger. In discussing this she was aware of, and yet apparently unconcerned by, the 'depersonalising' effect of thinking about the patient as 'body'.

F I think probably you - with those things you probably have depersonalized

Int Hmmm

F You've taken the person away from that I think

Nurse F: Second Interview

Although therefore sometimes appearing 'detached' from the moment to moment lived experience of her patients, Nurse F (like Nurse D) seemed to be particularly strongly orientated towards thinking about patients in terms of whether they were making progress as is illustrated within the following extract:

As Nurse F returns from her break she comments to me that she hopes Mrs Hargreaves' nebuliser will now be finished so that she can get a gas done and hopefully wean her PEEP¹⁵ (she has previously mentioned to me that Mrs Hargreaves will not be ready for extubation until her PEEP has been reduced). Nurse F sounds quite genuinely enthusiastic in making these comments, in a way which contrasts with the majority of the shift so far where I have had the impression that everything is very routine. I note my impression that Nurse F only appears to be really interested when her patient is seen to be 'moving on', and has little interest in the maintenance of the status quo.

Field Notes

In interview, Nurse F was ambivalent when discussing some of the above comments, perhaps due to a perceived implication that she was not thinking about patients appropriately. Nonetheless she acknowledged that:

F If there's anything I can do on my shift that's going to see them progress in their weaning or whatever it is that they're doing, weaning their inotropes or , even in just mobility ... Obviously I think I'm

Int Okay

F Meeting their interests 'cos they want to get better as soon as possible. Maybe it is just a concentration thing that actually I don't have to think about doing the mouthcare and the turns

Nurse F: Second Interview

¹⁵ Positive End Expiratory Pressure. A pressure setting on a ventilator used to maintain alveolar volume and thus improve gas exchange.

Although Nurse F contested the implication that she was not concerned with patients' moment to moment experience, my impression was primarily one of contrast with other participants. Compared to other participants, Nurse F's practice was particularly marked by thinking about patients in ways which recognised that they would "want to get better" and "make progress".

4.2.8 Nurse G

Although one of the 'experienced' participants, Nurse G did not proclaim herself to be a particularly expert practitioner. She would do as she was asked by medical or senior nursing staff in a relatively unquestioning way without any overt concern to present herself as an 'autonomous' practitioner. Nurse G made particularly clear distinctions between her nursing role and the role of "the doctors" and would rarely discuss or think about patients in 'medical' terms. Where her own view differed from that of others (such as regarding the appropriateness of medical intervention interventions) she tended to express these views as her own intuitive understandings (explored below) rather than through presenting her own understanding of the patient in 'medical' terms.

This stance towards 'medicine' enabled Nurse G to position herself as somehow in-between the world of medicine and the world of the patient and their family in a way which is captured in the following extract:

Mr Stevenson's daughter enquires about why Mr Stevenson received a blood transfusion overnight and Nurse G begins by explaining that his haemoglobin levels had been six or seven and that a man of his age and stature should have levels closer to ten. Whilst talking, Nurse G is looking from Mr Stevenson's wife to his daughter, and I am not quite sure they are following her. In a tone which I consider to be 'joking' Nurse G observes that the decision making is complicated, and suggests that it is something of a mystery to her as well. My impression is that this comment relieves some of the families' tension and uncertainty, and that Nurse G is trying to indicate that she too is only one of the 'little people' in the organisation in a way which makes it clear that she is in some way on the family's side.

Field Notes: Nurse G

This extract captures my sense of the way in which Nurse G would present herself as an 'ordinary person' who was just like the patient and their family. This distancing of herself from 'medical' ways of thinking about patients also seemed to influence her attitude towards the use of

technology and patient monitoring, and she would often appear not to take particular heed of the information given from such devices as the PiCCO¹⁶ cardiac output monitoring machine in the below example:

Nurse G has just reset something on the PiCCO machine and is waiting for the figures to settle before taking a reading. I gain an impression that she seems slightly impatient as she waits and comments that it is a “stupid machine”. After about a minute the Stroke Volume Variation (SVV) eventually gives a reading of 26%. On seeing this, Nurse G comments “twenty-six!” in an incredulous tone and turns away. I gain a feeling that she either does not believe, value or trust the technology.

Field Notes: Nurse G

In the main Nurse G appeared to take the view that nursing staff had responsibility for maintaining and calibrating such equipment whilst the interpretation of results lay within the remit of medical staff. Consequently she did not generally appear to think about patients in ways which depended upon an understanding of the patients’ physiology or as represented by technology.

Nurse G made frequent reference to forms of knowledge about patients which appeared ‘intuitive’. She would often claim to “just know” that a patient was not going to do well and yet find it difficult to justify or explain where this knowledge came from. The following example is typical:

She tells me that the nursing team need to have a conversation with Mrs Stevenson in order to get across to her how things are going. I ask why she feels it is important to have these conversations with the family today, and Nurse G gestures to Mr Stevenson saying to me very quietly that he looks as though he is “giving up”.

Field Notes: Nurse G

The following exchange occurred when Nurse G was asked to explain where this sense came from in a subsequent interview. Jeffersonian notation is retained primarily to demonstrate the hesitancy and pauses in her speech.

¹⁶ PiCCO® - Continuous Pulse Contour Cardiac Output measurement device (Trademark registered to Phillips)

- G** its hard to put into ↓words (4) er::m (3) and I don't know how I can put it into words
- Int** mmm
(2)
- G** it's just a f:eeeling that I've got (.) I was going to say in my bones but that
- Int** ((*laughs*)) mmm?
- G** That's not (4) hhhhhh I really and truly don't know how to put it into words

Nurse G: First Interview

Nurse G frequently expressed doubts over her patients' prognosis even when other members of the team did not. This claimed intuitive sense was not presented as a 'medical' understanding, but was often expressed by means of suggesting patients' *intentions* through phrases such as "he just wants to ...". The way that Nurse G spoke therefore appeared to suggest that she had an understanding of patients that arose from having a direct insight into the intentions and wishes of the patient themselves.

Nurse G habitually demonstrated relatively intimate patterns of communication including the use of touch, as she would often hold patients' hands or stroke their brow at the beginning of any episode of care. Nurse G verbally communicated with patients much more frequently and less self-consciously than some other participants, informing or telling patients about every small intervention or touch and appearing particularly attuned to the patients' immediate needs or comfort. I often also gained an impression that she spoke to patients almost abstractedly whilst she remained apparently focussed on her own thoughts. Many of these features are evident within the following extract:

Nurse G begins to replace the bag of saline for the arterial flush which is currently empty. As she does so Nurse G notices that Mr Thompson's arm is lying on the intravenous tubing and its roller clamp. She gasps "oh you poor thing", lifts his arm up and moves the tubing, then rubs the spot on his arm which was lying on the roller clamp. She frowns again as her gaze moves between examining Mr Thompson's arm and looking into his face, and comments again "Oh you poor darling". I am struck that, whilst these comments express her concerns *about* Mr Thompson, they are not apparently directed *to* him.

Field Notes: Nurse G

Nurse G therefore did not often appear to think about patients' prognosis or illness trajectory in the same way as other participants, but rather tended to think about patients in ways which were empathic and responsive to patients' 'here and now' experience.

This chapter has provided an overview of the work on the unit, and has introduced the seven primary participants in the study. Sections 4.2.2 to 4.2.8 have also begun to make clear that the distinctive nature of the practice of these participants could be defined by introducing contrasts between different ways that these nurses would think about patients. Nurses could focus on the 'routine' delivery of care, or may recognise and respond to the patient as 'unstable'. They may think about patients in terms of the 'work' which they need to do, or in terms which sought to understand the patient as a 'medical case'. Some participants could demonstrate an intimate or emotional involvement with the moment to moment experience of patients which contrasted with the way that others would recognise and respect normal social boundaries.

Although several such distinctions between apparently different ways of thinking have been introduced, they have not been fully explored or made explicit. Chapter five will now turn to a detailed analysis of these data in detail in order to make explicit the different ways in which these nurses were thinking about patients during the delivery of nursing care.

5.0 Seven ways of thinking about patients

Chapter four has provided an overview of nurses' work on the unit and an introduction to key participants in the study. This discussion has begun to introduce some distinctions which may differentiate different ways in which these nurses would think about patients. Within the current chapter these distinctions will be made explicit in order to set out the seven different ways in which participants in this study were found to think about patients. Sections 5.1 to 5.7 therefore characterise how nurses would think about patients as 'routine work'; as an '(un)stable set of body systems'; as 'body'; as a 'set of needs'; as a 'medical case'; as a 'social being', and as a 'valued individual'.

Prior to setting out these findings it is important to acknowledge that all participants in the study thought about patients in each of the seven different ways outlined. Although the recruitment strategy of the study reflected an understanding that more experienced practitioners *may* think about patients differently there was a sense in which this was not found to be the case. The practice of more experienced critical care nurses was characterised by the fluidity with which they could *move between* these different ways of thinking, rather than by their thinking about patients in ways which were entirely unique. The differences between novice and more expert practice are noted here but are fully considered in chapter six.

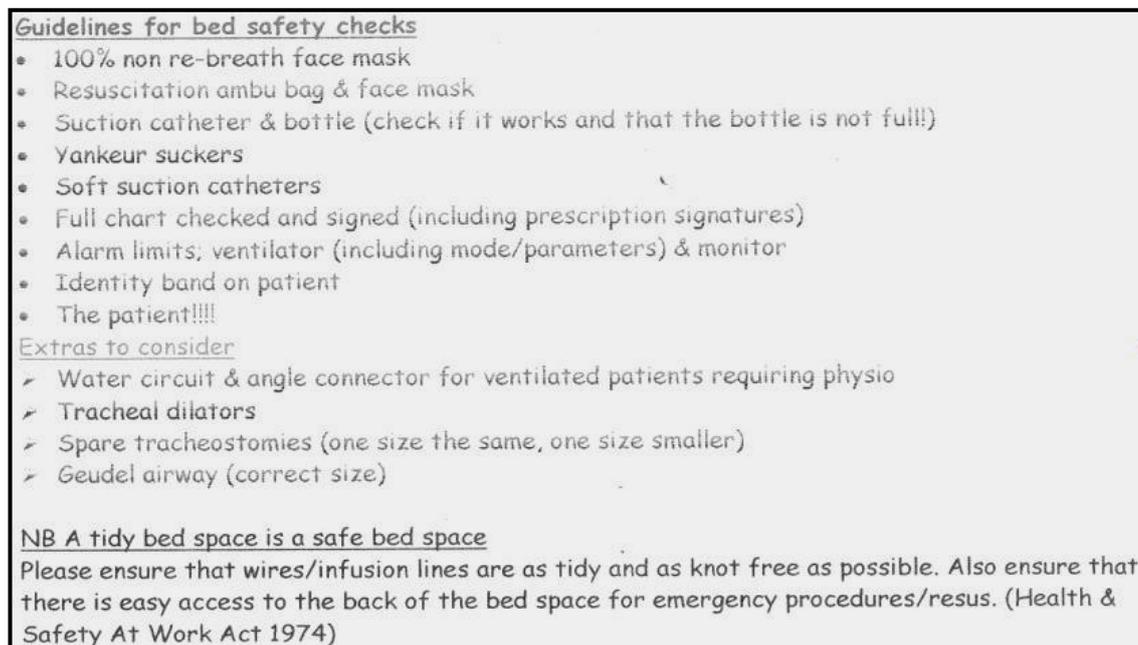
Consideration has also been given to the sequence in which to present these different ways of thinking. This decision has partly been informed by the fact that those ways of thinking presented early in this chapter introduce themes and distinctions which are elaborated upon in later sections. Very broadly speaking the order in which these ways of thinking are presented may also be seen as a hierarchy in which the patient is increasingly identified and recognised as a unique individual although this approximation must be considered with some caution. The ways in which these different ways of thinking may properly be seen to relate to such a "specification hierarchy" (Lemke 1995) is considered during discussion in chapter six.

This section is a presentation of these findings, and does not discuss their significance or relation to the substantive nursing literature. This chapter does make reference to the work of theorists such as Goffman (1959, 1961, 1974, 1981) and other discourse theorists where this enhances an understanding of how findings emerged from the analysis of these data.

5.1 Thinking about the patient as routine work

In section 4.1 it was observed that the unit was a place of work in which rules and routine ways of working were clearly evident and in which there was a major focus upon maintaining patient safety. Both of these factors are reflected in the “Guidelines for Bed Safety Checks” (Appendix 14) part of which is replicated below in figure 8. These guidelines were available or displayed within each bedspace on the unit.

Figure 8: Extract from the unit “Guidelines for Bed Safety checks”



Guidelines for bed safety checks

- 100% non re-breath face mask
- Resuscitation ambu bag & face mask
- Suction catheter & bottle (check if it works and that the bottle is not full!)
- Yankeur suckers
- Soft suction catheters
- Full chart checked and signed (including prescription signatures)
- Alarm limits: ventilator (including mode/parameters) & monitor
- Identity band on patient
- The patient!!!!

Extras to consider

- Water circuit & angle connector for ventilated patients requiring physio
- Tracheal dilators
- Spare tracheostomies (one size the same, one size smaller)
- Geudel airway (correct size)

NB A tidy bed space is a safe bed space
Please ensure that wires/infusion lines are as tidy and as knot free as possible. Also ensure that there is easy access to the back of the bed space for emergency procedures/resus. (Health & Safety At Work Act 1974)

The reference to “The patient!!!!” on this list of items to be checked marks a clear recognition by practitioners within the unit that there was a sense in which patient may be forgotten, even whilst the (excessive) four exclamation marks imply that this really should not be the case. The claim that “A tidy bed space is a safe bed space” further highlights the link between routine working practices and patient safety, and is given added emphasis through bold lettering and appeal to the authority of the Health and Safety at Work Act which invokes the power of the law (with implications of control, censure and punishment).

For these participants, the relationship between ‘work’, ‘tidiness’ and ‘safety’ was established by a Discourse of routine working practices which set up a way of thinking in which the ‘patient’ had virtually no role other than to be the site of ‘routine work’. This Discourse set up an expectation that nurses would undertake routine and predictable elements of care delivery at appropriate times, whilst maintaining tidiness, control and order within the physical environment for which

they were responsible (such as through keeping working surfaces tidy, bedsheets straight and intravenous lines untangled). At times this was acknowledged with some humour as illustrated by the following comment made after a participant and I had helped to turn a patient in bed:

I bend down to carefully straighten the bed sheets on my side of the bed and as Nurse 7 sees this she comments to me in a mock patronising tone
“Good boy Chris”

Field Notes: Nurse 7

When participants were thinking about patients in this way, this focus on keeping tidy and getting the work done was associated with a noticeable lack of engagement with the patient’s own experience. This lack of ‘engagement’ can clearly be seen in the following two extracts:

After one particularly violent cough, the other nurse moves around the bed and replaces the saturation probe on Mrs Yates’s nose. She makes no comment to Mrs Yates herself and does not break off from what she is saying to Nurse 2. Having replaced the probe, she moves around the bed and delivers a bolus of the sedating agent propofol. Throughout all of this, the nurse giving the handover remains orientated towards Nurse 2 and maintains her chain of thought in relation to the handover. At no stage in this interaction does she address Mrs Yates

Field Notes: Nurse 2

...at the end of treatment, I see that Nurse 5 is almost absent-mindedly tidying the monitoring cables – not only ensuring that Mrs Williams is not lying on any cables in a way that could cause discomfort, but also ensuring that the cables fall neatly away from the monitor itself and remain untangled

Field Notes: Nurse 5

Many nurses talked about the way this almost ‘obsessive’ focus on maintaining control and order was central to their identity as “Intensive Care nurses”. Close analysis of these data enabled this to be recognised as one aspect of a Discourse of routine working practices in which the patient was thought about as ‘routine’ work. Keeping tidy in this way was a habitual way of undertaking work, but thinking about the patient in terms of ‘routine’ work was also particularly characterised by a focus on those tasks that were acknowledged as predictable and universal, and which were “always going to need doing”:

..but those are routine to do things that are always going to need doing. Eye and mouthcare, turning, suctioning all need- Blood gases always need doing.

Nurse 5: First Interview

These “routine to do things” were undertaken simply because it was ‘time to do x’, or because ‘we always do x’. This Discourse therefore sets up a primary focus on the *things* that need to be done, rather than on any other aspect of the patient. It was a notable linguistic feature of data relating to this way of thinking that the ‘patient’ was frequently absent as a grammatical subject. In saying that they were going to “do a turn”, “do a gas”, or that they had “drugs to give”, nurses demonstrated a way of thinking about the patient as simply the site at which routine tasks or work were undertaken. Because these things *always* needed doing rather than representing unique needs, such talk constructed patients as having no relevant unique attributes.

The most common and significant ‘routine’ activity for nurses on this unit was performing observations or ‘obs’. Physiological observations were almost uniformly recorded not only hourly, but *on* the hour, and this hourly need to do the ‘obs’ imposed a structure to work on the unit. Participants would frequently talk about what they needed to undertake within the next hour (i.e. between sets of observations), or would otherwise make clear that doing the ‘obs’ was central to structuring or organising their time:

As she finished documenting the observations Nurse 7 comments to me that she tends to ‘cluster’ her care. I ask her why she does this with a patient such as Mr Norton and she tells me that doing so helps her to keep organised

Field Notes: Nurse 7

Nurse 5 looks up from the nurse’s station towards the group of doctors who are on the ward round. They are now with a patient a couple of beds away, and she stands up with the comment

“So – the 5 o’clock obs, do the ward round and do some eye and mouth care”

Field notes: Nurse 5 (time recorded was 16:50)

Routine ways of thinking about patients were therefore reinforced by this hourly need to ‘think about’ the patient as the thing / object / being to which things must be done. A striking feature of these data was that this hourly need to undertake observations had the effect of restricting what may be termed the ‘temporal horizons’ of these nurses. ‘Temporal horizons’ is a term which was

to reflect the fact that when thinking about the patient as 'routine work' nurses would only appear to think about the patient in terms of what was relevant within a relatively short period of time (such as in the next hour between sets of observations), rather than thinking about the patient as existing over a longer timescale. The significance of these restricted temporal horizons, and particularly the role of understanding the 'medical case' as a means of broadening them, are explored in Chapter seven.

Goffman (1974) notes that all 'frames' involve expectations about how deeply the individual is to be involved in activity, and that such involvement may be cognitive or affective. Within these data 'routine' behaviour was recognised by the way in which nurses would frame their activity as requiring no involvement. Thinking about the patient as 'routine work' required neither sustained concentration or thought (cognitive involvement), nor did it involve expressing any emotional connection with or empathy for the patient (affective involvement). This concept of involvement (and the distinction between cognitive and affective involvement) is of some significance to later discussion in relation to other ways of thinking.

The following extract serves to give an indication of the limited 'involvement' with patients which characterised 'routine' activity within these data:

Once I have checked the clonidine infusion with Nurse 2 she changes the infusion over at Mrs Yates's central line with no comment to the patient. As she works she places the old empty syringe on top of Mrs Yates and it rolls down the bed to rest against Mrs Yates's hand. Nurse 2 tuts and moves to catch it, but pulls back when she sees that the syringe has been stopped by Mrs Yates's hand and is not going to fall. It appears to me that Mrs Yates is not acknowledged by Nurse 2 to be anything other than a slightly uneven working surface!

Field Notes: Nurse 2

The activity of changing the syringe may be considered as 'routine' primarily *because* the nurse is not involved in what she is doing. She is neither concentrating upon what happens to the old syringe (hence allows it to roll), nor is she demonstrating a responsiveness to Mrs Yates own experience at this time (else she would have acknowledged her as something more than a working surface).

Some participants recognised that this lack of involvement in routine activity could lead nurses to adopt 'stock' or 'routine' phrases which were of little or no meaning to patients themselves:

N I think a lot of the times we say things that patients are not gonna understand
- like I'm just gonna suction you. Well that doesn't actually make any sense

Nurse 7: Second Interview

Through using such phrases which may be of limited meaning to patients nurses can be considered to be failing to respond to patients own concerns and experience. Another way of putting this is to note that where a nurse's d(D)iscourse failed to respond to such concerns and the patients' experience, they were adopting a Discourse which *constructed* the patient as having no such concerns or experience.

A similar lack of involvement was seen in an incident involving the care of Mrs Burns which was previously introduced whilst discussing the status of interview data in section 3.3.8. Mrs Burns had been confused and distressed throughout the shift in question, and this had been understandably exacerbated when she had been incontinent of faeces. The participant and I were helping her to clean up and change when the following was observed:

Nurse 3 then assists Mrs Burns in standing so that she can clean her bottom. As she does this her movements seem to me to be mechanistic. She seems distracted and turns her attention to me. We have had an earlier discussing my role as a nurse educator, and Nurse 3 chooses this moment to mention to me that she has heard about a potential job in California as a teacher. She continues to talk to me about this opportunity while cleaning Mrs Burns.

Field notes: Nurse 3

The reference to this nurse's "mechanistic" movements and my own characterisation of this practice as "distracted" both point to her lack of involvement in the activity. She is neither concentrating on her actions nor demonstrating any emotional sensitivity to the patients' distress and embarrassment, but is only thinking about the patient as little more than the physical site at which work needs to be done. Although this was not a routine activity in the same sense as being 'work' which "always needs doing" it is this lack of involvement which was the primary characteristic of routine activity. At this moment in time the nurse gave Mrs Burns no form of reassurance or explanation of what was happening, and thus did not engage with Mrs Burns as a person who had her own experience of what is happening. Thinking about the patient as 'routine work' therefore failed to recognise patients as having any relevant subjective experience, let alone having autonomy and control over that experience.

A *total* disregard for the patient as an experiencing subject was not seen in all 'routine' interactions. The following example was typical of many encounters and relates to an episode when a group of staff (including myself) were helping to turn Mr Turner who was heavily sedated and unresponsive:

We all now gather around the bed again to turn Mr Turner onto his right side. Initially communication with Mr Turner is restricted to both the second nurse and Nurse 6 giving very simple information or commenting regarding what was happening. (e.g. "Over to me"). These exchanges are abnormally loud for normal speech and I note that they seem quite impersonal in intonation.

Field Notes: Nurse 6

This 'commenting' whilst physically handling patients was a regular feature within these data and called for examination. Whilst routine activity was characterised by a failure to recognise the patient as an experiencing subject, Mr Turner *is* acknowledged as having an experience in as much as these comments are directed to him. Determining whether or not nurses were thinking of Mr Turner as having a (relevant) subjective experience was therefore dependent upon whether such comments were directed towards Mr Turner, or simply served to help co-ordinate activity between staff.

The analysis of the above data extract therefore requires consideration of what Goffman (1981) describes as "participation status". Other staff were certainly intended to overhear comments such as "over to me", but it is not clear whether Mr Turner is the primary "addressee" (Goffman 1981) for these comments or whether he is simply anticipated to overhear comments which were primarily directed to staff. A similar ambiguity was apparent in the analysis of other episodes within these data, and this ambiguity itself could be seen to serve a role. Communicating with patients who did not respond verbally could lead to a certain 'awkwardness' for some nurses (discussed further in section 5.6), whereas addressing comments and instructions purely to other staff would also be problematic as nurses would be seen (in front of others) to totally exclude the patient from discourse. In analysing such episodes it could be seen that these two problematic positions can be avoided by addressing comments such as "over to me" to an "open floor" (Goffman 1981). It was common within these data for nurses to address comments in such a way that they could be heard as directed to anyone who happened to be listening. In this way nurses could avoid the awkwardness that came from addressing an unresponsive patient, and yet avoid the charge of excluding or forgetting the patient.

The above considerations are relevant to the ways in which nurses would think about patients. Such patterns of communication did not completely ignore the patient, but neither did they construct the patient as the primary focus of nurses' attention. Although this remained a pattern of activity which could be characterised as 'routine', the fact that nurses avoided completely excluding the patient demonstrates that they retained some subsidiary awareness of the patient as an experiencing subject. The nature, status and significance of this 'subsidiary awareness' is explored further in chapter 6.

When thinking about the patient as the site at which work was undertaken, participants did not always meaningfully distinguish the physical 'patient' from other objects around them. The following extract describes a participant responding to an infusion pump which had been alarming due to an occlusion.

Nurse 3 approaches Mr Langden and begins to flush the central line with no explanation of what she is doing. As she tries to see what the problem is she is looking primarily at the central line itself. Nurse 3 says "turn please", although I consider this to be said monosyllabically and almost under her breath, and as she speaks her hand is already pushing Mr Langden's head to the side. Once Mr Langden has turned his head Nurse 3 comments on the fact that the central line is kinked due to the way it has been put in

Field notes: Nurse 3

Although Mr Langden was physically present in this incident, his body was not the primary focus of the nurses' activity. In the above passage, the participant's actions were directed towards the infusion equipment or the line which she flushed, examined and manipulated. The physical manipulation of Mr Langden's head appears simply as an extension of manipulating the line itself, and this physical mode of discourse itself constructed the 'patient' (the focus of the nurse's activity) as the site of work which was centred upon, but only loosely spatially identified with the physical body of Mr Langden. The data does not record this nurse making any use of gaze or alteration in posture to demonstrate an awareness of Mr Langden as an experiencing subject, but only acknowledged Mr Langden with the brief, truncated phrase "turn please". This 'monosyllabic' comment was uttered "under her breath", and appears to have served as a contextualizing marker for the nurse's actions (again addressed to an 'open floor'), rather than as a question or command which invited a response. Again, this marker may be taken as evidence of

the nurse maintaining some subsidiary awareness of Mr Langden as an experiencing subject even whilst treating him as a site of work.

Although routine work often related to tasks that “always needs doing”, and was associated with nurses habitually working in ways which maintained neatness and order, nurses’ lack of involvement in the work that they were doing was the primary characteristic of thinking about the patient as ‘routine work’. The key features of the patient as constructed by the Discourse of Routine Working Practices are set out in figure 9 below.

Figure 9: Thinking about the patient as routine work
The nurse is thinking about the patient as: <ul style="list-style-type: none">• The site at which work is undertaken.• Not demanding of concentration, emotional attachment or involvement.• Publicly known.• Only loosely spatially centred on the physical body.• Unchanging and predictable with no unique attributes.• Having no subjective experience.• Existing in the here and now rather than having a continued existence over time

5.2 Thinking about the patient as (un)stable

A key function of critical care units is to keep patients safe, and within these data this was demonstrated in the concern of nurses to ensure that patients were ‘stable’. Whether or not patients were considered ‘stable’ was constructed through a distinct Discourse of safety and stability. Within the terms of this Discourse the nurse’s role was to ensure the safety and stability of the patient by observing the patient (primarily via the media of technology) and through controlling detailed aspects of the patients’ treatment. Defining patients as stable particularly required nurses to ensure that specified physiological ‘targets’ or ‘parameters’ were achieved and maintained. These targets typically included oxygen saturations, partial pressure of oxygen, blood pressure, urine output, Central Venous Pressure and other observations. In so far as they were ensuring that patients’ physiology remained within these prescribed parameters nurses would think about the patient as an (un)stable¹⁷ set of body systems.

¹⁷ The formulation ‘(un)stable’ is used to indicate that in thinking about patients in this way nurses are constructing the patient as either stable or unstable

Participants talked about their ability to think about patients as '(un)stable' as central to their identities as critical care practitioners, and as an aspect of their role which they could enjoy or experience as exhilarating. This is captured in the following brief extract from an interview with a more experienced practitioner:

N Although you can get the adrenaline surge with the HDU patients when they go off I think A&E nurses, ICU nurses get the real sick patients who - you know. It's kind of everything needs doing yesterday and you're kind of chasing your tail and it just gets the adrenaline rushing.

Nurse 5: Second Interview

The way in which participants experienced this "adrenaline surge" was evident in the following comments which these field notes themselves record as being both familiar and yet in need of explanation and exploration. The extract records this nurse's reaction as she took over the care of Mr Thompson who had deteriorated during the previous day and was showing clear signs of SIRS¹⁸ and ARDS¹⁹:

Nurse 5 smiles broadly as she comments to me that this is "exciting". She jokes that she handed over a stable patient this morning, and that the day staff have 'broken him'. I do not feel she is implying that she finds the situation to be funny, but I am nevertheless intrigued by the light hearted and humorous way in which Mr Thompson's deterioration is commented upon. The emotional tone of her comment appears to me to be inappropriate in the context of what is happening to the patient, yet I feel they are typical of the comments and reactions of many nurses on the unit.

Field Notes: Nurse 5

Thinking about patients as (un)stable was therefore a way of thinking about patients such that they were understood as an (un)stable set of systems which may "go off" or "become compromised". A primary feature of thinking in this way was that the patient was constructed as unpredictable, and this potential instability meant that patients in critical care needed to be closely monitored and controlled in order to remain stable.

¹⁸ Systemic Inflammatory Response Syndrome. In relation to Mr Thompson this meant that he was requiring increasing amounts of support in order to maintain his blood pressure

¹⁹ Acute Respiratory Distress Syndrome.

The following data extract serves to illustrate many of the ways in which thinking about the patient as '(un)stable' could be characterised, and how nurses were dependent upon technology to ensure that patients remained 'stable':

The sister is catching up with Nurse 4 about what has happened during the day whilst Nurse 4 is in the process of changing over the noradrenaline²⁰ infusion. In this unit, inotropes are changed by 'piggy-backing' the two infusions²¹, and Nurse 4 is very closely attentive to the cardiac monitor as she weans down the original infusion. For 3 to 4 minutes whilst completing the transition Nurse 4 is completely motionless and is almost monosyllabic in her responses to the sister as she watches the monitor and responds every few seconds to changes in blood pressure by making alterations in the rate of the infusion. After a minute or two of trying to communicate, the sister leaves saying that she will catch up with Nurse 4 later.

As Nurse 4 finishes piggy backing the noradrenaline, I notice that she has not only weaned off the original infusion, but has also reduced the rate of the initial infusion from 11 to 9 ml / hr. She remains closely attentive to the monitor as she comments to me that "They want a mean pressure of 75".

Field Notes: Nurse 4

Whilst these notes describe the nurse as being 'closely attentive' to the cardiac monitor, her focus was not upon the accuracy of the readings or the setup of the display, but upon the meaning she was interpreting *from* the monitor. A critical care practitioner can readily make the inference that this nurse was closely focussed upon the patients' cardiovascular system and was making appropriate responses in order to maintain the patients' blood pressure. It is clear that this required a high degree of concentration, but is also noteworthy that she was highly involved in the 'here and now' as she responded "every few seconds" to changes on the monitor. Rather than focussing on patterns or trajectories within physiological changes, thinking about the patient as

²⁰ Noradrenaline is a powerful vasoconstricting drug which is delivered by a continuous infusion.

²¹ Piggy – backing refers to a way of replenishing the infusion whereby a second full syringe is started concurrently with the first before the nurse then respectively increases and decreases the rates of the new and old infusions until the old infusion has been discontinued. This avoids any potential break in the delivery of the drug as the syringes are changed.

(un)stable was a way of thinking in which only the 'here and now' was of significance. In doing so, thinking about patients as (un)stable constructs patients as existing in the here and now rather than as having an ongoing identity with a relevant past or future.

The concentration of the above nurse whilst 'piggy-backing' inotropes also illustrates the cognitive involvement (Goffman, 1974) which could be associated with thinking about the patient as (un)stable. Thinking about patients in this way did not always require such intense and sustained concentration, but nurses' ongoing involvement with the (un)stable patient was often evidenced in their commentary which could reflect an ongoing concern with whether they were achieving 'targets':

Nurse 2 documents the observations and adds up the fluid balance charts. She comments to me that
"I'm not achieving my balance".

Field Notes: Nurse 2

The focus of the participants in the above examples on the 'cardiovascular system' or 'fluid balance status' is typical in that this was a way of thinking about patients which concentrated upon discreet body systems. Nurses were not thinking about the patient as physically embodied, but rather were constructing the patient as a set of physiological systems which were largely known about through the medium of technology. This way of thinking about patients as a set of systems could be seen in the structure of the nurses' bedside handover. As noted in section 4.1, as a part of handover nurses were expected to describe patients as a series of discreet body systems (e.g. "respiratory wise"; "CVS wise"; "GI wise"). Thinking about patients as (un)stable therefore involved recognising body systems as discreet and distinct, rather paying attention to the relationships between these systems in a complex organism. This was a key distinction between thinking about the patient as (un)stable, and thinking about the patient as the 'medical case' (discussed in Section 5.5).

As references in the above extracts to "achieving my balance" or that "they want a mean pressure of 75" make clear, medical staff on the unit would usually set 'targets' or 'parameters' for blood pressure, urine output, Central Venous Pressure (CVP) and so on. These targets were usually formally stated and documented during medical ward rounds, often at the behest of nurses who would ask for such parameters to be set. Thinking about the patient as (un)stable largely related to whether or not these targets were met and was therefore a way of thinking about patients in

quantifiable and precise terms. This need for precision was recognised by staff on the unit and occasionally referred to with some humour. This is exemplified in the following comment by a nurse who had just totalled up the fluid chart at the end of a 24 hour period in the care of Mrs Hargreaves:

With a tone that seems to imply mock pride, Nurse 5 points out to me that Mrs Hargreaves has a fluid balance of -1548 ml and that the target fluid balance for the day was -1500 ml. She adds that she thinks that the team will forgive her the 48 ml.

Field Notes: Nurse 5

In this 'joke' the nurse appears to be thinking about the patient in two ways. In one sense, the patient is a being which needs to be precisely quantified and managed, yet by expressing the judgement that the 48 ml is of no clinical significance this nurse implies that she is thinking about the patient as a 'medical case' (see section 5.5). Following Goffman (1974), the source of humour may be seen to stem from the tension between these two "laminated" framings of the same situation. Given that the ways in which nurses would think about patients were generally distinct and mutually exclusive, humour involving such 'laminated' frames is explored as a negative case within chapter six.

'Targets', 'aims' or 'parameters' were usually set in precise and quantifiable terms, and a lack of precision could be a source of concern for some nurses, as the following extract involving one of the participants receiving a handover makes clear:

A junior doctor is standing at the chart and the second nurse calls loudly across him to inform Nurse 4 that

"The trouble is there's no aim. They want him on the dry side but there's no aim".

Field notes: Nurse 4

This nurse is articulating a claim that "on the dry" side is not appropriate as an aim because of the lack of precision. In the words of one medical consultant these targets were often set by "simply picking a figure out of the sky" and yet the precise quantification of targets had a noticeable impact on nurses' behaviour. Participants would often only respond to gradual changes in patients' condition when clearly stated 'parameters' were breached, without giving consideration to the relevance or appropriateness of these 'targets', or to the significance of changes in the patients' condition. This is made clear within a further extract from these data which describes

one of the most experienced critical care nurses in the study responding to the 'absolute value' of a parameter:

Mr Young's oxygen saturations drop to 83%. Nurse 5 comments to me that 'they' want his 'sats' to be above 85% and moves to the cubicle doorway. She watches intently through the doorway as the sats rise to read 84% and then 85%. Once Mr Young's monitor shows that his oxygen saturations are 85%, Nurse 5 brusquely turns away from the doorway and continues her conversation with me. It is clear that so long as they remain above this level she sees no immediate need to intervene.

Field Notes: Nurse 5

This critical care nurse was one of the most experienced participants, and yet this extract shows how her moment to moment practice could be guided by the absolute value of a (relatively arbitrary) target. She does not appear to consider the limited clinical significance of a change in oxygen saturations from 83% to 85%, nor does she demonstrate an overt regard for trends over time or what may have caused this change (though she did begin to investigate causes, trends and so on later in the shift when Mr Young's 'sats' remained below 85% for some time). Such data demonstrate that the use of such 'targets' could have a powerful impact on nurses' moment to moment decision making.

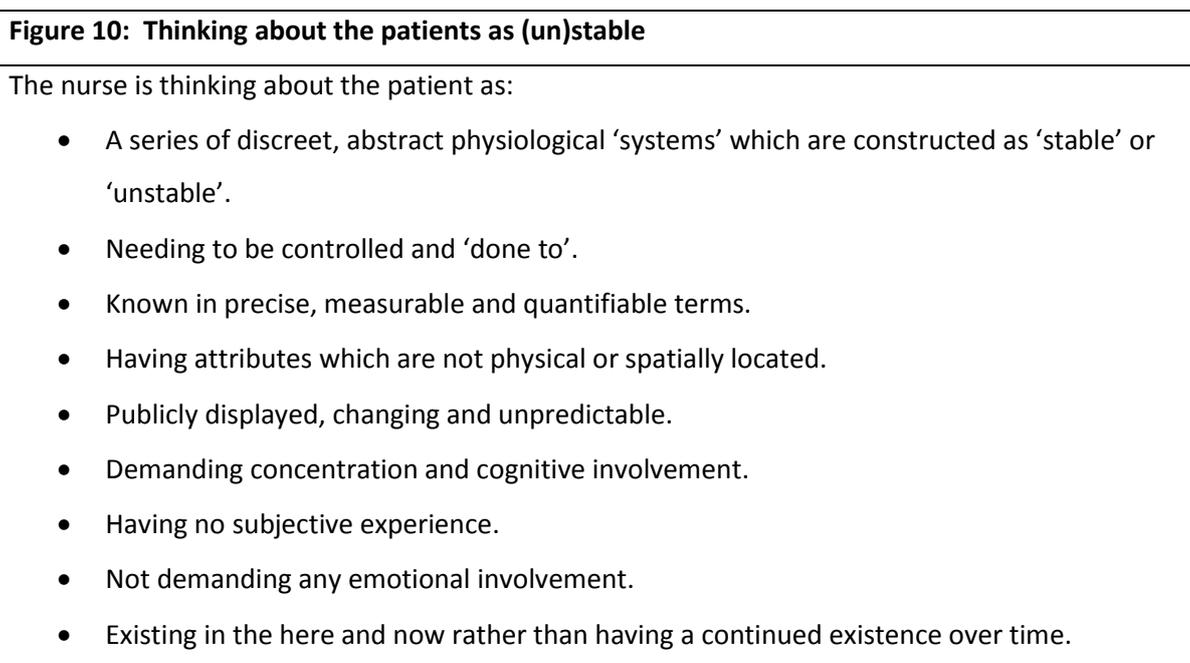
A final extract from these data in this section makes clear that thinking about patients as (un)stable did not require patients to be understood as being embodied or having a particular spatial location. The following episode was recorded whilst an experienced participant and I were sat at a nurses' station.

Nurse 5 looks away from the console and calls out to ask if the nurse in bedspace 4 is okay. The nurse and the patient in this bedspace are behind curtains, and the nurse calls back that she is fine. Nurse 5 raises her eyebrows, looks to me and gestures to the monitor where I see that the systolic blood pressure of this patient is reading as 60 mmHg. One of the doctors at the desk turns to tell us that the patient is still lucid and still producing urine and explains that this is why they are not "running around" more urgently. Nurse 5 acknowledges this then looks back to the monitor. She comments as the patient's systolic blood pressure drops to 55 that even if the patient is lucid "I don't like 55".

Field Notes: Nurse 5

It is the fact that this nurse is physically distant from, and cannot see, the physical patient in bedspace four which establishes that she was responding purely to the value of the blood pressure seen on the central console. The comments of the doctor, and the participants' later reference to "even if the patient is lucid" highlight that both the participant and the doctor can think about this patient in at least two contrasting ways. Within one frame (thinking about the patient as 'unstable'), the salient fact is the blood pressure which demands an appropriately urgent response by virtue of its absolute value and regardless of other factors. Within a second contrasting frame (thinking about the patient as 'medical case') the blood pressure is only accorded meaning in relation to its clinical significance. This participant appears to oscillate between these two alternative frames, or is at least ambivalent over which is most appropriate.

The key points of the above discussion regarding thinking about the patient as (un)stable are summarised in figure 10 below.



5.3 Thinking about the patient as a body

Despite the fact that physical illness or injuries to the body were the reason for patients' presence within the critical care unit, a primary focus on the body of the patient itself was not a particularly prominent feature of these data. This in itself was a significant finding, and in chapter seven potential reasons for this curious lack of focus on the body are explored. Whilst patients' bodies were frequently the site of nurses' work, nurses were generally thinking about or focussing on the

work which they were doing rather than on the body of the patient. Other than when involved in 'intimate' aspects of care such as washing patients, nurses tended to pay specific attention to the patients' body only briefly and to a specific purpose.

Naturally there were occasions on which the physical body of the patient was the focus of nurses' discourse, usually as a site of examination, and a distinctive Discourse of the body could be recognised in such encounters. This Discourse related to how the patient was seen and examined, and constructed a concept of how the patient 'looks':

Nurse 4 has earlier commented to me on a red area on Mr Richards' ankle and has removed his TED stocking ... she lifts up the sheet to expose Mr Richards' foot, and begins to prod and poke the exposed ankle in order to demonstrate the point she is making

Field Notes: Nurse 4

The Discourse of the body involves nurses in thinking about the patient as body which may be seen or examined, rather than an embodied person. In many ways this way of thinking about the patient can be described in terms of what the patient is *not*. The following provides a further example

Nurse 7 lies the bed flat and lifts the bedsheets, then begins to probe at Mr Norton's flank commenting to me that he has some apparent cellulitis. Nurse 7 asks me to roll Mr Norton towards me slightly so that she can see better ... Once he is on his side, Nurse 7 prods and probes once more at Mr Norton's side. Her only commentary is to me as she tries to highlight to me the extent of his cellulitis.

Field Notes: Nurse 7

By lifting the bedsheets and exposing Mr Norton (particularly with no comment or explanation) this nurse establishes Mr Norton as a thing for which issues of privacy and dignity do not arise. She asks me to roll the patient, rather than addressing the comment to him, and thus fails to recognise Mr Norton in any way as a participant in the interaction. Through ignoring his subjective experience and rights over his own body, this appears to be thinking about Mr Norton in a way which denies him an identity as a person to whom any explanation, apology or request is appropriate prior to such exposure. This is thinking about the patient as a visible and corporeal object which is to be examined, but little else may be said to positively characterise this identity.

Thinking about the patient as 'body' was also seen to involve only a consideration of how the body actually looks and responds, rather than interpreting what this means (which may involve thinking about the patient as a medical case). The following extract illustrates this difference in an account of how one relatively inexperienced nurse described only the 'surface features' of the body, and required Nurse B to hypothesise about what this may actually mean.

The nurse handing over mentions to Nurse 1 that at one point during the morning that Mrs Jones had become 'a bit grey', and that he had given her a nebuliser which was "nearly due" at that time. Later on, when asked by a doctor how Mrs Jones has been doing, Nurse 1 mentions this incident. She describes how Mrs Jones had become "a bit grey" but shrugs as she says this and adds that it "might have been some bronchospasm". My interpretation is that "a bit grey" is an inappropriately vague turn of phrase which requires justification.

Field notes: Nurse 1

My own descriptions of activity within the field notes offer further insights into the nature of this Discourse. On occasion physical interactions within the field notes were described in terms of 'prodding', 'probing', 'yanking', or as being 'mechanistic'. Whilst such descriptions are relatively infrequent in these data overall, this itself highlights how the perceived the "tenor" (Halliday, 1978) of these interactions contrasted with the majority of the practice which I observed. My use of this terminology itself marks my recognition of this contrast given that it is objects and not people who are prodded and probed.

The following data extract makes clear how this contrast could appear in the recording of a participant's practice:

Once she has documented the main observations, Nurse 4 moves close to Mr Thompson and addresses him by first name for the first time in the shift. She bends down close to him and speaks quite quietly and softly as she explains that she is going to shine a light in his eyes. As she checks his pupillary response, I notice that she is frowning which I interpret as an indication that she is not happy about having to cause this degree of discomfort to him.

Nurse 4 checks both pupils a couple of times and turns to me to ask for a second opinion. I sense that she is uncertain and is being careful not to state what

abnormality she thinks she may have seen. I check Mr Thompsons' pupils myself and think that the right pupil is slightly larger and slightly slower to respond than the left. As I tell her this she nods that this is what she too had thought. She approaches Mr Thompson once more and calls down to him loudly, almost shouting, to ask him to open his eyes. There is no response, and she immediately and performs a vigorous sternal rub with no observable hesitation. Although Nurse 4 initially appeared to me as concerned about Mr Thompsons' comfort when looking in his eyes, I can see a clear shift in her pattern of behaviour. My interpretation at the time is that as her concern for his condition mounts she feels able to perform more and more aggressive methods of assessment with less and less hesitation

Field notes: Nurse 4

At the beginning of this extract the nurse was described as close to Mr Thompson. Her speech was "quiet" and "soft" and Mr Thompsons' rights over his body were fully acknowledged. Within the second paragraph however there is an abrupt 'gestalt' change. Here, the participant inflicted a "vigorous sternal rub"²² with no hesitation, no warning and no explanation and in doing so the way in which she thinks about the patient can be seen to have changed completely. From previously acknowledging Mr Thompsons' subjective experiences and rights over his body, she has moved to a way of thinking about Mr Thompson as an object to be examined. Although changes and breaks in d(D)iscourse were not always so overt, this constant movement between different ways of thinking about patients was a constant and highly significant feature of these data and is explored further in chapter 6.

The example above relates to one of the more experienced participants, and it may be noted that the *failure* of some nurses to think about patients as 'body' could lead to an apparently ineffective assessments. The example below describes the practice of a less experienced participant in a similar situation to that described above:

Nurse 2 has documented the observations {and} then moves to the side of the bed and pauses. She gently shakes Mrs Yates's arm and calls her first name quietly. My impression is that Nurse 2 is hesitant as she pauses again before leaning over to rub Mrs Yates in the centre of the chest with her hand. I cannot clearly see Mrs Yates's facial expression from my position, but she makes no clear movement that I can see. I

²² A sternal rub is a deliberate "painful stimulus" intended to assess the patients' response to pain as part of a neurological assessment

have the impression that this manoeuvre was intended to be a sternal rub, although the manoeuvre is conducted so hesitantly and gently that I am not at all sure that it would serve its purpose as a 'painful stimulus'.

Field notes: Nurse 2

As she undertakes assessment, it may be seen that this nurse was continuing to think about Mrs Yates as a social being rather than as a 'body', and in consequence she conducts an assessment which may be ineffective (setting aside the evidence based debate over how and when 'painful stimuli' should be performed). Contrasts in these data such as that between the above two extracts suggest that expert nursing practice requires the ability to move between different ways of thinking about patients when this is appropriate. Section 6.3 fully explores this suggestion in order to demonstrate that this ability is itself central to the development of "clinical wisdom".

It should not be presumed that thinking about the patient as a body (or in any other way) necessarily represents practice which is problematic. As with other ways of thinking about patients, nurses could often think about the patient as 'body' only transiently as may be illustrated with reference to a further episode from these data. Mrs Green had been intubated after being admitted with stridor, and remained 'awake' although she was receiving low doses of sedation to help her 'tolerate the tube'. The participant and a physiotherapist were helping Mrs Green to turn onto her side to facilitate physiotherapy when the following was recorded.

As Mrs Green moves over onto her side, she coughs and gags very violently. There is a perceptible shift in the behaviour of both Nurse 6 and the physiotherapist. They break off their speech abruptly and stand absolutely still to observe Mrs Green as she continues to cough paroxysmally and becomes very red-faced. The monitor alarms as her heart rate and blood pressure go up markedly, although I do not see the nurse even look up to the monitor as she maintains her focus purely on Mrs Green. For almost a minute both the physiotherapist and Nurse 6 stand still and in silence and they concentrate their gaze entirely on Mrs Green. Both appear to me to have expressions of concern although neither of them speaks either to Mrs Green or to each other. During this episode the bedsheets have been pulled down so that Mrs Green could move, and her violent movement whilst coughing have now caused her nightdress to ride up leaving her somewhat exposed.

As Mrs Green's coughing begins to subside, Nurse 6 breaks her gaze away from her and appears to notice how exposed Mrs Green has become. Nurse 6 quickly adjusts Mrs Green's nightdress in order to cover Mrs Green again

Field Notes: Nurse 6

This extract again shows critical care nursing practice to require nurses to frequently change the ways in which they think about patients. The above passage contains two clear breaks or changes in the behaviour / d(D)iscourse of the nurse and the physiotherapist. The first change was triggered by Mrs Green's coughing and gagging, whilst a discernible second 'break' can be seen as the coughing subsided and the nurse covered up Mrs Green who had become exposed. In between these 'breaks', both nurse and physiotherapist were deeply involved in observing Mrs Greens' body as she coughed. They were seen to "break off" their speech and orientate themselves entirely towards the body of Mrs Green whilst remaining silent and still, giving Mrs Green their full attention. For this period of time, Mrs Green was not acknowledged as a participant in verbal discourse, but was simply thought about as an object to be seen and observed. As her nightdress was allowed to ride up unremarked it is clear that *at this time* the nurse was not thinking of the patient as a being for which issues of concern for dignity were relevant.

The above points serve to characterise how nurses think about the patient as 'body', but also begin to demonstrate that the different ways in which participants would think about patients can only be understood when it is understood that the ways nurses think about patient was rapidly changing.

Features of the patient as constructed by the Discourse of the body are summarised within figure 11 .

Figure 11: Thinking about the patient as body

The nurse is thinking about the patient as:

- A visible and corporeal 'thing' and site of examination.
- Uniquely differentiated only with reference to surface features.
- Demanding attention and concentration in order to be seen.
- Not demanding any emotional involvement.
- Having no subjective experience, and hence no concern over the exposure of the body / dignity.
- Existing in the here and now rather than having a continued existence over time.

5.4 Thinking about the patient as a set of needs

When thinking about the patient as the site of routine work or as (un)stable, nurses were primarily responding to their responsibility to undertake work or maintain parameters that were set by others. The critical care nurses in this study were also seen to think about patients in ways which constructed the work that they did as distinctively *nursing* and in which the role of the nurse was to meet theorised patient 'needs'. The 'theorised' nature of this way of thinking about patients was often seen through nurses' use of a vocabulary which was recognizably derived from nursing theory or models. In order to determine and meet patients' 'needs', nurses were required to know about many 'aspects' of the patient each of which generated a range of needs (hence psychological needs, family needs, physiological needs and so on).

This way of thinking about patients may be introduced with reference to the following episode in which the participant was preparing to undertake an ECG. Mrs Burns was very confused and apparently distressed, and the following passage describes the participant beginning to move her bed into a sitting position

Throughout this, Mrs Burns is talking to Nurse 3, and remains agitated in manner. I cannot make out her words, and suspect that Nurse A cannot understand everything that she is saying either, but is attempting nonetheless to do something that may improve her comfort and / or relieve her agitation. Nurse 3 is not particularly concentrating on engaging verbally with Mrs Burns at this time but remains standing with no effort to lower herself to the patients' eye level. As she adjusts the bed into a sitting position she is not watching Mrs Burns herself, but catches the eye of the sister who is passing by and the two exchange smiles across the patients' bed.

Once wearing the gloves and aprons, Nurse 3 draws the curtains and moves close to the patient. There is a short pause as she listens to the patients somewhat agitated speech. Again, I have the sense that it is the tone and agitation that she hears, rather than the patients' actual words. Certainly I am unable to make out exactly what she is saying. Nurse 3 then kneels again and looks the patient in the eye. She holds Mrs Burns arm and shoulder as she explains what is involved in the ECG she is about to perform. Her tone is quiet and sympathetic, but firm.

Field Notes: Nurse 3

The reasons for Mrs Burns' distress were not entirely clear, although her confusion may partly have been due to the fact that she had been given night sedation during the early hours of the morning. Despite Mrs Burns' agitation, the nurse did not initially give Mrs Burns time and attention in order to attempt to understand what she is saying, but maintained a degree of distance from Mrs Burns through her stance, failure to maintain eye contact, and her engagement with other staff. When she approached the patient more closely it was only after establishing the clinical nature of the contact (through donning gloves and aprons), and her interaction was characterised as a firm, but sympathetic, explanation. This nurse therefore recognised that Mrs Burns was distressed through conveying sympathy and by repositioning Mrs Burns, but it was not clear from this extract whether she expressed any particular empathy or emotional involvement with Mrs Burns. It was in a later discussion in interview that this participant constructed this encounter as one in which the distress was simply as a problem which had to be solved:

Int What was the purpose of that explanation, was it just to tell her what you were doing or was it to do something else as well?

N No no. It was a combination actually. A combination of, as I said a while ago she needs reassuring.

Int Hm Hm

N She needs er - you need to listen to her. And again before that I think I tried to get her consent for the ECG as well

Int Okay. So right its-

N Yeah. Reassurance and consent I believe is what I did.

Nurse 3: First Interview

It is notable that this nurse explained her actions in terms of Mrs Burns' "need" for "reassurance" and to gaining "consent", a terminology which is clearly a distinct and theorised vocabulary. The interpretation of Mrs Burns' distress as generating a "need" for "reassurance" therefore establishes her experience as a problem which requires a reasoned response rather than a more straightforward or instinctive personal response.

Although thinking about the patient as a set of needs was associated with a theorised vocabulary of needs, the transformation of a straightforward respect for others into a theorised 'need' for privacy did not always appear to actually *meet* that need:

Nurse 4 approaches the curtains and says "Knock, knock"

I have noticed that almost all staff say this when approaching closed curtains, presumably as a means of recognising the patient's privacy and dignity. Nurse 4 enters without awaiting a reply and once behind the curtains, she engages in social chat with the other staff for some moments before leaving. I see no apparent sign of discomfort in any of the three staff about having this 'social chat' literally across the patient's bed.

Field notes: Nurse 4

These considerations introduce the way in which participant could think about patients as having needs which had to be recognised and met. Further analysis will show that for these nurses, meeting 'needs' was the result of a cognitive process which did not require an affective or emotional involvement of the nurse, although the patient may be recognised as having some relevant subjective experience. It was also notable that 'needs' could often be recognised and met in a somewhat 'brisk' fashion:

Nurse 5 enlists my help to help her put on Mrs Hargreaves's TED stockings. There is little communication to Mrs Hargreaves herself whilst she is doing this, despite the manual handling and pushing and pulling of her legs that doing this entails.

Field Notes: Nurse 5

Once the turn is completed, Nurse 5 reaches for a hairbrush and swiftly brushes Mrs Hargreaves's hair.

Field Notes: Nurse 5

This 'swift and clinical' pattern of behaviour was not universal, but rather it was the theorised nature of needs which characterised thinking about the patient in this way. These features may be explored further in relation to an episode in which a participant was caring for Mrs Marshall who was a 63 year old lady who had experienced complications after bowel surgery. Mrs Marshall was deemed to be 'wardable', although she was experiencing on-going problems with the dehiscence of her wound. The following was recorded in the mid-morning whilst Mrs Marshall was still in her bed:

Nurse 2 turns to Mrs Marshall

"Right then Brenda"

Nurse 2 is looking down towards Mrs Marshall from a foot or two away from the end of the bed and she does not bend down to the patients' level or make other attempts

to see her face to face. Her tone is loud, and my impression is that she is trying to galvanise Mrs Marshall to action.

((lines omitted))

Nurse 2 moves Mrs Marshall's abdominal drain to the other side of the bed so that this will not pull whilst she moves. Moving the drain clearly causes some discomfort as Mrs Marshall makes a sharp intake of breath, and Nurse 2 apologises for this, although she is looking away from the patient as she does so. Having ensured that Mrs Marshall is free to move in terms of not being restricted by drips and drains, Nurse 2 stands back and watches as Mrs Marshall begins to move. Mrs Marshall moves herself along the bed and towards the edge of the bed so that she is ready to stand. Her movements in doing this are slow and she is breathless. I am aware that Mrs Marshall has some painful leg ulcers and suffers from arthritis, both of which have been causing her pain in addition to her recent surgery. Nurse 2 appears to pay close attention as she watches Mrs Marshall move along the bed, although I specifically note that she gives no encouragement or verbal instruction.

Nurse 2 places Mrs Marshall's walking frame in front of her then steps back and tells Mrs Marshall to stand, but gives no further encouragement or support as she does so. Once Mrs Marshall is standing she is stooped over the frame, and the nurse steps forward to say that she should stand straighter and briefly places her hand very lightly on Mrs Marshall's shoulder. I have the impression that Nurse 2 considered Mrs Marshall to be 'stuck' at this point. Once Mrs Marshall is standing up and has her balance fully Nurse 2 steps away again and watches as Mrs Marshall turns and sits herself in the chair.

Once Mrs Marshall is in the chair, Nurse 2 immediately approaches her, this time she is facing the patient and crouches down to be face to face directly in front of Mrs Marshall on the chair and tells her that she has done well.

Field Notes: Nurse 2

Within this extract, the characterization of the opening "Right then Brenda" as an attempt to 'galvanise' Mrs Marshall suggests that I interpreted this as a firm request or command. Once Mrs Marshall is moving there is a clear sense in which this nurse appears to disengage from Mrs Marshall both physically and in terms of verbal support and encouragement.

My own comments about Mrs Marshall's pain arising from her ulcers, arthritis and surgery highlight that I was concerned with her current pain and discomfort, and invite contrast with the practice of the participant whose physical distancing and lack of verbal encouragement portray a lack of such concern. It is important to note that this simply records my own first impression rather than to consider this as criticism of the participant's practice. There are many clear benefits to early mobilisation, Mrs Marshall was receiving appropriate analgesia, and it was not clear that more could have been done to prevent a certain degree of pain and discomfort whilst she did so.

There is therefore a clear contrast between two ways of thinking about Mrs Marshall at this time, one of which focussed upon her current experience, and another which highlighted the 'need' for her to move. This participant commented on this interaction as follows in a subsequent interview.

Int Was there a particular strategy a way of nursing that you were adopting while that was happening?

N By putting her in the chair?

Int Yeah. Not by putting her in the chair but well, by that and by the way it was achieved, by the way it happened

N Er. Just trying to regain her independence I think. Because I know that I know that at home she does normally, you know. What she would normally do at home would just be transferring

Int Mm

N She doesn't really go on long hikes or anything. So I was just trying to get her that kind of a sense of normality really and to get her to move herself rather than us moving her.

Nurse 2: First Interview

The sense of distancing from the patient which was apparent within the field notes is mirrored in the way that this participant talked about the interaction. This nurse draws upon a recognisable theorised Discourse in which "independence" is a recognisable nursing "goal", and in which moving to a chair is theorised as "transferring". It may also be seen that the need for Mrs Marshall "to regain her independence" begins to make sense of the nurse's distancing from Mrs Marshall (both physically and verbally). Thinking about Mrs Marshall as having a (longer term) need for independence is distinct from a way of thinking about Mrs Marshall in a way which highlighted her current pain and discomfort, and (as chapter six will elaborate) the participant was only able to think about Mrs Marshall in one way at any moment in time.

Other extracts from these data also demonstrate that thinking about the patient as a set of needs could set boundaries to the interaction between nurse and patient:

Nurse 6 notices that Mrs Green and her husband are trying to communicate, but that Mr Green is apparently getting frustrated by his inability to work out what she is saying. Nurse 6 asks if Mrs Green would like a pen and paper, then leaves immediately to get this ... I am particularly struck by the fact that she has not felt the need to do this earlier in her shift given that she has been caring for Mrs Green for 4 hours. The patterns of non-verbal communication I have witnessed between the nurse and Mrs Green appear to have been quite sufficient to enable Nurse 6 to meet Mrs Green's comfort needs, yet seem to be recognised by her as inadequate for other forms of communication.

Field Notes: Nurse 6

Mrs Green was intubated and therefore unable to communicate verbally. By giving the pen and paper to Mrs Green only in the context of communication with her husband this nurse recognised or constructed a difference between the ways in which she needed to communicate with the patient and the way in which Mr and Mrs Green may communicate. By thinking about the patient in terms of her nursing 'needs' Mrs Green was constructed as someone with whom intimate discussion, social chat or small talk was not appropriate or necessary. When thinking in this way, nurses therefore thought about patients as having needs which they may express, but not as people who were fully reciprocal participants in discourse.

The above sense of distancing, pace, and limited affective involvement in patients' lived experience are further seen in the episode below. The 'clustering' of care in the following extract may reflect this experienced practitioners' attempts to stay organised and to manage her time, but the extract is primarily presented in order to make further observations in relation to the pace of the encounter:

Nurse 5 approaches Mrs Williams once more to give her eye and mouth care. She explains quietly what she is going to do, and then swiftly moves to insert a mouth sponge into Mrs William's mouth. Although she watches Mrs Williams intently whilst she works and explains her movements continuously, my interpretation is that her movements are expert, swift and 'clinical' as she does so. Mrs Williams' eyes are cleaned in a similar fashion, and then her hair brushed. All of this is achieved in one

quick 'cluster' of care, and yet I am not at all aware of any reason for there to be a rush in what she is doing.

Field Notes: Nurse 5

There are numerous references to pace in this extract. The practice is described as "swift", and the whole interaction is summarised as a "quick" cluster of care despite there being no need to "rush". Nursing 'needs' are clearly being met in this cluster of care as eye and mouth care are given, yet whilst these 'hygiene needs' may always need doing this nurse does not demonstrate the complete disregard for the patients' experience that typifies purely routine behaviour. The nurse explains what she is doing continuously and pays close attention to the patient throughout, but this swift and clinical activity does not appear compatible with a high degree of emotional involvement in the patients' current lived experience. Again this highlights a way of thinking about patients as beings whose experience is known about but not empathically shared, and who have an interest in understanding, but not necessarily controlling, what is happening to them.

It was notable feature of these data that the verbal interaction between nurses and patients could be limited at times. Within interviews, some participants commented on this in relation to whether or not patients had a 'need' for such communication:

- 1 **N** we::ll I know when I work with some colleagues they (.)
2 orientate their patient
3 **Int** mm
4 **N** =and I think I- I should do that more
5 **Int** mmm
6 (1)
7 **N** but then is it gonna (.) have any beneficial effects for the
8 patient
9 **Int** okay
10 **N** and I do try and talk to them if I'm about to suction them .
11 hh (.) but I have suctioned and not really said a lot which
12 probably isn't very good
13 (2)
 ((several turns omitted)
14 **N** I think because patients don't (.) always < remember> (.)
15 being an ICU patient because they've been so sick .hh to
16 me maybe it has no relevance but you don't know what

- 17 they're feeling at that time so
18 (1)
19 I should probably talk to them more

Nurse 7: Second Interview

The discussion prior to this point in the interview was about “talking” to patients, and at line 2 this nurse transforms this into a theorised need to “orientate” the patient. In doing so she establishes the topic of conversation as relating to whether she has met the needs of a patient rather than on whether she has responded appropriately to another person. Talking to the patient is established as something this nurse “trys” to do (line 10), and suggested to be important only if it has “beneficial effects” (line 7) or is of “relevance” (line 16). Although this reflects a nurse talking *about* her practice, it nonetheless talk which reflects an identifiable Discourse in which communication is the subject of deliberation and in which the only relevant attributes of patients are constructed as those which generate identifiable needs.

Figure 12 below summarises the ways in which participants were found to think about patients as sets of ‘needs’.

Figure 12: Thinking about patients as a set of needs

The nurse is thinking about the patient as:

- A ‘patient’ who has ‘aspects’ which generate theorised ‘needs’.
- Understood cognitively, but not demanding of emotional involvement.
- An experiencing subject to the extent that this experience generates ‘needs’.
- A ‘person’ in a generalized sense, but one whose unique personal identity is known about rather than known.
- Having needs which relate to what the nurse must do within a specific but variable time frame (now; today; this week).

5.5 Thinking about the patient as a medical case

The Discourse of the medical case was recognised in the way that nurses would think about the patient so as to understand the course of the patients’ disease and to determine the interventions which may be necessary in order to influence this trajectory. Although thinking about the patient as ‘medical case’ involved forms of knowledge most clearly aligned with the discipline of

medicine, an understanding of the patient as 'medical case' was central to the practice of the critical care nurses in this study.

For both nursing and medical staff, understanding the patient as a medical case was very different phenomena to thinking about the patient as 'unstable'. This can be illustrated with reference to comments made about a patient called Mr Thompson during a staff room discussion. The participant I was working with had commented on how fascinating and interesting the 'medical case' of Mr Thompson was, and similarly the early morning medical ward round had spent considerable time reviewing this case. Nonetheless, Mr Thompson was considered 'stable' and the following exchange occurred during a coffee break in the staff room:

During coffee, three doctors are dividing out their workload for the morning and quickly review all the patients. Patients are purely referred to by bed number, and are quickly discounted as 'wardable', which I interpret as implying they are not of interest and require little intervention. Beds 2, 4 and 7 are declared wardable. One doctor comments that 'Bed 10' {Mr Thompson} is "not doing anything entertaining either". Nurse 5 and the other nurses in the room laugh and nod in agreement.

Field Notes: Nurse 5

From these comments it was clear that all staff could maintain a distinction between thinking about the 'interesting' medical case, and thinking about the exciting or "entertaining" unstable patient who may require urgent and immediate intervention.

Understanding the patient as a medical case required concentration and a high level of cognitive involvement which participants often articulated as being characteristic of nursing in critical care. This is shown in the following comment of one of the less experienced participants reflecting upon her time on the unit:

N I think its- its so much more in depth than on the ward. You have the opportunity to actually really properly get in to your patient more if you see what I mean. You really kind of know exactly what's going on.

Nurse 2: Second Interview

Similarly, one of the more experienced participants commented as follows:

Int So what is it about intensive care nursing that you like?
N Erm - the challenge
Int Hmm
N the results most of the time
Int Okay
N and the fact that you think. I couldn't really do a job where you didn't have to think.

Nurse 7: Second Interview

The nurses in this study therefore valued having to “get in to your patient more”, or having to “think”, and in large part this was achieved through thinking about the patient as a medical case.

Many characteristics of this way of thinking about patients were highlighted in an incident occurring early in the first shift that I worked with one of the more experienced nurses when I asked her to tell me something more about the patient she was caring for:

Her explanation is complex. Mr Fields' past history is summarised in only one or two quick sentences, and in what follows physiological relationships are constantly highlighted. Nurse 1 discusses his MAP²³ and his urine output, but then describes how his CVP²⁴ is lower than it was, and qualifies this with the comment that she has recently reduced his PEEP²⁵. Nurse 1 comments that “I'm happy” with a PO₂ of 10, and that “they want” to aim for a MAP of 65. I note that the monitor and 11:00 observations show a MAP of 61 which she too states that she is happy with. The nurse also comments that “I must watch his urine output” as she has stopped the furosemide an hour ago. I have a clear sense however that she sees these issues as coherent patterns which she is trying to convey to me as a perceived expert practitioner.

Field Notes: Nurse 1

In this extract my request for information elicited a response which rather than maintaining a focus on discreet body systems and their associated “targets”, demonstrated a way of thinking about the patient which highlighted physiological relationships, patterns, and links between these

²³ MAP – Mean Arterial Pressure (Blood pressure)

²⁴ Central Venous Pressure

²⁵ Positive End Expiratory Pressure – a parameter set on a ventilator

were thinking about patients in a number of different ways. Whilst thinking about the patient as (un)stable was necessary to manage 'targets' or 'parameters' of discreet physiological variables, it was only by thinking about the patient as a 'medical case' that the clinical significance of these issues could be recognised and discussed.

Consideration of the significance of changes in patients' physiology was sometimes apparent in the commentary which nurses would offer to me as an observer:

Nurse 1 is noting down the 12.00 observations whilst giving me a detailed explanation of how Mr Field is not now thought to be either over or underfilled, and that 'they want' him to have a total fluid intake of 125 ml/hr. She checks the rate the nasogastric feed is running at and performs a swift calculation in order to check that this is appropriate. She comments that his CVP is down, "but so is his PEEP", and notes that there is no swing on his Arterial line trace. All of this commentary is given to me from the end of the bed whilst we are stood adjacent to the charts.

Field Notes: Nurse 1

Although this participant was undertaking 'routine' observations, and also made reference to the 'target' fluid intake, it is also clear that in the later part of this commentary that she was in some sense putting all of this together in order to understand the relationships between 'CVP', 'PEEP' and the absence of a 'swing' on the arterial line.

For nurses in this study, thinking about the patient as a medical case therefore involved thinking about the patient as a complex system in which patterns may be recognised. A shared understanding of these patterns was often the basis of communication between myself and more experienced participants as the following illustrates:

Nurse 7 depends heavily on my own clinical knowledge to make links whilst giving this information. I recognise this pattern as one experienced practitioner talking to another and using a shared set of understandings / experiences to highlight patterns and concerns. At one point for instance she tells me that he has had a massive transfusion and that now his chest... Her voice trails off but she nods to the ventilator

to suggest that the transfusion may be one reason why he needs the ventilatory support that he does²⁶.

Field notes: Nurse 7

It was common for participants to communicate through highlighting such patterns, or to represent patients as an instance of a particular 'type' such as the patient who was described to me as having been admitted with "pneumonia on top of her COPD and diabetes...and that's it". Thinking about patients in this way enabled nurses to think about, and communicate about, patients as instances of known types.

Further features of this way of thinking about the patient are apparent within another extract which also relates to the practice of a more experienced participant.

The consultant looks up to Nurse 7 to comment that {name of a second consultant} is on tomorrow, and that Mr Norton will be on a furosemide infusion in the morning. Nurse 7 pulls a face and says that Mr Norton would not tolerate that. The consultant laughs and agrees that "I wouldn't diurese him", but adds that she should "not worry" about using the noradrenaline to maintain his blood pressure.

Field Notes: Nurse 7

The consultant and the nurse appear to share a judgement about the appropriateness of using diuretics in this instance. As well as implicitly acknowledging that the nursing staff would be bound to accept the decisions of the consultant on duty the following day, it is significant that these staff recognise that another consultant may interpret and respond to the same facts in a different way. The relevance to this study lies in the observation that these staff acknowledge that the 'medical case' may be understood differently by different people, and in doing so recognised the 'medical case' as being constructed. The focus of this discourse is therefore upon how the patient is understood rather than upon how the patient 'actually' is, and therefore represents a way of thinking about the patient as a being which is mentally constructed. On occasion this could be acknowledged with some humour:

The Senior Registrar comments that the flutter looks to be "two to one" – but notes that it cannot be due to the rate of the rhythm. The consultant looks up and comments

²⁶ The pattern this nurse is indicating may clearly be interpreted by a critical care practitioner to be implying that the patient may be suffering from a Transfusion Related Acute Lung Injury (TRALI)

that he thinks there is an underlying fibrillation as the rhythm looks irregular, and then adds in a jocular tone

“Unless you’re Mark of course in which case it’s Wenkebach”.

Field Notes: Nurse 7

This constructing of the patient appears to account for the high degree of cognitive involvement which was associated with thinking about the patient as a ‘medical case’. Participants would often display this involvement through ‘out loud’ reasoning and comments about the medical case whilst they worked. Although this could be considered as talking to themselves, Goffman (1981) has highlighted how such “self-talk” is a significant form of interaction which may be presumed to be orientated to others. Comments such as those in the extract below may therefore be presumed to have been directed to myself as observer as well as showing how this nurse was thinking about the patient as ‘medical case’.

Once we have finished turning Mr Norton, Nurse 7 steps back from the bed and looks up to the monitor for a moment and pauses. Mr Norton’s blood pressure has risen quite markedly since the turn, and she wonders out loud why his blood pressure is better when he is lying on his left hand side. I am not sure whether this is a genuine direct question to me, but hesitantly suggest that it may be due to his abdominal oedema. Nurse 7 nods and agrees

“Yes – I was thinking that”

Field Notes: Nurse 7

In this interaction both the participant and I demonstrate an ongoing interest in interpreting and hypothesizing about the changes in Mr Norton’s blood pressure. The exchange was preceded by a step away from the bed which physically distanced the participant from Mr Norton and made clear that the patient was being talked *about* rather than talked *to*. It is also clear that we were not thinking about the actual value of Mr Norton’s blood pressure at one fixed moment in time (such as in relation to a ‘target’), but rather that we were thinking about the patient as a complex physiological system which changes over time and needs to be understood. Again this was achieved by drawing upon a shared understanding of patterns given that the meaning of this exchange was dependent upon mutual recognition of a potential relationship between abdominal oedema, inferior vena cava obstruction and blood pressure.

The above discussion has introduced the idea that thinking about the patient as a 'medical case' required nurses to think about the patient as changing over time. This was further illustrated in the following comment made about Mr Vincent who had been admitted with a head injury:

Nurse 7 then documents the observations once more, and notes particularly that Mr Vincent is polyuric, gesturing to the chart which shows that his urine output has been more than 200 mls/hr for the past few hours. This comment is made thoughtfully, although she does not express any particular concern other than to say that he may just be "sorting himself out".

Field Notes: Nurse 7

It is clear that this nurse was not highlighting a concern with Mr Vincent's urine output out of context, but rather she indicated (through gesture towards the chart) that she was interpreting and theorizing this current situation within an ongoing and evolving situation. The comment that he may be "sorting himself out" itself takes the form of a 'restricted' code (Bernstein 1971 cited in Hymes 1996) which again appeals to a shared understanding of the context between myself and the participant. Part of this context is that Mr Vincent has a head injury and there is a possibility of worrying pathological reasons for a high urine output²⁷, yet to characterise him as "sorting himself out" is to suggest a potentially benign explanation for the high urine output. To understand that he "may be sorting himself out" was to recognise both of these potential interpretations and thus required a detailed understanding of the context. A key issue to note is that this understanding of context involved thinking about Mr Vincent as a medical case within an ongoing trajectory or narrative. For these nurses, thinking about the patient as a medical case involved understanding how that patient *was doing* within such an ongoing trajectory rather than simply focussing on how the patient *was* at any one moment.

Despite the fact that thinking about the patient as a 'medical case' was to draw upon 'medical' knowledge, the above considerations make clear that thinking about the patient in this way was a central concern for the critical care nurses in this study. Figure 13 overleaf lists the primary characteristics of patients as constructed by this Discourse.

²⁷ My interpretation at the time was that this nurse had a (low) level of concern that Mr Vincent may be showing signs of diabetes insipidus.

Figure 13: Thinking about the patient as a medical case

The nurse is thinking about the patient as:

- A complex system recognised through unique patterns or constellations of ordered and disordered physiology.
- Existing in a mental rather than a physical realm.
- Mentally constructed and thus *understood* rather than directly *known*.
- Having no subjective experience.
- Not demanding any emotional involvement.
- Having no unique personality or social role.
- Existing within an ongoing temporal trajectory or narrative.

5.6 Thinking about the patient as a social being

The above discussions have characterised five different ways in which participants thought about patients. None of the ways of thinking outlined above have recognised the patient as having a 'personal identity' in the sense of fulfilling a range of normal social roles, a biographical lifeline or other uniquely identifying "identity pegs" (Goffman 1963). The final two ways in which nurses thought about patients were those which did construct the patient as having such an identity.

In episodes throughout these data, nurses clearly responded to patients as people who held a full range of societal roles, rights and obligations. Such episodes constructed a Discourse in which nurses were thinking about the patient as a social being. This could be recognised through nurses' chatting or joking with patients in ways which made it clear that normal societal expectations about interpersonal interactions were being applied. Within these data, it was clear that thinking about patients in this way was not always readily or easily achieved all of the time. Particularly when caring for unresponsive patients it appeared that more experienced nurses were better able to engage with patient as 'social beings' as can be seen in the contrast between two nurses in the data extract below:

Nurse 3 introduces herself to the patient with the words

"Hello its me again. Just going to ..."

The end of the sentence is spoken quickly and half mumbled. I do not catch what she says but see Nurse 3 insert an electronic thermometer under Mr Walters' axilla, and then leave it there whilst turning to check the volume of urine in the patients' urometer. She then turns to the patients' chart to record her findings.

As she does this, the unit sister walks into the bedspace. She approaches Mr Walters and leans over his bedrail. She says

“Hello Mr Walters, how are you today?”

She pauses as though for a response, and has what I read as an expression of concern on her face as she looks directly towards Mr Walters face. She then continues with further comments and questions directed towards the patient

“You’ve got a five o’clock shadow there – I’ll have a word with {Nurse 3}”

Field Notes: Nurse 3

The awkwardness of this (inexperienced) participant who was focussing primarily on ‘routine’ work can be seen in the way that her ‘mumbled’ greeting tailed off, and contrasts with the interaction between the sister and Mr Walters. The more experienced nurse greets Mr Walters with a polite opening greeting / query “how are you today” which served to recognise Mr Walters as a social acquaintance. Contrasting with the interaction of the less experienced nurse the sister paused to await a response from Mr Walters and in doing so recognised him as a potential co-participant in discourse. My interpretation of her expression as “demonstrating concern” suggests that the sister was displaying some degree of affective or emotional involvement in Mr Walters’ welfare, although this could not be considered a particularly ‘intimate’ encounter. Within this interaction the sister was therefore thinking about Mr Walters as a person who may take part in verbal interaction like anyone else, and about whose welfare she has some concern.

The above example should not be taken to suggest that less experienced nurses did not think about patients as ‘social beings’ as it was clear that all participants were seen to do so on occasion. Section 4.2.2 has introduced an episode in which the smiling greeting of the inexperienced Nurse A - “I know you” - towards one patient was seen as one of the more striking examples of everyday social encounters within these data. Rather than suggesting that experienced nurses could think about patients in a way in which other nurses did not, the above extract primarily illustrates that more experienced nurses could move more fluidly between different ways of thinking about patients.

Some participants could portray thinking about patients as a ‘social being’ to be a significant factor in clinical judgement and decision making, as is suggested by the following extract from an interview:

N I don't know why but if a patient is in their pyjamas and they are sat out in the chair and they are eating and they've got a newspaper for some reason you can de-line²⁸ them ((*laughs*))

Int 'For some reason'. Go on - tell me what reason

N Because they look so much better

Int So it's the fact that the patient is sat out and looks so -

N I think sometimes it is. Because although his numbers have been fine, I think when they're in bed and they are not shaved and - they can look a bit - still quite poorly can't they?

Nurse 7: First Interview

Nurses themselves acknowledged that thinking about patients as a 'social being' was by no means their 'default' position. As one participant noted:

N WE see somebody really ill in be:d

Int Mm

N But they're not always that person they've actually got a personality

Nurse 5: First Interview

These extracts therefore suggest that for these critical care nurses there was something distinctive about seeing patients in pyjamas, who had shaved, and who were sitting out of bed reading newspapers and eating normally. Participants therefore acknowledged that they did not always readily think about patients as people who simply do the same things that other people in society may normally be expected to do.

On occasions the very ordinary and everyday quality of nurse-patient interactions served to downplay patient's identity as 'patient', and take emphasis away from the professional nature of the nurse patient relationship. When thinking about patients as 'social beings' there were times when nurses' communication could be particularly informal or casual as is illustrated by the following example in which one participant (and a student nurse) were beginning to introduce me to Mr Smith (sat a few metres away):

²⁸ "De-line". In the wider context of this discussion it is clear that the participant is referring to the removal of a patients' arterial line which would carry clear implications that the patient was no longer 'sick' enough to merit this level of monitoring.

Nurse 7 looks towards her patient and adds that this morning
“We’ve just been taking the piss out of each other to be honest”
Nurse 7 also tells me that Mr Smith is ‘wardable’ and that she is basically just ignoring
him.

Although these comments are ostensibly directed at me, the student nurse is laughing
as Nurse 7 speaks and Nurse 7 is regularly glancing towards Mr Smith and speaking
quite loudly as though she intends for him to overhear her remarks.

Field notes: Nurse 7

Whilst it may clearly be considered inappropriate for a nurse to ‘take the piss’ out of a patient in
the Critical Care Unit, it was clear that Mr Smith was intended to hear these comments. My
impression during the remainder of this shift was that, rather than “just ignoring” Mr Smith, the
participant in question was simply observing normal societal conventions regarding personal
boundaries and privacy, such as by not interrupting him whilst he was reading a newspaper. An
exploration of these comments therefore needs to take account of this context, and can be
illuminated by consideration of the following interaction with this participant in a later interview:

- Int** The first thing you said to me was we’ve just been taking the piss out of each
other to be honest
- N** ((*long laugh*))
- Int** And I could see what you mean having seen the relationship but do you find
humour’s an important part of your..?
- N** Erm
- Int** Is that just him or is that with other people?
- N** When it’s appropriate. I think that it is with him. Bed five²⁹ is similar - he’s
obviously got a good sense of humour. I tend to suss people out first
- Int** Yeah
- N** I wouldn’t be all funny if it’s not appropriate
- Int** No. I ‘m sure you wouldn’t
- N** I think most people quite like a bit of a laugh.

Nurse 7: First Interview

²⁹ The patient in bed five at this time was a ‘long stay’ patient recovering from botulism who was ‘awake’
and weaning from respiratory support. He was well known to many staff who often seemed to have a
similarly jocular relationship with him

This participant was clearly sensitive to the fact that “taking the piss” could be construed as being offensive or insensitive, and her defence draws upon an idea of Mr Smith as a person who is not only known to be “like most people”, but whose individual personality is known and whom she has “sussed out”. In this context the casual and informal ‘code’ she utilises (“taking the piss”) itself suggests that she was thinking about him as a social acquaintance rather than as a ‘patient’. I gained a strong impression in the field that this way of thinking about patients played a function in backgrounding patients’ illness and identity *as* patients. This impression is recorded within the following extract which also demonstrates the nature of the relationship between the above nurse and patient:

Mr Smith makes a comment to me about her being bossy and Nurse 7 strikes a pose with her hand on hip and mimes cracking a whip whilst making an appropriate sound effect. Mr Smith responds by asking her whether she also has thigh boots, and Nurse 7 deflects this mildly flirtatious comment by firmly telling him to get up. I make a note that the use of humour with Mr Smith is well judged and that in some sense she has his measure. The humour appears to serve a purpose of coaxing and encouraging Mr Smith, and also seems to help in backgrounding the work involved in recovery from a major operation.

Field notes: Nurse 7

In this interaction both nurse and patient are drawing upon a recognizable cultural stereotype of ‘Miss Whiplash’, and the interaction has the tenor of flirtatious banter between social acquaintances rather than an encounter between professional nurse and patient. Whilst “taking the piss” may appear to make light of the patients’ pain and anxieties, it may also be recognised that the open discussion of such issues may be considered overly intimate and inappropriate for passing social acquaintances. Downplaying Mr Smiths’ experience of illness therefore appears as an important part of recognising him as a ‘normal person’, and it is this balancing which is evaluated as being “well judged” within the above description of these interactions.

Although the above example relates to this participant having “sussed out” Mr Smith, nurses could also demonstrate that they were thinking about patients as ‘social beings’ by acknowledging social norms and conventions which were often suspended during the delivery of healthcare. In section 4.2.3 an episode was recounted in which Nurse B commented on a doctor who was “not thinking straight” due to his continued presence in a bedspace whilst a patient was using a bedpan, and which Nurse B herself explained with the comment that “I personally wouldn’t be

able to go to the toilet with someone watching me". The distinctive nature of such interactions lies in the contrast between thinking about the patient as a 'social being' and thinking about the patient as having a theorised 'need' for privacy or 'maintaining dignity' as outlined in section 5.4. Whilst it is obvious and common sense that another person or 'social being' would not wish to be observed using the bedpan, the recognition of patients as having a 'need' for dignity and privacy was associated with the sometimes superficial and tokenistic acknowledgement of such needs (such as through simply saying "knock knock" before going through curtains).

It is a normal expectation in discourse that co-participants will respond to what you say. For this reasons thinking about patients as 'social beings' could create difficulties for these nurses due to a sense of awkwardness or embarrassment when patients did not talk back to them. This was often the case in communication between nurses and patients who were unconscious or unresponsive as shown in the following extract which again describes the practice of one of the less experienced nurses:

After the handover has finished, Nurse 2 tells me that she will do the "checks and the obs". She then immediately goes to the side of the bed and looks down to Mrs Yates, takes her by the hand, says hello and introduces herself. After giving Mrs Yates her name Nurse 2 breaks off and hesitates. From this hesitation I gain an impression that she is feeling awkward or self-conscious about talking to the patient who is not replying to her. Nurse 2 looks up to the monitor and then down to her own hand which is holding that of Mrs Yates as though she has just become aware of what she is doing. She changes her grip and picks Mrs Yates's arm up with both hands and moves her wrist whilst looking at the monitor in a clear effort to see if she can obtain a trace on the arterial line.

Field Notes: Nurse 2

This incident was one of several in which participants (generally less experienced nurses) would display such a degree of awkwardness or hesitation in talking to patients who did not respond to them. In the above instance, this awkwardness led to a break or change in d(D)iscourse as the nurse "changes her grip" and moved to a more instrumental form of touch at the end of this extract. Several participants made comments about the embarrassment and awkwardness which could arise in situations when conversation would ordinarily be expected to be two sided, such as the commentary of the participant involved in the episode cited above:

- Int** ...you just looked like you felt really quite uncomfortable about talking to somebody who wasn't talking back. You sort of looked a bit uncertain, and what had been a friendly holding of her hand turned into something else
- N** Mmm. Yeah. I fully agree with that
- Int** ((*laugh*))
- N** I do get a bit uncomfortable about talking to people who don't respond
- Int** Can we just talk about why that discomfort? What is it that feels uncomfortable?
- N** Er ((*laughter*)) my own insecurity and - the embarrassment of them not speaking back. I mean I know cos its cos they physically can't
- Int** mmm
- N** but it's just something I don't particularly...
- Int** Okay. You say you find it embarrassing why is...
- N** Well I just think that
- Int** Is it?
- N** Not in that case no, but I kind of think in an out of work situation if you're speaking to someone and they don't really respond to you then that's always a bit embarrassing I think.

Nurse 2: Second Interview

This participant therefore suggests that by thinking about a patients as a social being she becomes subject to the same embarrassment that would result if a person did not respond to her in an "out of work situation". Conversely, the presence of this embarrassment and awkwardness itself could be taken as an indication that nurses are thinking of patients as the 'social beings' to whom these normal conventions apply.

Whilst all participants would at times think about patients as 'social beings', doing so was therefore occasionally problematic for the nurses in this study. The key characteristics of thinking about the patient as a social being are summarised in figure 14 overleaf.

Figure 14: Thinking about the patient as a social being

The nurse is thinking about the patient as:

- Someone who is a 'normal person' in the same way as the nurse and to whom normal societal expectations and conventions apply.
- Someone known as a social acquaintance rather than intimately.
- Having personal goals and aspirations and a subjective experience.
- Relatively uniquely differentiated and as having a unique personality which may or may not be known.
- Having social roles and an identity which projects into the past and future.

5.7 Thinking about the patient as a valued individual

Thinking about the patient as a social being did not establish an intimate relationship or demand a particularly high degree of emotional involvement between nurses and patients. Within the final Discourse identified within these data, the patient was constructed as a highly valued and unique individual and participants demonstrated an emotional involvement or empathy with patients' experience, and a personal investment in patients' outcome which was independent of normal professional or social roles. The 'valuing' of the individual was often evident in the time which participants invested in encounters with patients, and was also often characterised by silence:

Immediately after receiving her handover Nurse 2 goes straight to Mr Langden without pausing to put on gloves or aprons. She approaches the head of his bed on the side that he is facing toward and appears unhurried as she bends down towards him with her forearms leaning on the raised bedrails. Mr Langden's eyes are closed as she approaches, and Nurse 2 waits silently for a few moments until he opens his eyes. Mr Langden is the first to speak, and I have the impression that he was lightly asleep.

Field Notes: Nurse 2

Because it was often seen so transiently, thinking about patients as valued individuals was not a particularly prominent feature of the data. Nonetheless it was often momentarily evident in the ways that nurses would recognise patients as unique and valued individuals within 'private' moments.

One particularly memorable episode during data collection was the wedding on the unit of Mr Langden and his fiancé. Mr Langden was an 80 year old gentleman who had undergone emergency surgery for a small bowel obstruction, had a long history of cardiac disease, and was

not expected to survive his episode of illness. One of the participants had played a central role in caring for Mr Langden and was aware both of his very poor prognosis and of Mr Langden's wish to be married before he died. This nurse had spent some time investigating how this wedding could be arranged, and the following extract describes her return to work after a day off. The participant entered the staff room with a new hairstyle, and one of the other nurses commented on this before it was mentioned that:

"You've been invited to the wedding today"

Nurse 7 turns round and shrieks

"Oh my Go:::d – I organised that wedding"

Her voice is high pitched and the tone is a little put on or theatrical, but nonetheless it is clear that she is genuinely excited. It becomes clear to me that Mr Langden and Mary are to be married on the unit that afternoon. Nurse 7 jokingly asks whether she will be allowed to be a bridesmaid as she has had done her hair for the occasion. She appears quite genuinely moved as she finishes by saying

"I think I'm going to cry"

Field Notes: Nurse 7

A short time later once the unit handover had commenced I recorded the following:

The handover is given, and as Mr Langden's long medical history is read out Nurse 7 catches my eye and smiles to me. I have the impression that she is very proud of a private achievement which is not being publicly spoken about or acknowledged here.

Field notes: Nurse 7

These extracts illustrate some key characteristics of this Discourse. The participants' initial outburst is highly theatrical or 'upkeyed' (Goffman 1974) suggesting that the public forum of a handover may be an inappropriate place for a more authentic display of emotion. There is then a contrast between this initial response and the moment within the second extract when the nurse simply "catches my eye and smiles" as Mr Langden is referred to. In this 'crossplay' (Goffman 1981) the participant established a very different stance towards Mr Langden than that conveyed by the medical d(D)iscourse in which the handover was being given. It was only through this small and private acknowledgement that she demonstrated an emotional involvement with Mr Langden and his welfare, and in doing so constructed him as being a valued individual.

A further data extract (also relating to this participant and her care for Mr Langden) helps to illustrate why this way of thinking about the patient was not readily expressed. In a final interview

with this participant I asked her to read an episode from the field notes in which Mr Langden's wedding was described, and recorded the following:

- 1 ((17 second pause with some laughter as the participant reads
2 the written field note extract))
3 **N** arr:::↓ ((tone is quiet and reflective)) its making me feel a bit
4 emotional
5 **Int** is it why? (.) in what way
6 **N** well he he did die later
7 **Int** mmm
8 **N** hw- i- its just (.) just quite nice that they had their (.) wedding
9 (5)
10 ((quiet laugh))
11 (1)
12 **Int** .hh[hh]
13 **N** [oka]:y ↓ ((slightly louder again))

Nurse 7: Second Interview

Through her 'quiet and reflective' intonation as well as through her overt claims to feeling emotional, this nurse talked about this incident with an evident high degree of expressed emotion. Her description of the wedding as "quite nice" (line 8) may be considered a somewhat formulaic and weak expression, but is followed only by a prolonged pause of 5 seconds (line 9) suggesting that further elaboration is would be difficult or impossible. The participant herself brings this exchange to a close as she cuts off any further questioning at line 12 with her interjection of "okay". Through this high level of expressed emotion, together with these markers of difficulty and hesitation, this nurses' discourse can be understood as having constructing her feelings as inexpressible, intimate or private. In doing so she established herself as thinking about Mr Langden as a person to whom she had an intense, private and almost inexpressible emotional commitment.

This intimate and personal form of d(D)iscourse was not always easily heard or recognised on the unit in which other Discourses of the 'medical case', '(un)stable patient) or 'routine work' could predominate. Nevertheless, there were many occasions within these data in which (often transiently and through unspoken modes of discourse) participants demonstrated that they were thinking about patients as valued individuals. This was evident in the encounter below where the pace and 'tenor' (Halliday 1978) of the nurses' interactions is clearly contrasted with her previous

interactions. Mrs Yates was a lady whose illness meant that she was becoming increasingly peripherally oedematous, and the handover had highlighted that her wedding ring would need to be taken off in order to avoid risking the perfusion to her finger:.

Nurse 2 approaches Mrs Yates to do this. Her approach is very different than when she had been ostensibly talking to Mrs Yates earlier when the ventilator had been alarming. She bends close and holds Mrs Yates's hand as she explains what she is going to do, and reassures her that the ring will be securely held in the unit safe. Nurse 2 then applies some lubricating gel and gently twists the ring, edging it over Mrs Yates's knuckle until it is free in her hand. Once the ring is off she turns around looking for tissues, though as she looks she is still holding Mrs Yates's finger as though anchored there, and is absent mindedly rubbing the oedematous finger. Once she has seen the tissues, she is again very attentive and gentle as she wipes the finger clean of the gel.

Field Notes: Nurse 2

Nurses could be seen to be thinking about the patient as a 'valued individual' in such private and intimate exchanges, but would also do so through comments and talk to one another. In section 4.2.3 an episode was cited in which Nurse B commented on a patient who had been very unwell:

Nurse B appears clearly delighted to have seen this patient now "sat out" of the bed and commented that
"She looks so good!"

She gives a satisfied sigh, catches my eye, laughs, then looks away.

Field notes: Nurse B

In returning to this data, it is particularly notable that Nurse B closed down the possibility of further discussion through her laughter and looking away. The sense that Nurse B could not quite articulate what she was thinking at this time was one reason for returning to explore this comment in a later interview with this participant:

- 1 **B** O she'd gone through everything
- 2 **Int** You said that she's had, I'm sure you said that she'd
- 3 had the works
- 4 **B** But when you see someone who has improved so much and
- 5 you've cared for them and you've just seen them - And you're just
- 6 expecting them not to do well - as in die - and then

7 you kind of see that actually they might be fine.
8 That's a big thing isn't it? *((laughs))*
7 That's someones whole life is turned around, and
8 you've also sat in on those conversations with the relatives
9 and...ye::ah. So I suppose its partly that isn't it?
10 (2)
11 *((quietly))* Mmmmm - yeah

Nurse B: First Interview

By explaining her initial emotional response in terms of having seen “someone’s whole life turned around” this nurse sets up the “whole life” of the patient as the subject of this Discourse. This is therefore a way of thinking about the patient as having a “whole life” with both a past history and a projected future.

The above extracts have largely related to participants talking about patients, and a further example further illustrates how thinking about patients as valued individuals could be seen interactions between nurses and patients themselves. The participant in the below example was an hour into her shift caring for Mr Stevenson and was completing aspects of her initial assessment:

Nurse 4 then turns from me and approaches the bed. She bends down close to Mr Stevenson and asks him if he could open his eyes for her. There is no response just as I have seen no response from him all afternoon, but she repeats the question softly and waits before she touches him. She bends close to talk to him and strokes his temple as she apologises for having to shine a light in his eyes, and then attempts to open his right eye with her fingers. Mr Stevenson appears to be grimacing and his eyes are screwed shut. Very gently she tries to open his eye, asking him to relax and reassuring him that it will not take long and saying “sorry, sorry”. Mr Stevenson’s eyes remain firmly shut, and Nurse 4 stands, pauses momentarily and then shakes her head. It is clear to me that she is not prepared to use any degree of force in order to open his eyes to complete this assessment.

Field Notes: Nurse 4

This extract contains little detail of the words spoken by this participant, but it may nonetheless be seen that many paralinguistic features of this episode (physical closeness, the ‘soft’ speech, the intimate touch described as ‘stroking’) served to construct a high degree of expressed emotion

and intimacy. Within these data it was frequently through such modes of discourse that nurses demonstrated that they were thinking about patients as highly valued and unique individuals who merited this degree of emotional involvement. The extract below serves to illustrate how (through gaze; giving time, and responsiveness to distress) one participant recognised the patient as a 'valued individual' whilst performing a potentially distressing procedure:

Mick begins to cough and retch and Nurse 6 steps up to the bed looking to him. She pauses for a moment then reaches for the Yankeur sucker and asks if he wants her to use this to remove the sputum. Still coughing, Mick nods his assent and Nurse 6 performs oral suction. Mick is still coughing and gagging, and Nurse 6 is closely attentive to him as she works. Her movements are careful and controlled, and she appears to maintain direct eye contact with Mick throughout the procedure. She soon realises that the Yankeur sucker is adding to his distress, and asks a second nurse to pass her a 'soft' sucker instead. Again she pauses to look to Mick who again nods his assent, and Nurse 6 then delicately uses the suction catheter to perform deeper pharyngeal suction. Throughout this time Mick is clearly in some discomfort and distress, yet appears to remain fully in control of what is being done to him due to the careful and attentive way in which the procedure is being undertaken

Field notes: Nurse 6

Participants could therefore demonstrate that they were thinking about patients as valued individuals both in the ways that they talked about patients whilst in practice, and through their discourse with patients. Figure 15 below summarises the characteristics of this way of thinking.

Figure 15: Thinking about the patient as a valued individual

The nurse is thinking about the patient as:

- A whole human life that is highly valued.
- Entirely uniquely individuated.
- Encountered on an inexpressible emotional plane.
- An autonomous being with a subjective lived experience
- Having a whole life with a past history and a future, and a continued identity over time.

Section 5.1 to 5.7 have set out the seven different ways in which the critical care nurses in this study were found to think about patients. Key features of these different ways of thinking are

summarised in figure 16 below before Chapter 6 turns to a discussion of the significance of these findings.

Figure 16: Summary of the different ways of thinking about patients identified	
Thinking about the patient as...	Constructs the patient as ...
'Routine' work	The site at which work is undertaken. <i>Publicly known, unchanging and predictable with no unique attributes. Only loosely spatially centred on the physical body. Having no relevant subjective experience. Existing solely in the present moment.</i>
An (un)stable set of body systems	A series of discreet, abstract physiological 'systems' which are constructed as 'stable' or 'unstable' and which are controlled and 'done to'. <i>Publicly displayed, changing and unpredictable. Abstract and without physical attributes or spatial location. Known in precise, measurable and quantifiable terms. Having no relevant subjective experience and existing solely in the present moment.</i>
A 'Body'	A visible and corporeal 'thing' and site of examination. <i>A physical / embodied thing which is uniquely differentiated only in terms of surface features. Having no relevant subjective experience and existing solely in the present moment.</i>
A set of needs	A 'patient' who has 'aspects' which generate theorised 'needs' <i>Having a unique personal identity which is known about rather than known. An experiencing subject in as much as this experience generates 'needs'. Continues to exist over time because needs relate to what the nurse must do within a specific but variable time frame (now; today; this week).</i>
A Medical case	A complex system recognised through 'patterns' of ordered and disordered physiology <i>Mentally constructed and thus existing in a mental rather than a physical realm. Has no unique personality or social role and not recognised as having a subjective experience. Exists within an ongoing temporal trajectory or narrative.</i>
A Social Being	Someone who is a 'normal person' in the same way as the nurse. <i>Fulfils social roles and has a social identity which projects into past and future. Relatively uniquely differentiated, but the patients unique personality and personal identity may or may not be known. Has a personal experience, personal goals and aspirations.</i>
A Valued Individual	A unique, whole human life that is highly valued. <i>The valued individual has a past history and a future, and a continued identity over time. Acknowledged as being entirely unique even when not be known as an individual. The valued individual has an autonomous subjective lived experience and is encountered on an inexpressible emotional plane.</i>

6.0 Moving between ways of thinking and “clinical wisdom”

The aim of this study was to explore how critical care nurses think about patients. Before discussing these findings it is therefore appropriate to begin by taking stock of the extent to which this aim and the study objectives have been achieved. This preliminary discussion sets up the focus for the main body of this chapter which develops an argument that expert critical care practice requires nurses to have the “clinical wisdom” needed to move between different ways of thinking. This argument means that substantial sections of this chapter are devoted to a discussion which makes clear that the different ways of thinking identified are distinct and mutually exclusive, and to considering how differences between nurses of varying levels of experience are apparent in these data.

As a means of reviewing what has been established in presenting these findings it is helpful to revisit the objectives which informed the design of the study. These were to:

1. Identify critical care nurses’ different ways of thinking about patients.
2. Articulate these ways of thinking about patients as the features or characteristics of patients which are of primary significance in the discourse of critical care nurses.
3. Identify patterns of nurses’ practice that may be associated with the different ways of thinking identified.

Chapter five has set out seven patterns in the ways that critical nurses behave towards and talk about patients whilst engaged in nursing practice. These patterns (or Discourses) each construct an identity for the patient as a particular kind of being and thus seven different ways of thinking about patients have been identified (Objective 1). Chapter five has also articulated these ways of thinking in terms of the particular “features or characteristics of patients which are of primary significance in the discourse of critical care nurses” (Objective 2). However, presenting these findings has not as yet fully accounted for the relationship between ways of *thinking* about and *treating or behaving towards* patients, or clarified the “patterns of practice” associated with different ways of thinking (Objective 3). In one sense, the distinction between a ‘pattern of practice’ and a ‘way of thinking’ (referred to in Objective 3) is a matter of perspective. Chapter five has made clear that thinking about the patient as a ‘set of needs’ may lead to a “swift and clinical” pattern of practice, or that thinking about the patient as ‘(un)stable’ may lead to a pattern of practice which characteristically uses technology to control and monitor patients’ physiology. By conceptualising discourse as relating to what nurses say and do it becomes clear

that utilising a particular Discourse is both to think about the patient in a certain way and to adopt a particular pattern of nursing practice.

The above discussion demonstrates achievement of the study objectives but the presentation of these findings in chapter five has depended upon presenting the analysis of discreet moments in nursing practice. Although all participants in this study did *at* times think about patients in each of these seven ways, a full account of how these nurses thought about patients must also consider how these different ways of thinking about patients come together in their nursing practice. This is therefore the focus of the current chapter.

Although this chapter includes the presentation of further data it may primarily be considered as a discussion and interpretation of the findings set out in chapters four and five. This chapter (and those which follow) begin to discuss these findings in relation to previous scholarship, particularly that literature which relates to the varying degrees of 'involvement' (Goffman 1974) demonstrated by participants as they thought about patients in different ways. This aspect of these findings calls for discussion in light of claims that nursing expertise as requires emotional involvement with patients (Morrison & Symes 2011), or the suggestion that emotional detachment is a coping strategy or response to anxiety (Menzies-Lyth 1959). Any consideration of expertise in critical care nursing must also account for the seminal work undertaken by Benner and her co-workers (Benner 1984; Benner and Wrubel 1989; Benner et al. 1992; Benner et al. 1996; Benner et al. 1999) and the later stages of this chapter consider how these findings serve to develop an understanding of the "clinical wisdom" described by Benner et al. (1999).

The above discussion has made reference to these ways of thinking about patients as being *different* in the sense of being distinct and mutually incompatible, and section 6.1 is devoted to an examination of negative cases in order to support this claim. Section 6.2 then revisits the practice of individual participants and the influence of the sampling strategy in order to explore how these different ways of thinking about patients 'come together' in the totality of these nurses' practice, and how nursing expertise appeared to influence the ways in which nurses think about patients (section 6.2). With particular reference to the work of Benner et al. (1999) the chapter concludes by demonstrating that nursing expertise is characterised by the ability to move fluidly between these different ways of thinking about patients (sections 6.3).

6.1 Different ways of thinking are distinct

Although seven different ways of thinking about patients were identified, analysis of these data revealed three categories of apparent “negative cases” in which it initially appeared that ways of thinking may not be distinct. There were suggestions in some of these data that nurses were thinking about patients in more than one way, or as some form of synthesis of these ways of thinking. These negative cases included instances of the use of humour, nurses’ awareness of the ‘big picture’ and the fluency of expert practice. This section therefore discusses these ‘negative cases’ in order to clarify that the practice of participants was always dependent upon their thinking about patients in one distinct way.

The methods of data analysis set out within Chapter 3 themselves suggest that the ways in which nurses think about patients are distinct, given that the Discourses emerged through processes of identifying and comparing distinguishing features which marked them as such. Prior to commencing the study, it was noted that previous literature such as Hirschauer (1991), Timmermans (1997) or Benner et al. (1999) described a kind of “gestalt switch” which suggested a complete change in the way that practitioners were thinking about their practice and such ‘breaks’ were a primary focus for observation in this study. The field note data contain 262 instances in which nurses clearly appeared to change the way in which they thought about patients.

Some of these breaks were particularly clear and complete such as in the following example when two other nurses and I are helping to turn Mr Richards.

As we commence the turn, comments and explanations (such as “over you come”) are made to Mr Richards in a normal casual tone, and without looking at Mr Richards himself. As he is turned onto his side however, Mr Richards opens his eyes and Nurse 4 immediately stops what she is doing and greets him loudly “↑Hello there”.

My contemporaneous notes record my impression that her intonation conveyed a sense of this being a pleasant surprise as though Mr Richards were a welcome but unexpected guest in the group

Field Notes: Nurse 4

As Mr Richards opens his eyes there was a clear and complete transformation or reframing of this situation as he was suddenly recognised as a ‘social being’ who was aware of his surroundings and with whom nurses may interact meaningfully. Throughout these data participants were clearly seen to move from one distinct way of thinking about the patient to another through descriptions of their practice which captured clearly observable changes in their pattern of behaviour.

Despite this general finding, initial analysis identified 37 episodes in which it was not clear that participants were framing their sense of what was going on in any one way. These instances all related to the use of humour, seeing the ‘big picture’, or to the fluency of expert practice. The identification of such episodes therefore called for a re-examination of all of the data in order to further analyse incidents relating to these apparent negative cases. The first of these to be considered is the use of humour.

6.1.1 Humour

Humour and ‘joking’ may superficially appear inappropriate or insensitive in the context of delivering care to sick patients on a critical care unit, although humour is a well-documented feature of nurse patient relationships (Harries 1995; Pierlot & Warelow 1999; Dean & Major 2008). Instances of humour within these data presented particular challenges to analysis given that they represented occasions on which it was very difficult to determine any one way in which nurses were thinking about the patient.

These challenges were evident within the following extract which captures a comment made by an experienced participant about Mrs Williams. Mrs Williams was a lady who had been admitted three days earlier and who was unconscious although the underlying diagnosis was not clear. She had suffered from Diabetes Insipidus, and viral meningitis or encephalitis were considered possible underlying diagnoses:

When discussing Mrs Williams’ progress at the end of handover, Nurse 5 comments that Mrs Williams has a sodium level of 128, and that it was 130 earlier on in the day. Nurse 5 looks to me and comments in a joking tone that she is
“Not sure we can go home now”.

Field Notes: Nurse 5

There are several different ways of thinking about the patient in evidence within this extract. Discussing the *significance* of Mrs Williams’ serum sodium level set her up as a ‘medical case’, whereas reference to Mrs Williams going home framed her as a ‘social being’. In this joke the

nurse also acknowledged the tendency for nurses to make or express judgements relation to the absolute value of certain parameters (when considering the patient as '(un)stable'), and the humour is generated in part through contrast with how significant these changes are to the patient considered as 'medical case'. The above comment therefore appears to suggest that this participant was able to 'frame' or think about Mrs Williams as medical case, as (un)stable and / or as a social being at one and the same time.

On closer examination it can be seen that it is the very juxtaposition of these different ways of thinking about Mrs Williams which forms the basis of the joke. Humour is often understood as arising from the unexpected association of alternative interpretations of a situation (Moran & Massam 1997), and Goffman (1974) also notes that jokes arise from this kind of "frame tension". Analysis of other instances of humour within these data found that jokes or laughter were invariably associated with occasions on which two or more different potential framings or ways of thinking were "laminated" (Goffman 1974) in this way. The following provides a further example:

Nurse 7 is checking Mr Norton's TPN against the prescription with another nurse. They check all the elements of the prescription and then Nurse 7 turns to the second nurse to ask whether she is happy that this patient is Mr Norton. The second nurse replies that

"Yes I've met Richard"

Nurse 7 looks to the second nurse with an expression which I read as slightly quizzical and the second nurse laughs and comments that of course she does not know him socially. I detect a slight awkwardness in their demeanour, which I feel stems from recognition that, in some important way, neither of these nurses have in fact 'met' Mr Norton.

Field notes: Nurse 7

In this example, the ambiguity over what may be meant by having 'met' Mr Norton gives rise to an awkwardness expressed through laughter. Following Goffman (1974), such a lamination of alternative ways of framing a situation will always produce some form of recognisable frame tension which may be expressed through laughter. Throughout these data humour and laughter were consistently associated with occasions on which nurses appeared to be thinking about patients in more than one way at a time. This analysis of humour thus makes clear that such tension or humour is usually clearly evident, and suggests that in the absence of such tension nurses may only be understood as thinking about patients in one way at a time.

6.1.2 The Big picture

Participants made occasional reference to their awareness of a 'big picture'. Whilst not always immediately clear in meaning, there was a suggestion in these references that critical care nurses could "see the whole picture" in the way that Chaboyer & Creamer (1999) describe as a form of synthesis. Aspects of these data which demonstrated that participants had an awareness of, or made reference to, a 'big picture' were therefore considered as negative cases in the sense of being apparent exceptions to the general finding that the different ways of thinking about patients were distinct and mutually incompatible. It will be seen that an interpretation of these findings which draws upon the work of Polanyi (1958, 1966) can resolve the apparent tension between nurses awareness of a 'synthesis' and the fact that they think about patients in different and distinct ways.

An examination of the 'big picture' may be introduced in relation to an extract from these data relating to Mr Richards. Mr Richards was a gentleman of around 70 years of age who had been admitted to the ITU following an operation for small bowel obstruction during which he had suffered an intra-operative myocardial infarction. In this extract the participant and I were coming on duty and were receiving handover from a second nurse. Both this nurse and the participant were nurses with many years' experience:

The nurse gives the handover quickly and smoothly. After summarising Mr Richards' reason for admission and his past medical history, she is talking through his current condition when her voice drops as she tells Nurse 4 that Mr Richards has recently had an echocardiogram. She reports that this found him to have a septal defect and an ejection fraction of 15%. As the nurse mentions the ejection fraction she holds Nurse 4's gaze for a few seconds and pauses as though to emphasise the significance of the information she is giving.

Field Notes: Nurse 4

In discussing his medical history and ejection fraction, the discourse of this nurse highlighted the very poor cardiac function of Mr Richards as a 'medical case'. The subsequent pause, silence and holding of gaze at the end of the episode serve to convey an acknowledgement of the impact of this poor prognosis on Mr Richards as a 'valued individual'. The reference to Mr Richards as a 'medical case' therefore precedes, and thus sets the context for, the 'meaningful' pause, silence and gaze which acknowledge him as a valued individual. There is a clear implication that the participant and I are expected to understand this as a reference to Mr Richards *in the context* of a

poor prognosis, but this is not directly articulated. The two distinct Discourses serve as context for one another, but are not articulated at the same moment and neither of these two ways of thinking about Mr Richards conveys the full meaning of this interaction. The 'big picture' is tacitly understood between the two nurses.

Polanyi (1966) highlights that much of our knowledge is tacit simply because it may not be articulated. Whilst these nurses may understand or perceive a 'big picture', any sense in which these different ways of thinking are synthesised can only be as "personal knowledge" (Polanyi, 1958) that cannot be expressed through d(D)iscourse. This awareness of the 'big picture' cannot itself be considered to be a way of thinking about the patient given that these 'ways of thinking' are by definition expressed through discourse. This is an important claim. Though nurses may have personal and tacit knowledge of such a big picture, whenever they do or say anything (that is whenever they engage in nursing practice) they must do so through one particular Discourse.

Whilst nurses may have an understanding or awareness of a 'big picture', the moment to moment delivery of nursing care (doing or saying anything) requires that nurses move between different ways of thinking (or different Discourses). Further extracts from these data make this clear:

Nurse 7 begins to manually hyperinflate Mr Norton as the physiotherapist begins her treatment. There is little or no conversation directed towards Mr Norton during the treatment other than an occasional warning that suction is about to be performed. The discussion between the two is entirely focussed on Mr Norton and his treatment. During all of the treatment, the two are closely attentive to the monitoring equipment and ventilator, as well as closely observing Mr Norton himself.

(and shortly later)

Nurse 7 comments that she does not think his problems are really ARDS³⁰ because his gases are "not that bad", and his ventilator pressures are not high....(*lines omitted*). She summarises all of this by saying that if we did use the ARDSnet ventilation strategy³¹ then we would need to paralyse him. Nurse D pulls a face at this, and lets

³⁰ Acute Respiratory Distress Syndrome

³¹ ARDSnet are a network of researchers. The reference to a ventilatory strategy refers to protocols developed by this group.

the comment hang as the physiotherapist nods agreement. It is clear to me that both see this as a last resort which should be avoided.

Field Notes: Nurse 7

Within the first part of this extract, the nurse and physiotherapist are actively engaged in the delivery of physiotherapy treatment, and their focus is upon the 'body' of Mr Norton. At the beginning of the second part of the extract a focus on his blood gases, ventilation pressures and the diagnosis of ARDS makes clear that they are expressing judgements about Mr Norton as a medical case. What these practitioners do and what they are able to express is therefore related to one of these two ways of thinking about Mr Norton. At the end of this extract there is an apparent shared understanding of a 'big picture' as the participant pulls a face and lets the comment about paralysing agents "hang" whilst the physiotherapist nods, but again this big picture is tacitly conveyed rather than articulated. This focus on the 'big picture' is not associated with engagement in nursing practice in the sense of doing or saying anything directed toward the care of Mr Norton.

Chapter five noted that nurses could maintain a 'subsidiary awareness' of patients as experiencing subjects even whilst they moved between different ways of thinking. Polanyi's (1958, 1966) distinction between "focal" and "subsidiary" awareness serves to clarify the nature of these findings. Nurses may have a "focal" awareness of the patient as some form of 'big picture', synthesis, or "coherent distal entity" (Polanyi 1966), but this focus on a 'big picture' is not a way of thinking which may guide nursing practice at any one moment. To engage in nursing practice requires nurses to think about patients in distinct and different ways, and to maintain a "focal" awareness on only one particular aspect of the patient.

The need to maintain a focus on particular aspects of patients could cause challenges for participants. Polanyi (1966) notes a person who maintains a "focal awareness" of some particulars may risk losing sight of the "coherent entity" to which they had previously attended. This phenomenon was apparent within these data as illustrated in the interview extract below where a nurse is describing the way in which she could become "bogged down into what's happening":

N You can't always see the big picture though because you can get too bogged down into what's happening and become a bit oblivious maybe to the bigger picture

Int Okay can- I just want to explore that a bit

N ((*short laugh*))

Int How does that happen? You say you're bogged down - in what?

N Well ((*rising tone throughout*)) maybe technology and numbers?

Nurse 7: Second Interview

This participant here clearly articulates her own understanding that the necessity to focus on "technology and numbers" may mean that she loses an awareness of the big picture.

The finding that a focus on the 'big picture' cannot not be directly associated with engagement in nursing practice has major implications merits further elaboration. In 'The Tacit Dimension' Polanyi (1966) is directly concerned to explore how we come to know and know about other people, and proposes a system of hierarchies between the different sciences such that:

"The most primitive form of life is represented by the growth of the typical human shape, through the process of morphogenesis studied by embryology. Next we have the vegetative functioning of the organism, studied by physiology.... We rise beyond this at the level of conscious behaviour and intellectual action, studied by ethology and psychology..."

Polanyi 1966: p.36-37.

Polanyi therefore anticipates the findings of this study which demonstrate that the ways in which critical care nurses think about patients do in fact broadly reflect these distinctions. Critical care nurses *were* found to think about patients in terms of their physical shape and appearance (as 'body'); about patients as functioning organisms (as a 'medical case) or in terms of their social behaviour (as 'social being'). Although not the primary factor differentiating between these Discourses, a form of "specification hierarchy" (Lemke 1995) may be discerned in these findings. When thinking about the patient as 'body' nurses do not think about patients as fundamentally different to any other; whilst thinking about the patient as "medical case"; "social being" or "valued individual" identifies the patient as increasingly unique.

The significance of this discussion lies not only in the fact that nurses must think about patients in ways which do not uniquely differentiate that patient from any other, but also because they demonstrate that the delivery of nursing care cannot be dependent upon thinking about the patient as a "whole person". This claim is elaborated throughout the sections which follow, but the above interpretation makes clear that any "holistic" understanding which a nurse may have of

a patient as a “whole person” cannot itself direct nursing practice. Nurses may have an awareness of patients existing as such a coherent being, but this may only be tacitly inferred rather than articulated, and cannot be conveyed in any meaningful behaviour or communication. Nursing *practice* requires nurses to think about patients in discreet and mutually exclusive ways.

6.1.3 The fluency of expert practice

Although nurses’ “ways of thinking” about patients were distinct within these data, there were episodes where participants’ practice appeared particularly ‘fluid’, and where ‘breaks’ in d(D)iscourse were not readily apparent. The episode recounted below provides such an example and relates to the practice of an experienced participant. At a first reading this passage appears to reflect a synthesis in which the clinical ‘needs’, ‘body’ and the ‘valued individual’ are all recognised simultaneously, and for this reason such episodes were analysed as potential ‘negative cases’. Nonetheless, the text in this extract has been shaded in order to give some illustration of how this can be seen as a stream of rapidly shifting and changing, but nonetheless distinct, Discourses.

To perform suction she moves around the bedside and is now standing facing Mr Young. The procedure itself is done quickly and wordlessly, and as Mr Young retches and coughs at the end of the procedure Nurse 5 looks carefully at the contents of the suction catheter. As his breathing settles once more Nurse 5 begins speaking to him again but there is a clear change in her voice. I note that she is speaking quieter now and that there are changes in her intonation. It is my feeling that this procedure has been distressing for Mr Young and I interpret these changes in Nurse 5’s intonation as conveying sympathy for this. She explains that she will need to perform suction again, and does so, looking only at Mr Young’s face and the movements of his chest. I gain an impression that this more restricted gaze represents a narrowing of focus which may be significant to the study. She leans over now and speaks again, this time so quietly that her words are barely audible to me. It is my sense that Nurse 5’s gaze and quiet intonation convey a sense of intimacy and concern, which I attribute to her acknowledging the distress she is causing him. She quietly asks if she can place her hands on his chest once more to feel his breathing, and pauses in this position for a few moments of silence as she concentrates on his breathing. She is looking only at Mr Young himself now – the saturation probe has actually become detached and there is no reading on the monitor. She listens again to his chest with the stethoscope before breaking away.

Field Notes: Nurse 5

KEY

Thinking about the patient as a set of needs

Thinking about the patient as a social being

Thinking about the patient as a valued individual

Thinking about the patient as a body

My own observer impressions or descriptions not attributed to any particular discourse in the practice of the participant

Although this colour coding makes the point somewhat crudely, this illustration demonstrates how the entirety of practice described within these data may be seen as d(D)iscourse within which critical care nurses are constantly reframing their sense of what it is that is going on and thinking about patients in different ways. Rather than thinking about the patient in all of these different ways simultaneously, this nurse's movements and changing gaze suggest a rapid and frequent 'reframing' of the immediate context of care. This analysis of the 'fluidity' of expert practice does not contradict the finding that nurses may only think about patients in one way at a time, but rather suggests that expert practice is dependent upon an ability to move rapidly and fluently between different ways of thinking.

6.1.4 Implications of the finding that ways of thinking are distinct

The above discussion makes clear that the participants in this study thought about the patient in seven different ways which were distinct, and that critical care nurses may not think about any patient in more than one way at any moment in time whilst engaged in nursing practice. Whilst nurses may have awareness that patients may *be* a "coherent entity" (or a 'whole person'), this tacit awareness cannot itself guide nursing practice at any one moment. The practice of critical care nursing requires critical care nurses to think about patients in a range of different ways, and (as will be argued) to move between these ways of thinking as appropriate to the moment.

These findings are of significance as they run counter to claims such as that of Benner et al. (1999) who assert that expert critical care nurses

"are not ordinarily involved in compartmentalized thinking or performance. Rather they think and act across multiple domains simultaneously, as the situation demands"

These findings call for a re-examination of such claims given that at any moment in time the way in which nurses think about patients *must* be “compartmentalised”. An understanding that nurses think about patients in ways which are different, distinct and mutually exclusive therefore challenges the work of nursing theorists, educationalists and policy makers who assert that nursing is directed towards the patient as a ‘whole person’.

These findings most clearly problematise the work of theorists working within what Parse (1992) discusses as the ‘simultaneity’ paradigm. The work of such theorists including Rosemarie Parse and Martha Rogers is characterised by a view that nurses must view patients as “unitary” and “irreducible” (Rogers 1990) and not as “the sum of particulate attributes” (Parse 1992: p.35). The analysis of these data makes clear on the contrary that the unitary and cohesive nature of human being may only be tacitly understood. Foucault (1969) is clear that Discourse itself does not allow for an expression of such a unified subject:

“instead of referring back to *the* synthesis or *the* unifying function of *a* subject, the various enunciative modalities manifest his dispersion” (Foucault 1969: p.60)

In their efforts to articulate a view of the person as unitary and irreducible, theorists such as Parse (1992) or Rogers (1990) are therefore attempting to say the unsayable.

Theorists working within what Parse (1992) terms the ‘totality’ paradigm include writers such as Orem (2001) or Roper et al. (2000) who view patients as having distinct physiological, psychological, social and spiritual attributes. Although theorists such as Orem (2001) or Roper et al. (2000) have been historically influential on UK nursing education and practice, it is notable that concepts of ‘holism’, or of ‘holistic’, ‘person centred’ or ‘person focussed’ care continue to be used very broadly and loosely. A directive that nurses should deliver care which is “person-centred” (NMC 2010), or deliver care from “from one human to another” (DH 2006; RCN 2010) does not provide guidance or support to nurses who cannot at any one moment in time think about the patient as such a cohesive “person”. There is a need for leaders and policy makers to articulate these directives clearly in ways which recognise that person-centred care must involve thinking about patients in a range of different ways.

6.2 Expertise and ways of thinking

The above discussion makes clear that the critical care nurses who participated in this study thought about patients in seven different ways which were distinct and mutually exclusive. Whilst all participants within the study thought about patients in each of these seven ways, the distinctive nature of their practice in these findings lay primarily in the ways in which nurses moved between different ways of thinking. In particular, the recruitment of participants who were a mixture of novice and more experienced critical care nurses enabled the recognition that more expert practitioners could not only use individual Discourses more effectively, but also demonstrated much greater fluidity in moving between different ways of thinking about patients.

The accounts of the seven individual participants in section 4.2 highlighted ways in which the practice of each nurse was unique. The unique nature of individual nurses' practice must therefore be examined in light of the fact that all participants moved between the same fundamental ways of thinking about patients. Section 3.2 has highlighted that all of d(D)iscourse is closely related to issues of identity, and the distinctive nature of each participant's practice can be most readily understood in relation to the ways in which these nurses used these Discourses to project and assert their own identity.

6.2.1 Individual participants ways of thinking about patients

It was noted in section 4.2.2 that Nurse A did not identify herself as a developing *critical care nurse*, but rather as an employee who was just "doing her job" and who tended to habitually think about practice in 'routine' terms. Nurse E (section 4.2.6) was particularly conscious and protective of her status and identity as an experienced acute care nurse, and would characterise aspects of 'routine' work and of the focus on 'stability' as 'obsessive' whilst herself preferentially focussing upon patients' recognisable 'nursing needs'. The final novice participant was Nurse C (section 4.2.4) who clearly identified herself as a developing critical care nurse, and demonstrated an early understanding and acceptance that thinking about patients as a 'medical case' or as '(un)stable' were of central importance to critical care practice.

The experienced nurses in this study also tended to demonstrate preferences for certain ways of thinking about patients. Nurse B (section 4.2.3) expressed a strong personal ethic according to which thinking about the patient as either a 'social being' or a 'valued individual' was natural, unproblematic and simply "thinking straight". Nurse D (section 4.2.5) presented herself as a maverick who was happy to break the rules, but did so by tending to justify her actions in terms of

the patient as either a 'medical case' or as a 'social being'. Nurse F (section 4.2.7) characteristically avoided getting caught up in the here and now, minute to minute experience of the 'social being' or the individual', and was adept at managing time so that the 'work' could be done whilst she maintained a focus on patients trajectory of recovery as a 'medical case'. Nurse G (section 4.2.8) appeared to identify herself as a 'nurse' in a way which she herself contrasted with an identity as an 'ITU trained nurse'. Nurse G remained closely aware of the here and now experience of patients as 'social being' or as 'valued individual', and valued her intuitive understanding of the 'individual' in preference to thinking about the patient as a 'medical case'.

The above review serves to emphasise that all participants in this study were moving between the same fundamental ways of thinking about patients, but yet begins to show how the unique nature of their practice was expressed in the way that they would move between, adopt, resist, or prefer particular forms of Discourse. At the outset of the study it was considered likely that more experienced nurses would think about patients in ways which differed from novices, yet importantly no ways of thinking about patients were unique to either novice or experienced nurses.

This finding is itself of significance. Goffman (1974) notes that all frames carry different expectations about how deeply the person should be involved in a particular activity, and yet the nursing literature consistently asserts that that expert nursing practice is characterised by nurses' "emotional involvement" with patients (Tanner 2006; Morrison & Symes 2011). These findings problematise such a claim given that these critical care nurses (including the most expert) would at times think about patients in ways which did not demand any such emotional involvement. Nurses' lack of emotional involvement in their work has often been viewed negatively, and been understood as a defence against anxiety (Menzies-Lyth 1959) or a means of protecting nurses from the "unbearable emotional weight" which they may experience (Benner et al. 1999). These findings make clear that the nurses in this study did not always think about patients in ways which required such emotional involvement, and thus call for a reappraisal of how experts may think about patients in ways which are different to other practitioners.

6.2.2 Differences between novice and experienced participants

Analysis of data comparing the practice of novice and more experienced critical care nurses suggested two key differences between these groups. Firstly it was noted that experienced nurses would use individual Discourses more effectively, and secondly (as was noted in section 6.1.3)

more experienced nurses demonstrated much greater fluidity in moving between different ways of thinking about patients.

The following extract illustrates how nurses need to learn to speak or use different forms of discourse more effectively, and relates to an incident where one of the inexperienced participants was talking to a surgical team:

The registrar leading the surgical review turns to ask

“How’s he doing?”

Nurse 6 pauses briefly, then replies that Mr Turner is

“OK I think”

She reports that Mr Turner has just had a chest X-Ray and that the physio has reported some reduced air entry. I am not sure whether she is reporting what is uppermost in her mind (as this is what she has most recently done), or whether she is deliberately constructing an account beginning with the respiratory system. The surgical team glance to one another, and then the registrar asks whether Mr Turner has a stoma. Nurse 6 replies that he had an end to end anastomosis performed. This appears to put the conversation back ‘on track’ and the team appear to relax as they move on to enquire about whether Mr Turner has a drain.

Field Notes: Nurse 6

It is clear from the ‘difficulty’ in this account that this inexperienced nurse did not give an initial response to the question “how’s he doing?” that was considered appropriate. Her response gave information about the “medical case” just as a more experienced nurse may have done, but this account makes clear that she needed to learn how to use the Discourse of the medical case in ways that were more refined and sensitive to the situation. An account of the medical case which begins with “respiratory issues” may have been deemed appropriate if directed to a critical care practitioner, but in this account the nurse has failed to appreciate or respond to the specific and immediate concerns of the *surgical* team. In addition to thinking about patients in different ways, critical care nurses must learn to use the different Discourses associated with these ways of thinking appropriately.

More experienced nurses also moved between different ways of thinking about patients more rapidly and fluidly than did their less experienced colleagues. This is apparent in the contrast between the following two extracts from these data, the first of which relates to the practice of an experienced critical care nurse:

Nurse 5 is talking to Mrs Williams' son. As I approach them I notice that the blood pressure alarm on Mrs Williams' monitor is continuing to sound and see that the systolic blood pressure is 97 mmHg. Nurse 5 glances up to the monitor then looks back down to the infusion pump and increases the rate of the noradrenaline infusion from 3 to 4 mls/ hr. All of this is done with no apparent loss of concentration or break in the conversation she is having with Mrs Williams' son. A few moments after she has increased the noradrenaline, Mrs Williams' son asks her about the blood pressure, and what a normal blood pressure is. In her reply, Nurse 5 highlights that it is not really a 'normal' blood pressure that counts, and that Mrs Williams' is doing perfectly well at present with her current blood pressure.

Field Notes: Nurse 5

This contrasts with the below account which relates to the practice of an inexperienced participant responding to a blood pressure alarm in the presence of the patients' family:

As Nurse 6 finishes drawing up the drugs, the blood pressure alarm on the monitor sounds. Mrs Venn's blood pressure is now 79/37 and yet although Nurse 6 looks to the monitor she does not silence the alarm and continues preparing to administer the medication. She does not explain what she is doing to the visitors or to Mrs Venn herself.

She begins to administer the IV drugs, and the alarm continues to sound continuously for five minutes as Nurse 6 administers the medication. I see that the two visitors are looking intently at the monitor and are exchanging glances which suggest some concern. After a few minutes they ask about the monitor and Nurse 6 replies with an explanation that the red line is the blood pressure, the green line the heart rate and so on and concludes with a smile and the phrase "so lots of lines" before turning her attention back to the monitor. I feel that she has not picked up on the visitors' concerns and has offered them no explanation or reassurance about the continuous alarm that is sounding.

Field Notes: Nurse 6

Within the first account, the experienced Nurse 5 recognises and responds to the 'instability' of the patient so fluidly that there is no apparent loss of concentration or break in the conversation with the patients' relative. In the second example, the less experienced Nurse 6 appears 'stuck' in

the routine activity of giving the medication despite a large number of cues which suggest that the patient should be seen as 'unstable'. (Shortly after observing this episode I felt it necessary to intervene and ensure that the nurse received support from senior staff in order to ensure patient safety and appropriate support for the patients' relatives).

The above extract describes one of the first occasions on which this novice nurse had administered intravenous medication, and is characteristic of the rule following and procedurally focussed practice of novice practitioners described by Benner (1984) and Dreyfus & Dreyfus (1985). Nonetheless it remains noteworthy that this nurse does not respond to the powerful cue provided by the low blood pressure and the associated alarm, and there is a need to account for her failure to do so. Although her behaviour could be taken to reflect a lack of knowledge, poor prioritising, or a failure to recognise what Benner et al (1999) would highlight as the "salience" of the alarm, it was clear in later discussion that this nurse was able to articulate how important and urgent this problem was. A recognition that nurses think about patients in different ways therefore provides an additional perspective from which to understand this 'rule' orientated behaviour. Whilst the expert practitioner moves fluidly between different ways of thinking about patients, this novice critical care nurse may be seen as stuck within 'routine' ways of thinking. Responding to the patient who has a low blood pressure requires first that the patient is considered potentially unstable. The practice of this novice nurse is characterised by her failure to change the way in which she thinks about the patient whilst the more expert nurse was able to move between different ways of thinking about the patient as the situation demands.

These considerations highlight that nurses need the knowledge and skills which will guide their practice whilst thinking about the patient in any *one* way, and also need an ability to *move between* these different ways of thinking. In relation to the above examples, these distinguish the skills needed to interpret and respond to the low blood pressure of an unstable patient, and the ability to think about that patient as potentially '(un)stable' in the first place. Section 6.3 further explores the ways in which nurses may move between different ways of thinking about patients.

6.3 Moving between ways of thinking about patients

The fact that nurses must *move between* different ways of thinking about patients follows logically from the finding that they *do* think about patients in different ways. It also emerges as significant that the fluidity with which nurses' move between these ways of thinking appears related to expertise. This section therefore further explores how these nurses moved between

different ways of thinking about patients in order to clarify how these findings contribute towards understanding the nature of expertise in nursing.

It will be shown that different ways of thinking about patients may only be judged appropriate or inappropriate to a particular moment rather than being inherently 'right' or 'wrong'. It will also become clear that the way(s) in which nurses think about patients is closely related to what nurses see. These two strands of discussion lead to an interpretation that moving between different ways of thinking may be understood with reference to the Aristotelian concept of 'correct perception'. This conclusion itself leads to an examination of how these findings help to clarify the aspect of nursing expertise characterised by Benner et al. (1999) as "Clinical Wisdom".

6.3.1 Appropriate and inappropriate ways of thinking

The way in which particular ways of thinking about patients may be judged appropriate or inappropriate can be introduced with reference to the following incident:

Once we have transferred Mr Quinn to the chair, I step back whilst Nurse 6 ensures he is comfortable and disentangles the lines once more. As she is doing this Mr Quinn retches violently and Nurse 6 looks away from what she is doing to look at his nasogastric tube and the drainage bag connected to it. She comments that there is "stuff coming up" as she can see it in the drainage bag. Mr Quinn himself frowns at this comment, and I cannot help but wonder what the purpose of this communication was meant to be as it did not appear to me to address either the patients' distress or likely concerns.

Field Notes: Nurse 6

There is nothing intrinsically wrong with a nurse noting that a patients' nasogastric tube is draining, is not blocked, and thus that the patient cannot actually be sick. It may be recognised that this is a legitimate and reasonable understanding of the 'medical case' which constitutes an important part of an overall assessment of this situation. What feels 'wrong' in this account is not that the nurse thinks about the patient in this way, but that she is demonstrably doing so at the moment that she is talking to Mr Quinn. The inclusion in this account of my comments about the patients' "distress or likely concerns" reflect my own perception that it would have been more appropriate to think about the patient as a person who was distressed at that particular moment in time.

Another perspective on the above example is to highlight that the nurse 'sees' the nasogastric tube as a problem to be solved, rather than 'seeing' other aspects of the situation such as Mr Quinn expressing anxiety. In order to elaborate on how nurses see and perceive it may be recalled that section 6.1 presented an incident which made clear that seeing a patient open their eyes was a powerful cue that the patient should be framed as being, or perceived as, a 'social being':

As he is turned onto his side however, Mr Richards opens his eyes and Nurse 4 immediately stops what she is doing and greets him loudly
"↑Hello there".

Field Notes: Nurse 4

Other instances within these data make clear that what nurses perceive is not always so straightforward:

Nurse 1 then breaks off to pick up the patients' urometer, and as she sees the contents of it she comments loudly.

"O would you look at that!"

My contemporaneous notes described this as an 'exclamation' rather than a simple statement, and as she speaks she is smiling very broadly. She then adds

"I'm so happy! We've got a urine output. Oh I'm happy now"

She hangs up the catheter bag and turns back to record the figures on the chart with a twirl, and still grinning. I am struck by the spontaneous and apparently authentic and genuine emotional reaction which she is displaying

Field Notes: Nurse 1

This nurse demonstrates a high degree of emotional involvement in what she is doing which appears out of place within the context of measuring urine output. There is no sense of the irony or "mock pride" with which nurses commented upon having achieved a 'target' (see section 5.2), and the participant not only declares herself to be 'happy', but elaborates this display through 'twirling', smiling, intonation and stress which lead me to characterise her speech as an 'exclamation'. This display of "authentic and genuine" emotion would not be directed towards an (un)stable set of systems, but is only appropriate in a context in which the nurse thinks about the patient as a valued individual.

In the above extract the nurse *sees* urine in a urometer, but it is therefore clear that she *perceives* something much more than this. In order to clarify the distinctions between 'thinking', 'seeing'

and 'perceiving' it is useful to note with Gumperz (1999) that within any culture there are expectations about the way in which certain 'cues' may be framed. This suggests that critical care nurse learn to 'frame' situations in particular ways: seeing a full urometer enables the nurse to perceive (and thus think about) the patient as a 'valued individual' who is showing signs of recovery or improvement.

Moving between different ways of thinking therefore appears dependent both upon nurses' ability to 'see', and upon how they 'perceive' what they see. In order to think about patients in different ways, critical care nurses therefore need to be open to seeing and perceiving cues which may be relevant. Within these data, this appeared to be achieved through the way in which participants would survey or 'lighthouse' (Scholes 1996) their surroundings. This was most clearly documented within these data on occasions when nurses were closing individual interactions with patients:

The sister leaving the room appears to close this episode of interaction with Mr Young, and Nurse 2 looks briefly around the patient, the monitor and then the clock as she comments

"So:::::"

It is 10:05 and clearly time for observations.

Field Notes: Nurse 2

After finishing giving the drugs and her documentation, Nurse 4 steps back and stands at the corner of the bed. She looks around the monitor, ventilator, and Mr Thompson in the bed, before turning to leave.

Field Notes: Nurse 4

This rapid cyclical changing of focus did not only occur at the end of identifiable episodes of care, but was also seen to be an integral regular feature of critical care nursing practice:

Once Mr Fletcher is on his side, the physiotherapist begins to auscultate his chest whilst Nurse 7 moves quickly around the bedspace tidying cables and repositioning the saturation probe. The ventilator alarms and I see that Nurse 7 continues moving, although her focus shifts between the monitor, the ventilator and the infusions.

Field Notes: Nurse 7

Critical care nurses therefore learn to remain aware of and see many different cues which may lead them to think about patients in different ways, but the distinction between what nurses see and what they perceive is of particular relevance to the education and development of critical care nurses. Whilst junior nurses in critical care may often be encouraged to “look at the patient”, such an injunction is not at all clear once it is understood that doing so may lead a nurse to frame or perceive the patient in a range of different ways (as a ‘body’, as a ‘social being’, or as a ‘set of needs’). Practitioners and educators within critical care need to recognise that nurses learn to perceive and think about patients in ways that are appropriate.

6.3.2 Correct perception and Clinical wisdom

Within the nursing literature, concepts of ‘perception’ (Scott 2000; Niven & Scott 2003) or perceptual ‘grasp’ (Benner, 1999) often imply that nurses should perceive patients as persons. The above arguments make clear that nurses do in fact perceive patients in many different ways, and that therefore there cannot be any *one* way in which nurses should perceive patients. This section therefore explores the concept of ‘correct perception’ in order to make clear that the ability to perceive (and hence think about) patients in ways which are appropriate to the moment is an essential aspect of nursing expertise.

The notion of ‘correct perception’ is implicit within the Aristotelian concept of *phronesis* or practical wisdom which is frequently drawn upon within nursing scholarship (Benner 2000; Polansky 2000; Pask 2003; Sellman 2003; Chan 2005). Aristotle notes that:

“{Phronesis} is concerned with the ultimate particular, which is the object not of knowledge but of perception – not the perception of qualities peculiar to one sense but a perception akin to that by which we perceive that the particular figure before us is a triangle” (Aristotle 1984: Nichomachean Ethics, 1142a.26-29)

Aristotle (1984) elaborates on the nature of this correct perception with reference to the practical syllogism. Syllogistic reasoning involves making a valid inference from two premises (Priest 2000), and may be illustrated with reference to an example from these data. Section 5.4 introduced an episode in which Nurse 2 appeared to perceive and think about Marshall as a ‘patient’ with a need for independence rather than paying attention to the degree of pain and discomfort that Mrs Marshall the ‘valued individual’ was experiencing. In doing so the nurse offered little comfort or support to Mrs Marshall at the time that she was mobilising even though the patient was

clearly experiencing some pain whilst doing so. Setting these findings out as a syllogism makes clear the grounds upon which the nurses' perception of Mrs Marshall may be judged appropriate or otherwise.

- Premise 1** It was an appropriate goal for Mrs Marshall to regain the ability to mobilise independently
- Premise 2** For Mrs Marshall to regain independence it was necessary to treat her as a 'patient' with this need for independence
- Conclusion** It was appropriate for the nurse to perceive Mrs Marshall as a patient with this need

Without making a definitive judgement about whether this nurses' perception was appropriate (i.e. making a judgement on whether the conclusion is true), it can nevertheless be seen that the above argument is valid. To deny that it was appropriate for the nurse to perceive Mrs Marshall as a patient would require examination of the premises of the argument: that is to question whether at this time mobilising independently was an appropriate goal, or whether achieving this goal required treating Mrs Marshall as a 'patient' who had such a need.

The relevance of these points becomes clear in light of the work of Benner et al. (1999) who draw upon the concept of phronesis to provide an account of the "clinical wisdom" which they depict as a central aspect of critical care nurses' expertise. Benner et al. (1999) do not provide a detailed examination of Aristotelian thought in order to clarify the relationship between phronesis and the "clinical wisdom" they describe, but this relationship may be explored through the examination of one episode described by Benner et al. (1999) as a "breakdown in smooth practice". In this example a nurse is describing the management of a seriously injured trauma patient in an out of hospital context where she is preparing to intubate:

"I grab my Ziploc bag, and I begin to open it, and I look back at him and he opens up his eyes, just as clear as ... he was just so lucid at that point, he looked me – directly at me in the eyes and said, "Help me". I just stopped dead in my tracks and I was like... I forget everything that was going on. I just, I had no idea, nor did I care"

Nurse cited in Interview: Benner et al. 1999: p. 110

Within this account, the patient opening his eyes and appealing directly for help are clearly powerful cues to perceive the patient as a “social being” or a “valued individual”. By contrast, preparing to intubate in order to manage this patient’s clinical needs requires the nurse to think about, and thus to perceive, the seriously injured person as having “needs”, as “body” or as “(un)stable”. The breakdown in expertise captured in this account lies in the way in which this nurse becomes ‘stuck’ rather than continuing to move between these different ways of thinking about the patient.

Benner et al. (1999) comment on the above incident as follows:

“To cope, it is commonly necessary to objectify the patient for the moment and become very task orientated. The momentary objectification sustains and protects the nurse from the unbearable emotional weight in order to perform skilfully throughout the event and therefore serves a good”

(Benner et al. 1999: p.111).

Benner et al. (1999) offer no evidence or more detailed analysis to support their interpretation that this breakdown of expertise was related to a failure of the nurse to “objectify” the patient. Within the current study there was no evidence of participants experiencing an “unbearable emotional weight” from which they needed to be “protected”. What Benner et al. (1999) describe as “objectification” may be simply understood as attending to the ‘body’ or ‘instability’ of the patient in a way which is appropriate to the moment. Rather than nurses experiencing “unbearable emotional weight”, these data suggest that thinking about the patient as a ‘body’ is a way of thinking in which emotional responses simply do not arise. In is in other contrasting contexts that nurses may think about patients as a ‘social being’, or ‘valued individual’, and when thinking about patients in these ways emotional responses are naturally elicited. To perceive and think about patients in ways which are appropriate requires moving between these positions – perhaps very rapidly - but this need not involve a deliberate or subconscious process of “objectification”.

Benner et al.’s (1999) account may therefore be questioned in that there is no necessity to explain any emotional detachment or lack of involvement as a coping strategy. This is not to deny that some nurses may exhibit such coping responses, but is to affirm that they are not a necessary feature of expert critical care nursing practice. To characterise expert practice as requiring

“objectification” as a means of “coping” is unnecessary, appears as an apology for aspects of critical care practice, and fails to celebrate the true nature of critical care nurses’ expertise.

7.0 Thinking about patients and talking about persons

The preceding discussion has made clear that critical care nurses in this study thought about patients in different ways. It has also established that expertise in critical care practice is dependent upon the “clinical wisdom” that enables nurses to think about patients in ways that are appropriate to the moment. However, in presenting how participants *did in fact* think about patients no consideration has been given to whether it is *necessary* for critical care nurses to think about patients in all of these different ways. This chapter therefore draws upon the existing literature in order to demonstrate that each of the ways of thinking about patients identified in this study makes a valuable contribution to the practice of critical care nursing. A second strand of discussion considers how and why participants talked about their nursing practice so as to portray some of the ways in which they thought about patients as ‘impersonal’ and hence illegitimate. These considerations serve to reveal the central tension revealed by this study: that whilst critical care nurses must think about patients in many different ways, these participants expressed a view that nurses may only legitimately think about patients as persons.

Some early elaboration of the above points is necessary in order to set the context for this chapter and to explain its structure. In chapter five, different ways of thinking about patients were distinguished in part on the basis of the degree of “involvement” (Goffman 1974) these ways of thinking demanded. Despite the fact that nursing practice is often argued to be dependent upon an involvement or engagement with the experience of the individual (Benner & Wrubel 1989; Bishop & Scudder 1997; Tanner 2006; McGrath 2008; Morrison & Symes 2011; Vouzavali et al. 2011), four of these ways of thinking about patients (as ‘routine work’; as ‘body’; as ‘(un)stable’ and as ‘medical case’) did not require any emotional involvement on the part of nurses. Although all participants could readily think about patients in these ways whilst engaged in practice, they nevertheless talked *about* their practice in ways which suggested that these ways of thinking were problematic.

An example from these data serves to clarify this point. When thinking about a patient as a ‘medical case’, nurses would frequently communicate by referring to patterns of illness or disordered physiology. In this context it is understandable that a nurse should refer to a previous patient as having been “the hip yesterday”, and yet one participant who did refer to a patient in this way later reflected to me that “it is horrible the way we do that”. When asked in a later interview why it was “horrible” the participant replied that:

N Well its just so::: (.) you know (.) th- that was a patient that was a per:son

Nurse 5: Second Interview

Not only did this nurse feel the need to justify why it is 'horrible' to describe a patient as "the hip", but her correction at the end of this response makes clear that it is preferable for her to present herself as recognising the individual as being a 'person' than as a 'patient'.

Later discussion will explore in detail how participants talked about their practice so as to present themselves as caring for persons, but these considerations enable a central distinction to be drawn which shapes this chapter. Thinking about patients as "routine work", as "(un)stable", as "body" or as "medical case" did not require any emotional involvement of the nurse and these ways of thinking were characterised by participants as being 'impersonal'. In contrast, thinking about the patient as a "valued individual", as a "social being" or as a "set of needs" was not constructed as being problematic. Two strands of argument are therefore presented in order to demonstrate that all of these different ways of thinking play an important role in critical care nursing practice. Firstly, section 7.1 will examine nursing practice associated with these 'impersonal' ways of thinking in order to demonstrate that they are indeed necessary and make a valuable contribution to critical care nursing practice. Secondly, section 7.2 will demonstrate that ways of thinking about patients deemed 'personal' (those which do require emotional involvement) are not on their own sufficient to underpin all of critical care practice. Both elements of this discussion proceed by examining how these patterns of practice relate to prior literature describing the work of critical care nurses.

Section 7.3 then revisits aspects of the data in order to examine the ways in which participants expressed a view that nurses may only legitimately think about patients as persons. This then leads to an exposition of the central tension uncovered by this study (section 7.4): that whilst critical care nurses must think about patients in many different ways, when talking about their practice they express a view that nurses may not legitimately think about a patient as anything other than a person.

7.1 Practice associated with 'impersonal' ways of thinking

The above discussion has suggested that thinking about patients as "routine work", as "(un)stable", as "body" or as "medical case" were characterised by participants as 'impersonal'. Although the reasons for this characterisation are fully considered later in this chapter (section

7.3), it is nevertheless clear from earlier discussion in chapter five that these four ways of thinking have one feature in common. This is that these ways of thinking did not require nurses to demonstrate any emotional involvement or engagement with the lived experience of the patient. The sections below therefore discuss the contribution of these ways of thinking to critical care nursing practice.

7.1.1 Routine

'Routine' ways of thinking are associated with task orientated patterns of practice, and managing time around the predictable elements of care needed by all patients. As made clear in section 5.1, these predictable elements of care commonly included giving eye or mouth care, or the nurse's role in undertaking common investigations procedures such as chest X-rays or ECGs (section 5.1). 'Routine' patterns of work were also manifested in nurses' habitual behaviours which served to maintain control and order within the physical environment such as the habitual tidying of working surfaces, intravenous lines, and by extension, to the 'tidying' of patients themselves (through straightening bedsheets and so on).

Many of these habitual behaviours have been recognised in prior literature. Manias & Street (2000a) have described the "tyranny of tidiness" within critical care, whilst Philpin (2007) has noted how activities such as 'tidying' may be associated with patient safety through maintaining neatness and order. It is therefore 'routine' activity which keeps the environment tidy, manages time, and ensures the correct functioning of equipment. All of these features are recognised as essential in maintaining an environment where risks may be managed and people kept safe (DH 2005; RCN 2010). Whilst routine or ritualised ways of working have been problematically contrasted with evidence based or person centred care (Melia 1987; Walsh & Ford 1989), ritual behaviour has been studied more sympathetically from an anthropological perspective (Strange 1996; Philpin 2002, 2007). From this perspective, and for these participants 'routine' activity was a feature of their practice to such an extent that a caricature of the critical care nurse with 'OCD' emerged not only as a recognisable stereotype but also as central to developing an identity as a critical care nurse.

My earliest impressions in the field (section 4.1) highlighted that the critical care unit was a place of work, and it was also notable that 'routine' ways of thinking were central in enabling nurses to find or manage the time in which to do so. The ability to control the 'pacing' of nursing activity is recognised as an important skill in any environment (Gobbi 1998), and newly qualified nurses working in critical care have been found to experience particular anxiety about time management

(O’Kane, 2012). Nurses in this study demonstrated an ongoing concern with managing time in many ways. Participants would often maintain “to do” lists, or maintain personalised written recordings of work which required attention in the form of “scraps” (Hardey et al. 2000) made on any available piece of paper such as glove packets. Through such means nurses demonstrated an ongoing concern with remaining “organised” or “up together”. The routinisation of work can therefore be seen to be a key strategy for time management, and Waterworth (2003) has observed that the use of routines itself reduces the time and pressure required to *manage* time.

For the nurses in this study, the need to complete activities within anticipated timeslots was heavily influenced by the hourly demand to document patient observations. As noted in section 5.1, this could restrict the ‘temporal horizons’ of critical care nurses such that they were only thinking about the patient in terms of the next hour or the shift. Routine activity sets up a way of thinking about the patient in the here and now and which contrasts with an appreciation of how the patient *is doing* over time. This focus only on the here and now may be problematic and of potential significance to patient outcomes. For example, Crocker & Scholes (2009) have observed that critical care nurses can delay initiating weaning patients from ventilatory support until after they have performed other (routine) duties.

By its nature, ‘routine’ activity carries no expectation of either emotional or intellectual “involvement” (Goffman 1974). ‘Routine’ patterns of practice could therefore be recognised as problematic when nurses failed to ‘involve’ themselves in interactions with patients when it would generally be judged appropriate to do so. In relation to incidents presented within these data, it is in this sense that it is wrong to ‘routinely’ help to clean a distressed elderly lady who has been incontinent of faeces; or to communicate with patients through meaningless ‘stock’ phrases such as “I’m just gonna suction you”. Such ‘problematic’ routine activity was therefore often characterised by patterns of speech which demonstrated the nurses’ lack of involvement. These patterns can clearly be seen to relate to findings from other literature such as the “handling-and-commenting” described by Hirschauer (1991), or the one way information giving described by authors such as Baker & Melby (1996) and Leathart (1994a & b) where patients are simply “informed” or “told” what was happening to them.

‘Routine’ work thus tends to set up a way of thinking about work which needs to be done within the ‘here and now’, and routine activities serve an important function in helping nurses to maintain safety, manage time and anticipate demands. Whilst these data include examples of participants thinking about patients as being ‘routine work’ at inappropriate moments,

particularly in relation to some patterns of communication, this does not mean that it is never appropriate to think in these terms. Critical care nurses will not be helped to make sense of their role, and patient safety will not be improved, if these important aspects of the work that critical care nurses do are dismissed as problematic. Thinking about patients in 'routine' ways cannot therefore be dismissed as 'wrong', but rather may only be characterised as appropriate or inappropriate to the moment.

7.1.2 Nursing an (un)stable set of systems

As discussed in section 5.2 thinking about the patient as (un)stable involves a focus on monitoring and controlling patients' physiological status in order to ensure that precisely quantified and explicitly stated "parameters" and "targets" are achieved. Practice is directed towards maintaining these targets in relation to discreet body systems, and the nurse's role may therefore involve managing ventilator settings and oxygen delivery so as to achieve "respiratory" parameters, or administering fluids or drugs to achieve "cardiovascular" targets.

Although a range of previous literature has described aspects of 'routine' work, the literature reviewed has not previously described nurses thinking about patients in this way on the basis of empirical findings. Prior studies have not characterised the entirety of this pattern of practice, though thinking about the patient as '(un)stable' nevertheless represents the "ongoing vigilant assessment" described by Chaboyer & Creamer (1999) as being a central aspect of the critical care nurse's role. Monitoring and supporting patients who have failing body organs is central to the purpose of critical care (WFCCN 2007). Despite the fact that this is a way of thinking about patients which does not require any emotional involvement, it is also notable that technical competence and "knowing what you are doing" are highly valued by patients and their relatives (O'Connell & Landers 2008). An ability to think about the patient as '(un)stable' is therefore clearly of central importance to critical care nursing practice.

Thinking about the patient as (un)stable highlights some potential risks within critical care practice which have not been highlighted in the literature reviewed. This is due to the way in which nurses could respond to 'targets' or 'parameters' independently of any consideration of their clinical significance. This is particularly significant given that this is a way of thinking which is heavily dependent upon technology, and it is known that critical care nurses may at times have an inappropriate trust in technology (Browne & Cook 2011). There is therefore a need to understand more about the potentially powerful influence of such 'targets' on the moment to moment

decision making of nurses, and for practitioners to give careful consideration to justification for setting them.

It was also highlighted in section 5.2 that participants appeared to gain a particular satisfaction from this aspect of their role. These nurses talked about the “adrenaline rush” associated with caring for a “really sick” patient as characteristic of critical care nursing, reflecting Crocker & Scholes’ (2009) observation that critical care nurses can prefer patients who are “stimulating or exciting”. Whilst the curative focus of critical care is often associated with the dominance of medicine (Christensen & Hewitt-Taylor 2006), it is noteworthy that participants saw this pattern of practice as particularly epitomising their nursing role. Critical care nurses in this study appeared in part to judge their success or failure in relation to how well they maintained ‘stability’ and achieved targets (often in terms of commentary on whether they had “mended” or “broken” patients).

Characterising this way of thinking about patients to be ‘impersonal’ relates to those critiques which suggest that high technology environments can be ‘objectifying’ or ‘depersonalising’ (Gadow 1985; Locsin 1995; Barnard and Sandelowski 2001; O’Keefe-McCarthy 2009). The level of observation which critically unwell patients require means that the environment is characterised by the presence of monitoring equipment, charts, and devices such as catheters or nasogastric tubes which allow for the display and measurement of (normally hidden) aspects of the body. In this respect the critical care unit resembles the “panopticon” described by Foucault (1977) in which:

“each individual, in his place, is securely confined to a cell from which he is seen ...He is seen, but he does not see; he is the object of information, never a subject in communication” (Foucault 1977: p.200)

Although the use of technology *allows* for the patient to be such an “object of information”, the distinction between what nurses see and what they perceive set out in section 6.3 makes clear that it is not technology itself which is objectifying. Any ‘objectification’ is dependent upon what nurses perceive. These data have made clear that whilst a urinary catheter may allow for the display of ‘information’ about the patient, seeing urine in a urometer could enable nurses to perceive the ‘valued individual’ who was recovering, or (on another occasion) the ‘social being’ who would not wish the catheter bag to appear in his wedding photographs. As has been noted

previously (Cussins, 1996; Locsin, 1998; Barnard & Sandelowski, 2001) the potentially objectifying impact of technology is dependent upon its use by practitioners.

Given that physiological monitoring and support of critically ill patients is the primary purpose of critical care units, the ability to think about patients as (un)stable is of central importance to critical care nursing practice. It is not disputed that that thinking about patients as (un)stable may be considered inappropriate at times, such as when talking to patients and families, or if responding to inappropriate and poorly considered 'targets' or 'parameters'. Nonetheless, the central purpose of the critical care unit to monitor and support patients who are critically unwell makes clear that it is necessary for critical care nurses to think about patients in this way.

7.1.3 Nursing the body

Although organic critical illness was the reason that patients were admitted to the critical care unit, a focus on the body was not a prominent feature of how participants thought about patients. Thinking about the patient as 'body' was associated with examination and assessment when the patient may be "prodded", "poked" or given a "painful stimulus" but this focus on the body was seen relatively infrequently and briefly. The finding that patients' bodies are not a major focus for critical care nurses' attention is itself significant. Rather than focusing upon the body, critical care nurses in this study spent more of their time thinking about patients in ways which may be considered disembodied or situated in a "virtual environment" (Sandelowski 2002) such as when thinking about the patient as '(un)stable' or as 'medical case'.

Other than highlighting the limited degree to which participants did focus upon the 'body' of patients, this pattern of practice describes little that has not been previously noted within the nursing literature in distinctions such as that between "instrumental" rather than "affectional" touch (Schoenhofer 1989). Despite the concern of participants that this was an 'impersonal' way of thinking about patients, thinking about the patient as 'body' was not problematic for nurses during the actual delivery of care. Within these data the 'problem of the body' that Lawler (1991) describes did not arise for participants when thinking about patients AS body. Issues arising from the body such as embarrassment or sexualisation can arise only in a context in which the patient is seen as a 'social being' to whom societal rules and expectations about the exposure of the body apply.

7.1.4 Understanding the medical case

Thinking about patients as ‘medical cases’ involved thinking about patients as complex systems in which patterns of ordered and disordered physiology could be recognised. Participants expressed satisfaction that their critical care practice made them “think” and that they had opportunities to “properly get into your patient more”. Thinking about the patient as a ‘medical case’ can thus be seen as representing aspects of the “intellectual work” (Chaboyer & Creamer 1999) which critical care nurses need to undertake in order to understand the complex supportive treatments which they initiate and deliver.

It was noted in section 5.5 that thinking about patients as ‘medical case’ also enabled these nurses to comprehend how the patient *was doing* over a period of time, rather than just how the patient *was* at any one moment. Such an understanding enabled critical care nurses to contextualize what was *currently* known about the patient so as to appreciate how the patient’s illness was changing over time or moving towards some form of resolution. This was made clear in the way that participants would often note patients’ progress in ways which indicated that they could perceive a ‘direction of travel’:

Nurse 7 notes particularly that Mr Vincent is polyuric although she does not express any particular concern other than to say that he may just be “sorting himself out”.

Field notes: Nurse 7

Nurse 4 tells me that Mr Stevenson’s antibiotics have now been discontinued and that we are “Waiting to see where we’re going”

Field Notes: Nurse 4

N He’s actually he’s doing very well considering what he’s had done and the incident that happened... I think he’s on track for where he should be.

Nurse 7: First Interview

In making judgements about patients who are “sorting themselves out” or on track” these participants displayed an understanding of the ‘medical case’. This distinctive feature of thinking about the ‘medical case’ is particularly important. Thinking about the patient as existing and evolving over a period of time starkly contrasts with the way that nurses’ ‘temporal horizons’ could be restricted by their work. Participants in this study spent a lot of time involved in the

'here and now' as they managed time to complete 'routine' work; or responded to minute to minute changes in the patients' physiology as patients were perceived as '(un)stable'.

The value and distinctive nature of thinking about the patient as a 'medical case' is made clear through one of the central themes within the "Birth of the Clinic" (Foucault 1973). Foucault describes a transformation in the late 18th Century as medicine became increasingly identified with "philosophical" forms of knowledge (which theorise and question origins and causes), rather than with purely "historical" forms of knowledge (which simply describe). Through this distinction Foucault (1973) makes clear that disease has a "double reality". In relation to these findings, focussing purely upon maintaining the physiological parameters of an (un)stable patient in the here and now may be seen as responding to "historical" knowledge. It was "philosophical knowledge" coming from an understanding of the patient as a 'medical case' which enabled nurses to understand the meaning and significance of changes in the patient condition and to perceive a trajectory or direction of travel. In this sense an understanding of the medical case "restores the logical necessities of time" (Foucault 1973: p.95).

An example from these data can make clear the importance of distinguishing between transient 'here and now' changes in particular parameters, and issues that are of real significance to the 'medical case'. Several participants commented to me that patients' relatives could often become focussed on such minor and transient changes. The following comment makes clear how different this is from understanding the significance of this information in relation to the "medical case":

N I mean I've had patients relatives before now and ((*mimicking*)) 'ooh the oxygen is up to thirty five and it was thirty yesterday' and its like -its still only thirty five ((*laughs*)) And kind of 'respiratory rate is now twenty instead of twenty four' and you know - they're really focused on a number and it's kind of like it doesn't mean anything to you

Int Mmm

N It's not telling you anything about how well your mum's doing.

Nurse 5: First Interview

Such comments make clear that nurses themselves recognised a distinction between simply focussing on "a number" (which they themselves may do at times), and understanding the medical case. In consequence, participants noted to me that they would "try and avoid specifics

with numbers and things” when talking to patients’ relatives, or would not mention transient ‘dips’ in a patient’s condition “so long as the big picture remained the same”.

An understanding of the patient as a medical case is therefore necessary in order for nurses to understand the treatments which they initiate and deliver, and to support patients and their families through the trajectory of critical illness. In this context it is not at all clear why literature continues to critique “biomedical models” as antithetical to “care” (Christensen & Hewitt-Taylor 2006), or as instilling values which are “barriers to compassion” (Kings Fund 2009).

7.2 Practice associated with ‘personal’ ways of thinking about patients.

The above discussion has made clear that ‘impersonal’ ways of thinking about patients may nevertheless make an important contribution to critical care nursing practice. The sections which follow outline the contribution, and the limitations, of thinking about the patient as a ‘valued individual’, ‘social being’ or ‘a set of needs’ to critical care nursing practice. Together these arguments demonstrate that not only *do* nurses think in all of these different ways, but that the practice of critical care nursing *requires* them to do so.

7.2.1 Nursing the valued individual

Participants characterised ways of thinking and talking about patients as ‘personal’ when these were ways of thinking in which the nurses demonstrated some form of emotional or affective “involvement” (Goffman 1974) with patients. Thinking about the patient as a ‘valued individual’ was characterised by the highest levels of emotional involvement and expressed emotion. When thinking in this way nurses’ communication with the patient was often intimate and personal, involving physical closeness and “affective touch” (Schoenhofer 1989).

This pattern of practice thus reflects the “altruistic and emotional aspects of caring” which are most frequently celebrated in the nursing literature (O’Connell & Landers 2008), though Morse (1991) notes that such “involved” nurse-patient relationships require or demand the investment of time. It was apparent within these data that thinking about patients as ‘valued individuals’ was associated with nurses giving substantial time to patient interactions. This needed to be balanced with the fact that other ways of thinking about patients also made demands on critical care nurses’ time. As Almerud et al. (2008) have noted, in critical care:

“Clock time is at a premium. Clock hours are squandered caring for machinesand if you have even more apparatus, machines, then you have to nick time from somewhere”

It is clear that nurses cannot think about the patient as a 'valued individual' all of the time given that if this were the case then nurses would not be able to manage or find time for other parts of their role. One consequence of the fact that nurses think about patients in different ways is that nurses are able to manage time by engaging and disengaging (that is to become more or less involved) with patients.

Regardless of whether time is available for them to do so, it would not be appropriate for nurses to only think about patients as 'valued individuals'. Whilst nursing is often characterised as uniquely responsive to the experience of the individual (e.g. Benner & Wrubel 1989; Bishop & Scudder 1997; McGrath 2008; Vouzavali et al. 2011). It was noted in chapter two that this view is often propounded in opposition to 'positivist' and 'scientific' ways of thinking and that parts of this literature may be characterised as "a rhetoric that resists the discourse of science" (Paley 2005: p.113). Without a recognition that nurses think about patients in ways other than as 'valued individuals, the argument that decision making in critical care cannot be "articulated in positivist terms" (Christensen & Hewitt-Taylor 2006: p. 301) is simply "celebrating the possibility of error" (Paley et al. 2007: p. 696). Although thinking about the patient as a 'valued individual' represents an ideal of nursing care which is often celebrated in the literature, it is neither possible nor desirable that this should be the only way for critical care nurses to think about patients.

7.2.2 Nursing the set of needs

Thinking about the patient as a 'set of needs' involves a focus on discreet aspects of the patient so as to theorise and respond to their 'needs'. This way of thinking was often clearly evident through the use of a theorised vocabulary as patients were described as having "psychological needs" rather than as people who are distressed; or as "mobilising" rather than as moving. Nonetheless, nurses would still demonstrate some degree of emotional involvement whilst thinking about patients in this way.

The theorised nature of this way of thinking about patients appears to reflect how nurses themselves have interpreted, understood and taken up models of nursing to which they are introduced in their education and training. It represents that pattern of practice which Morse (1991) describes as a "therapeutic" nurse patient relationship in which the patient is considered primarily in a "patient" role and only secondarily seen as a "person". Whilst such a view may be

criticised for "viewing the patient as a set of needs and the nurse as a set of functions" it has been argued that such a way of thinking does nonetheless help to ensure that patient needs are met (Endacott 1998: p.69).

Critical care nurses themselves may readily recognise the distinctive nature of this way of thinking about patients. This was made clear in a teaching session (recorded in my research journal) I delivered to a group of critical care nurses on the subject of 'psychological support' needed by critically ill patients. Students had been asked to consider how they may understand critically ill patients' psychological needs, and whilst collating students' responses to a flip-chart I placed their responses in two columns. Through this approach, these practitioners were clearly able to identify and distinguish between the private and emotionally laden responses which related to thinking of the person as a 'valued individual', and those responses which reflected thinking about patients as having theorised psychological 'needs'. My journal recorded that this appeared to be a strategy which had a clear impact on students:

Drawing upon ethnographic insights throughout this session clearly engaged students and the findings were clearly recognised. One student vocalized this recognition by yelling "get out of my head!"

Research Journal: 4th December 2009

The response of these students suggests that presenting these findings to practitioners served to validate and affirm aspects of the practice of these experienced nurses. Whilst thinking about the patient as having theorised 'needs' may help to meet those needs, the above example itself makes clear that critical care nurses themselves may recognise that this is only one of the ways in which they think about patients.

7.2.3 Nursing the social being

Thinking about the patient as a 'social being' was characterised by the use of casual, informal language and the appropriate use of humour. Communication with the patient was not intimate, but took the form of polite or good humoured 'chat' which did not involve the high degree of emotional involvement which typified thinking of the patient as a valued individual.

Practices associated with this pattern of practice have been described in a range of prior literature such as that which discusses humour in nurse-patient relationships (Harries 1995; Pierlot &

Warelow 1999; Dean & Major, 2008) or the value of chat” or social talk as a clinical tool (Fenwick et al. 2001). Analysis of these data highlighted two particularly significant issues in relation to the contribution made by such practice to critical care nursing. Section 5.6 noted that by foregrounding the patients’ identity as a social being rather than as a ‘patient’, social chat may help to normalise their experience by backgrounding the patients’ critical illness. Such an interpretation is supported by the finding that “social chat” has been perceived as beneficial from a patient’s perspective in other care environments (Fenwick et al. 2001).

A second noteworthy aspect of this ways of thinking is that thinking about patients as ‘social beings’ may influence patterns of communication between nurses and patients within critical care. Whilst embarrassment and awkwardness have previously been noted in nurses’ patterns of communication with unresponsive patients (Lawler 1991; Leathart 1994a; Baker & Melby 1996), a linguistically orientated analysis offers a means of understanding this embarrassment. Participants in talk ordinarily have powerful expectations that social communication will be a two way process, and it is therefore completely natural that the confounding of these expectations when patients do not respond can lead to embarrassment. The counter-intuitive conclusion is that communication between nurses and patients may actually be impeded if nurses think about patients as ‘social beings’.

These findings suggest that nurses who are new to critical care need to learn to (or at least get used to) talking to patients who are unresponsive. One nurse who had little initial experience of critical care observed to me at the end of the study that she had learned to “rabbit away” to patients:

N Now I’m used doing it so I’m a lot more. I talk to my patient even if I’m -
I say ‘oh shall we put on a bit of music’ or something, and I actually talk as if
they’re sat up talking to me

Nurse 6: Second Interview

The ability to talk to patients *as if* “they’re sat up talking to me” therefore appears as a skill which is learned or acquired over time which needs to be considered in the training and development of critical care nurses.

Thinking about patients as social beings therefore plays an important role within the practice of critical care nursing, although it is also clear from the foregoing discussion that critical care nurses must also have an ability to think about patients in other ways.

7.3 Talking about persons

The critical care nurses taking part in this study moved between seven different ways of thinking about patients, and the above discussion makes clear that each of these ways of thinking plays a necessary role in critical care nursing practice. Nonetheless, it was noted in section 7.0 that participants appeared to consider it inappropriate or ‘wrong’ for nurses to think about patients in ways which were impersonal. This section therefore considers how and why participants talked about their practice so as to suggest that nurses may only legitimately think about patients as persons.

The majority of data in which nurses talked *about* their practice were collected in interviews, and an understanding of this context is highly significant. Some of these different ways of thinking about patients were only constructed as being problematic when nurses were retrospectively talking *about* their practice. This difficulty can be introduced through discussion of two related data extracts. The first of these describes two nurses helping to turn a patient known as Mr Turner:

Initially communication with Mr Turner is restricted to both the second nurse and Nurse 6 giving very simple information or commenting regarding what was happening. (e.g. “Over to me”) These exchanges are abnormally loud for normal speech and I note that they seem quite impersonal in intonation.

As we turn Mr Turner however, he opens his eyes, and I see that he is quite red-faced and appears to be biting his ET tube. As this happens I notice a distinct change in Nurse 6’s pattern of communication. She bends down, her voice is quieter and she uses Mr Turner’s first name

“Hello Thomas”

She continues by explaining to Mr Turner that the tube is there to help his breathing, and that he should try not to bite.

Field notes: Nurse 6

This extract describes a change from a ‘routine’ pattern of practice to a way of thinking in which a critical care nurse responded to a person experiencing some distress. After reading the above extract in a later interview the participant in question commented that:

N Reading that actually it’s actually quite bad isn’t it in relation to nursing in intensive care? But it’s something that you see a lot actually. Reading that is very familiar.

The original data extract describes a nurse responding to a person in distress, caused no concern or difficulty for these nurses at the time, and is recognised by the nurse in question as being a familiar everyday occurrence. There is therefore a real need to explain why the immediate response of this participant was to characterise her practice as “quite bad”.

This nurse is responding to a written description, and participants did occasionally make comments such as “I can see problems with it now when it’s written down”. Even so, there are no instances in these data of participants challenging or questioning such descriptions of practice. In data relating to the above episode the descriptions of giving “simple” information, “loud” speech or “impersonal intonation” were accepted as accurate, but nonetheless taken as *criticism* of her “quite bad” practice. Later in this discussion the participant commented that “I think it does get kind of impersonal at times”.

A concern with behaving or thinking in ways which were ‘impersonal’ was a common theme in the talk of participants, though invariably such behaviour was characterised as ‘wrong’ or accompanied by some form of apology. For example, one participant was at pains to point out that any ‘depersonalisation’ was “very subconscious” whilst she assisted a surgeon in the physical exploration of a patients’ severe facial wound:

N I think probably you (.) with those things you probably have depersonalised

Int °mm hm°

(2)

N You’ve taken the person away from that I think .hh very subconsciously

Nurse 5: Second Interview

Nurses could also apologise for the fact that their practice could require them to think about the patient as ‘(un)stable’

Int Can you think now of any particular kinds of patients where your thinking would be completely different to the way you were thinking about {Mr Smith} today?

N Well yeah your - the sickest ICU patient

Int Yes

N You are - unfortunately focusing more on

their observations. I mean you are obviously caring for them as a person but in quite a different way.

Nurse 7: First Interview

The monitoring of critically ill patients is a primary function of critical care units. There is therefore a need to explain the remarkable finding that a critical care nurse considers it “unfortunate” that at times she has to focus on patients’ observations.

One explanation for these findings relates to the fact that (as noted in section 2.5.1), discourse is intimately associated with identity. By presenting themselves as aware that such practice was “bad” or “unfortunate” these nurses may be seen to be adopting public “stance”. Such stance taking consists in the public display of judgements or attitudes, and is a key means by which people manage their “projected self” (Biber & Finegan 1989; Blommaert 2005; Englebretson 2007). It can be seen that a key problem for participants lay in the fact that thinking or talking about patients in ‘impersonal’ ways was not readily compatible with maintaining an identity as a ‘nurse’.

This may be shown in relation to further episodes from these data. One participant was asked in interview to discuss the short extract from the field notes replicated below:

Once she has given the handover for Mr Langden, the night nurse moves away from the table into the area at the foot of the bed. She ... turns back to Nurse 2 to say “Did I say that he wants to be called Joe?”

Nurse 2 shakes her head and both laugh as the night nurse comments that this is “the most important thing”.

Field notes: Nurse 2

Within the interview the following exchange took place:

Int We say it’s the most important thing but I’m just wondering - is it?

N I don’t- I don’t think it is to be honest

Int Okay ((*laughing*))

N ((*laugh*)) I think it’s something that if, you know if it was forgotten then the nurse taking over can establish for themselves.

Int Okay

N You know it's the kind of thing that if you've not looked after the patient before you can ask all that sort of thing anyway. I think, and I don't know if this is a really un nursey thing to say ((*laughter*)) but I think the most important thing is making sure the patient's safe.

Nurse 2: Second Interview

The initial comment that the patients' preferred name was "the most important thing" can be understood as a public display or acknowledgement of what *should* be important to nurses. By contrast, within an interview context this same nurse asserts that safety is always the priority but notes that this is not a legitimate "nursey" view to express.

A similar point may be made in relation to another incident in which a participant commented as follows when talking about how a patient was (transiently) exposed whilst they were 'unstable':

N Privacy and dignity is one of the nursing

Int mmmmmm

N Things that nurses are supposed to - you know - the role I suppose ((*laughs*)) But at that time it wasn't exactly the most important thing to keep the patient covered, it was to make sure that they maintained their airway and they were breathing.

Nurse 6: Second Interview

This nurse makes a clear distinction between prioritising airway and breathing, and a focus on "privacy and dignity" that are central to a *nurses* role. Despite the fact that nurses cannot and do not think about patients in any one way which may be characterised as "a person", these data make clear that nurses themselves consider their identity as a 'nurse' to be dependent upon doing so. Some of these complexities in this position are made apparent through discussion of the following incident:

Mr Williams comments to myself and Nurse 5 that one or two of the nurses have said that it helps them to have pictures of what Mrs Williams looks like normally. Nurse 5 replies emphatically

"Oh definitely"

Field notes: Nurse 5

There appears nothing problematic in the above extract from the field notes, but discussion of this incident in a later interview led to the following exchange:

- 1 **Int** he said that one or two of the nurses had said it helps to have pictures
2 of Mary there and you (.) chipped in and said quite emphatically yeah
3 definitely .hhh (.) H:ow does it help?
4 (2)
5 **N** °I don't think it does but it makes him feel better°
6 (1)
7 **Int** °OK°
8 **N** I mean its- its nice (.) Its nice for us to see her as a person as well as
9 the patient in the bed
10 **Int** Hm mm
11 **N** But at the same time its something for him to focus on as well

Nurse 5: First Interview

Although at lines 8-9 there is a weak and formulaic acknowledgement that it is “nice” for her to see the patient as a person, this participants’ earlier response at line 5 is central to understanding these data. In an interview situation, and removed of any need to ‘manage’ how she is perceived by Mr Williams or colleagues, this nurses’ immediate response is to suggest that having a photograph of a patient does not help her, but rather to recognise that the presence of the photograph (or possibly Mr Williams’ belief that the photograph helps the nurses) may help Mr Williams to ‘feel better’.

The analysis of these data therefore makes clear that participants held to a view that nurses may only legitimately talk and think about patients as “persons”, and this could not readily be reconciled with elements of their role as critical care nurses. This was overtly acknowledged on only one occasion in this study in a comment by one of the more experienced participants. It is perhaps significant that the following comment was made at the very end of an interview and after the tape recorder had been turned off:

“If you always thought of them as a person it would be time to get out as well. I think those are the ones who leave ITU within a month”

Nurse 5: Contemporaneous note made following second interview

This comment (which has the tone of an admission or confession) was the only occasion within these data when any participant made an overt acknowledgement that critical care nurses should not always think of patients as persons.

7.4 A central tension: Thinking about patients and talking about persons

The above discussion makes clear the central tension uncovered by this study. Critical care nurses must think about patients in many different ways, yet express a view that they may not legitimately think about a patient as anything other than a person. This section therefore reviews these findings in order to clarify and elaborate upon the nature of this tension.

These findings should not be taken to imply that participants were unaware that they were caring for a person, or that the care they delivered was not 'holistic'. Section 6.1.2 has highlighted how these data provide clear evidence that these nurses had a subsidiary awareness that the patients they cared for could be understood as a 'whole person'. The major contribution of this study is to highlight that this 'whole person' may only be understood tacitly, whilst the delivery of nursing care requires nurses to focus upon, and therefore think about the patient as, discreet aspects of this "whole".

Holding to the view that nurses may legitimately only think about patients as 'persons' made it difficult for participants to talk about and reflect upon aspects of their practice. These findings are therefore of practical relevance given that critical care nurses need to be able to talk about the totality of their practice in order to reflect upon, develop, and make sense of their role. This will not be facilitated if nurses only feel able to talk about those aspects of their practice which involve thinking about patients in legitimate 'nursing' ways. These findings therefore offer a perspective on the tension between the 'ideal' and the 'real' ways of nursing (Melia 1987; Scott, 2006). Neonatal critical care nurses have described their role as "walking the line between the possible and the ideal" (Hall et al. 2010: p.307), and yet these findings make clear that for these participants there was an:

"artificial 'theory / practice' gap in nursing: in which codified ideas about what nursing ought to be; and what nursing actually involves are subject to a considerable disparity between aspiration and achievement" (May & Fleming, 1997: p.1097)

The disparity between the work which critical care nurses undertake and their own ideals about the nature of the nurses' role was primarily revealed through analysis of data obtained in research interviews. Such a projection of an "idealised" nurse within research interviews has previously been noted by Allan (2001) who commented that although real nurses were "good enough":

“Nurses' descriptions of their relationships seemed at times too positive, even unreal to me...this 'fantasy nurse' was giving, caring, motherly and warm whereas the real nurse was there if needed, emotionally aware but not intimate" (Allan 2001: p.55).

There is therefore a dissonance between the realities of critical care practice and nurses' espoused ideals about the nature of nursing care. Whilst this study has focussed upon an analysis of the realities of critical care practice, chapter eight will make clear that part of the reason for this dissonance is that these ideals themselves are not expressed or understood with clarity.

It is important to examine and understand the nature of this dissonance. It was noted in chapters one and two that critical care nurses are known to experience “moral distress” through trying to balance their perceived work responsibilities and moral obligations Cronqvist et al. (2004). It is also recognised that dissonance between the ideals and the reality of nursing practice can be a cause of emotional exhaustion or burnout (Bakker et al. 2005; Maben et al. 2007; Sabo 2011) which is itself a factor which militates against the delivery of high quality care (Kings Fund 2009). Drawing together the conclusions and recommendations from this study will therefore particularly highlight that there is a need to communicate the ideals of ‘person centred’ care in ways which do not conflict with the fact that critical care nurses think about patients in different ways.

8.0 Conclusions and recommendations

Before presenting the conclusions of this study and the recommendations which follow from them it is necessary to give consideration to the trustworthiness of these findings and to the degree to which they be relevant and transferable to nurses in other settings. These issues are therefore addressed in section 8.1. Section 8.2 then summarises the contribution which this study makes to nursing scholarship, both within critical care and more broadly. Finally, section 8.3 then makes recommendations for future research, policy, practice and education which are based upon these conclusions.

8.1 Trustworthiness of the study and transferability of findings

In order to consider the “trustworthiness” (Lincoln & Guba 1985) of these findings it needs to be recognised that this study has taken the form of an ethnographic enquiry into the practice of seven primary participants working within one critical care unit in the UK. The data obtained have primarily consisted of field notes obtained during participant observation and the transcriptions of 13 interviews, and these data have been analysed drawing upon approaches from ethnography and discourse analysis. It is therefore necessary to consider the extent to which these findings may be considered trustworthy, transferable and relevant by nurse practitioners and scholars working in other settings.

Lincoln & Guba (1985) highlight that the ‘credibility’ of a study rests upon the data being sufficient to support the analysis presented. These data contain few references to events that were considered at all unusual or remarkable by participants and thus describe ‘everyday’ practice within the unit which may be recognisable to other critical care nurses. Chapter 3 has provided a detailed audit trail relating to key decisions involving the choice of study site and sampling of participants; engagement in the field over a period of 8 months, and the reasons for determining that it was appropriate to leave the field. Together with the fact that saturation was reached in the analysis of these data these factors give confidence that these data reflect the primary ways in which these critical care nurses were thinking about patients in their everyday practice.

The sufficiency of these data may be questioned on the grounds that participants may have thought about patients in ways not made evident in these data, or by questioning whether the phenomena examined within this study relates to what nurses *really* think. To such an objection it may be noted that the study has conceptualised ‘ways of thinking about patients’ so as to specifically exclude any mental phenomena independent of what nurses actually do and say.

Whilst “thinking” may be conceptualised differently within other academic and research traditions, one significant contribution of this study is itself to provide a perspective from which the way in which nurses think about patients may be examined.

The “confirmability” of data may be taken to refer to their objectivity or neutrality such that independent observers would agree about the data’s relevance or meaning (Polit et al. 2001). The field note data in this study in particular have been acknowledged as a constructed account based upon my own interpretations and observation. Whilst no claim can be made that these data are ‘objective’ in a naïve sense, my own influence upon the collection, recording and analysis of these data has been made explicit throughout this thesis.

Traditional means of enhancing the credibility of qualitative studies may include ‘triangulation’ or ‘member checking’ (Polit et al. 2001). These methods are rendered problematic by the perspective of linguistic ethnography which makes clear that what people do and say is highly dependent upon context. Because participants had a problematic concern to present themselves as ‘nurses’ within the context of a research interview, there can be no straightforward ‘triangulation’ between what nurses do in practice and the way that they talk about that practice. Furthermore, given that these interview data may be considered as ‘discourse about discourse’, any formal member checking of findings could only have been considered to generate discourse *about* ‘discourse about discourse’. These considerations make clear to a wider research community that data obtained in research interviews may not be naively considered to reflect what participants “really think”, and that the analysis of such data must account for the context in which that discourse has been elicited. Whilst this study has not straightforwardly utilised ‘triangulation’ or ‘member checking’ in order to enhance the credibility of findings, these findings are nonetheless based upon multiple forms of data which have been analysed from multiple perspectives, and have taken full account of the ways in which participants talked about their practice.

Although the above points problematise aspects of the research interview, it was noted in section 3.3.8 that data obtained in these interviews were profoundly affected by the study design. The fact that participants were asked to discuss specific interactions which had previously been directly observed minimised the extent to which nurses talked about events ‘in general’. These data make clear that interviewees will inevitably describe events in a way which manage how they present themselves, and thus make clear the problematic status of the decontextualised research interview. Whilst the status accorded to interview data is a particular strength of this

study, these considerations have wide implications given the frequency with which interviews are utilised as the sole method of data collection in nursing research.

The “dependability” of data analysis relates to whether findings are consistent and replicable (Lincoln & Guba 1985). Chapter three has described in detail the processes of data collection and analysis so as to enable others to form judgements on these issues, and analysis has included the examination of negative cases. Data analysis has drawn upon my own insights as a critical care nurse and consequently my own influence upon study design, data collection and data analysis have been made fully explicit throughout this thesis. Linguistic ethnography holds that the “close analysis of situated language use” (Rampton et al. 2004: p.4) is vital in gaining insights into culture. These findings have therefore been illustrated through the ‘micro’ analysis of individual interactions, so as to “tie down” the ethnographic analysis by “increasing the amount of reported data that is open to falsification” (Rampton et al. 2004: p.4). As the discussion in chapter seven demonstrates, the dependability of these findings is further enhanced by the fact that they bring a new perspective to, but are largely consistent with, a substantial body of previous scholarship in critical care nursing.

In a study exploring a phenomena as abstract or ephemeral as ‘how critical care nurses think about patients’ there is a particular need to demonstrate that the findings are “worth paying attention to” as relevant and important (Lincoln & Guba 1985: p.290). Section 1.2.1 noted my own feeling at the outset of this study that “the expectation that nurses should always think about patients as persons appeared to me as a commentary or criticism of aspects of my practice”. The discussion within chapter seven has made clear how these findings demonstrate that this expectation is not only shared by other critical care nurses, but also prevents them from understanding and talking about their practice. This finding itself is the primary reason for paying attention to the study overall.

The presentation of these findings has provided a rich description of nursing practice within the unit which will enable other critical care nurses to make judgements regarding the extent to which these findings are transferable to their own areas of practice. The wider transferability of this study rests upon differentiating between those findings which emerge from the methodological grounding of the study, and those which arise due to a substantive focus on critical care practice. The conceptualisation of ‘different ways of thinking about patients’ has been developed from a wide range of discourse theorists (Goffman 1959, 1974; Foucault 1969, 1973, 1977; Lemke 1995; Potter 1996; Wetherell et al. 2001; Blommaert 2005). This conceptual

underpinning makes clear that all nurses must think about patients in different ways (as indeed all people in any context must think about other people in many different ways). The broad central findings of this study are therefore of the widest possible application: all nurses must think about patients in different ways, and expert practice must require the “clinical wisdom” to move between these different ways of thinking.

Patients’ needs may change rapidly in critical care environments, and this may be a factor in explaining the rapidity and fluency with which participants in this study moved between different ways of thinking. However, these findings also made clear that participants could perceive a change of ‘context’ in highly nuanced ways, only some of which related to the critical nature of patients’ illness. In a study which included participants from hospice, emergency department and ward settings, Gobbi (1998) notes that “fluency of thought” is recognisable to nurses as a sign of increasing expertise. There is therefore little reason to suppose that the rapid and fluent way in which expert nurses moved between different ways of thinking is particularly unique to critical care nursing. It is less immediately apparent that the particular ways in which these critical care nurses have been characterised as thinking about patients will be the same for nurses in other contexts, although neither are there reasons to suppose that critical care nurses think about patients in ways which are unique.

Nurses in emergency departments, operating theatres, paediatric or neonatal critical care units may clearly have occasion to think about patients as ‘(un)stable’, yet patient safety is a priority in any clinical environment. Whilst thinking about patients as ‘unstable’ may be less prevalent, or take a slightly different form, in other environments it is nevertheless plausible to consider that non critical care nurses may think about patients in this way. Similarly, there is little reason to suppose that critical care nurses are unique in thinking about the patient as a ‘medical case’. As Gobbi (1998) has shown, nurses working within palliative care settings, cardio-thoracic wards or emergency departments require an understanding of the ‘medical case’ no less than that demanded of critical care nurses.

There are therefore good reasons to believe that other nurses may find that these findings are transferable to their own care environments, and the detailed descriptions of the practice and its context within this thesis give them a means of determining the degree to which this may be the case.

8.2 The contribution of the study to nursing scholarship

A review of the contribution which this study makes to nursing scholarship therefore requires consideration of how these findings are of relevance to critical care practice and to the nursing literature more broadly.

The discussion in chapter seven has made clear that aspects of these findings serve to confirm, or enhance an understanding of, previous research in critical care. Critical care units have previously been described as dominated by a focus on safety (Philpin 2007) which may lead to a “tyranny of tidiness” (Manias & Street, 2000a). Similarly, critical care nurses are known to derive satisfaction from the ‘intellectual work’ which they undertake (Chaboyer & Creamer 1999), or on occasion to enjoy caring for patients who are “stimulating or exciting” (Crocker & Scholes 2009). One key contribution of this study is to provide a perspective which begins to clarify how all of these disparate influences come together in the moment to moment delivery of nursing care.

Chaboyer & Creamer (1999) have called for accurate descriptions of the realities of critical care nursing in order to make potential critical care nurses aware of the unique attributes of the speciality and to develop appropriate educational programs. In developing such a description this study has found that even practicing critical care nurses find it difficult to articulate the entirety of their role in a way that can be reconciled with their status *as* nurses. These findings therefore give insight into some of the tensions and contradictions which are a source of stress or emotional exhaustion for critical care nurses (Bakker et al. 2005; Cronqvist et al. 2006; Lawrence 2011; McAndrew et al. 2011).

Previous nursing literature has often focussed upon and celebrated the “altruistic and emotional aspects of caring” (O’Connell & Landers, 2008), yet these findings make clear that expert nursing practice is not always dependent upon thinking about patients in ways which require “emotional involvement” (Tanner 2006; Morrison & Symes 2011). Critical care nurses do not necessarily ‘objectify’ patients in order to cope with their emotions but simply think about patients in different ways some of which involve their emotions and some of which do not. There is therefore a need for a re-examination of that literature from Menzies-Lyth (1959) through to Benner et al. (1999) which suggests that such ‘objectification’ of patients in critical care nursing practice is necessarily a coping strategy.

The existing literature often implies criticism of some of the ways in which critical care nurses think about patients. For example, Walsh & Ford (1989) problematise 'routine' thinking; technology has been argued to be 'dehumanising' (Almerud 2008), and 'biomedical' models have been suggested to be reductionist (Christensen & Hewitt-Taylor 2006). Highlighting that nurses think about patients in different ways makes clear that such critiques are limited in scope. It is only properly possible to argue that it would be reductionist to think about the patient *only* or *inappropriately* in biomedical terms, 'dehumanising' to think about the patient *only* or *inappropriately* in terms of technology, and antithetical to evidence based practice to *only* or *inappropriately* focus upon 'routine' work.

Nursing has long been characterised by attempts to define itself (Nightingale 1860/1969; Henderson 1966), and has often been differentiated from medicine through characterisations of the biomedical viewpoint as reductionist. Nursing theory has developed with an aim of providing nurses with a unique "perspective on the patient" (Marrimer-Tomey & Alligood 2006), and this perspective often implies that nurses should think about patients as *persons* (Gadow 1985; Watson 1988; Morse et al. 1990; Lawler 1991; Barker 2001; Melia 2004; McCormack 2010). To mirror the arguments advanced above, these findings make clear that safe and effective critical care nursing will not be achieved if nurses *only* or *inappropriately* think about patients as 'social beings' or 'valued individuals'. Nevertheless, throughout their careers in education and practice nurses are socialised to a view that delivering 'person centred' care is central to their identity as nurses, and the fact that participants did hold such a view was itself apparent within these data.

Whilst thinking about patients as social beings or valued individuals *may* be considered to constitute thinking about the patients as a person, it is clear that these ways of thinking do not recognise all aspects of patients. Close analysis of the practice of critical care nurses combined with an exploration of the nature of d(D)iscourse has therefore shown that an awareness of a patient as a '*whole* person' cannot be conveyed in any meaningful behaviour or communication. Although policy makers and professional regulatory bodies continue to assert that nurses should think about patients as persons (DH 2006; DH 2008a; DH 2009; NMC 2010), these findings make clear that there can be no ONE way of thinking about patients which underpins all of nursing practice which may be characterised in this way. This study has made clear that nurses think about patients in several discreet and mutually exclusive ways, and that suggesting that nurses should think about patients as persons is not only of little or no value in explaining or guiding nursing practice, but also actively hinders practitioners from talking about their practice.

These arguments make clear that there is a need to reappraise a wide body of literature which seeks to theorise 'holistic' or 'whole person' care. This will include review of those nurse theorists who explicitly set out to consider the perspective which nurses may have on patients, but also extends to other scholarship which suggests that it is somehow wrong or illegitimate for nurses to think about patients in certain ways. To argue that technology is 'objectifying' (Gadow 1985; Locsin 1995; Barnard and Sandelowski 2001; O'Keefe-McCarthy 2009) is to implicitly argue that it is wrong to think about the patient as object. To construct a duality between a "power/knowledge grid" and "nurturance / knowledge grid" (Street 1992) is both to uncover and to propagate a view that that nurturance is the preferred way for nurses to think. There is a need to re-appraise this wide body of literature in light of two deep seated and related assumptions that have been uncovered by this study. Firstly it may be noted that prior scholarship has tended to make the assumption that there is only one legitimate way in which nurses may think about patients. Secondly there is a presumption that for nurses to talk or think about patients in particular ways is to reveal attitudes or values which will impact upon patients' experience of receiving care.

These findings make clear that nurses think and talk about patients in many different ways, and therefore that it cannot therefore possible to make presumptions about nurses' values or attitudes on the basis of their using any one particular form of Discourse. These data have demonstrated that nurses may (when thinking about the medical case) describe patients in terms such as "the hip yesterday", but this study did not uncover any evidence of a relationship between nurses talking in this way and the overall care which patients received. Rather than being inherently 'wrong', such a way of talking about a patient may only be judged inappropriate within a particular context. It may also be noted that the nurses who participated in this study demonstrated themselves to be highly responsive to nuanced changes in context.

Nursing expertise has long been associated with concepts of perception or "perceptual grasp" (Benner et al. 1999; Scott 2000; Niven & Scott 2003). The interpretation of these data through the work of Aristotle (1984) and Benner et al. (1999) has made explicit the relationship between concepts of perception in the nursing literature, and the Aristotelian concept of *phronesis* upon which they often draw. In doing so this study adds to knowledge about the nature of nursing expertise by clearly articulating the nature of the "clinical wisdom" (Benner et al. 1999) that is necessary to think about and perceive patients in ways that are appropriate to the moment.

In this regard the study has clarified a phenomenon which is only hinted at within some existing literature. As an example, there is a suggestion that nurses should think about patients in an appropriate way within the following question posed by Tschudin:

"Is it a 'person' or a 'patient', 'my darling John' or a 'body' that is being cared for? It may all be the same person, but the way we see and approach the human being in need matters." (Tschudin 2002: p.124)

Nurses have also long been known to draw upon different forms of knowledge (Carper 1978; Liaschenko & Fisher 1999), and have been described as "bricoleurs" who draw upon 'bits and pieces' of knowledge in ways which are practical and necessary to "get the job done" (Gobbi 2005). The account of 'clinical wisdom' or 'correct perception' set out within section 6.3.2 provides an interpretation which shows how these 'bits and pieces' may come together. These findings also make clear that whilst nurses may *know* the patient to be a whole person, the delivery of nursing care does not require them to *think about* the patient as such.

These findings do not fundamentally question the need for care which may be described as person-centred, holistic or directed towards the whole person. The fact that these participants could not reconcile their ideals of person centred care with the ways that they did in fact think about patients simply makes clear that these ideals themselves need to be expressed with clarity. There is therefore a need to explain and conceptualise 'holistic' or 'whole person' care in ways which recognise nurses think about patients in a range of different ways and to be explicit that the 'whole person' can only be tacitly understood. The delivery of nursing care requires nurses to think about patients in different and discreet ways, none of which in themselves may be said to constitute thinking about the patient as a 'whole person'. The totality of nursing practice may be conceptualised as being directed to the whole person only when nurses demonstrate the clinical wisdom to think about patients in ways which are appropriate from moment to moment.

8.3 Recommendations

In order to introduce recommendations on the basis of these conclusions it is important to emphasise that the finding that critical care nurses think about patients in different ways should not be taken as a defence or apology for any shortcomings in nursing practice. It is clear that there is a widespread concern that the 'human' aspects of care can be neglected in many aspects of healthcare (Kings Fund 2009; Parliamentary and Health Service Ombudsman 2011). These

findings also point to specific ways in which practice may be enhanced given that they are for example consistent with prior research highlighting that critical care nurses do not always communicate with patients appropriately (Usher & Monkley 2001; Alasad & Ahmad 2005). Recommendations based upon these findings therefore give consideration to how the direct delivery of care may be improved, though the primary focus of recommendations is to address the central tension uncovered by the study. This is the tension between the fact that whilst critical care nurses are required to think about patients in many different ways they hold a view that they may only legitimately think about patients as persons. Recommendations are therefore made for critical care practice and education, nurse education more broadly, future research and policy.

8.3.1 Critical care practice and education

These findings support those of Gobbi (1998) who has argued that a key task for nurse education is to helping practitioners develop the discreet knowledge and skills which are necessary to use differing forms of Discourse. Nurses need to develop the knowledge, skills and attitudes that are necessary in order to respond immediately to the acutely (un)stable patient; to understand the complex 'medical case'; to examine the 'body'; or to empathise with the 'valued individual'. In addition to the ability to think about patients in these particular ways, this study also makes clear that the development of critical care practitioners must also seek to develop their ability to move between these different ways of thinking. The rigid rule following behaviour which is known to characterise 'novice' performance (Benner 1984; Dreyfus & Dreyfus 1985) may also be associated with the finding that novice nurses did not always move appropriately between different ways of thinking about patients. Examples within these data have shown that a novice may well know what ought to be done in order to care for an 'unstable' patient, but this itself is not sufficient to ensure that they perceive that patient as 'unstable'. Nurses may get 'stuck' in one way of thinking about the patient, and poor 'prioritisation', or the delivery of care which appears 'routine' and 'impersonal', may reflect a failure to think about the patient in a way which is appropriate rather than a lack of knowledge or uncaring attitudes. Practitioners and educators in critical care therefore need to recognise that nurses must perceive patients in a particular way (such as 'unstable' or as a 'valued individual') before they can respond to them as such. The common injunction to "look at the patient" may be of little help in guiding an novice who may need guidance on whether they are expected to 'see' the patient as 'body', as '(un)stable', or the distressed 'social being'. Through guidance, reflection and role modelling, attention needs to be brought to the way that expert critical care nurses survey or 'lighthouse'(Scholes 1996) their surroundings so as to seek cues which help them to perceive patients in ways which are

appropriate to the moment. Through discussing discreet incidents in clinical practice, or the use of simulation and debriefing, nurses may be helped to understand the different ways that they may see, perceive and hence think about patients.

The primary function of critical care units is to monitor patients who are suffering from or at risk of organ failure, and consequently nurses in this environment have a particular need to think about patients as '(un)stable'. The dominance of this way of thinking within these findings makes clear that many of the moment to moment judgements and decisions of staff can be heavily influenced by 'targets' and 'parameters'. These data suggest that such targets may be set in a fairly arbitrary fashion, or are characterised as simply "giving staff an idea", and yet their profound (and possibly unintended) influence on nurses behaviour calls for healthcare teams in critical care to give careful consideration to their role. In order to inform the appropriate use of such 'targets' there is a clear need for research to clarify the relationship between the use of such 'targets', clinical decision making, and patient safety and clinical outcome. For example, the influence of a 'target' PO₂ (partial pressure of oxygen) on decision making could be highly significant given that those strategies which improve survival in critically unwell patients are not always those which lead to short term improvements in oxygenation indices (Petrucci & Iacovelli 2007).

Managing time is a key task for nursing staff in critical care, and hourly demands such as the need for observations means that practitioners may often only be thinking about in terms of what needs to be done in the next hour or shift. In order to understand the treatments which they initiate and deliver nurses need the ability to think about and articulate how a patient 'is doing' (rather than merely how a patient 'is'), and to understand the trajectory of the 'medical case'. Whilst it is clear that critical care nurses need the biomedical knowledge necessary to understand the patient as medical case, these findings suggest other ways in which such an understanding may be promoted. Within these data it was notable that junior nurses were frequently asked how their patient *was* at that moment, whereas their understanding of the trajectory of illness may be more effectively developed through questioning about how the patient *was doing* in terms of their progression as a 'medical case'. Whilst the development of novice critical care nurses may require them to stay at the bedside so that they are able to maintain safety and remain aware of how a patient is, these data suggest that time away from direct patient contact may also have a valuable role. These findings suggest that time away from the immediate bedside may be necessary for nurses to 'get their head around' patients and thus to develop their understanding of the medical case.

8.3.2 Education

Whilst the above points are directed specifically to critical care practice, these findings allow for recommendations to be made in respect of nurse education more broadly, and particularly for pre-registration education. It has been claimed that the use of biomedical models to underpin nurse education may reinforce values which act as barriers to compassionate care (Kings Fund 2009), yet it is clear that an ability to understand a patient as a 'medical case' is a vital component of nursing practice. It is necessary to challenge the view that 'biomedical knowledge' is by its nature reductionist, and nurse educators must make explicit that this is a legitimate and vital way in which nurses will at times think about their patients. This may only be achieved in a context in which it is explicitly recognised that no one way of thinking about patients is sufficient to underpin all of nursing practice.

My research journal provides an example of how recognising that 'impersonal' ways of thinking may be appropriate to some situations can be usefully transferred directly to an educational setting:

Teaching Basic Life Support to year one students, I noted that they were very hesitant in covering the face of the manikin in order to use a pocket mask. In this teaching I found it helpful to make the point that they needed to learn to see themselves as looking after the "airway" of the "casualty" or "patient", and that their hesitance may arise from seeing the "face" of the "person"

Research Journal: 4th December 2009

In order to avoid establishing or reinforcing that view that only some ways of thinking about patients are legitimate, nursing curricula must therefore recognise that nurses think about patients in different ways. Unless developed with great care, the underpinning of a curriculum by any single conceptual framework may serve to reinforce a view that only some ways of thinking about patients are legitimate. Nurse educators, and particularly those who design pre-registration curricula, should therefore explicitly recognise that nurses are "bricoleurs" who draw upon 'bits and pieces' of knowledge (Gobbi 1998, 2005) and who think about patients in many different ways.

This study has taken what nurses actually do and say as its focus, and in doing so has made clear that unclearly expressed ideals of person centred care are of limited help in explaining or articulating nursing practice. In order to limit any perceived gap between nursing theory and nursing practice,

practice itself must always hold a central place within nursing curricula. Educationalists must therefore recognise that whilst nurses may gain knowledge and skills in a theoretical context, it is only through engagement in nursing practice that nurses may experience how all of these different ways of thinking come together in clinical practice. Any cohesion between these different ways of thinking may only be gained as “personal knowledge”, and educationalists must therefore draw upon constructivist approaches which encourage students to put these “bits and pieces” together for themselves. Educators (and particularly those with responsibility for education in practice) may also play a key role in enabling students to develop ‘clinical wisdom’ through encouraging reflection on, and discussion of practice, so as to develop an awareness that nurses do move between different ways of thinking about patients.

8.3.3 Future research

This study has made clear that the relationships between the ways in which nurses see, treat think about and talk about patients are complex. Whilst healthcare is not always delivered with care and compassion (Parliamentary and Health Service Ombudsman 2011), the response of healthcare policy and nursing literature is to increasingly affirm or imply that it is necessary for practitioners to think of patients as persons. These data make clear that such an assertion is both unclear and actively hinders practitioners from talking about their practice. There is therefore a need for future scholarship and research to clarify and articulate the aims of ‘whole person’ or ‘holistic’ care in ways which do not construct some ways of thinking about patients as illegitimate, and the above conclusions have begun to outline how this may be achieved.

It should be recognised that in claiming that nursing has a unique knowledge base and a unique professional perspective on patients, nursing scholars are reinforcing views that only some ways of thinking about patients are legitimate. Nursing has historically constructed itself as different from medicine (May & Fleming 1997) and this “ideology” has previously been identified as a source of interdisciplinary conflict in critical care (Coombs 2004). Comparative studies which explore how other health care practitioners think about patients may therefore be of value in examining the nature of this conflict. There is for example no reason to presume that medical practitioners think about patients purely in terms of the ‘medical case’ any more than nurses think about patients purely as a ‘set of needs’. Studies which make clear the ways in which different health care practitioners think about patients could uncover areas of similarity as well as difference, and ultimately play a role in enhancing multidisciplinary relationships and understanding.

This study did not set out to develop the theory or models of nursing, nor to appraise the ways in which 'person focussed' care has been conceptualised in the literature. Nonetheless these findings will be of interest to nurse theorists given that they conflict with a view implied by a wide body of scholarship that nurses should think about patients as persons. Participants clearly thought about patients in ways which were different and distinct, and in section 6.1.4 it was noted that this is not compatible with the argument of theorists such as Rosemarie Parse (1992) and Martha Rogers that nurses must view patients as "unitary and irreducible" (Rogers 1990). Despite the influence of theorised models on aspects of how participants thought and talked about patients, these nurses did not think about patients in ways which clearly mirrored key distinctions made by models in common usage in the UK such as those of Roper, Logan and Tierney (2000) or Orem (2001).

Although this study has not examined care delivery from the patient perspective, it nonetheless makes clear that there cannot be a *presumed* relationship between how nurses think about patients and patients' overall experience of care. Nurses think about, and talk about, patients in many different ways, and an understanding of context is crucial in determining whether these ways of thinking are appropriate. Within these data there was no evidence that nurses talking about patients in ways which may be considered objectifying (such as saying "the hip yesterday") had any impact on the totality of the nursing care they delivered. There is a complex relationship between the ways that nurses talk and think about patients, and no presumption can be made that a particular way of talking reveals generalizable attitudes or values that will impact upon the delivery of care. Consequently, there is little value in scholarship which characterises discreet behaviours as 'objectifying', '(un)caring', '(de)humanising' and suchlike through methods which do not relate these behaviours to patient outcome and experience.

The above discussion essentially reformulates a premise of linguistic ethnography that all forms of talk are closely responsive to context, and within this study overall this point is of particular importance in relation to the role of the research interview. The analysis of interview data proved a valuable means by which institutional Discourses could be identified and recognised, but this talk *about* practice this study did not illuminate how nurses drew upon and moved between these Discourses whilst in practice. Although every attempt was made to ensure that interviews took place within a supportive and non-threatening environment, analysis of these data nonetheless made clear that participants worked to establish and maintain their identity as nurses throughout the interviews. These factors therefore call for careful reappraisal of the role of the research interview in nursing research.

A recent National Institute of Health and Clinical Excellence (NIHCE) Clinical Guidelines Development Group have concluded that no harms were likely to follow a proposed recommendation that future clinical guidelines should be based upon a requirement to “see the patient as an individual” (NIHCE 2011). This study begins to make clear that even such a broad injunction as this may be based upon an appropriate evidence base. These findings also make clear that requiring practitioners to ‘see’ or ‘think about’ patients in specific ways is problematic, and suggest that such recommendations may usefully be more clearly be aligned to what practitioners are expected to actually do and say in specific contexts.

This study has been conducted within one critical care unit in the UK. Differences in national and organisational cultures and differences in clinical speciality may influence both the ways in which nurses’ think about patients and nurses’ ideas of what is legitimately part of the nurses’ role. Given that these findings highlight the disparity between these ideals and what nurses actually do, there would be value in replicating this study in contrasting international contexts in order to inform a broader understanding of the relationships between nurse education, theory and practice.

8.3.4 Policy

Current UK health policy emphasises the need to enhance the human experience of healthcare and ensure that care is delivered with compassion. This need is often expressed through assertions such as that nursing is dependent upon the ability to care from one human to another (DH 2006a; RCN 2010). Whilst the goals of such policy are clearly important, these aims must be communicated clearly if they are to avoid implying that some of the ways in which practitioners must think about patients are intrinsically wrong.

Policy makers continue to express aspirations that health care should be person focussed (DH 2010a; DH 2010b) or that health care practitioners should value each person as an individual (DH 2009), but should take care that in doing so they do not reinforce a view that there are only some legitimate ways in which nurses may think about patients. Without clarity there is a risk that some of ways in which nurses must think about patients will be negatively characterised as ‘impersonal’, thus hindering practitioners from reflecting upon and talking about their practice. There is therefore a need for policy makers to recognise that generalised and acontextual invocations to “focus” on persons, or “value” individuals may be of little value, and serve only to reinforce vague or unachievable ideals. Instead, it will be important to set context for such

guidance and to recognise that safe and competent care requires nurses to think about patients in a range of different ways. The goal of 'person focussed' care may best be achieved through directives which make clear what patients expect or need nurses to do and say within specific contexts, rather than upon what nurses should 'focus on' or 'value'.

9.0 Summarising the study

This study set out to explore how critical care nurses think about patients. Undertaking this study has not only identified and characterised different ways in which critical care nurses do think about patients, but has also made clear that these 'ways of thinking' are a significant and previously overlooked area of enquiry. This thesis concludes by summarising the key findings, and highlighting their significance and implications.

Close observation of what critical care nurses do and say reveals distinct patterns in the ways that they behave towards and talk about patients. Adopting the perspective of discourse analysis allows for these patterns to be considered as Discourses, each of which constructs an identity for the patient as a particular kind of being. As nurses move between these different Discourses or patterns of practice they think about patients in different ways. All the participants in this study moved between thinking about the patient as 'routine' work; as a 'body'; as '(un)stable'; as a 'set of needs'; as a 'medical case'; as a 'social being' or as a unique 'valued individual'. Close linguistic analysis of these data together with the examination of apparent negative cases has shown that these ways of thinking are distinct and mutually incompatible.

The fact that nurses think about patients in a number of different ways does not imply that they do not know or are unaware that they are caring for a person. Nurses can have a tacit awareness that these different ways of thinking are aspects of one coherent whole, but these findings make clear that nurses may only think about patients in one way at a time, no *one* of which may be characterised as thinking about the patient as a 'whole person'. This is due to the nature of discourse which means that at any one moment nurses may only think about or talk about patients in one way. Consequently it is not clearly problematic if nurses on occasion think or talk about patients in ways which do not require any emotional involvement with the patient and which may therefore be characterised as impersonal. Nurses move between different ways of thinking, and whilst all participants in this study did think about patients in such 'impersonal ways' it was also notable that they could all demonstrate an emotional involvement with patients when this was appropriate to the moment. A significant contribution of this study has been to describe these affective and emotional aspects of care in the context of all that nurses do and say, and to make clear that a focus on these aspects of nursing care in isolation risks constructing unreal descriptions of practice.

Because nurses may only think about a patient in one way at any moment in time, critical care nurses must move between different ways of thinking about patients. Within these data this was shown in the way that participants would frequently 'reframe' the immediate context of care so as to move from one way of thinking about patients to another. Whilst all participants were found to think about patients in fundamentally the same ways, more experienced nurses were distinguished by their ability to move fluidly between these different ways of thinking. These data therefore suggest that expert nurses do not think about patients differently to novices, but make clear that expert practice requires nurses to have the "clinical wisdom" (Benner et al. 1999) necessary to perceive and think about patients in ways which are appropriate to the moment.

Despite the fact that their practice required them to think about patients in many different ways, analysis of data in which participants talked about their practice revealed that these critical care nurses held a view that nurses may only legitimately think or talk about patients as persons. This was shown within interview data where nurses suggested that thinking about patients as 'routine', as 'body', as 'medical case', or as '(un)stable' could be characterised as impersonal and consequently not "nursely". Consequently these critical care nurses found it difficult to talk about, understand and reflect upon those aspects of their nursing practice which required them to think about patients in ways which did not demand any emotional involvement.

Discussion of these 'impersonal' ways of thinking in light of existing literature makes clear that it is necessary for critical care nurses to think about patients in these ways. Critical care is defined by the need for high technology monitoring and intensive body system support, and requires that critical care nurses are able to think about patients as potentially 'unstable'. 'Routine' ways of thinking were important in enabling these participants to manage time, and 'routine' activities such as tidying, organising and maintaining control over the physical environment could be seen to play a role in maintaining patient safety. These data also show that an understanding of the patient as 'medical case' not only enabled participants to play their role in delivering complex supportive therapies, but was also a key means by which nurses would recognise and communicate patterns of disordered physiology, and understand the trajectory of patients' illness.

This study therefore reveals a dissonance between nurses' ideals of person centred care and the reality of critical care practice. Whilst participants expressed a view that nurses may only legitimately think and talk about patients as persons, examination of the different ways that critical care nurses think about patients makes clear that this ideal is literally unachievable and

does not explain or guide nursing practice. This finding is of particular significance given that prior literature suggests that such dissonance between the ideals and the reality of care delivery may contribute towards the stress and emotional exhaustion which critical care nurses are known to experience.

These findings therefore make clear that there is a need for those working in areas of nursing practice, nurse education, nursing scholarship and healthcare policy to recognise and legitimise the fact that nurses must think about patients in different ways. A major contribution of this study has been to introduce the concept of 'different ways of thinking about patients' which itself provides a conceptual framework or shared understanding which will enable nurses to talk about, understand and develop the totality of their nursing practice.

This study has examined *nursing* practice and did not set out to examine the interplay between nursing and other professional cultures within critical care. Nonetheless these findings demonstrate that nurses themselves play a role in constructing those differences between healthcare professions which can be a source of inter-professional conflict. Nursing theorists lay claims to ideals of affective caring which are unique to nursing, yet the untheorised nature of some of the ways in which participants thought about patients suggests that other professionals may also think about patients as 'unique individuals' or as 'social beings'. Thinking about the patient as a 'set of needs' may be relatively unique to nursing, but nurses in critical care also think about patients as a 'medical case' in much the same way as their medical colleagues presumably do. It is likely that different professional groups therefore think about patients in ways which are shared. Developing an understanding that all healthcare practitioners think about patients in many different ways may therefore play a role in clarifying areas of commonality rather than difference, and thus serve to enhance multidisciplinary relationships and understanding in the practice of healthcare.

The dissonance between the finding that nurses think about patients in different ways, and participants' view that nurses may only legitimately care for 'persons' makes clear that there is a need to reconsider how the ideals of 'person focussed' care should be articulated to all healthcare practitioners. Unless this aspiration is expressed with clarity there is a risk that nurses may come to consider that only some ways of thinking about patients are legitimate, and that unrealistic and literally unachievable ideals may be reinforced. Nurses need to recognise that their practice requires them to have the discreet knowledge and skills necessary to think about patients in

different ways, and to develop the “clinical wisdom” necessary to move appropriately between these different ways of thinking.

There is a need for nurses in practice, education and scholarship to avoid presuming a relationship between the quality of patient care and the fact that practitioners may at times think or talk about patients in certain ways. Whilst there is a relationship between the ways that nurses think about, treat and talk about patients within any one Discourse, nurses draw upon many different forms of discourse in their practice. A nurse may therefore refer to a patient through phrases such as “the hip yesterday”, but this simply reflects one of the ways that they think about patients and should not be taken as an indicator of the overall care that they give without a full understanding of context. Similarly, nurses must at times think about patients in ways which do not require any emotional involvement, and yet there was no evidence within these data that such ‘objectification’ was necessarily problematic or constituted a ‘coping strategy’ for participants. Nurses must think about patients in many different ways, and it is therefore not helpful to negatively characterise some of these ways of thinking through means such as the portrayal of biomedical views as ‘reductionist’.

These findings highlight the need to reappraise a wide body of literature, theory and policy which suggests that nurses should think about patients as persons. Although it is essential that patient experiences should reflect the ideals of humanity, care and compassion expressed within the NHS Constitution (DH 2009), these ideals will not be achieved by simple assertions or implications that nurses should think about patients as persons. Whilst participants in this study may have had a tacit understanding or subsidiary awareness that the patient was a person, detailed analysis of their nursing practice makes clear that thinking about patients as persons is an ideal which is of little or no value in understanding or guiding nursing practice from moment to moment.

Critical care nurses in this study were able to think about patients in many different ways, but were only able to talk about providing care to patients as persons. These findings reflect a deep tension between the work that critical care nurses are expected to do, and their ideal that nursing care involves caring for ‘persons’. The above considerations have outlined the future scholarship and research which may be needed for nurse educationalists, leaders and policy makers to communicate the ideals of ‘person focussed’ clearly so as to avoid constructing a dissonance between the possible and the ideal.

Appendix 1: Search Strategy

Early ad hoc searches enabled the identification of key words / search terms which guided an initial formal search strategy as set out below. Literature searching was undertaken initially through the CINAHL database, and results of these searches are shown in the tables below. Elements of the below searches were duplicated on AMED, Psycinfo, and Medline databases.

Key

- AB Search of abstracts
- MH Search utilised mapped subject headings (MeSH terms)
- KW Search by keyword
- TI Search for keyword in title

Qualitative studies in critical care		
S1	(MH "Critical Care") OR "critical care" OR (MH "Critical Care Nursing") OR (MH "Critical Illness") OR (MH "Critically Ill Patients") OR (MH "Intensive Care Units")	44940
S2	AB "qualitative" OR "naturalistic" OR "ethograph*" OR "phenomenolog*" OR "grounded theory" OR "hermeneutic*"	43758
S3	S1 AND S2	961

Nursing Ethnography		
S4	AB Nurs*	164709
S5	AB ethnograph*	3617
S6	S4 AND S5	1183

Personhood and Person centred care		
S7	AB "personhood"	268
S8	KW "person centred "	714
S9	MH "Nursing Models, Theoretical"	3634
S10	S7 OR S8 OR S9	4589
S11	S 10 (limited to 2007 onwards)	1381
S12	S10 AND S1 <i>(restricted to critical care)</i>	59
S13	MH "Caring"	5123
S14	S13 AND S4 <i>(restricted to Nurses / nursing)</i>	1888
S15	S14 AND S1 <i>(restricted to critical care)</i>	115

Nurse patient relationship		
S16	(MH "Nurse-Patient Relations") OR (MH "Professional-Patient Relations")	35099
S17	S16 AND S1 <i>(restricted to critical care)</i>	882

Thinking and synonyms		
S18	(MH "Thinking") OR (MH "Emotional Intelligence")	2674
S19	S18 AND S4 <i>(restricted to nurses / nursing)</i>	330
S20	AB "knowing the patient" OR TI "knowing"	182
S21	MH "intuition"	802
S22	TI "perception"	5928
S23	S22 AND S4 <i>(restricted to nurses / nursing)</i>	458

Specific factors impacting on the way in which nurses may think about patients		
S24	MH "expert nurses" OR TI "expert*"	5255
S25	S22 AND S1 <i>(restricted to critical care)</i>	194
S26	TI "technol*"	19681
S27	S26 AND S4 AND S1 <i>(restricted to critical care AND nurses / nursing)</i>	95
S28	MH "communication"	34152
S29	S28 And S4 AND S1 <i>(restricted to critical care AND nurses / nursing)</i>	430
S30	MH "culture"	9666
S31	S30 AND S1 <i>(restricted to critical care)</i>	108

Additional searches were undertaken using the term "personhood" (and synonyms) in the 'Philosophers Index' database in order to inform discussion of issues raised in section 2.3.

Details of audit trail

In order to identify literature for inclusion within the review, the titles and / or abstracts of papers relating to the searches in **BOLD** in the above were examined against the inclusion / exclusion criteria below. Where searches produced large numbers of hits (>250) the search results were further restricted by date to identify the most recent literature. The date set varied by topic, although in general was restricted to 10 - 15 years except where literature could be considered seminal.

Further search strategies

Given the abstract and ambiguous nature of the concepts at the heart of this study, the above searches often produced multiple hits of little relevance. Identification of papers for review of the study was heavily dependent upon following up references identified through these initial searches, and through the identification of authors publishing papers of particular relevance.

Searches were also made for relevant literature on the websites of the following organisations:

World Federation of Critical Care Nurses (WFCCN)

British Association of Critical Care Nurses (BACCN)

Intensive Care Society (ICS)

National Institute for Health and Clinical Excellence (NICE)

Royal College of Nursing (RCN) (including RCN Critical Care and In-Flight Forum)

The Cochrane Library

Department of Health

The Kings Fund

Inclusion and exclusion criteria

Literature was included and excluded from the review in relation to the degree to which it was directly relevant to the aims of the study using the criteria below

Literature included:

Primary research report, literature reviews; concept analyses.

Literature reporting on or analysing the views / understandings / experiences of practicing nurses.

Studies which revealed or suggested relationships between nursing practice and how critical care nurses think about patients

Literature excluded:

Opinion articles and case study reports

Focus on highly selected patient groups in critical care (e.g. death and dying; specific, single diagnosis patient groups)

Studies conducted in paediatric critical care

Studies reporting only on patient experiences

Not available in English language.

Studies reporting purely on approaches to nurse education and training without reference to the views / understandings / experiences of practicing critical care nurses

Studies which did not explore the relationships between nursing practice and how critical care nurses think about patients

Appendix 2: Confirmation of ethical approval



Health Research Authority

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Dear Mr McLean

Full title of study: A participant observation study exploring the ways in which Intensive Care nurses think about their patients.
REC reference number: 06/Q1704/90

Thank you for your letter of 11 September 2006, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Vice-Chair.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised.

Ethical review of research sites

The Committee has designated this study as exempt from site-specific assessment (SSA). There is no requirement for other Local Research Ethics Committees to be informed or for site-specific assessment to be carried out at each site.

Conditions of approval

The favourable opinion is given provided that you comply with the conditions set out in the attached document. You are advised to study the conditions carefully.

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

<i>Document</i>	<i>Version</i>	<i>Date</i>
Application		06 July 2006
Investigator CV Mr C McLean		04 June 2006
Protocol	3	09 September 2006
Covering Letter		06 July 2006
Letter from Sponsor		09 June 2006
Peer Review		18 May 2006

Compensation Arrangements		08 June 2006
Advertisement	1	01 September 2006
Participant Information Sheet: Staff	2	01 September 2006
Participant Information Sheet: Patient	2	01 September 2006
Participant Consent Form: Participant	2	01 September 2006
Response to Request for Further Information		11 September 2006
Letter from [REDACTED] Critical Care Manager		04 September 2006
Reply Slip	1	01 September 2006
CV for Dr M Coombs		
CV for Dr M Gobbi		

Research governance approval

You should arrange for the R&D department at all relevant NHS care organisations to be notified that the research will be taking place, and provide a copy of the REC application, the protocol and this letter.

All researchers and research collaborators who will be participating in the research must obtain final research governance approval before commencing any research procedures. Where a substantive contract is not held with the care organisation, it may be necessary for an honorary contract to be issued before approval for the research can be given.

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

06/Q1704/90

Please quote this number on all correspondence

With the Committee's best wishes for the success of this project

Yours sincerely

Dr Anneke Lucassen
Vice-Chair

Email: GM.E.hio-au.SWHRECB@nhs.net

Enclosures: *Standard approval conditions SL-AC2*

Copy to: Dr Martina Dorward
University of Southampton
Research Governance Office, Legal Services
Room 4001, Building 37
Highfield
Southampton

Appendix 3: Information to unit staff

A participant observation study exploring the ways in which Intensive Care nurses think about patients: Information sheet for Unit Staff

Introduction

A research study is currently taking place on the unit which aims to explore the ways in which intensive care nurses think about their patients. The way in which intensive care nurses think about their practice may be unique, and this study aims to explore what it is to 'think like an intensive care nurse'.

Primary study participants will all be nurses from the Intensive Care Unit. The researcher will be spending time working alongside nurses in the unit in order to observe their practice and see how they deliver nursing care. The researcher will also conduct interviews with these nurses.

This information leaflet aims to explain how this research may affect work on the unit and the impact of the research on other staff. Please take time to read the following information and feel free to ask the researcher if there is anything that is not clear or you would like more information about.

What is the researcher's role on the unit?

Data is being collected using the method of participant observation. This will involve the researcher in working closely alongside study participants. The researcher's role is primarily observational, and this will involve writing field notes regarding what is observed. The researcher is however an experienced intensive care nurse and may at times participate in the delivery of some aspects of patient care.

It is important for all staff to be aware that the researcher will aim not to influence the nursing care that is being observed. In particular this means that he will in no way be teaching, guiding or supervising those nurses with whom he is working

Who is being recruited to the study?

Six nurses from this unit will take part in the study, consisting of three experienced ITU nurses and three nurses who are new to work in a critical care environment. This unit has been selected for the study as it is a typical mixed critical care unit. Two participants will be recruited to the study at any one time.

Initial participants will be selected from those nurses who express an initial interest in participating in the study. Later participants may be approached directly by the researcher where they are seen to approach aspects of their practice differently from other nurses taking part in the study.

How will other staff on the unit be included in the research?

The research may be interested in interactions between the study participants and other members of staff on the Intensive Care unit where these interactions relate to the care that the nurse is delivering. As the care of the Intensive Care Patient involves input from many members of

the healthcare team it would not be possible to gain prior consent from all staff who may participate in the delivery of care to a particular patient.

The words or actions of any member staff on the may be recorded where these interventions are relevant to the aims of the research and involve the nurse who being observed at that time. Where these notes are taken, staff would only be identified by professional role (e.g. Consultant, Physiotherapist 1; Sister; Doctor 2). No further personal information will be recorded. If you have any concerns at any time over your involvement in the study then please do not hesitate to discuss these with the researcher.

Where possible, unit based staff are asked to assist the researcher in ensuring that healthcare professionals who visit the unit are aware that this research is being undertaken and of the potential that they may have this limited involvement in the study.

Do I have to take part?

You should be aware that formal consent will only be obtained from the nurses who are the main subject of the study. The researcher will make efforts to ensure that all staff working on the unit are aware of the research and given an opportunity to discuss concerns. However you should be aware that your words and actions may be included within the research as outlined above unless you inform the researcher of any objection you have.

If you have any objection to taking any part in the study in the limited sense outlined above then you should tell the researcher. If you do object, then the researcher will not record any of your words or actions and no information about you will be recorded or used in the study.

All staff on the unit may assist the researcher in helping to ensure that members of staff visiting the unit are also aware of the research and of their right not to participate. It would also be helpful if unit staff could pass on details to the researcher of any member of staff who does have an objection to their words or actions being recorded.

Will the research impact on the care given to patients?

The impact of the research on the work of the unit should be minimal. If you feel that the research is in any way negatively affecting patient care then please discuss this with the researcher, or raise your concerns with the Unit Lead nurse. At all times the needs of patients will be prioritised over the needs of the research.

Is consent being obtained from patients?

All patients (or their families) will be approached to ensure that they have no objection to the researchers presence or participation in their care. Although primarily there to observe how nursing care is being delivered, the researcher is an experienced Intensive Care nurse and may assist in delivering some aspects of patient care when this is appropriate.

What should I do if I am not happy about the way the research is conducted?

If you have a complaint about the way that the research is being conducted then you are invited to discuss this with the researcher in the first instance. In the event that you feel unable to do so,

or wish to pursue a complaint further, then you should discuss the issues with the Unit Lead Nurse who will pursue your concerns through university channels.

Thank you for taking the time to read this, and for your anticipated co-operation in completing this study.

Contact for Further Information

For any further information about this study please contact:

Mr Chris McLean

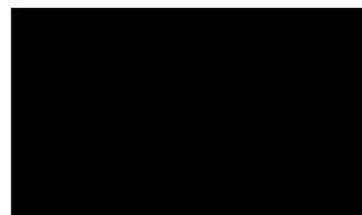
{contact details redacted}

Appendix 4: Managers confirmation of access to study site

04 September 2006



Healthcare NHS Trust



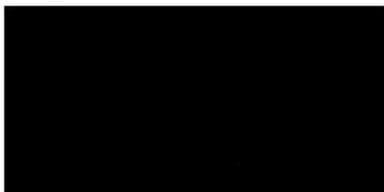
Southampton & SE Hampshire Research Ethics Committee

Dear Sir

Re: A participant observation study exploring the ways in which intensive care nurses think about their patients. 06/Q1704/90.

I would like to confirm that I have discussed the above research proposal with Christopher McLean and that I have given my authorisation for the research to be undertaken on the Intensive Care Unit at the  Hospital.

Yours sincerely,



 BSc (Hons) RGN.
Critical Care Manager

Appendix 5: Participant information sheet

The following information was given to participants prior to their giving written consent to participate in the study

A participant observation study exploring the ways in which Intensive Care nurses think about their patients.

Participant Information sheet: Version 2

Dated: September 2006

You are being invited to take part in a research study. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask me if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

Thank you for reading this.

What is the purpose of the study?

The way in which intensive care nurses think about their practice may be unique. This study aims to explore what it is to 'think like an intensive care nurse'.

Specifically, the study will explore whether intensive care nurses think about their patients differently at different times or under different circumstances. The study aims to understand these 'ways of thinking' and how they relate to the way we give nursing care.

The data for the study will be collected over a period of between 3-6 months in 2006-7.

Why have I been chosen?

This unit has been selected as it is a typical mixed critical care unit.

Six nurses from this unit will take part in the study, consisting of three experienced ITU nurses and three nurses who are new to work in a critical care environment.

If you are willing to consider taking part in the study then please return the reply slip attached to the researcher. Initial participants will then be selected from those nurses who reply and express interest in this way.

Later in the research you may be approached directly by the researcher and asked to consider participating. This may be because the researcher may have seen that you appear to approach aspects of your practice differently from other nurses taking part in the study.

Do I have to take part?

No. It is up to you to decide whether or not to take part.

If you decide to take part you are still free to withdraw at any time and without giving a reason.

Should you choose to withdraw from the study then data that has already been collected from you would not be used without your specific permission.

If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form.

What will happen to me if I take part?

The researcher will work alongside you for up to four hours at a time, usually on between three and five occasions. The researcher may help you in delivering some aspects of patient care when this is appropriate, but is primarily there to see how you deliver nursing care and to understand why you practice in the way that you do. To do this he may ask you some questions about what you are doing and why.

The researcher will need to see you caring for a number of different patients. This will be arranged through asking you at times to discuss which patients you will care for with the researcher as well as with the senior nurses responsible for patient allocation

You will also be asked to give three tape recorded interviews, each of which will last up to one hour. During interviews you will be asked to reflect on your practice and to comment on what you were thinking and feeling at particular times.

Two interviews will take place during the period that the researcher is working on the unit. The final interview will occur approximately three months later, once the initial data has been analysed. Interviews will take place during your normal working hours or at a mutually convenient time, and will be conducted in a private area in the vicinity of the Intensive Care Unit.

What are the possible disadvantages and risks of taking part?

The research may ask you to consider sensitive or painful issues, and there is a small chance that this could cause you distress. If this were to happen then the researcher would immediately stop any activity such as taking notes or recording the conversation and offer you appropriate support. Further support is available to you through approaching your mentor, unit clinical facilitator or manager.

What are the possible benefits of taking part?

The study does not set out to provide you with any explicit benefits. You may experience some benefit from the questioning and reflection on care that are essential features of the study. Given the nature of the issues you will be asked to consider, it is possible that this may enable some personal and / or professional growth.

What if I am not happy about the way the research is conducted?

If you have a complaint about the way that the research is being conducted then you are invited to discuss this with the researcher in the first instance. In the event that you feel unable to do so, or wish to pursue a complaint further, then you should discuss the issues with the Unit Lead Nurse who will pursue your concerns through university channels.

Will my taking part in this study be kept confidential?

Any information which is collected about you during the course of the research will be kept strictly confidential. All the researchers' notes and typed interview transcriptions will be fully anonymised so that you cannot be personally identified. This anonymised information will be stored on a University of Southampton networked computer with password protection.

You should be aware that this confidentiality may not be absolute if the researcher has serious concerns about your professional conduct. If the researcher did have such concerns then these would firstly be discussed with you in order to help you to manage the situation and seek appropriate support. In extreme cases, if patient safety were threatened then the researcher may need to discuss the issues with senior nursing staff on the unit.

What will happen to the results of the research study?

The primary purpose of this research is to study for a PhD award. It is likely that the findings will also be presented through the publication of papers, and conference presentations. Senior nurses for the unit will be given further details of publications for dissemination amongst unit staff. Both the completed thesis and additional publications may involve the direct quotation of things you say, although not in such a way that you could be personally identified. The views of all study participants will be considered when deciding how to report the research findings within the unit itself.

Who is organising and funding the research?

Study fees and research time for the study are being met in part by the University of Southampton where the researcher is employed. This research is not being funded by any external organisation.

Who has reviewed the study?

The study has been subject to internal peer review within the School of Nursing and Midwifery, and by the Southampton and South West Hampshire Research Ethics Committee (B).

Contact for Further Information

[Contact details omitted]

Appendix 6: Managing risks to patients in the field

A tension was perceived between the researcher's professional obligations, those professional obligations as perceived by other staff on the unit, and the need to adopt an observational stance as researcher. In order to manage these tensions, the following guidelines were discussed and agreed between the researcher and key unit staff at the outset of the study. These issues were also discussed with participants prior to gaining consent.

Clinical emergencies.

In emergency situations the priority will be to ensure the safe care of the patient. In such cases, the researcher will directly participate in care until patient safety is ensured. Such involvement will be limited to a scope of practice that will be agreed with the lead nurse for the unit and commensurate with the indemnity provided through the trust honorary contract. When relevant to the research question, data gathered during emergency incidents will however be included within the study.

Sub-Optimal Practice

The study aims observe and describe naturally occurring real practice, it cannot be supposed that the practice of all participants will always represent 'best practice'. Consequently it is essential that participants are assured that the research findings will remain confidential, and that the researcher is not seen as an agent of the unit management.

Where a nurse's practice is perceived as sub-optimal, the researcher will intervene only if patient comfort or safety is threatened, and only to the extent that is necessary to maintain patient safety. Should this occur then the researcher will explore the issues with participants in the course of the study, and will where appropriate encourage participants to discuss the matter further with senior nursing staff. The confidences of staff will not however be broken without their express permission unless meeting the criteria set out below.

Professional Misconduct / Incompetence

The researcher will intervene if behaviour is witnessed that clearly constitutes professional misconduct, or incompetence of a degree that directly threatens patient safety. Intervention in these circumstances will be such as is necessary to stop the behaviour and establish patient safety, following which the researcher will discuss concerns with the nurse involved. Such concerns will also be subsequently reported and discussed with the senior nurse for the unit.

These reporting procedures may also be followed in the event of participants making disclosures of past professional misconduct, where there is any concern that this past behaviour implies an ongoing risk to patients.

Embedded poor practice.

As a separate issue from consideration of individual nurses, it is possible that 'embedded' practice within the unit culture may be perceived as falling short of best practice. Where the researcher has concerns about an area of practice in this sense, the issue will be discussed with the senior nurse for the unit. It is understood between the lead nurse and the researcher that such issues will be raised as general comments on unit practices in such a way and at such a time as to ensure that the practice of no one nurse is implicated.

Appendix 7: Revision of field notes

Section 3.3.6 has highlighted that a process of re-writing and clarification of the field notes was necessitated by the analytical approaches adopted. This expanded illustration demonstrates and explains the approaches taken to doing so.

Original Extract

As his breathing settles once more Nurse 5 begins speaking to him again but there is a clear change in her voice. She is speaking quieter now and her tone appears to convey some sympathy for the distress this is causing. She explains that she will need to perform suction again, and does so. The focus of her gaze has narrowed further now, and she is intently focussed looking to Mr Young's face and the movements of his chest.

Revised Extract (changed text highlighted)

As his breathing settles once more Nurse 5 begins speaking to him again but there is a clear change in her voice. **I note that (1)** she is speaking quieter now **and that there are changes in her intonation**. **It is my feeling that this procedure has been distressing for Mr Young and I interpret these changes in Nurse 5's intonation as conveying sympathy for this. (2)** She explains that she will need to perform suction again, and does so **looking only at** Mr Young's face and the movements of his chest. **I gain an impression that this more restricted gaze represents a narrowing of focus which may be significant to the study. (3)**

(1) Rather than noting simply as 'fact' that the participant was talking more quietly, it is analytically significant that this was a notable to me as an observer. This addition makes this explicit.

(2) The original text implies unproblematically that the procedure of performing suction was distressing for Mr Young. This revision simply makes explicit that this was my own interpretation, as was the understanding of this change in intonation as conveying "sympathy".

(3) The references to "focussing" are not clear in meaning in the original account as they refer to concepts which were thought to be emerging during early stages of analysis in the field. These reformulations make a clear distinction between what was actually observed (the participant looking in a particular direction), and the impression that this may be of analytic significance.

Appendix 8: Questions / prompts to guide interviewing

The following questions were devised to guide questioning in relation to specific episodes or incidents during interviews.

- How the participant understood or thought about those episodes at the time.
- How the nurse themselves felt that they were thinking about the patient during the incident, or features of the patient that were responded to during it.
- The nurses' goals and motivation during the incident - what they were aiming to achieve
- How they would characterise the nature of their relationship with or attitude towards the patient at this time.
- The extent to which they consider the practice observed to be typical of their own practice, and of the practice of others within the unit
- Whether they were personally satisfied with the care they gave at that time.
- To explore any perceived internal dissonance in these accounts.
- To consider situations in which they might care for or think about patients differently.

Appendix 9: Jeffersonian transcription symbols

The primary conventions of Jeffersonian transcription have been adopted and are taken here from Wetherell et al. (2001).

(2)	Number in brackets indicates a pause in seconds
(.)	Short (untimed) pause
.hhh	Speaker in-breath (the more 'h's the longer the in breath)
hhh	Speaker out-breath (more 'h's the longer the out breath)
((<i>italics</i>))	Double bracketed italicised text indicates nonverbal activity or other commentary
-	Sharp cut-off of the prior word or sound
::	Stretching of the preceding sound (more colons the greater the stretching)
()	Empty parenthesis indicate an unclear fragment on the recording
(guess)	Words in a single bracket indicate a "best guess" at an unclear fragment of speech
.	Fall in intonation
,	Continuing intonation
?	Rising inflection
<u>Under</u>	Underlining indicates speaker emphasis
↑↓	Placed immediately before marked rising or falling intonational shift
CAPITALS	Speech which is noticeably louder than that surrounding it
° °	Degree signs indicate talk which is noticeably quieter than that surrounding it
> <	"More than" and "less than" signs indicate speech which is noticeably quicker or slower than surrounding talk
=	Contiguous utterances or 'latching'
[]	Onset and end of overlapping talk
[[Double left bracket indicates speakers start a turn simultaneously

Appendix 10: Illustration of Content Coding

The extracts below are all taken from the field notes for the same single period of observation, and are selected in order to give some illustration of how content coding was achieved.

Field note 1 15.15

Mr Williams begins giving an extended account of his wife's antihypertensive medication, and produces the data sheet for the medication to which she has recently been changed. He has highlighted several potential adverse reactions and side effects of the medication, pointing out that his wife had suffered from some of these. Nurse 5 listens to him and nods attentively and sympathetically as he speaks, but it is clear to me that her focus is on managing his anxiety and that she does not share his concerns that her condition may in any way be related to this change in medication. The nurse who is preparing to handover is now late getting off her shift and is looking on, but my overwhelming impression is that {participant} is making time for Mr Williams as an immediate priority. Once he has explained his concerns, she gently acknowledges them, but also refocuses him on the fact that Mrs Williams is receiving appropriate treatment for all the potential causes of her condition, including antiviral and antibiotic treatment. As she prepares to disengage and return to the second nurse an infusion pump alarms and Mr Williams looks up apparently startled. Nurse 5 turns to him immediately and explains that the alarms on equipment are simply there to tell nurses that something needs attention, and are not in any way an indication that something is wrong. As she gives this explanation Mr Williams looks up to the monitor and Nurse 5 anticipates his questions, and begins to slowly and sympathetically explain to him what the monitoring is telling her. In all of this I am struck by the way in which she picks up on the concerns of Mr Williams from his slightest glances and expressions.

Dealing with families and visitors

.....

As the nurse gives her the handover Nurse 5 is facing the nurse and nodding throughout. I am aware that {participant} was in charge of the unit for the morning, and was doubtless aware of the majority of the information handed over. Nevertheless the junior nurse giving the handover begins by telling her the history behind Mrs Williams' admission, and the reasons for admission as the necessary pre-ambule to explaining details about her current support.

.....

.....

Sharing information
(receiving bedside handover)

Once the main body of the handover has been given, the two begin once more discussing the family concerns and the family's recent discussion with the doctors. Although the two are some distance from Mrs Williams, Nurse 5 drops the level of her voice as they hold this conversation. I am also struck that it is only when discussing the information given to her family that the second nurse mentions the likely diagnosis of viral meningitis for the first time. Also during this conversation, Nurse 5 comments that Mrs Williams has a sodium level of 128, and that it was 130 earlier on in the day. {Participant} looks to me and comments in a joking tone that she is "Not sure we can go home now". I am again struck by the fact that the discussion turns to issues relating to diagnosis and prognosis only during, or prompted by, the consideration of the families' needs.

Talking about families

.....

As the two begin the treatment they continue to address Mrs Williams directly, and there is little initial discussion between them as the physiotherapist begins her treatment and Nurse 5 'bags' Mrs Williams. What communication there is between them is achieved economically. After one of the first passes of the suction catheter the physio looks up to ask "Two mls of saline?" Nurse 5 responds that "its there – I can feel it in the bag", and pulls a grim face at the thought. After this brief exchange both practitioners turn their attention once more to Mrs Williams directly and address their comments once more to her. This easy communication between the two continues for the duration of the treatment, and appears to be based on an easy understanding of each others' roles and shared expectations. Many sentences are unfinished "Are you all right to keep on....?" "Can you feel...?"

Assessing breathing / Dealing with breathing problems

(Assisting with chest physiotherapy)

.....

As they continue with the treatment and Nurse 5 continues bagging Mrs Williams, I see her looking around the bedspace. She leans back in order to get a clear look at the equipment at the back of the bed, and appears to be visually checking that emergency equipment is readily available. I recognise what she is doing as her initial "Bedside" checks at the outset of the shift – she is barely concentrating at all as she continues to 'bag' Mrs Williams, although glances down occasionally to check the rise and fall of her chest.

Equipment / safety checks

Once the two are ready to turn Mrs Williams, Nurse 5 once more addresses Mrs Williams to apologise for uncovering her, and reassures her that the curtains are drawn and that she will be covered by a nightie. This information and reassurance is straightforwardly but sympathetically given. As the three of us help to turn Mrs Williams Nurse 5 continues to address Mrs Williams throughout, informing her in advance about every small change in position or movement.

Moving and handling

.....

Once the treatment is completed, the physiotherapist moves away to write her notes. As this happens there is an abrupt change in the pace of Nurse 5's movements. Although remaining close to the bed she turns away from Mrs Williams to say goodbye to the physiotherapist, and is now talking much more loudly. Nurse F addresses her comments to me as well as the physio, and I feel that I am once again within the focus of her attention, whereas this focus was closely restricted to Mrs Williams and the bed during the delivery of treatment. As she chats to the physiotherapist at the end of treatment, I see that Nurse 5 is almost absent mindedly tidying the monitoring cables – not only ensuring that Mrs Williams is not lying on any cables in a way that could cause discomfort, but also ensuring that the cables fall neatly away from the monitor itself and remain untangled and between the monitor and the patient.

Tidying up

Appendix 11: Content Codes

Code	Subcategories
Hygiene needs	
	Giving eye / mouthcare
Saying hello / greeting patients	
Equipment / safety checks	
Using monitoring equipment	
Dealing with distress	Dealing with sickness
Doing ECG's	
Helping patients use the toilet	
Overcoming communication difficulties	
Nutrition / feeding	
Dealing with doctors	Medical review / Talking to doctors
	Medical discussion (between doctors)
	Talking about doctors
	Assisting with procedures
	Ward rounds
Giving drugs	
Doing observations	
	Observing pressure areas
	Measuring Urine
Sharing information	Receiving bedside handover
	Unit Handover
	Handing over information
	Giving handover
Talking about families	
Physical assessment of patients	
Ensuring comfort	
Noticing change	Observing improvement and deterioration
	Noticing alarms
Assessing breathing / Dealing with breathing problems	
	Assisting with chest physiotherapy
	Dealing with ventilators
Working with other nurses	Teaching and learning
	Asking / not asking advice
	Looking out for others
	Discussing priorities
	Comparing assessments
	Getting help
	Talking about patients
Maintaining dignity (or not)	Ensuring privacy
	Maintaining decency

Looking after the tube / trache	
Looking after infusions	Using inotropes
Doing blood tests	Doing a gas
Being organised	Having nothing to do
	Using 'To Do' lists / making a plan
	Clustering care
	Following routines
	Preparing for the unexpected
Suctioning	
Moving and handling	
Managing and using sedation	Waking patients up
Dealing with families and visitors	
Dealing with central lines	
Using guidelines	
Looking after fluid balance	
Extubating patients	
Being bossy	
Tidying up	Ensuring patients are presentable
Episodic care	Clustering care
	Leaving patients alone
	Having nothing to do
Enjoying themselves	Joking
	Having fun
	Social chat
Breaking rules	
Getting the TV or music for patients	
Losing attention	Getting distracted
	Not noticing patients
Commenting on patients interests	
Anticipating changes in medical management	
Dealing with blood pressure problems	
Using medical information	
Looking after NG tubes	
Hearing concerns	
Surveying the bedspace	
Other misc physical intervention	Performing PR examination
	Removing wedding ring
Talking to patients	
Watching patients	
Forgetting information	
Using physiological Targets	

Appendix 12: Extended example of linguistic analysis

In order to illustrate the methods of analysis utilised, an extended commentary / analysis is offered of the following co-texts from these data. Whilst this analysis may appear to involve some strong claims on the basis of these extracts in isolation, it should be recognised that the findings of the study are based upon taking this approach to the entirety of these data.

Field Note Extract

We are looking at the board listing patients' names on the unit which has a name against Bed 10, and yet there is clearly no patient in the bed. I joke to Nurse F that the patient in bed 10 is looking a little thin, and Nurse 5 replies that

"He was the hip yesterday".

There is a short pause before she then adds with a slight laugh

"...but there was more to him than that". Nurse 5 looks up to me and comments that it is horrible "the way we do that", meaning referring to patients as "the hip". I am not at all sure why Nurse 5 should pick up on this point at this time. All nurses in the unit, most particularly during the unit handover given by the senior staff, have referred to patients in this way very regularly whilst I have been on the unit, and yet this is the first time that I have heard any nurse acknowledge that there may be anything amiss in this way of addressing patients.

Field Notes: Nurse 5

Extract from a later interview referring to the above incident

(N = Nurse / participant: Int = Interviewer)

- | | | |
|----|------------|--|
| 1 | Int | okay (.) erm actually just picking up(.) this is picking up a language |
| 2 | | thing again and its another erm (.) its another very common thing |
| 3 | | .hhh there was one day when I made a little joke as there was a |
| 4 | | patients' name on the board and the patient wasn't in the bed and I |
| 5 | | just said who's he he's looking very thin |
| 6 | N | <i>((laughs))</i> |
| 7 | Int | =or something .hh and you said oh he was the hip yesterday |
| 8 | N | <i>[[([loud laughter])</i> |
| 9 | Int | [and then the was a pau- (.) there was <u>pau:se</u> and then you |
| 10 | | laughed and then you said oh there was more to him than that |
| 11 | N | <i>((continued laughter))</i> |
| 12 | Int | and then you actually went on to say why do we <u>do</u> that its horrible |
| 13 | | the way we do that (.) so (.) why is it horrible I mean that's what you |

14 said at the time you did say we all do that (.) oh the hip in the bed
15 N we DO::: erm
16 Int why w- well I mean (.) [not so much why we do it
17 N [because
18 Int =as why we think it's horrible to do it .hhhh
19 N Well its just so::: (.) you know (.) th- that was a patient that was a
20 per:son
21 Int mm mm
22 N and to just completely sort of break them down like that and its
23 becom- you know s- >you know< (.) I s- y- I suppose (.) working in
24 this environment it's a very medical environment
25 Int mmm
26 N and quite often I will say to the doctors so and so as in name them
27 and they'll go which bed is that?
28 Int right (.) really erm ↑mm
29 N so you have to then say (.) bed three the laparostomy or whatever
30 .hh and more often than not I think as nurses we try to cert- I-I'm
31 not saying we're perfect I mean we do still say oh that was the hip
32 from yesterday .hh (.) I think more than doctors we do try and
33 personalize ((*short laugh*)) the poor patient (.) but we are
34 challenged on a daily .hhh so we pick up on it (.) but it i::s that was
35 a person
36 Int yeah
37 N hh .hhh you know he happened to have had a hip replacement or
38 whatever but he was a person at the end of it .hh ((*laughing*)) so to
39 just depersonalise him as being a hip in a bed is pretty horrible

Nurse 5: Second Interview

Discussion

In a dynamic reading of this text, the first noteworthy aspect of the interview transcript is the laughter at lines 6,8 and 11. This laughter appears to indicate some form of 'trouble' for the participant as she recognises the description of this patient as "the hip" although the nature of this difficulty is more difficult to articulate given that the laughter may fulfill a number of functions. On one analysis, the laughter means that the nurse may legitimately avoid taking her turn at talk until the interviewer formulates a specific question. An alternative explanation is that the laughter itself represents her recognition of the tension between the description of the

patient as “the hip”, and her acknowledgement that this is both “horrible” and “common” within the discussion recorded in the field notes and her subsequent affirmation of this at line 15.

At line 19 the participant hesitates and then repairs her answer to why she characterises this as horrible. The phrase “that was a patient” is reformulated as “that was a person” with (stress on the word person) on line 20. This statement serves to contrast ‘a person’ with the description of the patient as ‘the hip’, and her reformulation of this statement suggests a distinction may be drawn between ‘patients’ and ‘persons’ and suggests that it is more inappropriate to label a ‘person’ as “the hip” than it is to so label a ‘patient’. A Discourse of a ‘person’ is therefore invoked in contrast to another (as yet unidentified Discourse) which refers to the patient as “the hip”.

At line 22 the d(D)iscourse of ‘the hip’ is associated with “breaking down” before the participant again appears to encounter difficulty and hesitation at line 23. This may be understood as reflecting the fact that the participant takes a stance which is clearly condemnatory of this “breaking down” Discourse of “the hip”, and needs to maintain an identity as somebody who would not wish to refer to patients in such a way whilst explaining her own previous use of the phrase.

This balancing is achieved between lines 23 to 29 as the participant elaborates her response by reference to the “medical” environment, and reference to the necessary communication with “the doctors”. In doing so, she dissociates herself from the Discourse of “the hip” which is now characterised as “medical”. By characterizing this Discourse as ‘necessary’ she acknowledges the authority and power of this medical Discourse (or at least implicitly acknowledging her own inability to resist it) in the claim at line 29 that “you have to then say”. This “medical Discourse” is further characterised in line 29 through the utilisation of technical terminology – “the laparostomy”.

Overall, the participant in this extract is seen to position herself in regard to an identifiable Discourse which may be characterised as medical, and which has features of “breaking people down”, which uses a specialist / technical vocabulary, and which is clearly heard as a prevailing discourse associated with power and authority.

The existence and nature of this Discourse is unsurprising, but serves to highlight the ways in which it is characterised by and resisted by this participant. In lines 30 to 35 this participant begins to articulate a counter Discourse to the earlier “medical” Discourse. She begins to speak for what

“we” (i.e. nurses in general) do and implicitly therefore to contrast this with what doctors do. This “nursing” Discourse is clearly heard as attempting to resist the prevailing Discourse but as being relatively powerless through the way in which “we” are characterised as “trying” to do things, or of being “challenged”. It is also notable that there is no evidence within the field notes that this participant showed any hesitation in referring to the patient as “the hip”, but that this Discourse which characterises ‘what nurses do’ emerges from the way that she talks about practice rather than from what was observed.

As well as indicating the relative power status of the two Discourses, the “nursing” discourse is clearly orientated primarily to what nurses themselves do (or to what nurses *say* they do). The focus of her discourse is upon what “we” do, or try to do, rather than upon what the patient “is”. This is most clearly evident in the use of the terms “personalize” and “depersonalize” in lines 33 and 39 where personalizing and depersonalizing are presented as active verbs.

Within the terms of this emerging Discourse it therefore appears that ‘a person’ is something that nurses create in their discourse, as opposed to (for example) being something which nurses see or recognise. The phrase “the poor patient” in line 33 appears as an expression of sympathy, but may be heard as one which serves to infantilise the patient and further reinforces their lack of ‘voice’ within this discourse which focuses upon what the nurse does. The repeated use of the term “person” in lines 20, 35 and 38 further suggests that personhood is a central concern within this ‘nursing’ Discourse. This counter discourse may therefore be characterised as a discourse of “Nursing”, and is one which is relatively powerless, has its focus upon what Nurses do, and particularly values the work which nurses do as involving care for “persons”.

Appendix 13: Completed proforma characterizing one Discursive formation / Discourse

A Discourse of (IN)STABILITY
Topic, entity or process constructed <p>This Discourse serves to construct the primary requirement for the nurse to maintain the safety and physiological stability of the patient.</p>
Nurses role / identity <p>The nurse's role is to maintain the safety and stability of the patient through observation of the patient (primarily through the use of monitoring and technology) and through their knowledge to control detailed aspects of the patients' medical treatment (e.g. infusion rates / ventilator settings). The nurse's primary aim is to "achieve" physiological "targets" or "parameters" (which define the patient as stable) and to observe the patient in order to ensure that these targets are "maintained" so that the patient is safe.</p> <p>In achieving and maintaining targets the nurse acts as an agent of the institution and with relatively little autonomy. Targets are set by others (usually medical staff) and within the terms of <i>this</i> Discourse it is not the nurse's role to question or consider the relevance or appropriateness of these 'targets' in relation to the patients evolving clinical condition. The nurse is delegated the authority to alter aspects of the patient's medical management only within parameters that are set by others. Consequently the nurse has limited personal accountability for the patient outcome, particularly for any longer term outcome.</p> <p>As the physiological stability of the patient is constructed as the primary concern, the nurse is not required to demonstrate any form of emotional or affective involvement / engagement with the patient.</p> <p>Although this Discourse may threaten the nurse's identity as an autonomous practitioner, the ability to maintain patient safety and stability is central to the way in which critical care nurses identify themselves as capable and expert practitioners. High levels of cognitive engagement, 'know-how' and concentration may be required to achieve or maintain patient stability, and the ability to maintain stability of the patient may be a source of pride in the nurse's expertise, or even be exhilarating as nurses experience an 'adrenaline surge' in performing this role. Conversely, anxieties over the stability of patients can be a source of major anxiety for less experienced nurses.</p>

Patient role / identity

The patient is constructed as a series of discreet physiological systems which are relatively unpredictable. The short term (minute to minute or hour to hour) future of the physiological organism is unknown as the patient may “go off” or become “compromised”, and consequently the patient is treated as a being which needs to be controlled in order to maintain stability and safety.

The focus on maintaining stability and on achieving ‘targets’ means that the patient is primarily known about in terms of precise, numeric and quantifiable information. The patient is not constructed as embodied as their stability primarily relates to the way in which their internal physiology is represented / constructed through the use of technology. The patient is recognised as a unique being only to the degree that nurses may “know” the patient in the sense of knowing the patients typical physiological responses, but the personality and subjective experience of the patient are not attended to. As the nurse’s role is to control aspects of the physiological organism, the patient is not recognised as being an autonomous being.

The focus of this discourse on the ‘here and now’ stability of the patient means that both the history and future of the patient are disattended. The patient has no ‘narrative’ identity and is not acknowledged as having a personal identity or societal roles.

Function of the discourse and relationships between its elements

Together with maintaining patient safety, keeping patients ‘stable’ is recognised as being an overriding priority of the organization / institution. The particular focus on safety and stability appears as a particularly powerful Discourse within the critical care unit (or is unique to it) and is therefore a source of particular anxiety to inexperienced critical care nurses. As such this discourse serves an institutional need, and the formal coercive power of the institution is the source of authority as the nurse is held accountable only for whether they have maintained the parameters / targets they have been set. Nurses feel that they ‘fail’ or ‘succeed’ in relation to how well they maintain / achieve targets (or whether they have ‘mended’ or ‘broken’ patients).

Ideological functioning and relations to other Discourses

The Discourse is closely related to the Discourse of routine working practices, but differing in the focus being on the patient’s stability rather than on purely enabling the institution to function.

This Discourse asserts the power of the institution over the nurse, and therefore conflicts with Discourses which emphasis the professional role or the ‘medical’ expertise of the nurse. The power of this discourse however means that nurses may find that they become “bogged down” in “technology and numbers”.

There is also clear dissonance between this Discourse and those which emphasise the holistic nature of nursing, or recognise the personal identity of the patient. The Discourse of stability will often be acknowledged as the more powerful, and justified by appeals to 'prioritising', although these alternative Discourses may mean that the nurse should acknowledge the patient in some degree to avoid appearing "insensitive".

Context or Activities typically involving the discursive practices constituting the Discourse

Care of ventilated ("ITU") patients.

Undertaking and recording observations

Situations constructed as being particularly 'high risk' (piggy backing inotropes; "going for the tube")

Administering aspects of 'medical' treatment (e.g. fluid administration; changing inotrope rates; giving oxygen)

Second part of the nurses handover (i.e. focused on current status and support. Usually introduced "so today" "CVS wise" etc)

"Stepping back" into a monitoring role to review monitors etc (e.g. when a second professional is 'with' the patient or undertaking a procedure)

Specific linguistic features of the Discourse

Nurses physical presence within the bedspace is necessary at all times (as this is equated with safety)

Monitoring / technology are primary channels or modes of discourse

Lexicality / vocabulary

"Parameters" "targets" "achieve"

"busy" patients; "easy" patients"; "not much going on"

Patients may "go off" or "be compromised"

Precision and quantification

"mending" and "breaking" patients

Discourse will downplay the agency of the nurse in determining goals:

"I need to ..."

"they want"

Appendix 14: Unit Guidelines for “safety checks and handover”

Guidelines for bed safety checks

- 100% non re-breath face mask
- Resuscitation ambu bag & face mask
- Suction catheter & bottle (check if it works and that the bottle is not full!)
- Yankeur suckers
- Soft suction catheters
- Full chart checked and signed (including prescription signatures)
- Alarm limits; ventilator (including mode/parameters) & monitor
- Identity band on patient
- The patient!!!!

Extras to consider

- Water circuit & angle connector for ventilated patients requiring physio
- Tracheal dilators
- Spare tracheostomies (one size the same, one size smaller)
- Geudel airway (correct size)

NB A tidy bed space is a safe bed space

Please ensure that wires/infusion lines are as tidy and as knot free as possible. Also ensure that there is easy access to the back of the bed space for emergency procedures/resus. (Health & Safety At Work Act 1974)

Guidelines for bedside handover

- Name & age
- Days since admission
- Relevant past medical history.
- Reason for present admission.
- Next of kin.

Brief summary of events - Intubated/extubated investigations etc (it is not your responsibility to list every single event)

(Work through the observation chart!) Current state regarding:

- Airway
- Breathing
- Circulation includes fluid balance
- Renal
- Blood glucose/neuro status
- Drains/wounds/pressure areas/dressings
- Infection risk
- Resuscitation status
- Other issues-family/social
- Plans: Today & Future

Work through current drug prescription printout.

Infusion checks:

- ✓ Prescription & parameters
- ✓ Rate/Concentration
- ✓ site of infusion / compatibility



Appendix 15: Practice background of the participants

Within the text of the thesis, participants are referred to as Nurses A-G or Nurses 1-7. As a further measure to ensure the anonymity of informants, these practice backgrounds are presented here independently of the participant to whom they refer.

The backgrounds of the three “inexperienced” nurses were as follows:

- I. Completed her initial training with an undergraduate degree in the UK, and prior to working in ITU she had worked primarily on a surgical ward. She had been qualified for 2 ½ years at the commencement of the study, none of which had been spent in critical care areas.
- II. The least experienced nurse within the study overall who had qualified as a nurse with a degree in nursing from the local university only three months prior to the study.
- III. Had been qualified as a nurse for 13 years after training in her home country overseas. She had gained post-qualifying experience in a range of clinical areas including a medical ward, outpatients, and psychiatric unit for children. Since moving to the UK she had worked in a rehabilitation setting, a respiratory unit, and most recently on a ward specialising in surgical ward environment. She had no prior experience of critical care.

The backgrounds of the 4 more experienced participants were:

- IV. Had prior experience working in Emergency Department and medical ward environments. She had begun work on the critical care unit after moving to the region just over three years prior to the study and had completed her ENB100 equivalent ITU course approximately a year before commencement of the study.
- V. Had originally qualified as an Enrolled Nurse before undertaking an RGN conversion course. Apart from a 3 year break, she had worked on the unit for all 27 years that she had been qualified. Although considered part of the ‘expert’ group this participant had never undertaken a specialist Intensive Care Nursing qualification.
- VI. Had been qualified for six and a half years in total, and had worked on the unit for 5 years at the commencement of the study. She had completed her ENB 100 equivalent course three years previously.

- VII. Had been qualified for 15 years after having completed her training as an RGN. At the commencement of the study this participant had worked in critical care nursing for 13 years, and had obtained her ENB100 approximately 10 years previously. She had been working on the unit for just under three years.

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