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Searching For Intuition: Discovering The Unsayable Within Discourses Of Nursing Practice

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ABSTRACT

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SEARCHING FOR INTUITION: DISCOVERING THE UNSAYABLE WITHIN DISCOURSES OF NURSING PRACTICE

by Mary Olivia Gobbi

This study outlines a hermeneutical journey which investigated the contested concepts of intuition, reflection, thinking and knowing- in -action. Situated within the 'world' of nurses and their patients, participant observation enabled the lived experiences and narrative accounts of four registered nurses to be explored and analysed. When the traditional methodological frameworks associated with ethnography and participant observation proved inadequate, the author drew upon insights from postmodernism, discourse analysis, Nightingale and Foucault to develop and evaluate the study.

Three significant points emerged.

First, an epistemological discourse of the grey/rainbow is encountered. This discourse acknowledges that 'all cannot be said'.

Second, it is argued that intuition refers to a signifying process which enables the practitioner to indicate a particular state of being of Self to Other.

Fieldwork evidence suggested that when registered nurses 'know' in practice, they utilise a range of searching activities which orientate the Self/Other, thereby enabling plurisensorial, embodied knowing/doing to contribute to their judgements. This process, named actioning, may be accompanied by *silencing* and a nursing equivalent of *regard (gazing)*. Finally, nursing is portrayed as a bricoleur activity which predates the 'post modern', incorporates the modern, and struggles to express itself within the constraints of a Cartesian Discourse.

LIST OF CONTENTS

cont. LIST OF CONTENTS

cont. LIST OF CONTENTS

cont. LIST OF CONTENTS

cont. LIST OF CONTENTS

LIST OF TABLES, FIGURES AND RELEVANT VIGNETTES

LIST OF APPENDICES

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CHAPTER 1

THE PROLOGUE

1.1 Introduction

This thesis is located within the 'world' of nurses and patients. The study constitutes a hermeneutical journey which explores:

Intuition/Reflection/thinking in action in the context of the learning and development of registered nurses in practice.

The vehicle for the journey was participant observation which revealed something of the lived experiences of 4 registered nurses (V, T, P and myself) during regular, short incursions into their respective fields of practice. Researching as a *bricoleur*[1] who struggled with Cartesian/positivist constraints, I was encouraged by the writings of Ely et al. (1997) and Parker (1997). When the traditional formats for a thesis construction led to inadequate representations of the person studies and the research process, I adopted the structure outlined in Table **1**. The rationale for this modification is that:

- attempts to utilise the traditional format led to unnecessary repetition of themes, concepts and argument and consequently hindered the development of a cohesive narrative;
- the fieldwork experiences necessitated a critical reappraisal of the initial literature review, challenging existing methodologies concerning the role of the researcher in the field;
- locating the person studies sequentially before the literature review enables the reader to be contextualised and familiarised with the issues which are subsequently debated;
- the approach enables a dialogic interaction between the various stages of the study's development;
- the sequence is commensurate with the author's position as researcher. It represents the primacy of action, her stance as bricoleur and mirrors the problems which arise when researching contested topics like intuition within a nursing context.

[1] According to Van Maanen (1995), Levi Strauss refers to the Bricoleur as a modest collector of bits, pieces and fragments.

Table 1. Two modes of representation

'Traditional' Format	This Thesis	Thesis structure and content
Abstract	Abstract	Abstract
Introduction (pertinent context).	Introduction (pertinent context).	Prologue (chapter **1**). Orientation for the reader, the nursing context (chapter **2**).
Literature Review.		
Method, study design and intended analysis.	Orienting the reader to the problems of investigation.	Investigating the tacit, intuitive, reflective, and knowing -in- action (chapter **3**).
Account of the empirical work.	The process of investigation.	Doing It: the preparation and process of the person studies (chapter **4**).
	Account of the empirical work.	The Person Studies: accounts from the field (chapters **5, 6, 7**).
Findings.		
Evaluation of the study.	Analysis and method justification.	Justifying the empirical work. Exploring and challenging existing models of investigation, participant observation, and discourse analysis (chapter **8**).
	Literature reviewed in the light of the fieldwork.	Discourses of the unsayable: Searching and Orienting Self/Other. Reflection/thinking/knowing in action (chapter **9**).
	Findings.	Winnowing, Journey's end: or which tales to tell? (chapter **10**)
Implications and conclusions.	Implications and conclusions.	The Epilogue: Future Tales for education and practice (chapter **11**).

Whatever format is adopted, it is recognised that attempts to achieve a 'seamless narrative' (Potter, 1988) may change significant aspects of the Tale. It is rather *which* Tale(s) is/are told as the account unfolds (Van Maanen, 1995). To paraphrase Bamberger and Schon (1991: 207), unexpected insight may evolve in my and your world of making sense as we recognise the Tale through the making of the Tale itself. Van Maanen (1988) discusses how, as the writer of this text, I am also its privileged reader and 'within limits', the only one to speak with some

advantage and special authority on my intentions and textual assumptions. Whilst this is a powerful assertion of authority and to some extent denies the author's capacity for deception, it facilitates a style of conviction and confidence which may convince the reader if not the author, the paradox in producing a *bricolage*.

Through accounts of the empirical work and literature, the study explores those debates which concern learning the 'intuiting', 'thinking', 'reflecting', 'knowing', 'seeing' and 'doing' of nursing practice. I shall argue that British nursing demonstrates both modern and post-modern features. Nursing is inherently a bricoleur activity which arises when the deficiencies of positivism were already apparent.

> But how will you look for something when you don't know what it is? How on earth are you going to set up something you don't know as the object of your search? To put it another way, even if you come up right against it, how will you know that what you have found is the thing you didn't know? (Meno to Socrates, 1966: 128[2]).

Meno's dilemma persisted throughout the preparation and development of the study and is especially pertinent when considering whether nursing, like virtue, can be taught/caught. For example:

1 How will I look for intuition/reflection/ thinking in -action if I don't know what it is (they are)?

2 How will I set up something I don't know as the object of my search?

3 How will I recognise intuition/reflection/ thinking in -action should I come up right against them (it)?

The first point is traditionally addressed through a literature review. Here one's reading and interaction with the texts of others enables the investigator to formulate, albeit perhaps tentatively, a working hypothesis concerning the nature of the topic (s) under investigation. However, as chapter **9** clearly demonstrates, the slippery, contested and multifaceted nature of the umbrella concepts of intuition, the tacit, reflection and thinking -in- action, produced a variety of hypotheses. Indeed, the universality and existence of the concepts is questioned. Although the

[2] From Plato: The Meno, Gutherie edition.

study inevitably forayed into the philosophical, it is not *essentially* a philosophical thesis and thus it required a strategy which would enable *investigation* to commence- the second problematic of the Meno. Chapter **3** discusses the dilemmas associated with designing an empirical study to analyse intuition, the tacit and thinking. Literature review and the 'in action' dimension supported the adoption of *participant observation* as the investigative tool.

The third, and possibly most challenging problematic was the *recognition* of intuition/ reflection and thinking- in- action. Whilst questions arose concerning the *specifiable* nature of these concepts, chapters **3** and **8** demonstrate how applying insights from *discourse analysis* enabled these elusive concepts to be addressed and analysed.

In Socrates reply to Meno, he pointed out the trick question that:

> He would not seek what he know, for since he knows it there is no need of the inquiry, nor what he does not know for in that case he does not even know what he is to look for (1966: 130).

The study endeavoured to search for both the known and the unknown. Indeed, a particular irony is the *uncertain* and *unsayable* nature of nursing practice itself. Chapter **2** considers the implications of Nightingale's (1969) statement that she uses the word *nursing* 'for want of any better', asserting that the very elements of nursing are 'all but unknown' for both the well and the sick. Over a century later, contemporary discourses reveal a consistent struggle to discover the nature of nursing, to define, classify, and delineate it. The prize is a privileged knowledge base which could accord to nursing status as a profession. Chapter **2** locates this struggle within the socio-economic roots of nursing history (see Baly, 1995). Recognising the unsayable and the plurisensorial gaze of the registered nurse in early fieldwork experiences generated a review of Foucault's 'La Clinique' and a return to Nightingale's 'Notes on Nursing' (Chapter **9**).

The empirical work depicts scenarios of life, death and the struggle to care, when practitioners operate in the 'grey'. The individual tales[3] reveal the tensions evoked by discourses of case and person as they conflict and interact when nurses strive to act with a sense of rightness. It is proposed that this analysis of nurses

[3] The Tale will refer to the constructed narrative/plot of the Thesis, tale with a small case 't' refers to individual accounts and sub plots.

and nursing reveals an epistemological discourse of the grey/rainbow. Where Foucault argues that medicine solved the problem of the dead body, it is nursing practice which deals with the problem of the (live) body or somology (see Lawler, 1991). Medicine offered to positivism the discourse for dealing with death and by implication provided the body as Object. It is argued that nursing may offer discursive strategies to deal with 'the grey/rainbow', the 'living', the 'embodied' and the 'invisible'.

Given the historical and contemporaneous impact of Schon (1983), the Dreyfus brothers (1986) and Benner et al. (1984, 1992, 1996), observations of the study participants were contrasted with the work of these writers. Particular reference is made to the 5 stage model of skill acquisition developed by Dreyfus and Dreyfus. Chapters **5, 6** and **7** summarise the person studies of V, T, P, and outline my interaction with them. These individual person studies underpin the overall study. Their impact generated a reappraisal of seminal texts concerning participant observation, ethnography, discourse analysis and intuition, reflection/ thinking- in -action (chapters **8** and **9**).

The study endeavours to be reflexive, analysing its origins and destinations. Attempts are made to reveal the implicit and explicit assumptions and textual readings which shape the construction of the study. This construction incorporates through assimilation, reproduction, generation, and emulation, various accounting practises and repertoires, recognising the inevitable influence of the Cartesian legacy in discourse and the author's stance as bricoleur.

1.2 Researcher -as -bricoleur: implications when constructing the text

Denzin and Lincoln (1994) argue that the qualitative researcher's role may be likened to the *bricoleur* producing as the textual product *a bricolage* which is:

> a complex, dense, reflexive, collagelike creation that represents the researcher's images, understandings, and interpretations of the world or phenomenon under analysis (p3).

Through researching -as- bricoleur, the thesis exposes the struggle to work 'between and within competing and overlapping perspectives and paradigms' as the encounter with the texts of others and self exposes me to the 'diversity of ontologies, epistemologies and methodologies' expressed in a multiplicity of genres

(Denzin and Lincoln 1994: 3). Chapter **8** discusses the effect of these genres whose discourses reveal temporality, space and context culminating in 'messy' texts. However, for the purposes of this thesis, there is a perceived requirement to produce a 'seamless' coherent account with explicit knowledge claims, rather than these 'messy' texts outlined by Marcus (1994:568 in Denzin and Lincoln op cit.). As Marcus argued, 'messy' texts are interesting because they are symptomatic of a struggle to produce 'unexpected connections' and 'new descriptions of old realities'. However, my texting is a struggle to account for that which has no definition (nursing) and that whose existence and nature is contested (intuition/reflection). Through explicit acknowledgement of the ethical, political and epistemological dimensions to this research, there resides the possibility of knowledging that which is within, and between, nurses and their practice. The educational implications of the study are debated in chapter **11**.

So as the Prologue unfolds, let a Tale and tales commence.

1.3 Study Origins

The thesis originated when I encountered the writings of Argyris and Schon (1974) and Schon (1983, 1987). Initially Schon's metaphors seemed attractive, enabling easy identification with the 'messy, uncharted waters' of my experience both as nurse and educator. Furthermore, Schon's critique of the dominant techno-rational influences and his exposition of the artistry in professional practice resonated with experiences in a health care system dominated by medicine and an emerging market ambience. Nonetheless, I was left with niggling doubts relating to exemplars from practica which were dissimilar to 'my' world of people, illness, emotions and technology. Indeed, socialisation as a nurse and nurse teacher left me uncomfortable with the language of cases, problems and frames. However, a span overseas engaged in development work across a wide spectrum of professional education and vocational training ensured that I did not begin to address these doubts until my return in 1992 when 'challenged' to do so as a research student. Whilst I had incorporated elements from Schon's work in my own teaching, I was surprised to discover that not only was 'reflective practice' topical but it had become, as Jarvis (1992) aptly argued, a 'bandwagon'. Lauder (1994) likened nurse education's adoption of reflective practice with the pursuit of the 'Holy Grail'. Indeed, as

argued elsewhere (Gobbi, 1995) one questions whether these reflective exercises genuinely reveal theories- in- use and a body of nursing knowledge/knowing. If so, they may convert Plato's 'right opinion' into knowledge via the tether of public approbation and scrutiny.

Socrates posited that teaching does not exist, there is only recollection. Knowledge arises from questioning, not teaching and 'so a man who does not know has in himself true opinions on a subject without having knowledge' (Meno, 1966: 138). True opinion is distinguished from knowledge by 'tether', a process which occurs when the reasoning behind true opinion is established. When the reasoning is elicited, true opinion becomes knowledge, 'and that these two, true opinion and knowledge, are the only things which direct us aright and the possession of which makes a man a true guide' (Meno, 1966: 155). This assertion has historically located nursing as only having uncharted 'true opinion', and inhibited nurses from attaining the status of 'true guides' due to the absence of a systematic, legitimated body of knowledge.

Exploring Schon's work and delving into the writings of Polanyi, Dreyfus and Dreyfus, and Benner, I became increasingly interested in the developmental aspects of professional practice, the tacit, and the intuitive. This early literature review provided a focus for enquiry and identified some of my underpinning assumptions. These queries and hypotheses which subsequently 'launched' the empirical work are outlined in table **2**. They emphasise the traditional epistemological question which became a reference point for the study, namely:

> What is it that the competent practitioner knows when s/he engages in practice and secondly, how has s/he learnt whatever it is that s/he knows?

Table 2. Queries and informal beliefs: Spring 1993

1	Can the educator practitioner make sense of/identify the professional's thoughts- in-action so that the profession may gradually articulate itself to itself and its novices?
2	How relevant is Schon's model given that it is itself cognitive, logical and rational? Nursing operates within the contexts of applied science, bureaucratic institutions, and within the inter/ intrapersonal zones of practice.
3	The 'feelings' of knowing may be determined by theories in action, but this approach seems to negate the interplay between the 'humanness' of the person, the theory, the context, the options and other affective pressures.
4	To capture the essence of the reflection- in -action, the moment has to be seen in the action present in the 'real world' practicum
5	The 'real world' situation of the student and practitioner deals with 'real' time. In the action present, practitioners have periods where action takes precedence over reflection.
6	Within the triad of student -teacher- practitioner, it is the dialogue between practitioner and teacher which has often been neglected in the research arena.
7	The knowing held by the competent practitioner may be believed by both the practitioner and other observers. Thus, this knowing is believed to exist, its presence may be recognised, although not identified. The presence of the knowing is seen through the outcomes of the practitioner's actions. The person who may be able to translate or articulate what the practitioner is doing is of course a fellow practitioner: someone familiar with the language, who 'has been there', can understand the context and may know which frames to look for... 'Being there' by implication confers to the other a recognition, a belief in the existence of the experience and its implicitly shared meanings.
8	I considered that Nightingale had encapsulated the contemporary argument concerning the problems of the scientific model, intuitive knowing and the notion of feminine knowing, as represented by nursing knowledge being women's knowledge.
9	From Polanyi, I acquired the Discourse associated with the 'act of hope,' the recognition of the person and the idea of trust.
10	Would it be possible for an observing practitioner to identify their own tacit knowledge through the observation of another, where the notion of reflection as a 'looking at oneself in the mirror' may be applicable?
11	It is the integration of thought in, and to, action that reveals the competent practitioner.

1.4 Retrospective Analysis

The explicit and embedded perspectives outlined in table **2** reveal a commitment to investigating the action through 'being there' and an inevitable tendency to engage with participant observation. Furthermore, I was clearly concerned about attempts to separate thought from action, or more particularly, to rely exclusively upon evidence produced from purely cognitive models. I was expressing a desire to look from within as a nurse, seeking claims about a particular way of seeing that may exist, or at least were being subordinated to other practises. Whilst this was an exciting yet somewhat introspective process, I noted that these presumptions needed to be questioned. At this point, I encountered literature which substantiated some of these positions. Whilst this was both refreshing and liberating, there was an acknowledged danger that I could become too attached to perspectives which I had not critically analysed, but for which I felt an affinity because they articulated my own concerns as a nurse practitioner (i.e. being a 'deviant' who had resisted the extremes of the nursing model/ theorist positions, which I had neatly labelled as being the product of an unthinking compliance with North American influences!). Whilst aware that my socialisation as a nurse would influence the study and would need to be appraised continually for its potential impact, I could not anticipate the manner in which this might unfold.

Analysing aspects of nursing practice associated with discourses of intuiting/reflecting and thinking- in -action is both epistemological and ontological. Thus, like Polkinghorne's discussion concerning the 'academic' and the 'practice' of psychology and the role of pragmatic action, it would be important to 'make explicit' the epistemological assumptions encountered through the research. Indeed, there appeared to be parallels with Polkinghorne's remarks that:

> In developing its own body of knowledge, the psychology of practice created a fragmented collection of discordant theories and techniques. It was the actual interactions between practitioners and clients that provided the data in which the knowledge of practice was built (Polkinghorne, 1992: 146).

This paragraph could easily be paraphrased with the substitution of 'psychology' for 'nursing' with the inference that nursing practice is a postmodern activity. This theme is explored in chapters **10** and **11**. Through participant

observation, part of the source material would be the knowledging practises recounted through self/other, patient/nurse and nurse/other interactions; in other words, the intersubjective dimension.

Mindful of the inevitable delays in arranging access to clinical settings, I continued the preliminary literature review whilst negotiating access. One pre-requisite was the construction of a research proposal for the local N.H.S Ethics Committee and it was for this reason that an explicit 'objective' statement was devised, i.e.

Title of Project

> The learning and development of registered nurses in clinical practice, with specific reference to their use of intuition, reflection/ thinking- in- action.

Objectives of the study and practical benefits envisaged

1 To consider whether the nurse educator can make sense of/identify the professional's thoughts -in - action so that the profession may gradually articulate itself to itself and its novices.

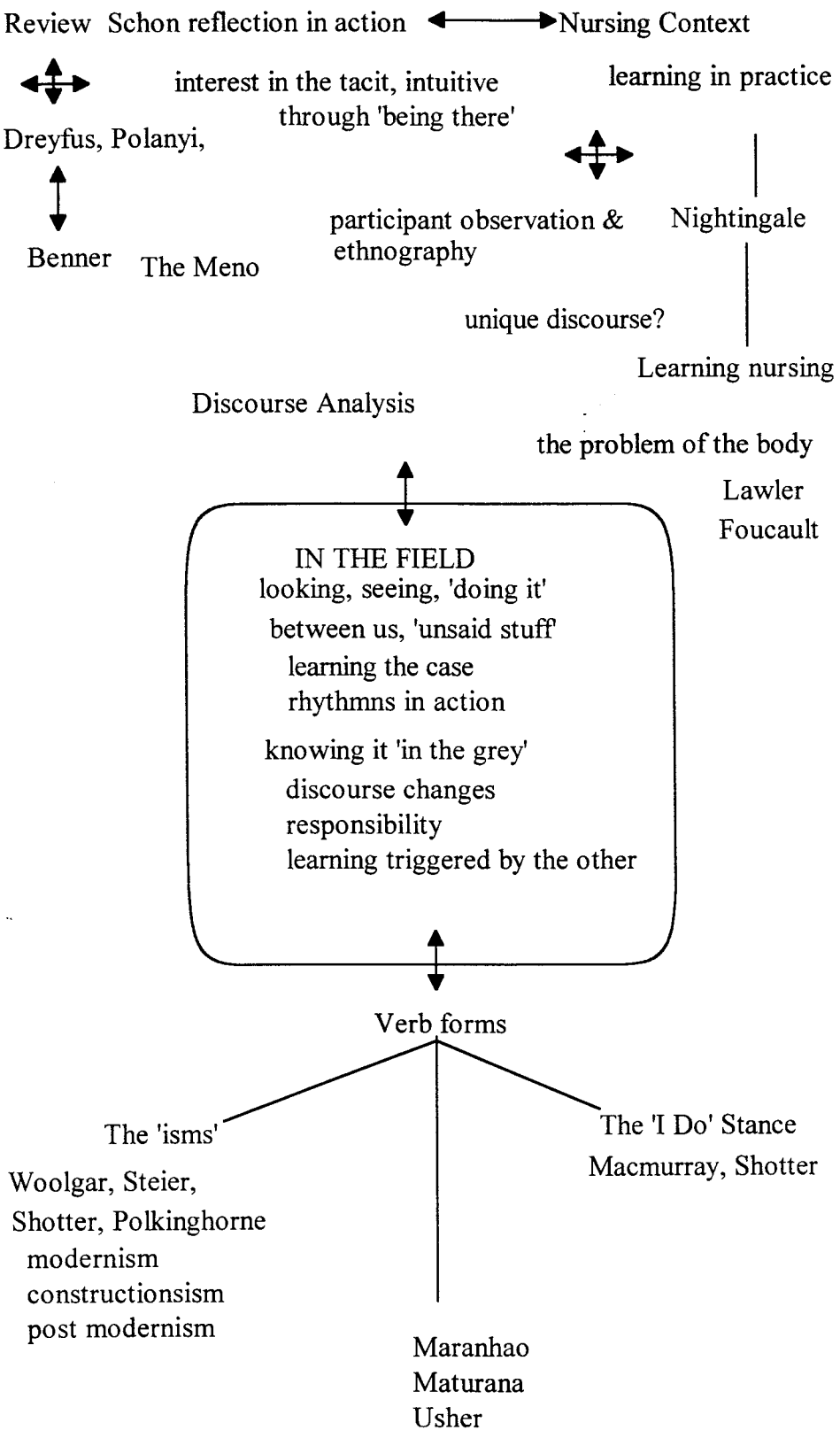
2 To develop strategies which may facilitate the learning and development of registered nurses within the clinical setting.

Whilst the title encapsulated my intentions, the format of the Ethics Committee proposal influenced its construction.

1.5 Summary

The Prologue has demonstrated that any investigation of the chameleon concepts of intuition, the tacit, thinking and reflecting in- action is problematic. This brief introduction to the study has outlined its origins, intentions, and anticipated difficulties. Figure 1 outlines the conceptual and experiential influences which will shape the bricolage. The expedition has been dispatched and proceeds with an exploration of the nursing terrain.

Figure 1. Summary of key influences upon the study



CHAPTER 2

NURSING: for want of a better?

The Problematic of Nursing: Can it be defined? How is it learnt?

> Can you tell me - is nursing something that can be taught? Or does it come by practice? Or is it neither teaching nor practice that gives it to a man/woman but natural aptitude or something else[1]?

2.1 Introduction

This chapter contextualizes the fieldwork setting, the occupational practice of nursing. Given the nature of nursing activity and practice, it is important to situate nursing within its historical context, the development of the professions, women's work, oral cultures, the particular legacy of Nightingale, and some of the ontological and epistemological questions which arise in any consideration of nursing activity. Whilst the chapter commences with Nightingale's perspectives on the learning of nursing, chapter **9** will explore the *nursing gaze/regard* in greater detail.

Not withstanding debates concerning the cultural and historical differences between Ancient Greece and contemporary society, the pedagogical dilemmas raised in the Meno have significance for a practice - based occupation like nursing. As Greenwood (1984) noted, nursing is a practical discipline and 'whatever else it might be is about people, their actions and interaction and as such is a social phenomenon'. However, Dreyfus and Dreyfus (1996), drawing on their study of Heidegger, argue that in the domain of nursing as exhibited by the nurse who is 'expert in caring' there can be:

> no clinical *knowledge* as Plato would define it, but there can and must be clinical *understanding*. Thus, in caring, as in the case of the *application* of medical theory, one finds a practice requiring involvement for which there can be no theory (1996:47).

Furthermore they make an astounding claim:

> Thus, nursing has an even more privileged place among western skills than that of providing an outstanding example of the essential place of practice and intuition in a theoretical discipline. Nursing is also - and this constitutes its total uniqueness - a domain which shows forth clearly that in some human areas there is no place at all for abstract, objective, universal theory, nor for analytic rationality.

[1] Paraphrase of the Meno.

> Besides being the perfect model of a craft (*techne),* the caring practices of nursing provide a paradigm case of skills that have no theoretical component at all (1996: 47).

In chapter **11** I shall dispute some of these claims. However, I acknowledge this view that nursing cannot acquire a unified and codified body of knowledge and furthermore has no place for it. This perspective resonates with aspects of neopragmatism which:

> accepts the postmodern conclusion that there can be no coherent predictive body of knowledge based on a transparent access to an independent reality (Polkinghorne, 1992: 151).

Nursing would thus be located *outside* traditional professional constructs. Given the contemporary drivers for evidence based medicine and practice, the impact of these statements upon the occupational group is profound and is debated in chapter **11.** Let us proceed with a contextual review of 'nursing' and pertinent issues in post registration education.

2.2 Learning Nursing

In the preface to 'Notes on Nursing', Nightingale (1969:3[2]) outlines her definition of nurses and nursing. The nurse is a woman who has 'charge of somebody's health', whilst her knowledge is something that 'everyone ought to have'. This is distinguished from medical knowledge 'which only a physician can have'. Nursing knowledge is that which is 'essential' to care for the sick or to promote health; knowledge one *ought* to have. Nightingale defines nursing knowledge as being:

> .. how to put the constitution in such a state as that it will have no disease or that it can recover from disease.

Nursing is thus largely restorative, nurturative and evidently *know how.* Nightingale describes 'facts which the nurse alone can recognise', attributing them to the nurse's powers of observing and her extensive knowledge of the patient and his circumstances. However Nightingale also considered that 'the very elements of nursing are all but unknown'. She offers hints to the woman who wishes to learn how to nurse, exhorting her to 'teach herself', because she, Nightingale, does 'not pretend to teach her how'. The Notes reveal perspectives on the pedagogy,

[2] The Dover edition 1969 is an unabridged version of an original text dated 1860.

epistemology and syllabus associated with learning, being and knowing as a nurse. Many of these comments refer to what constitutes a 'good' nurse.

2.3 The good nurse

From Nightingale's attributes of the model nurse we find the idea of a/the **nursing gaze/regard**:

> The very alphabet of a nurse is to be able to read every change which comes over a patient's countenance without causing him the exertion of saying what he feels .. ..the nurse.. ought to understand in the same way every change of her patient's face, every change in his attitude, every change of his voice. And she ought to study them till she feel sure that no one understands them so well. She may make mistakes, but she is on the way to being a good nurse (1969:127).

The good nurse has to *learn how to read every change* and thus, by inference, must *learn how to see/sense/observe*. Indeed, Nightingale gives a plethora of plurisensorial examples of what nurses should know, be able to observe, and do. Table 3 indicates Nightingale's passionate attention towards the vision of nursing she was trying to promote. Predating the UKCC's intention to produce the 'knowledgeable doer' (UKCC, 1989), she argued for the 'intelligent' observer, advocating what contemporary writers would refer to as a 'holistic' approach in the context of both the home and hospital setting.

Nightingale believed that it is impossible to learn practical knowledge from any book and, whilst acknowledging the role of the 'home nurse',- she stated that it can only be 'thoroughly learnt in the wards of a hospital'. The importance of experience is evident in these remarks:

> Nothing but observation and experience will teach us the ways to maintain or bring back the state of health... If you find it helps you to note down such things on a bit of paper, in pencil, by all means do so. Perhaps it more often lames than strengthens the memory and observation (1969:113).

Edgar (1993) argues that the virtues associated with the 'good' nurse 'need not be jettisoned'. He proposes that attention to what 'nursing is not' would enable a redefinition of the moral tradition 'free of the subordination that continues to hamper the development of nursing'.

Table 3. Attributes/features of the good nurse derived from Nightingale

• ought to know what a sick human being is
• ought to know how to behave to a sick human being
• ought to know her patient is a sick human being and not an animal
• should have the 'enthusiasm' to follow her 'calling' properly and for her own satisfaction and interest in her patient will look after her patient, initiate observations and action
• this observation must be intelligent and whilst obedience to the physician is necessary, 'obedience alone is a very poor thing'
• observation should be 'tested'
• the nurse should be 'confidential, sober, honest, religious and devoted,.. should respect her own calling,.. be a sound and close, quick observer, and of delicate and decent feeling'
• 'good nursing consists simply in observing little things which are common to all sick, and those things which are particular to each sick individual'
• be a 'clear reporter' who can present the facts from which she derives her opinion
• must be able to enquire into all the conditions in which the patient lives
• would have a knowledge of the sanitary laws (ventilation, warming, nutrition, housing)
• is a good manager
• communicates well
• considers the immediate environment upon the patient (physical, sensory, social and recreational)
• considers the 'mental health' of her patient

Analysts of Nightingale's work (e.g. Woodham Smith: 1950, Bradshaw: 1994, Van Peet: 1995) all testify to her emphasis upon the vocational and spiritual aspects of nursing practice as well as the importance of being a 'good' and 'intelligent' practitioner. The tension between Nightingale's commitment to the vocational spirit of nursing and the secular approach to care advocated by Bedford Fenwick is discussed by Bradshaw (1994). Reference to the spiritual dimension is included not only to prevent its traditional oversight, but to enable representation of fieldwork interactions. Bradshaw (1994) argues that the spiritual dimension of nursing practice may be found through the application of classical theological concepts and the recognition that spiritual care is:

> to be found in the unconditional love[3] of the nurse for her patient because of its foundation in the all embracing love of God; not a separate component of nursing, but its essence and ethical base revealed in the attitude and activity of the nurse's care (1994: 331).

Campbell (1984) argues that this love is 'moderated', a view contested by Bradshaw. The unknown author of 'The Cloud of Unknowing' states that 'all rational creatures' possess two distinct powers; that of knowing and that of loving. Within a secular context one can speculate how/whether a (D)[4] discourse of 'love' might be expressed, and indeed if there are connections between the powers of loving and knowing in respect to 'knowing something is (not) right'[5]. Bradshaw speculates that a covenant[6] metaparadigm for contemporary nursing could be subsequently refined into a pastoral model of care able to:

> unite science and art, nursing practice and patient care, because of its foundation in the love and freedom and order of creation (1994:330).

Bradshaw claims that this covenant paradigm can be adopted for all nurses whether they know the roots of the paradigm personally or not. One difficulty which arises when attempting to research *from* a perspective of nursing is whether such a distinctive frame of reference exists. Collins and Fielder (1981) suggest that the paradigms of 'others' have not been sufficiently developed to incorporate, acknowledge or articulate a nursing world-view. The study is located within the Anglo/American, Antipodean or Western nursing traditions. These traditions are inherently associated within certain socio-historical contexts, roles of women, industrialisation and demography. It is important to acknowledge the global differences in the status and expressions of nurses and nursing, for as Paterson and Zderad (1976: ix) remarked, nursing 'reflects the qualities of the culture in which it exists'. Within the United Kingdom (and many teaching hospitals in particular), the legacy of Nightingale and the associated moral tradition provides

[3] From a theological perspective there is the *distinction between Agape* and *Eros:* the former being a love which gives itself and the latter the erotic/sexual attracted love for another. *Koinonia* occurs when there is a community of agape.

[4] Defined in chapter 3.

[5] Indeed during one observation visit, I over-heard an auxillary nurse referring to a nurse as someone who 'really loved' her patients.

[6] Bradshaw explains: 'a covenant in the biblical sense suggests a relationship which is based on mutual sharing and self-giving, which are grounded in freedom; a personal commitment that holds for both better and worse' (1994: 4).

an intertextual thread to any analysis of nursing practice. Similarly, as Bradshaw demonstrated, one finds the influence of humanistic and existential philosophies within the advocated and articulated models of nursing.

2.4 Doing Nursing: woman's work and an oral culture

The full significance of Agan's (1987) comment that nursing is known by the action verb 'nursing' rather than by a neutral noun, as seen in occupations like medicine, law and education, was not at first apparent. However, I soon encountered fieldwork discourses which focused upon aspects of 'doing' and noticed the preponderance of verb forms in the discourse of practice. The implications of this 'doing' dimension are explored throughout the thesis and offers a particular 'voice/sense[7]' to the study.

The relationships between nursing, women's knowledge, women's work, intuition and verbs like sensing and feeling have influenced both insider and outsider perspectives of nursing and nurses (see Agan 1987, Hagell 1989). Indeed, some argue that nursing has also been subject to the male dominated rule governed norms which emanate from positivism (Street, 1992). Nightingale, perhaps the first nurse researcher, and early critic of positivism, questioned:

> Why have women passion, intellect, moral activity - these- three- and a place in society where no one of these can be exercised? (in Poovey, 1991: 205)

Where Nightingale challenged the boundaries which determined that women *had no place* to exercise particular talents, contemporary authors seek to determine and question the boundaries which *control* the place in and through which women are positioned.

The presence of a strong oral culture within clinical nursing has been discussed by Street (1992) who described a stereotyping of clinical nursing. This stereotype asserts that nurses do not read, think, talk or write about nursing and that nurse managers do not support clinicians, whilst nurse academics have lost touch with practice. The presence of such traditions has major implications for teaching, learning and research especially in relation to the transfer of tacit knowing from one generation to the next. For example, Maranhao (1991) when discussing the impact of the first printed bible writes:

[7] Here the word sense refers to the perceptual awareness of something.

> The flow of meaning which in an oral context goes from speaker to spoken word, in a written context goes from reader/interpreter to text. When speakers are the bedrock of meaning, shifts in significance were shifts in the lifeworld. With the anchoring of signification to readers, a discrepancy was introduced between the changes occurring in the lifeworld and in the text (Maranhao 1991: 242).

Thus it is argued, texting itself may cause shifts in the lifeworld of practice. Benner (1984) refers to 'handed down practices' through which tradition and clinical knowing are transmitted. Benner and Wrubel (1982) discussed how they discovered nurses in a surgical area using 'a shared language of clinical appraisal' concerning wound care. However, when questioned, the nurses admitted that they had not shared their meanings nor understandings of these descriptors, and consequently, as Benner and Wrubel identified, there was not a 'consensus' for this language. Some evidence for an *assumed* shared language, is found within this study as these two brief illustrations from study participants T and V indicate:

T He has a flushed look: you know, 'cerebral.'

V The 'weakness' of it.

These examples suggest the embedded use of aphorisms within the oral culture of nursing, and thus as Kelber[8] suggests, one should question why the aphoristic is privileged. Fischer and Abedi (1990) outline three different types of dialogue through which oral traditions express their discourse as dialogue; namely:

- colloquial oral communication between two face to face persons;
- the Greek etymological sense of cross play between arguments;
- the juxtapositions of points of view in a political struggle for hegemonic control of the interpretation of how the world (in this case nursing or patients) should be seen.

The person studies exhibit these three forms. Being attuned to the discourses encountered within practice and attending to their differential meanings contributed to the analysis. For example:

[8] In Maranhao (1990:77).

> ... talking to Mr X with tuberculosis, I used the word 'case': in this instance it indicated that I was talking abstractly and not about him as an individual. As I said it, I registered that fact (notes July 1994).

This attempt to ascertain whether there was a language in, and of, nursing was an assumption which itself had to be constantly evaluated. So within the preparatory and analytical phases of the research, the motivation to reveal nursing discourses was rather like the analogy of the Janus face: a looking out towards the knowledges and knowing from other disciplines and, a looking - in towards the experienced, articulated, observed, perceived and tacit nursing experience of colleagues and self. As I strove to reconcile the two I began to encounter recurrent expressions and their associated contexts. I wrote:

> Thus to write, to produce the 'text' of this thesis may involve a selection, a choice between polemical forms, or the emergence of a style which may enable these different forms to be accommodated. Any attempt to articulate an 'integrative' approach could seem to be reverting to a pre-enlightenment perspective. Indeed it could be argued that for congruence or integration of the researched and the research, a study of nursing practice and/ or a study of nurses should deal with the representation (s) and meanings discovered between, and of, the 'knowers' and 'knowing'. Smith (1992) speculated that within nursing it is perhaps time to 'affirm and preserve the personal and holistic nature of knowing' recognising that knowing is discovered and created in the interaction of the knower and the known. However, the knower and the known may be 'one' and the same person (Winter, 1994).

This text reveals the appropriateness of discourse analysis, the metaphors associated with phenomenology[9] and a struggle to move beyond the constraints of my usual written style. These muses demonstrate that the concepts of role/self/ other become essential, yet inadequate facets of the study. When these intertextual threads become subsumed within the text they need to be revealed.

2.5 Nursing - an emerging discipline?

Nursing is frequently acknowledged as being an emerging field of enquiry (Gerrity: 1987, Morse: 1991) which, through an inadequacy of research training in nursing, has led to many nurse researchers not only acquiring the paradigms of other disciplines, (see Gortner: 1983, Morse :1991, Bradshaw 1994), but also, as

[9] van Manen (1990: 7) refers to phenomenology as being 'in a broad sense, a philosophy or *theory of the unique*'.

Pearson (1978) argued, 'borrowing and emulating' others. The host departments for nurses are/were predominantly education, philosophy, and the social sciences, in particular sociology, psychology and anthropology.[10] In the context of the UK, Macleod Clark and Hockey (1989:6) described how nurses were 'largely dependent on members of other disciplines, especially the social sciences for the study of their own profession'. Occasionally the discipline was inappropriate for the question posed. Pearson (1978) illustrated this point by citing experimental psychology and time/ motion studies, where, in the former, it is assumed that variables can be controlled and in the latter, that extraneous factors are ignored. Such inherent assumptions within a research tool constructed from either of these perspectives would be incompatible with research undertaken in practice settings where the situational contexts may be the predominant determinants of action (I note my expression of the primacy of the contingent). Indeed in a different context, Shotter reminds us of the dangers associated with disregarding the 'bustle':

> Classically, once we have perceptually foregrounded an entity for study, we are also used to treating it as having its own isolated existence, and ignoring its background; we are used to treating it as existing only in virtue of its continued interaction with its background surroundings (Shotter, 1993:33).

Chapman (1986:15) warned of the potentially detrimental outcomes of nursing being viewed as a secondary agent in larger social processes. She comments that the 'notion that nursing practice and discourse has its own intrinsic dynamism and interest is lost to the social analytical gaze.' This view is echoed by Watson (1985) and Hagell (1989) who suggest that attention should be focused upon the possible significance and effects of methods originating from fields where there is persistent use of words like 'science', 'social', and 'sociology' in the assumed paradigms of qualitative methodology. Morse (1992) argues that it is important to acknowledge that when nurses use qualitative methods for nursing research, the contexts and situations 'generally differ' from those found in the disciplines from which the methods were originally developed. It is therefore necessary to evaluate

[10] Certainly some of the first nursing departments within the Higher Education sector were located within the Medical Science Faculties. However, the recent move of Schools of Nursing and Midwifery from the N.H.S into Higher Education, has witnessed a variety of locations for nursing.

research methods in respect to the contexts from which they are both derived and applied. Greenwood (1984) proposed that:

> nursing theory must be tried, tested and substantiated in practice i.e. the messy, idiosyncratic real world of the wards and community and not some artificial approximation to them.

There is little doubt that early nursing research works were influenced by the paradigm of positivism with its associated western male dominance. New approaches have emerged, especially critical theory and feminist writings which have challenged traditional perspectives; for example - Williams (1989) a UK thesis on ethnography in nursing, Lawler's seminal piece on nursing and the problem of the body (Lawler 1991), Street's (1992) ethnography of Australian nursing. However, these three writers admit to viewing their research through the lens of the appropriate social science, illustrating what Meleis (1991) called the 'out of discipline theorisers' who may or may not be nurses themselves. 'Non- nurses' tended to be social scientists or general educators, for example Menzies (1960). Savage (1995) claims to write as an anthropologist, yet as a former nurse acknowledges that her study was facilitated by insights acquired as a nurse. As the fieldwork demonstrates, I was positioned as both practitioner and researcher, within and yet external to the fieldwork contexts.

2.5.1 Research alliances

As part of the evolutionary process, research 'alliances' were forged with other disciplines originating with medicine, education and the social sciences (Gortner 1983). Gortner remarked that 'reliance on sociological and anthropological techniques has provided a good capability for description, but perhaps less ability to draw associations and causation'. In contrast, she acknowledged Munhall's (1982) point, that experimental or scientific methods may be incompatible with a humanistic, holistic philosophy and therefore should be discarded! Whilst Gortner maintained that nursing's current theory was rationally or deductively generated, with few empirical verifications, she then posited that eventually the two major modes of enquiry may interface. She argued that the profession 'can accommodate' multiple paradigms (analytic, humanistic) and modes of enquiry (naturalist, experimental, historical). This is a typical 'integrative approach' characteristic of

both feminist and nursing traditions. However, Morse (1992: 15) contends that one danger of the 'evolving approaches' or the tendency to 'self teach' is a mixing and adaptation of various techniques and methods which whilst ' "do- able", violates the assumption of data collection techniques and methods of analysis of all the methods used'.... producing a 'sloppy mishmash'. Morse advocated that if such a blending or adaptation were to be done it should be undertaken by experienced researchers and not the neophyte. Whilst the scholars of the 60s- 80s may have employed the research tools of others, nursing Discourse continues to define itself as both Art and Science. One wonders whether this is a claim concerned with the collective acceptance of empiricist and contingent repertories, or a statement of 'difference'. These various claims acknowledge the existence of different styles, forms and philosophies. It may seem inevitable to discover that both 'forms' of Discourse co exist, or were revealed in paradoxical, apparently inevitable, tensions evocative perhaps of wider societal pressures. Lawler (1991) acknowledges the problems that may arise:

> if nursing moves towards non-positivist methods to articulate its knowledge it risks continuing as a marginal discipline for as long as science relies so heavily on positivist paradigms (Lawler, 1991: 225).

Within many western cultures, the legacy of Descartes is the philosophy of dualism. Dualism represents and linguistically constructs reality through two independent principles which are usually binary opposites, for example good/evil, theory/practice, art/science and mind/body. Attempts to move beyond this discursive practice are problematic (see chapter **9**).

2.6 Moving from a practice based discipline to a profession?

In striving to become a profession, nursing theorists are challenged by the ideological drivers in their respective research communities; they may conform, resist or compromise, engage in hegemonic or confrontational activity. Weiner (1990:13) discussed the importance of recognising this link between the origins of a theory and the research process. One difficulty in outlining nursing practice is the variety of social contexts in which nursing activity occurs. Nursing engages with the diversity of human experience between health and illness, from conception to death. Paterson and Zderad (1976:4) describe how:

> nurses not only have the opportunities of co -experience and coresearch with patients the meaning of life, suffering, and death, but in the process they may become and help others become more - more human.

Caring has been defined as the 'central and unifying domain for the body of knowledge and practices in nursing' (Leininger[11]: 1981, Tinkle and Beaton: 1983). Thus whilst the *social processes* may constrain or empower the practicum, they are not the only influences. For as Paterson and Zderard advocate, nursing is an intersubjective,[12] transactional experience necessarily involving both a **mode of being and a doing of something.** Paterson and Zderad are, in discourse terms, exhibiting both the performative and constative aspects of text[13]. Nursing practice is thus essentially an espoused person to person activity and any methodology utilised should inherently recognise this.

2.7 A person based practice

When eliciting common meanings in practice from observation, narratives and interpretative accounts, hermeneutics and discourse analysis are most relevant. As a text and discourse producer who acknowledges that meaning is conveyed, or signified by language, it is important to attend to the words used to describe people. For example, the images conveyed by words like 'respondent' or 'research subject' may appear to objectify and sanitise the personhood of the individual who is co-operating in a fellow person's research. Steier (1991:165) discussed how terms like 'subject,' 'bind us to modes of discourse that place the participative role of those others in more of an input /output mode rather than grounding it in a mutual process'. Polkinghorne (1988:183) stressed the importance of developing approaches to research which could be sensitive to the unique characteristics of human existence, because 'the object of their inquiry, the human being, exists in multiple strata of reality, which though interrelated, are organised in different ways'. However, whilst Polkinghorne recommended further hermeneutic enquiry involving attention to the meaning of narrative, his language is itself 'impersonal', for example the reference that human beings are 'objects of inquiry'. The concept of 'persons in

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[11] Cited Roach (1987).

[12] Adapting van Manen's (1990) reference to the intersubjective, I conclude that nursing is intersubjective due to its relational dimension to the 'other', i.e. nursing does not exist without the presence/relationship of, and between, 'nurse' and 'other'.

[13] As debated in chapter 4.

relation[14] to each other' is a most appropriate analogy. Thus it is argued, nursing may be particularly suited to the challenge of evolving approaches to research sensitive to the person. Nursing has to some extent been the victim of attempts to ignore the characteristics of humanity referred to by Polkinghorne. van Manen (1990:2) argues that the research method should 'maintain a certain harmony with the deep interest that makes one an educator (parent or teacher) in the first place'. To ignore the impact of 'deep interest' is to impoverish the research account through either a lack of attention to the 'pre- givens[15]' of the writer, or the impact of the 'deep interest' when researching.

2.8 Contemporary issues in post registration education and practice

Whilst nurse education is currently located within the Higher Education (HE) sector, its funding is primarily from the N.H.S. within the context of purchaser/provider relationships. Health Services face a future of increasing rapidity of change, and uncertain, complex health care development (WHO, 1997). As Oulton (1997) discussed, professional development in nursing is affected by key transitions in society, health care, the workforce and nursing, i.e. value for money pressures; the demand that practitioners assume more personal responsibility; regulatory changes to ensure continuing competence; alterations in work contracts; moves towards community based services and workforce changes. Quinn (1994) outlines the recent destabilisation of the traditional models of education and training and a shift towards new paradigms of health care education. Bines (1992:18) analyses the moves from apprenticeship models of professional education through a technocratic phase to the current post - technocratic era. The characteristics of the post - technocratic model is one where:

- knowledge is used for practice;
- competence is developed in a 'practicum', which is 'where students have access to skilled practitioners who act as coaches';
- there is a partnership between higher education and employment through contract learning;
- professional tutors work in partnership with practitioner-educators;
- there are developments in research and reflection skills;

[14] A term coined from Macmurray (1957, 1961).

[15] Gadamer (1993) refers to that which is 'pre-given' in each situation.

- there is a move towards integrated courses less bounded by subjects or disciplines.

Other agendas include moves towards multidisciplinary education (WHO: 1988, D.O.H.: 1993); statutory requirements for maintaining effective registration (UKCC, 1994); the emergence of new and specialist roles within and at the borders of established nursing practice (Warr, Gobbi and Johnson, 1997); and those drivers influencing Higher Education (Dearing, 1997). These contemporary factors impact upon both practitioner and educator, shaping and influencing the milieu of their learning environments whether in, or removed from, the workplace.

2.9 Evaluating the research

Several issues arise when one analyses notions of validity, reliability and claims about this research. Whilst it is important to address such questions, it is equally pertinent to cautiously avoid justification per se which may hinder further critical awareness.

As previously indicated, it was appropriate to question the extent to which Plato's 'right opinion' forms part of the intuition/reflection/knowing story. If, as Gutherie (1966:106) suggests, in the 'changing world of experience' there can only be opinion or belief, rather than stable and lasting knowledge, then in striving to be a 'true guide', it would be essential to tease out the 'opinions, beliefs and knowledge' embedded within the praxis. Furthermore, the traditional privilege accorded to knowledge rather than right opinion (Plato), raises questions about the validity and worthiness of types of knowing/knowledge. These issues are most pertinent when researching in this 'changing world of practice' where there are 'unstructured' problem areas (Dreyfus and Dreyfus, 1986) which may necessitate the 'control of emotions' whilst utilising complex knowledge which is 'integrative in the context of particular circumstances' dependent upon both the person and the situation (Lawler 1991:226). The relational nature of nursing is evident and led Benner (1984:42) to assert that nursing cannot be adequately described by 'strategies that leave out content, context and function'. Thus the contextual, contested and constructed nature of the study become significant. One relevant claim is that people cannot be reduced to the 'isolated variables' previously mentioned. Human interactions within social contexts involve a host of 'variables', including those of a physiological origin

which may represent momentary, diurnal or circadian changes in function. One could thus argue that no two moments are ever identical but rather offer the potentiality for distinctive attributes of similarity or difference[16]. Thus, within this study, claims concerning universality or generalisation should be viewed with extreme caution, despite any natural inclination to justify or ponder upon such possibilities in the attempt to achieve Potter's (1988) 'seamless coherent narrative'. It is left to the reader, nurse or not, to judge whether the accounts offered are sufficiently similar to other human experiences as to be in some way representative. The text may reveal *my* notions of representation rather than *yours*; this too becomes subject to analysis, in other words *whose* narrative is being revealed and exposed. Perversely of course, the extent to which an experience by a person must, by definition, be within the universal range of the species capacity to experience may imply that the experience is a particular aspect. As Greenwood (1984) argued, some findings may be generalisable to other situations of a like kind. If a claim is being proposed it is perhaps the extent to which the elements discussed form part of a *communis sensus*[17] within a given culture of nursing. Chapter **8** will debate the connections between text production, interpretation and meaning with particular reference to participant observation.

2.10 Summary

This chapter has offered a glimpse into the many shards and fragments which are located within the fabric of the study. Many of these fragments will recur and be subject to further exploration, for example, the possibility that nursing practice is neopragmatic. The chapter has discussed some of the contextual and historical influences which influence the construction and form of the bricolage. Let us leave the detailed literature review for the present, and begin to engage with the fieldwork and the rationale for its adoption.

[16] Chapter 8 expands upon the status accorded to similarity and difference (Woolgar 1988).
[17] Indeed the acceptance of 'communis sensus' as a concept is itself not without question.

CHAPTER 3

INVESTIGATING THE TACIT, INTUITION, THINKING, REFLECTION AND KNOWING -IN -ACTION

3.1 Introduction

This chapter demonstrates that participant observation, interview and accounts of accounts were inevitable, although not innocent, methods of investigation. The literature review (chapter **9**) confirms that the contested, apparent and frequent interchangeability of the concepts precluded a single definition prior to engagement in the field. Chapter **1** identified the relevant Meno dilemmas. This chapter considers the second and third problematics, namely the search for, and recognition of, these 'unsayable', 'undefinable' discourses/activities. This (re)search strategy was influenced by a critical appraisal of the following themes:

- perspectives on investigating intuition, the tacit, reflection/thinking and knowing in action;
- investigating nurse activity;
- preliminary justifications for the use of participant observation;
- differences between novice and experts;
- the connections between the words uttered and the associated /attributed thinking;
- creating the texts and their analysis (see chapter **8** for a detailed analysis);
- interpreting meaning.

3.2 Investigating the intuitive, tacit, thinking and reflecting in action.

The potential methodological 'headaches' which arise when eliciting the tacit knowledge of the expert are debated by nurse researchers like Meerabeau (1992) and Benner (1984, 1996). They argue that verbal methods alone are not sufficient because practitioners create new knowledge which is not codified or published. Eraut (1985) discussed the problems of authenticity, incomplete memory and tendencies to reconstruct which may impact upon any analysis of 'ongoing thoughts' and post hoc accounts. Whilst Benner, Eraut, and Meerabeau acknowledge the merit of investigating through both observation and the articulated account of action, Dreyfus (1982) argues for the account of the individual rather than the observer:

> Less trustworthy than personal recollection of skill learning experiences, but helpful, is the careful observation of subjects as they undergo real - world learning. Here again reports by subjects on what they have learned are not obviously unreliable, but the changing nature of their mental activity can sometimes be described (Dreyfus, 1982).

The study was designed to include both forms of investigation generating material which was usefully contrasted. Steier's (1991:167) argument that patterns of tacit knowing may 'get unconcealed in conversation', and that attention to stories may reveal 'social ways of seeing and doing' supported the possibility of eliciting 'ways of seeing, knowing and doing nursing' through discourse. This position is supported by Polanyi (1956) and Polkinghorne (1988) who consider that the analysis of narrative(s) can reveal, at a cultural level, shared beliefs and the transmission of values. Ergo, if a function of narrative is to enable the transmission of values, then the 'tacit' elements in such transmission may be elicited through analysis. Extending this concept to the transmission of values and knowledge from one person to another, it was speculated that analysis of the discourse and associated activities may enable the 'tacit' or the 'intuitive' to be revealed. This presumption was supported by those who allude to the connection between discourse, knowledge and expertise, i.e. Foucault (1972, 1973), Fairclough (1992) and Benner (1984, 1996). These arguments supported the viability of the study objective to ascertain 'whether the nurse educator can make sense of/identify the professional's thoughts in action so that the profession may gradually articulate itself to itself and its novices'.

3.2.1 Investigating nurse activity

In seeking to investigate both practitioner activity/performance and any thoughts/reflections/intuitions which were associated with the event (whether preceding, accompanying or consequent to the event), the options within in - patient settings are those outlined by Abdella and Levine (1954), namely:

a) continuous observation by following one individual;

b) continuous observation by staying in one area and recording everything that happens within it;

c) diary keeping by the individuals under study: both during and after duty periods;

d) intermittent, instantaneous observation: work sampling.

Whilst any combination of these four techniques was possible, for essentially practical reasons and personal preference, a combination of a) and d) was employed. It was recognised that other strategies were needed to access the participants' perceptions and interpretations. In conclusion, the study's original aims were to be achieved by:

- direct & participant observation;
- researcher's immediate and recalled experience, thoughts, feelings and behaviours;
- participant's immediate and recalled experience, thoughts, feelings and behaviours;
- pertinent knowledge/knowings gained from other 'informants;'
- material gleaned from tape recordings, accounts of commentaries, interviews;
- analysis of pertinent documents.

3.2.2 Participant Observation

The roots of participant observation as a research activity are primarily those of anthropology and sociology. The respective techniques, vagaries and attributes of participant observation are well documented in the literature from Gold's (1958) exploration of Junker's continua through more expansive commentaries namely: McCall & Simmons (1969), Spradley (1980), Hammersley & Atkinson (1983), Burgess (1984), Van Maanen (1988), Jorgensen (1989), Hammersley (1992), and Atkinson and Hammersely (1994). Gold extended Junker's theoretical conception of the roles of the sociological fieldworker using the two poles of complete participant and complete observer. The term participant observer is traditionally used to describe the observing fieldworker who participates in the life of a group or situation under study. Through daily observations and conversations with the participants, the researcher contrasts the lived experience accounts with the researcher's observations (Becker 1969). The extent to which the researcher actively participates in the field, is concealed, or enacts a formal or informal role are typical variants within Junker's continua. The nature of the relationship between the researcher and others in the field is influenced by their respective role expressions. The expectations of this relationship have evolved from the more behaviourist era of Gold to the recent insights offered by the constructionist, feminist and

postmodernist schools (see Atkinson & Hammersley: 1994, Jordan & Yeomans: 1995, Parker: 1997).

Table **4** contrasts the study intentions with the research situations where participant observation is thought to be appropriate. Jorgensen's summary infers that participant observation methods assume that there is a phenomenon to be discovered and by inference a noumenon or 'reality' to be encountered in its 'natural' state. The predominant criticisms of participant observation arise from contrasts which emerge between the parameters of objectivity/ subjectivity; truthfulness, fidelity, reliability, validity, application and transparency. Claims concerning the general applicability of findings from one setting to another depend upon the degree of 'uniqueness' or face validity between the cultures or persons observed. Chapter **8** explores these issues further when the methodological concepts are addressed.

Table 4. Appropriate uses of participant observation (adapted from Jorgensen: 1989)

• when little is known about the phenomenon *(in this case intuition/reflection/thinking, the learning and development of the nurse in practice).*
• when there maybe important differences between insider and outsider perspectives the phenomenon may be obscured from the view of the outsider/public view *(the nature of the praxis inferred that this may be a possibility).*
• where the research problem is concerned with human meaning and interactions *(the research was seeking to research in the context of practice where interactions between nurses and others was the focus of nurse work. The meaning attributed by the researcher and participants were essential components to the study).*
• when the researcher can gain access to the field of study. *(as a practising registered nurse I was capable of researching 'behind the screens').*
• the phenomenon is sufficiently limited in size and location to be studied as a case *(through observing individuals, they constituted a 'case', although the term infers an inanimate objective association).*

3.3 Meno Dilemma: Identifying the object of the research

Greenwood (1984) remarked that in order to 'identify a thing as a thing of the relevant sort' requires that the person observing the activity should possess the same concept in order to identify it correctly. Consequently, Greenwood argues that nursing research should be carried out by 'insiders', proposing that whilst practice is

> ..specific, local, individual and full of concrete content. It is inherently dynamic. The method chosen to investigate it must therefore be sensitive and responsive to all these idiosyncratic features.

Thus, Greenwood suggests, whilst the settings and situations may be particular, they may be particulars of a kind which may offer the potential to be generalisable to other situations of a like kind. Similarly, Polkinghorne (1988:4) outlines the connections and relationships between perceptions, namely whether they are:

- the same as, or not;
- are similar or dissimilar;
- are an instance of;
- stand for something (i.e. an icon, index or symbol);
- are a part of;
- are a cause of...

Analysing research material in the context of these potential relationships facilitates categorisation and interpretation. It assumes that the researcher recognises the subject matter in some way and that the phenomena exist. Whilst the literature review found no universal agreement about the phenomena, it was possible to identify factors associated with alleged intuitive episodes. These characteristics could be used as potential signposts for analysis.

3.4 Differences between novices and experts

When exploring the *learning and development* of the practitioner, acquaintance with potential differences between novices and experts was necessary, especially in relation to their discourse and performance. It is noticeable that many studies restrict their analysis to the cognitive dimension. Generally speaking differences are elicited through verbal accounts or performance analysis.

3.4.1 Verbalising the rationale.

One technique, 'thinking aloud', ascertains the reasoning processes involved in simulated case studies or problem solving events e.g. Putzier et al (1985) with critical care nurses; Corcoran (1986) with hospice nurses and Boreham (1986) with physicians and medical students. Putzier et al (1985) summarised the respective merits of these approaches: namely that whilst verbal reports may offer indirect evidence of strategies employed, they may not reveal the complete nature of the processes. Simulations are criticised for being incomplete representations of actual patient settings and may not incorporate or reflect the context and personal involvement of the participants when in 'real' situations. However, the influence of 'thinking aloud' or 'verbalising whilst performing' is contested. Benner (1984), Dreyfus and Dreyfus (1986) suggest that the expert's skill may decline whilst verbalising a skill, a position supported inferentially during the discussion on focal and subsidiary awareness[1]. In contrast, Corcoran argues that thinking aloud may enhance clinical decision making, whilst Henry et al. (cited by Orme and Maggs, 1993) suggest that verbalisation does not significantly effect proficiency or efficiency. Greenwood and King (1995) compared the verbal reports of 9 pairs of novice and expert orthopaedic nurses, finding that: (1) 'thinking aloud' does interrupt cognitive processing; (2) the inclusivity and complexity of the concepts used by the novice and expert appeared to be the same; (3) the concepts identified by both groups were 'almost exclusively physically oriented'; (4) experts consistently used more strategies to 'manipulate' the information they possessed. Although Greenwood and King criticise their study, their focus on the cognitive process neglects the possibility of verbal reasoning activity between the nurses. Whilst they acknowledge Ericsson and Simon's (1993) point that 'professionals do not normally think aloud, they think silently', Greenwood and King did not compare through observation the *activities* involved, thereby possibly observing 'silent' thought. They claim that expert nurses do not need to use 'conceptual repertoires of bewildering inclusiveness' in 'mundane nursing activity;' and 'it is the quality of the thinking underpinning everyday practice that critically determines the overall quality of care

[1] See chapter 8.

patients/clients receive'. Unfortunately Greenwood and King overlook the possible interaction between the dormant conceptual repertoires and the mundane!

3.4.2 Analysing performance: The five stage model of skill acquisition (Dreyfus and Dreyfus 1979, 1982, 1986, 1996)

This model was derived from analysis and systematic descriptions of changes in the perceptions of the task environment reported by performers in the course of acquiring complex skills. Table **5** summarises the key features of the Dreyfus model where each stage is characterised by qualitatively different perceptual and/or decision making modes.

Table 5. Five Stages of Skill Acquisition, Dreyfus & Dreyfus (1986:50)

SKILL LEVEL	COMPONENTS	PERSPECTIVE	DECISION	COMMITMENT
Novice	context free	none	analytical	detached
Advanced Beginner	context free & situational	none	analytical	detached
Competent	context free & situational	chosen	analytical	detached understanding & deciding involved in outcome
Proficient	context free & situational	experienced	analytical	involved understanding. Detached understanding
Expert	context free & situational	experienced	intuitive	involved

It was apparent that the developmental references to performance and 'intuition, reflection and thinking in-action' would be useful parameters from which to consider the fieldwork observations and experiences. The following parameters which are detailed in Appendix **1** were subsequently used to aid the interrogation of the fieldwork data (see chapter **10**).

- components/elements
- recognition and concentration
- approach
- salience
- response
- rationality/deliberation

- performance
- judgement
- perspective
- decision
- commitment (understanding, deciding and outcomes)
- locus of control
- awareness
- self evaluation
- teaching/learning implications

In addition, the study was informed by the analytical summaries found in Appendices **2, 3** and **4**. These summaries were constructed from Dreyfus and Dreyfus (1979, 1982 & 1986, 1996) and Benner et al. (1984, 1985a, 1985b, 1992, 1994, 1996).

Dreyfus and Dreyfus emphasise the importance of both analytic and intuitive processes in the professional practitioner's management of complex situations. Skilfulness is considered to incorporate both psychomotor & mental performance. From Dreyfus' perspective, the most critical distinction between the novice and the expert is the difference between the 'detached, rule following beginner and the involved intuitive expert' (1986:50).

Dreyfus and Dreyfus offer various descriptors for states of 'rationality', for example, calculative, deliberative, rational, arational, transitional and irrational. They question the assumption that the ultimate goal is necessarily rational behaviour with its association and connotation with calculative thought. Rather the term **arational** could be used to describe behaviour in which the action is performed without conscious, analytic decomposition and recombination: the latter being a characteristic of the expert (1986:36). Irrational behaviour is defined as behaviour which is contrary to logic or reason. However within the realms of tacit knowing and its accompanying action, the recognised expert may not be able to articulate or exhibit logic or reason, yet is perceived by others to be 'expert' and 'skilful'. This raises the question as to whose judgement determines the nature and value of that which is deemed 'logical or reasonable,' 'rational' and indeed 'skilful or expert'.

Calculative thought is claimed to be predominant in the novice, advanced beginner and competent stages, where the individual consciously weighs the possibilities and probabilities of a given situation. Calculative rationality draws inferences from isolated, and often context free, facts and cues, which then elicit a pre learnt response, akin to classic problem solving. In contrast, with detached deliberation the individual considers the validity of his intuitions, considering these intuits rather than necessarily adhering to the maxims, guidelines and rules normally associated with the present situations or others like it. Furthermore if the expert is to continue to learn then it is claimed some part of the mind must remain aloof and detached.

In challenging or complex situations, the expert may recognise that 'his current clear perception' is the result of an unacknowledged element which is inappropriate or faulty: here the expert may adopt a detached open deliberation which enables the perspective to change in relation to the previously identified salient and non salient features. This ability to envisage other future positions enables alternative solutions to be liberated, in some instances generating a truly creative response (Dreyfus' 1986). Through collaboration with Benner et al., Dreyfus and Dreyfus consider expertise in nursing practice remarking that:

> By "deliberative rationality," on the other hand we mean the kind of detached, meditative reflection exhibited by the expert when time permits thought... nursing skill, unlike say, long range planning, rarely allows much time for meditative deliberation (in Benner et al. 1996: 43).

Thus *time is needed* for meditative/deliberative rationality. Deliberative rationality stands 'at the intersection of theory and practice':

> It is detached, reasoned observation of one's intuitive, practice based behaviour with an eye to challenging, and perhaps improving, intuition without replacing it by the purely theory based action of the novice, advanced beginner or competent performer (1996: 44).

Whilst the portrayal of action is apparently separated from thought, Dreyfus, Dreyfus and Benner (1996) articulate the concept of embodied know- how. In addition, it was important to consider:

- the extent to which expertise may be contextually based;

- whether there might be skills/ attributes which may be necessary as an individual 'moves' through a particular developmental stage;
- the impact of the client to the learning situation in practice, i.e. what might be learnt about and from the patient;
- whether one could distinguish through observation the nature of the 'calculative and deliberative rationalities' in practice.

Finally, the model is not without its critics (see English, 1993 and Eraut, 1994). There are several embedded assumptions which are outlined in Table **6.**

Table 6. The Dreyfus & Dreyfus (1986) 5 Stage Model of Skill development: assumptions within the text.

• It is assumed that the novice has an 'innate ability' and is provided with 'sufficient opportunity' (p20). Progression from one stage to another is contingent upon appropriate experience.
• The model indicates that the individual receives a programme of instruction at the novice stage (p21).
• **'If** the performer is talented, ultimately his best performance will result from the intuitive use of similarity and experience, and he will perform as an expert' (p35). I have highlighted the word ***if*** because it infers a connection between talent and expertise.
• That Dreyfus' work focuses upon the 'unstructured' areas of both decision making and practice.
• Dreyfus' work originated from a desire to investigate aspects of the philosophy behind the development of expert systems/artifical intelligence. Within this debate, the Dreyfus brothers are not without their bias.
• The skills analysed are ***not*** solely psychomotor, but involve the acquisition of mental skills which are integral to the skilful performance of complex activities (also Benner, 1984).
• Not everyone will be able to become experts and move beyond the competent stage. Within nursing this has been stated by Benner (1984) and is inferred by the U.K.C.C. (1994). It is also questioned whether the institutions concerned desire increased numbers of 'experts' (Benner, 1984).
• In the unstructured areas of practice, skilful performance is contingent upon sufficient and varied experience which is contextually bound. Thus an individual may be expert in elements of a role but not in others (Dreyfus 1986:20).

3.5 The connections between the words uttered and the attributed/ associated thinking

The potential for a discrepancy between action and verbalised account *by virtue of expertise* has been demonstrated in the work of DeMaio (1976), Corcoran (1986) and Greenwood and King (1995). Aquinas questioned the assumption that the 'external utterance' signifies a particular intellect or concept (Clark Edition, 1972). Einstein in his discussions with Wertheimer challenges the assumption that we think in words:

> I very rarely think in words at all. A thought comes, and I may try to express it in words afterwards (Wertheimer, 1961:222).

Einstein then wonders whether there *is* a method to understand thinking:

> I am not sure whether there can be a way of understanding the miracle of thinking. Certainly you are right in trying to get at a deeper understanding of what really goes on in a thinking process.

Thus not only are there inherent problematics associated with the assumed simultaneity between words and thought, there is the difficulty of their translation into text, where the handling of dialogue is an inherent difficulty. Swearingen (1990:65) aptly remarked, 'as a form of discourse, dialogue is itself betwixt and between'. He argued:

> **What** is written down and what **can** be written down, as ethnographers well know, are different but enormously powerful determinants of any written record (1990:50).

3.6 Creating the text of the thesis, generating accounts: texting.

Analysing accounts and 'accounts of accounts' naturally involves an engagement with 'texts and talk' inviting consideration of the domain of discourse analysis especially as participant observation /ethnographic activities culminate in texts. Insights from Discourse Analysis (DA) provide a structure from which it is possible to investigate and interpret accounts whether they are encountered in the literature, or generated from the fieldwork. However, the question quickly arose as to whether DA was sufficiently rigorous to deal with an interpersonal activity like nursing which incorporates the two forms of knowing outlined by Steedman (1991), namely: (1) the knowing of person with an associated moral significance, and (2) the knowing of case. Analysis should manage the two forms through a

process of interpretation which resides in the interplay between text and reader (Steedman, 1991). A detailed review and justification for the use of DA is addressed in chapter **8**. Here I outline those accounting practises, definitions and transcription conventions which will aid the reader.

3.6.1 Accounting practises and definitions

The diversity of perspectives and interpretations accorded to the concept of 'discourse' necessitate that both reader and I share a common meaning to the terms 'discourse and text'. Given the nature of the empirical work, 'discourse' was used in its most open sense after Gilbert and Mulkay (1984) who considered both talk and writing as topic and resource for analysis. For the present, the term *discourse* will refer to both spoken and written (including the plurisensorial) material encountered through the thesis. Whilst analysts (e.g. Fairclough 1992, Potter and Wetherell, 1987) tend to be specific in their usage, they readily admit to there being no set procedure for 'doing' discourse analysis. However, each researcher should clearly identify their own process and procedure. Fairclough (1992) for example, distinguishes between the following uses of 'discourse' and 'text':

Text: one dimension of discourse: any product whether written or spoken (but not the visual as might be inferred by Gilbert and Mulkay's analogies)

Discourse without an article is a three dimensional notion whereby:

> Any discursive 'event' (i.e. any instance of discourse) is seen as being simultaneously a piece of text, an instance of discursive practice, and an instance of social practice (Fairclough, 1992:4).

Discourse used with an article refers to types or conventions of discourse. In this context, discourse practices of an institutional or organisational nature and discourse types which reflect genres or styles. To enable clarity and coherence, the following conventions will be employed.

I shall adopt Walker's (1988) use of the upper and lower case D in discourse to distinguish between:

- speech or everyday talk as discourse;
- a discipline or body of knowledge as Discourse;
- where both are simultaneously applicable I shall use the term (D)discourse.

Text will be understood to be any written, spoken, or non verbal product of (D)discourses. Consequently, within various texts it is possible to find both forms of (D)discourse. Transcriptions may evoke the nature of the discourse as spoken, but may also refer to recalled discourse, underpinning Discourse or intertextual[2] (D)discourses. From Fairclough (1992), I employ the following terms:

Discursive practice is an analytically distinguishable dimension of discourse, for example, the use of a particular repertoire.

Discourse practices refer to the manner in which particular organizations, institutions or societies express their discourse: in this study perhaps the practices encountered within a clinical setting.

Discourse type refers to the conventions (e.g.. genre and styles) that are noticed when people engage in discourse.

The conventions adopted for the analysis of the extracts incorporated within the study are adapted from Jefferson (1985), Potter and Wetherell (1987) and Edwards and Potter (1987). In designated sections of the thesis, distinctions between the various forms of (D) discourse will be indicated through textual coding. The following synopsis identifies the predominant symbols and their associated meanings.

Symbol	**Meaning**
(//)	overlap in talk
(.)	pause, if a long pause then (.)
...	omitted material
[ ]	explanatory / clarificatory material
( )	brief comments or acknowledgements
<u>word</u>	underline to indicate a meaning emphasis
WORD	upper case denotes pronunciation emphasis
<u>WORD</u> =	meaning and pronunciation emphasis
(?)	uncertainty about accuracy or content
: colon	indicates exaggerated vowels
< or >	'greater than' or 'less than' signs indicate significant changes in the rate of speech, i.e. faster or slower paces respectively.

[2] Intertextuality refers to the existence of 'prior or other' texts located within the text under examination (after Fairclough, 1992).

3.6.2 Representing (D)discourses in Transcriptions.

Transcripts were occasionally coded to reveal the various forms of (D)discourse present, in this instance a Discourse associated with patho- physiological processes (in italics); everyday nursing discourse (indicated here by bold italicised text) and an underpinning/ intertextual discourse with its implicit and explicit issues of power/status/knowledge and social identities (indicated by **bold** type).

Fieldwork Extract (from a conversation with V.)

> V (.) Ye:s, I suppose there was an incident a couple of weeks ago and a gentleman was actually ***suffering from*** *pulmonary oedema* and we were ***watching the amount of fluid he was taking on board and his urinary output fell*** and rather than *treat with frusemide to extract the fluid off (.) er they were treating him with* ***IV maintenance fluid*** *and* **I was arguing against that** and I didn't want to put the ***IV Maintenance fluid up.*** But I actually **referred to the person in charge on that particular shift and spoke of my *feelings*, they put forward their case, how they saw it and said that 'No that was the *right* thing to do',** but again I was in this situation of **actually knowing this time**, actually knowing that it wasn't the correct thing to do but (.)(//)
>
> M How did that turn out?
>
> →V Well it did make him ***positive*** slightly, but I can't remember by how much and **I've got a few (.) um** [laughs], it's very difficult to describe a few sort of ***looks*** of **'you did that?'** when I was ***handing over*** the next morning... (V month 18).

3.6.3 Handling laughter

Dealing with laughter in its various forms was another difficulty in composing and reading the transcriptions. An adapted version of Jefferson is used because, as she discusses, laughter tends to be reported/named as an occurrence rather than appropriately analysed. Consequently, interesting features of the analysis may be obscured. Types of laughter may be mentioned for example: bubbling, chuckling, ironic. Jefferson adapted Goffman's term 'flooding out' to refer to occasions when 'someone is attempting to talk, laughter cannot be contained and invades the talk'. This is a notion shared by participants to conversation.' (Jefferson, 1985:29). In this next fieldwork example the arrow→ indicates that laughter occurs and its form is indicated in parenthesis:

→M ... in relation to how much of that was sort of knowledge of actually (.) the, er (.), tactile experience ? [flooding out laughter, long pauses with more flooding out laughter from M and T] (T month 7).

Jefferson's concept 'put in' laughter refers to instances where the laughter is only a segment of the sentence. In Jefferson's exemplar, this form of laughter was noticed in the context of an obscenity which differs from this next example:

→T ... but I know because I have squashed penises before ['put-in' laughter] but they (.) they reduce very easily (.) enough to get a catheter in ...

This sentence refers to a potentially difficult clinical scenario. T's problem as speaker is to articulate something which 'unknown others' (i.e. readers of the transcript) may find socially unacceptable. Lawler (1991) discussed the problematic caused by a relative absence of discourse concerning the body and how this impacts upon nurses: this was self evident in this interaction between T and myself. In the previous example, one notes the presence of laughter, but as Jefferson points out, the presence or non presence of laughter may be an 'accomplice to the doing of some particular activities:' activities which are managed as an interactional resource and consequently may be an indicator of something that deserves attention. This is another variant on the notion in ethnography and discourse analysis that what may be *significant* is that which is *absent, in conflict, apparently idiosyncratic or neglected.*

Gilbert and Mulkay (1984: 186) discuss how ' humorous discourse is simply one aspect of their [the participants] ability to construct diverse interpretations of their social world'. Attending to irony and humour is important, for example humour is thought to have a recentring role in relation to intuition (Bastick, 1982).

3.6.4 Shared thoughts and movements

Occasionally, speakers may not actually verbalise something, but indicate that they shared the same thought as the other (conversation) participant. This acknowledgement may be explicitly noticed in the interaction, the linguistic format being Repeat + Acknowledgement token. Jefferson, when analysing a particular discourse event, comments that:

> Here, the speaker is not seen to be saying something, but as reporting a thought she had: a thought she now sees that a co participant also had, that is, a shared thought; a thought she now sees that would have remained but a thought had that co participant not done activities which indicated that he was thinking the very thing she is saying she thought, too (1985:32).

Other forms of the acknowledgement token are found within the fieldwork in non verbal exchanges and observed actions where the activities themselves appear to confirm an assumed 'shared thought', 'shared understanding' or capacity to 'see/sense' the thoughts of the 'other'.

> ...he [the patient] began to talk about how his lower abdomen felt more 'full', he rubbed his abdomen as he spoke, indicating and saying that he could 'feel things'. There seemed to be an acknowledgement by those present that there was therefore a deterioration (Fieldnotes with T, month 9).

There are two facets of particular note in this extract. First we notice **Gaze/Regard/Looking** accompanied by a **silent** acknowledgement token, reminiscent of literal silence (see van Manen, 1990, chapter **9**). Secondly, the notion of the 'shared thought', when extended to other activities like movement and moment provides a vehicle for considering concepts like 'shared moments' in which there was a 'sharing of activity'. In these instances the notion of 'communis sensus' or 'collective phenomena' becomes wider and more expressive, *indeed less exclusively cognitive*.

> Alice[3] thought to herself, "then there's no use in speaking". The voices didn't join in this time, as she hadn't spoken, but to her great surprise, they all *thought* chorus(I hope you understand what *thinking in chorus* means- for I must confess that *I* don't).

Herein lies the challenge of analysis.

3.7 Meanings and context

Dey (1993: 39) writing in the context of qualitative research, reminds us that meanings are context dependent; are negotiable between different observers; that one can ask participants 'what they mean'; but participants' intentions are not always a reliable guide to interpretations and the research process may involve analysing changes over time. As Dey (1993) outlined, data can be analysed through phrases,

[3] Alice in Wonderland, page 128.

key incidents or the complex interplay of material or social factors which can influence change. Dey advocates that when exploring an action in depth, one should analyse the context, processes and intentions of the activity. As the person studies reveal, attempts were made to represent these various facets in the written accounts.

3.8 Summary

To some extent the venture to explore the 'unsayables' would be messy, political and subject to a contentious validity. I have demonstrated that participant observation, interview and accounts of accounts were inevitable, although not innocent, methods of investigation. The worthiness of the expedition, its processes and outcomes would require a debate which subsequent chapters will address. From an observational perspective, there is the problematic of discerning between acts which may be considered 'intuitive' and any thoughts or feelings associated with the act. Such a discernment acknowledges the discourse constructed by Dualism and is criticised by philosophers like Macmurray (1957, 1961). The chapter has defined its use of (D)discourse analysis and the associated accounting practises.

The study is now ready to offer a detailed account of the empirical work.

CHAPTER 4

'DOING IT'

4.1 Introduction

This chapter explores the factors which influenced the *doing* of the empirical work. By nature, such an account tends to be descriptive, portraying the 'warts 'n all' narrative with, to use the parlance of discourse analysis, its attendant implicit and explicit attributions (Edwards & Potter, 1992). The chapter addresses:

- ethical issues and associated conflicts;
- acquiring research participants;
- record keeping;
- dress & field impressions;
- being in the Field.

The chapter concludes with a brief pen portrait of V, T, P and myself to introduce the reader to each participant.

4.2 Ethical considerations and formal access

The implications of being a registered nurse when working with other professionals in the field has implications for the conduct of self and others. Dawson (1994) distinguishes between the person and professional action, namely that:

> A professional action is no longer seen as an action performed by a certain type of *person*, but rather, as a certain type of *action*. A true professional is someone who performs ethical actions, and professional bodies are increasingly turning to codes of practice in the belief that they are the best way of guaranteeing the ethical conduct of professionals.

In proposing a *cognitivist* perspective, he warns that when acts are perceived as being sanctioned by the profession rather than the individual, then the professional is likely to respond to the Code rather than to the individuality of the client and by inference their situation. This is a predictable yet inherent conflict within professional practice, constituting part of the experienced tensions when operating within 'the grey'. I interpret the U.K.C.C. Professional Code within the framework of a moral stance derived from the Judaeo -Christian tradition, accepting the responsibility for such interpretation and actions. The International Council of Nurses (ICN, 1996) declared that the ethical issues which apply to nursing

research and educational contexts are 'essentially the same as those that apply in practice'. The ICN summarized these 'guiding' principles as beneficence, non-maleficence, fidelity, justice, veracity and confidentiality. They associate the main ethical issues with informed consent, interaction with vulnerable groups, reconciling conflicts of interest, having the competence to conduct research and fulfilling professional responsibilities. The person studies indicate how my understanding of the moral-ethical dimensions within the study informed my judgements and subsequent actions. These outcomes may have been different for a non nurse, a fellow nurse unfamiliar with the ICN Code, or one with a different frame of ethics, tradition and beliefs. Germain (1985) offers a more detailed discussion concerning the ethical dilemmas encountered by nurses engaged in participant observation within clinical settings. This transcript extract from V illustrates the influence of the U.K.C.C. Code of Practice and its 'assumed common meaning':

> V ... And I said 'NO, we can't leave because it's not safe and I'm not prepared to take things like that'. We can't can we? It's breaching the Code of Conduct really (month 7).

Mendus (1993) when analysing feminist perspectives on the ethics and politics of care concludes that:

> ... if references to care are understood not as claims about women's nature, but as reflecting on the extent to which moral obligations are both unchosen and conflicting, then an ethics of care can supplement an ethics of justice, and can also provide a more realistic account of both men's and women's moral life.

The extent to which these respective 'ethics' and perspectives on care/justice[1] provide an intertextual thread to the participant's actions (including myself) would itself be a major thesis for study. However, given the gender orientation of nursing and its relationship with medicine, such possibilities cannot be excluded and are encountered within the fieldwork. As Dawson remarked, where Codes of Practice do exist, they influence the professional procedural strategies. One procedural strategy is the requirement to submit one's research proposal to an Ethics Committee.

[1] Several ' traditional' virtues, including 'justicia' hold the feminine gender in their Latin root.

4.2.1 Approval: ethical and other

The process of acquiring ethical approval and access was facilitated by first seeking the informal consent of the appropriate Senior Nurse Manager. Following a fruitful meeting, permission was granted for access to the clinical settings subject to clarification with the nurse advisor to the local Ethics Committee. The advisor recommended that the proposal should be submitted to the Ethics Committee. Whilst it was considered *technically* unnecessary for the research to be submitted to the Ethics Committee, their sanction would grant legitimacy to the project, facilitate access, and demonstrate that nurse research was being undertaken! The remit of the Ethics Committee was focused towards issues concerning patients, relatives and concerns about litigation. The application form was designed to meet the requirements of scientific, medical oriented research. Whilst there were 'ethical' issues inherent in the study, because they did not explicitly concern patients and relatives it was not considered 'technically' necessary to submit a proposal to the Ethics Committee. Approval was granted, but the episode illustrated the inadequate scope and range of jurisdiction of the Ethics Committee *at that time* and the desire that nurse research should be *visible* to others.

4.3 Potential Sources of Conflict

Whilst the conflict between the clinical and research role is the most obvious and well documented one, there are other potential tensions e.g. expectations of managers, time management, publication issues, personal preferences, and the management of conflicts should they arise. For example, where one exercises a conscientious objection to particular aspects of practice, then research in such areas would be exceedingly problematic (induced abortion, some uses of electroconvulsive therapy). In order to prevent unnecessary dilemmas, I identified these potential difficulties and adopted appropriate strategies. Following consultation with the nurse managers and the research participants the following procedures were agreed:

4.3.1 Observation of Problematic/Unprofessional practice

Should this occur, I would limit interventions to occasions when there was a clear breach of the Code of Practice or a situation in which a patient could come to

(significant) harm. I would respond with the minimum intervention required for patient safety before liaising with the local nurse manager.

4.3.2 Requests for feedback

If requested, informal feedback would be given to the local nurse manager at the end of the fieldwork phase. This would be restricted to generic issues and would not be personalised to the research participants. I would not give feedback about the performance of a research participant nor others in the field without their consent

4.3.3. Vulnerable Clients

When meeting vulnerable clients, I would seek the advice of the local nursing staff in respect to the appropriateness of my involvement.

4.3.4 Avoidance Strategies

I decided to avoid working with a practitioner whose practice was known to be dubious. I was not seeking the perfectionist, rather I was striving to avoid unnecessary professional and clinical conflict. One can become an accomplice through omission as well as commission.

In the case of other difficulties, I intended to seek advice from either the local nurse manager, or the nurse member of the Ethics Committee. These early discussions enabled the participants and me to respond co operatively when difficulties arose or were anticipated. There is little doubt that previous experience as a clinical teacher both in the UK and overseas operating in 'difficult' settings enabled me to respond appropriately to such problems. These ethico- moral dimensions to practice reveal attributions of responsibility and accountability.

4.3.5 Loyalties

The felt, perceived, moral claims of the researcher and participants may engender tensions and 'loyalties' which are the consequence of relational ties with one or more of the following:

- the patients;
- the research participants;
- the researcher (myself);
- the profession;
- the organisation;

- the research itself.

Becker (1969)[2] when referring to the work of Fichter and Kolb (1953) discussed the problem of loyalty which may be experienced by social scientists. It is significant that it is **perceived as a problem**, rather than a natural possibility to be managed and revealed. Analysing the consequences of such loyalties forms part of the research account. For example, my 'loyalty' or responsibility to the patient led to the actions outlined in vignette **1**. Interestingly, without such intervention, the research itself would have been diminished by the resource the actions subsequently provided.

Similarly, loyalties towards the research participants or others in the field determine that some data is selectively not included in this final report (Savage, 1995). Primarily data is omitted because of the 'potential' harm that may occur to an individual, myself, or an ethical principle that might be broken (e.g. consent, confidentiality). This 'potential harm' has to be balanced against the 'good' that may be achieved by locating the thesis in the public domain. However the understandings obtained at the onset of the research project need to be honoured unless they are subsequently re-negotiated.

This next fieldwork example illustrates the tensions experienced when there is a disparity in knowledge and standard involving patient care. In this instance, I offered information, weighed up the implications and did not intervene further.

> I also found some parts of the night disquieting, my professional knowledge was challenging some of the work patterns that I found around me..... the extent to which knowledge was and wasn't known by the staff.... I was identifying problems that I would have wanted to resolve if I had been in a position to do so... yet I couldn't address the issue apart from highlighting it and trying to suggest alternatives. Here I was involved in making a judgement as to the efficacy of what was being done and whether I was in effect not contributing to good practice myself.... however I cannot say that I was happy with the decision... This is the contextual problem of not being able to deal with situations through some sort of negotiated authority by virtue of position, explicit knowledge and/or personal relationships, which in this situation I was unable to justify (notes).

[2] In McCall and Simmons (1969).

4.4 Practical constraints

A pragmatic limitation (or benefit!) constraining and facilitating the fieldwork was being a part time student and worker, needing to juggle employment time with the research. Complete immersion in the field for lengthy periods of time was not possible. The attraction of pursuing a more 'longitudinal' approach seemed a neat resolution. In the thralls of initial optimism and influenced by Street (1992), I estimated that if I attempted the equivalent of one, four hour observation period a week, I would be able to carry out the fieldwork and handle some of the data simultaneously. Whilst this target had arisen following a literature review of doctoral observation studies of nursing, it soon transpired to be an ambitious target compromised by:

1 the difficulty in acquiring participants;

2 the respective vagaries of 'off duties' and times when I was free from work commitments;

3 a general 'fatigue' factor experienced by attempting frequent observation periods concurrently with employment and description;

4 neglecting to consider that most of the studies reviewed had been undertaken as full time doctoral studies!

However, the principle of working with the practitioner once a month was incorporated into the design. The duration and frequency of the observation periods varied between the participants reflecting their respective contexts. Whilst there were occasions when events lengthened the time interval (for example holidays, sick leave), the frequency of observations enabled flexibility and continuity in the respective settings.

Planned orientation, a 'familiarization day', (Croll, 1986) enabled the research procedures to be rehearsed within the work environment of each participant. This was arranged for three reasons: (1) to negotiate the working relationships in the field; (2) to enable 'safety' issues to be addressed in respect to my being a registered nurse participant observer; (3) to gain informal consent from others present in the field. Whilst most texts on participant observation overlook the impact of 'shift work', job mobility and patient mobility on the presence (or absence) of 'others' in the field, Street described how such variants have consequences for the

research. One effect is that whilst the research participants and I quickly became acclimatised to one another, throughout the fieldwork phase others were encountering 'me' for the first time and requiring some degree of explanation/ familiarization (this applied mostly to patients and their families). These necessary social introductions reiterated the purpose of the research and my role in the field.

4.5 Acquiring participants and locations

Delamont (1992) highlights the benefits to be accrued from studying the unusual, the bizarre, the similar, the dissimilar and familiar in both setting and persons. The importance of trying to include diverse settings and different individuals seemed appropriate, hence the three settings (emergency work, hospice/community and acute hospital wards) and the qualification/ experience levels of the three research partners (one newly qualified, one graduate, experienced in her context and another very experienced 'expert' practitioner). In contrast to *my* experience, I researched in contexts, albeit geographically different, where I had considerable previous experience (V), where I had none (T) and where I had limited experience (P). As an educator, I had taught aspects of the three specialities to degree registration level.

Unfortunately, the selection/acquisition of the individual participants proved to be more difficult than anticipated and delayed the fieldwork phase considerably. The initial design had been to stagger the research thereby enabling me to 'hone' my skills with one participant before commencing with another. I intended to include two newly qualified Project 2000 diplomates and two more experienced practitioners preparing for their ENB Higher Award[3]. This ambition was thwarted by several factors. First, I was unable to obtain a volunteer from the first annual cohort of Higher Award candidates. In retrospect, I suspect that this was because they were the first cohort and that 'participant observation' may have been threatening to these experienced practitioners. Second, I approached the cohort as a group, when a more prudent strategy may have been to approach individuals through an intermediary thereby avoiding the 'face to face' element and group dynamic influence.

[3] A new national award in which a professional and academic qualification recognising both practical and theoretical achievement at degree level.

The first Diplomate nurse was acquired easily, a teacher responsible for the first graduating cohort provided me with a list of those who had local employment and might be interested. The first person I contacted agreed to participate (V). I had anticipated similar success with the second group graduating six months later. Unfortunately, despite finding someone who initially agreed, nothing materialised. By the time it was clear that *nothing* was going to happen, I had missed the opportunity to work with that cohort.

Whilst recruiting the intended participants had not been completely successful, I persevered and guided by the experience, tried two different approaches. A colleague acted as an intermediary to approach an experienced qualified nurse who was soon to complete her post registration degree (T). I directly approached another (P) who I had previously met in the course of my role as a nurse educator. Another colleague had also acted as an intermediary and we were both optimistic that a male nurse could be recruited, unfortunately the circumstances in the clinical area changed and made it inappropriate for observational work.

Meanwhile, I had been working with V for some months and as the unfolding process was generating a wealth and sufficiency of material, the necessity for working with so many practitioners was itself challenged. Finally, I worked with V for 18 months (100 hours of observation) , T for 16 months (100 hours of observation) and P for 6 months (30 hours of observation).

4.6 In the Field

4.6.1 Record keeping

Following the recommendations of qualitative researchers, (e.g. Hammersley: 1992, Jorgensen: 1989, Strauss: 1987, Strauss & Corbin: 1990, Spradley: 1980) notes/ accounts were kept in a sequential order named according to the participant thereby creating 'diary' accounts of observations, memos, impressions and recorded conversations. I adopted the traditional format of allowing a significant margin to enable contemporary jottings. An aide memoire list derived from the studies outlined in chapter **3** was used as a memory prompt at the end of each shift (see appendix **5**). I also reflected upon my role expression and judgements during the observation period. This next list outlines the usual sequence of record keeping.

i An account of the observation session (description of the events, activities and contexts). During the observation session I would jot down memos and significant 'quotes', sometimes reminders may have been recorded on tape. At the end of the shift, these jottings would aid the development of the initial descriptive account.

ii Notes, muses, significant points and impressions (comments, reflections, insights) would be compiled. Some points would emerge in the process of producing the descriptive account, others would emerge in retrospect.

iii Any transcribed recordings[4] which occurred during the fieldwork day.

iv Transcribed interviews with descriptions of their context and associated impressions.

v As the data accumulated, margin notes and cross references would be added as memos.

vi When revisiting accounts, additional notes maybe added and dated.

vii Where similarities seemed apparent, the pertinent extracts would be copied and stored in relation to the 'theme'.

Rather like Wetherell and Potter (1992), there was a recursive nature to the processes of hearing, transcribing, reading, interpreting, comparing and contrasting the various textual accounts. When a particular understanding or event was generated then the original materials would be revisited to clarify, confirm or question the interpretation. Regular cross referencing occurred as items of apparent significance, similarity or difference were encountered. As information accumulated

[4] The recorder used was a Sony Professional Walkman WM-D6C with a tie microphone. A voice activated recorder was inappropriate because the level of background and extraneous noise would be overwhelming and cause breaches of confidentiality as well as drain the batteries and exhaust the tapes! In fact recording during a shift was exceedingly problematic, the close proximity of individuals to one another in the acute settings when combined with the rapidity of interchanges and physical movements considerably inhibited recordings. Furthermore, the deliberative actions involved in moving a hand to switch on the recorder could interfere with the spontaneity of the situation. However, wearing the tape recorder in the acute settings it was possible to capture brief snatches of conversation in breaks or treatment rooms. Whilst initially I attempted direct recording of observations, the physical opportunities to do so were restrictive and occasionally bizarre, for example being found apparently 'talking to myself' in the sluice! I thus reverted to making pen jottings on a small pocket notebook, similar to those used by the nursing staff themselves. This was far less obtrusive and blended more naturally with local mannerisms.

and ideas were generated, topics were explored and analytical texts, flow charts or diagrams emerged. Diary notes were made of other significant events and recorded according to the participant's setting, or in a series of topical/ general files.

As journal keeping is an advocated strategy for researchers, I persevered for about 12 months, aware that previous attempts to maintain a diary in other contexts had not been successful. Whilst diligently kept for the first year, I found I was repeating material between different files and becoming frustrated. Analysing where I was being most productive, I realised that I naturally kept notes and jottings from which analytical accounts and rhetorical questions emerged. I abandoned a 'formal' diary account and adopted a series of general files dating the written contributions. This strategy quickly accumulated a rich and diverse record of musings, reflections, analytical questions, notes, essays and quotations written on various types of paper, about different topics and in different genres etc. I was researching as *bricoleur,* compiling and collecting fragments and shards of information. This transition phase seemed to match a developmental phase in the research process itself where descriptions became more focused and hypotheses or queries raised. This accounting process monitored the hermeneutical journeys.

Early observations in all settings, but particularly with V, were primarily general, inclusive and descriptive. With increasing familiarity, as Spradley (1980) outlined, I tended to focus and become selective. Focus and selectivity became possible when repetition or apparent similarity are noticed and then tested against theoretical insights (Schon 1987, Hammersley 1992). With each new setting, I consciously endeavoured to 'be open' and inclusive, although I inevitably contrasted experiences and observations between settings. This was particularly relevant when for a six month period I was researching simultaneously in the three settings.

In 'writing up' the fieldwork, one particular feature seemed to be a consequence of my nursing background. When constructing the descriptive accounts of the shift with their significant events, I found that my recall was partially patient based and occasionally this generated two sets of notes. One version was patient based whilst the other set was a narrative account of the shift more akin to traditional 'ethnographic notes'. The two types of writing complemented one another and produced interactive insights. By constructing

accounts which were patient based, the shift time management is recounted differently[5]. It is possible that I was employing skills learnt in the oral culture where time is restricted and the nurse develops strategies to retain information to 'pass on' later. Street (1992) discussed how nurses manage/develop an oral culture within the context of competing work demands where the settings are temporarily and spatially constrained:

> My personal experiences of taping oral conversations with nurses for analysis and recollection demonstrated the sophistication of their skills of memory, description and analysis... They were capable of maintaining continuity of thought despite constant interruptions and of constructing telling arguments or critiques through conversation (Street, 1992: 269).

In analysing and reviewing my notes, the 'patient focused' accounts tended to evoke visual memories enabling the interactive and non verbal elements to be noticed. The notes exhibited a variety of different styles and genres, for example there were brief, almost staccato accounts of patient details, which switched tense between the present to past. Sometimes these tales revealed diverse associations with time and space.

The importance of recording one's initial observations as soon as possible is an acknowledged necessity, enhancing the reliability and accuracy of the information and reducing the influences of memory and hindsight bias. I endeavoured to make immediate jottings as near to the events as possible, however when I joined T in the community settings I found it difficult to write in any depth at the end of the day. I noticed this almost immediately and assumed it was a combination of fatigue and 'coming out of role', in some way connected with the nature of the work being observed. Certainly, these were observation periods that required considerable attention and focus. As a researcher, I worried about the fidelity of the observations, although I was aware that I had no difficulty in writing copious notes from my jottings. When this seemed to be a feature of nearly every observation session, I began to question more closely what was happening. I observed that T did not make extensive notes on the day either, writing memos rather than detailed notes. I discussed this with T and her colleagues and discovered

[5] Examples in vignette 1.

that it had become usual practice for the nursing team to compile their detailed patient notes on the subsequent morning. I speculated whether I had inadvertently mirrored local practice, was responding to the nature of the observation work, or stumbled across a 'natural defence mechanism?' This was a problem I had not encountered in other settings, and I concluded that it might be related to the nature of this fieldwork context and a need to distance myself from the practice at the end of the day. Perhaps this was a form of 'debriefing/ deroling' from the emotional and physical stresses engendered when relating with the dying and their carers. Revisiting Street's analysis of the factors contributing to the oral culture, my awareness of this activity was heightened.

In addressing record keeping, I have indicated elements which may be attributed to my nursing background. The patient focused accounts must have contributed to the analysis through their organisation and structure. However the precise significance of such an intertextual thread is difficult to establish, raising further speculations concerning the interplay between *the role of sameness and difference* in observation and interpretation.

4.6.2 Handling the interviews/ recorded conversations

At first I selectively transcribed recorded conversations[6]. However, it soon became apparent that I needed to transcribe all the conversations in order to capture the nuances of context, flow and sequence, making notes of the interactive nature of the dialogue rather than just the content. These recorded conversations were transcribed in their entirety as soon as was practicable; normally within a week of the event. I would listen to the recordings making notes which recalled and exemplified activities associated with the interaction. After this 'first play back' I would then focus on the transcription, transcribing literally and crudely. Subsequently, passages which were to be analysed in detail would be listened to again (and again!) and the appropriate transcription conventions adopted. This stage inevitably re- focused my attention on the auditory record and provided a memory cue; a useful 'refresher', albeit at a temporal distance from the original event.

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[6] Recorded conversations refers here to any of the following: those 'organised' as interviews, informal interviews occurring during a shift, spontaneously arranged 'conversation snatches' or dialogues with T when travelling in the car.

4.6.3 Observer fatigue and 'others' tolerance

The nursing literature highlights issues of observer fatigue and 'subject' tolerance. However, being an occasional visitor, rather than one totally immersed in the field, provided its own protection, and thus I was comparatively 'fresh' on observation days. Apart from the 'write' up issue mentioned in T's setting, the predominant fatigue factor was that generated by the worker/researcher tension of part -time research. I regularly checked the 'tolerance' level verbally with the participants, and as the field relationships developed, we were able to establish the degree of proximity that was mutually tolerable. T[7] was likely to be most vulnerable as neither of us could 'escape' when travelling together in the car. I believe that I was sufficiently sensitive to these situations and contexts.

4.7 Dress and Field impressions

I discussed with each participant how I should be introduced to others in their areas. Usually we adopted the conventions of the setting, thus I was variously introduced as Miss Gobbi, Mary Gobbi, Mary, as a 'colleague' or 'nurse teacher/tutor who is 'doing some research' (with me), or 'has come to learn from me.' Occasionally this would be expanded to describe the nature of the research, i.e.

'on how qualified nurses learn in practice.'

Sometimes members of staff would recognise me from my role as a nurse teacher, particularly in the latter periods of the research due to the longevity with which I had been in the area. At first, I was a relatively 'unknown' newcomer. In the community settings with T, name badges were not worn and so T would introduce me according to the persons visited, seeking their consent to my presence. Often patients/relatives were just naturally curious and so their questions were responded to openly and truthfully, (but not necessarily extensively) balancing their interest with any indication of concern. On the whole, patients/relatives were more interested in my role as a 'teacher' than they were about my presence as a 'researcher' and seemed to express a willingness to be indirectly associated with research which was 'to do with nurses and the way they learn in practice'. The majority of patients were very co-operative, articulating that they considered it important for them to be able to help (student/other) nurses learn. Staff usually

[7] T at this stage was working as a home care sister and was making domicillary visits.

expressed interest in what I was doing, and I quickly learnt a fixed response 'I am studying how trained nurses learn in practice' which seemed to be adequate. It would not be unusual for staff to contribute their own thoughts at this stage.

When both V and T changed posts during the research, consent was required from their 'new' colleagues. In this extract, V is describing her interview for a new post and the indirect perceptions of my role are apparent:

> V ... I know what came up, the research thing that you are doing on me.
>
> M Oh, right, was that a problem do you think?
>
> V No, I said you'd probably be doing it for another year anyway. (//Um) I took all the bits of paper[8] as well in case they wanted to see.... When I told them that you were a tutor and you come along with a tape recorder they just went: 'Oh that sounds terrible' (she mimics their intonation). I said, 'it's not, it's not'. I said to them. ....' it doesn't actually happen within the patient area because of patient conversation, because you have to consider patient confidentiality' ... And so I sort of calmed them down on that and I thought well, you've got to let them know (V month 9).

Usually in an ethnographic account, the entry and exit periods to the field seem to be clearly marked and indicated as phases. In this study however, patients, staff and others continually change and move. Consequently, the researcher and participants are being perceived in the context of their on -going relationships and development. The boundaries of 'time' on the research are inevitably different.

4.7.1 Uniforms

The manner through which field relations influence the researcher's ability to collect accurate and truthful information is frequently discussed in the literature (e.g. Burgess 1984, Hammersley & Atkinson 1983, Jorgensen 1989). One visible aspect of the field relationships is that engendered by the clothing and accoutrements that one wears. Nursing uniform is a perennial political issue, the source of numerous arguments at local and national level. Traditional uniforms are criticised for representing female servitude in clothes that are unsuitable for lifting,

[8] This refers to the Ethics Committee proposal, a copy of which was given to V, T and P with the words 'intuition' and 'reflection' erased.

evoke connotations of the military (or the Convent), and promote stereotypical images of nurses (Walsh and Ford: 1989). Nonetheless, institutional uniforms were worn in the hospital and hospice settings where their presence and form is symbolic. James (1984) humorously discussed the dilemmas she encountered, whilst Street as a non nurse outlined her strategies to 'blend in' without wearing a uniform. Savage (1995) discussed the minutiae of the associated apparel, the extent to which one wore hospital badges, scissors, pens etc. Making decisions about 'uniform' is a significant judgement which may facilitate or hinder 'going native'.

On a personal level, I was reluctant to join the ranks of the 'white coated' observers characteristic of early observation studies by nurses (Wells, 1980) and I had a personal antipathy to wearing, unnecessarily, the uniform of a doctor, scientist or technician! Wearing a staff nurse's uniform, I could be perceived as a 'native', whereas wearing my 'nurse teacher's' uniform might evoke power/knowledge differentials. During the course of the study, the local uniform was due to be changed and a consultation process was in progress. Consequently, some staff thought that I was wearing one of the potential new designs!

Following discussions with the nurse managers, it was agreed that I should wear a 'neat uniform like a nurse', but not identical to the hospital uniform. An identification badge was required. A timely challenge from a colleague made me reconsider whether a uniform[9] was necessary and revisiting Street's study, I decided to wear a uniform for three reasons. First, a' nurse like' uniform would enable me to be recognised as a nurse, yet be immediately distinguishable from the 'native' nurse. Hence, staff, patients and relatives should not be unnecessarily confused by the expectation of a particular role expression from me. It was likely that I might be initially perceived as being akin to an 'agency/bank nurse'. Second, working in a clinical area it seemed prudent to wear a 'uniform' if only for infection control and safety reasons, i.e. both patients and I would be protected from the dangers associated with wearing mufti. Finally, I needed some form of identification for security reasons. I purchased a name badge which stated Miss Mary Gobbi: Nurse Teacher /Researcher. Incorporating my Christian name would enable an increased familiarity for those for whom it was appropriate.

[9] No uniform was worn in the community.

In selecting a uniform, I required something that would enable me to carry the tape recorder unobtrusively whilst being functionally safe. In order to wear the recorder and be discrete with the microphone, I required a large 'pouch pocket' at the front. I found a suitable white tunic[10] with navy culottes for the winter and a light blue and white stripe skirt for the summer. I made a hole in the tunic behind the pocket and was able to thread the microphone lead under the tunic and up to the shoulder fasteners where it could be slipped onto my shoulder[11] and be secured discreetly with sellotape.

This outfit enabled me to 'blend in' whilst being sufficiently 'different'. Occasionally I was mistaken for a doctor or a physiotherapist, the white tunic was responsible for this. Unfortunately it was the only colour available despite my earlier protestations! The name badge caused its own humour, generating enquiries which ranged from a houseman alleging that I was a spy from the Trust, to a few elderly patients who thought I was the modern version of a Sister Tutor, Nurse Inspector or a local 'matron' (images of Hattie Jacques?) My age must have been showing, or was I inadvertently demonstrating the 'stance' of an experienced nurse? Indeed one patient considered that I must be a very senior person and took everything that I said as having particular importance: a fact that the staff used to their advantage! When contemplating Savage's comments comparing her age with that of the staff, I observed that these incidents occurred predominantly in V's setting: the acute hospital ward where there were more students and younger staff members than in the hospice, emergency or home settings. It could be argued that it was the different contexts, or that with my increasing experience undertaking the research I was no longer engendering these responses.

Despite odd moments of humour and momentary confusion, the outfit seemed to serve its purpose, with staff and patients generally accepting me as being like a 'bank nurse[12]'. The settings themselves would influence the expectation of 'itinerant' staff and the role they were accorded, for example the hospice was used to having observers/visitors and had developed protocols for people accompanying the home care sisters.

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[10] Eventually discovered at a naval/uniform outfitters.

[11] It was noticeable that few people seemed to notice the microphone, eventually I only commented upon it if I noticed someone staring at it.

[12] A casual nurse providing cover during staff shortages.

Working in the community setting with T was different, mufti was the norm, and it was not appropriate to wear or use the recorder in people's homes. Other differences were in the form of introductions, notions of consent and the bodily postures that I may have actioned (consciously or otherwise).

4.8 Role, self/other, agency and relationships (Between us, within me, or, out there?)

Analysing 'being in the field' is as a crucial part of the research process, illuminating the idiosyncrasies and challenges encountered and is explored further in chapter **8.** The participative, interactive and transactional nature of the research reminds us that 'we all require each other **morally** to conform to the 'situations' emerging into existence between us' (Shotter, 1993:8). These 'between us' situations engender some of the potential problems identified in Table **7.** The person studies will illustrate how some of these issues were managed in the Field.

Table 7. Potential impact of 'role' upon the participant observer.

Potential Impact	Source
being buffeted by most powerful influences & friendships	McCall & Simmons 1969. James, 1984.
human relationships, rapport with participants	Janes in McCall & Simmons
being able to give accurate and truthful information	Jorgensen 1989
affective participation	McCall & Simmons
anxiety effects	McCall & Simmons
emotional & physical reactions	Hammersley & Atkinson 1983
organisational issues	McCall & Simmons
being a 'native'	Hammersley 1992
effect upon the situations and the conflicts emerging	McCall & Simmons
mental and physical energy required which may divert energy from the research efforts	Pretzlik 1994
participants prior knowledge of me	
one's ethical & professional stance when 'bad' or 'unsafe' practice is witnessed	Mills et al 1994

4.8.1 Stance: 'being' like a ...?

As Viddich (1955:33) comments:

> ..whether the fieldworker is totally, partially or not at all disguised, the respondent forms an image of him and uses that image as a basis for response (cited Delamont 1992).

Similarly, the fieldworker forms images of those perceived to be present in the field, and it is from these images that the fieldworker responds. As a nurse educator, I was aware that nurses, especially those in uniform, adopt particular 'stances' and thus to some extent one might 'embody' being a particular type of nurse (see Goffman, 1971). Both Street and Savage noticed the nurses' stance and recognised that their own changed during the fieldwork. They discussed how these respective stances seemed to engender particular responses, for example a patient's expectation of their competence (Savage, 1995). This next extract illustrates the conscious decisions I made in respect to my responses and positioning. T and I have been discussing the extent to which the patients were able to 'blank me out', or whether my presence was 'irrelevant' when T was engaged in one to one dialogue.

T ... No, I don't feel that they are particularly bothered by that. I feel that if they were, they wouldn't talk (um).

M which is //(yeah)// is what I had noticed and I know on one occasion I went away because I could see they (.) they were, you know their eye moved towards me //(yes)// and I thought 'No, no I need to back off'//

T //and you can tell by their gaze and things. And if you are sitting quite close to them they are looking somewhere else //(yes)//you know they are not concentrating on you//

M because I was quite amazed today with Mrs X, there wasn't quite anywhere for me to sit. And I was kind of bending down so that my eye was near enough level, and I was quite amazed that it didn't appear to be bothering Mrs X//

T // and I am very aware that if I start saying 'if I get you a chair Mary', or 'I'll get you this' then it makes it //

M it breaks it//

→T yes, it breaks it and things. And I have to rely on you just to //(yep)//sit down [mutual laughter]

M Yes, which I usually manage to do, but I had to physically crawl over today! Yes, I just wanted to check that I wasn't getting in the way there.

T No, I'd tell you, people tell you if you're.. (with T Month 4)

The research (er) is thus located within and between us, both 'here' and 'there'. Through exposition of contemporaneous and *post hoc reflexivity* I/You examine 'my self and agency'. As Sampson observed:

> The most important thing about people is not what is contained within them, but what transpires between them (Sampson, 1993:20).

What transpires 'between us' in the field becomes significant as this account demonstrates. Mr.K. is terminally ill and this is a first home visit by T.

> We introduced ourselves, and went to sit down in the front room. I had to sit next to Mrs K. I indicated the pouf, but she suggested the sofa. I was then in a difficult position as there was a large triangular pillow there, and so I had to hold myself firmly so as not to touch her or fall into the middle of the sofa. I was aware that I was in a bad position and needed to try and be careful with my body positioning and postures. T asked a few details ... most of the time it was the wife who replied although, when directly looking at the husband, T managed to get him to talk... Of course in people's homes you can't go around rearranging the furniture in order to construct eye contact! ... In fact Mrs. K. became tearful, at this point we were sitting so close together, I touched her and she turned around quickly and asked me not to- she didn't want to break down. I then realised that no offence had been taken ... but the need to 'not break down' was common to both of them [husband and wife]..... Later she turned to me and actively touched me for comfort, but that was at her initiation (with T, month 9).

In this example there is both 'simultaneity' and 'intentionality' as each participant is potentially engaging at both an individual and collective level. As Benner (1996:5) remarks:

> Expert coaches use indirect language, coaching through attitudes, bodily posture, tone of voice, the questions asked and the way the nurse cares for the patient. Expert coach knowledge is relational and contextual.

4.8.2 Disclosures

Inevitably, through working in close proximity with V, T and P, I became the privileged recipient of personal information and confidences. Throughout the period of the fieldwork there were occasions when events from a person's personal life

influenced their decisions, motivations, health and professional life (and indeed vice versa due to the impact of nursing upon the personal life). In a spirit of beneficence, collaboration and justice, the extent to which these events are publicly explored has been the negotiated product of the participant's consent and my judgement.

4.9 The participants

Before commencing the next three chapters which represent the 'person' studies of V, T, and P respectively, I offer a short 'pen portrait' of each participant so as to contextualise the reader.

V

We first met in the summer of 1993. V had entered nursing in her mid twenties following a successful career in the financial services industry. She was in the first local cohort to undertake Project 2000, registering as a nurse in September 1993. Whilst her original intention had been to work as a community nurse, at that time, newly qualified nurses were not encouraged to enter community settings until they had at least completed a preceptorship[13] period. The setting was located within a regional centre for Cardio Thoracic specialities. Fieldwork commenced in October 1993 and continued for the next 18 months, with a follow up interview in the Spring of 1996. During this period V experienced job insecurity due to the short term contracts which had been introduced to deal with the financial cutbacks in the N.H.S. Towards the end of her second contract, her partner was relocated, she thus changed her job to be nearer to his new post. This stimulus enabled her to seek a position in a community setting which had been her original and long term ambition. Finally in the Spring of 1996 we met and reviewed our period of collaboration together. At this time I verified her consent for the details to be entered in this 'pen portrait' and the final 'person' study outlining her development is composed with her consent.

T

A colleague introduced me to T who was working in a local palliative care setting as an experienced staff nurse having prior experience in general surgery. She had qualified locally in 1989 and was just finishing the final semester of her part time post registration degree. I commenced working with her in the Autumn of 1994

[13] A period of about 6 -9 months supervised experience following registration.

and continued on a regular basis until Spring 1996. During this period, T successfully completed her degree, completed a specialist post registration course, and obtained a home care sister's post. Consent for the study was obtained from T.

P

I had first met P when she was enrolled upon a post registration course as a student. P had been qualified for twelve years. Following registration, P had five years experience in a range of medical and surgical settings followed by seven years in Accident and Emergency work. She had acquired considerable experience and expertise as a senior staff nurse in Accident and Emergency nursing in both the UK and USA. She held specialist qualifications in Accident and Emergency nursing, Advanced Life Support and was currently studying for a Business Studies qualification. In addition, she was an experienced and qualified supervisor/assessor for a pre and post registration students. After six months, she applied for another post within the Trust where it was inappropriate for me to continue with the research. P has given consent for the study.

M

I qualified as a registered general nurse in 1978 whilst undertaking a combined programme to obtain a Diploma in Nursing with registration. My subsequent clinical specialities were in cardiovascular and thoracic nursing (where I gained specialist qualifications) and Neuromedical nursing - having experience as a ward sister in both settings. I entered nurse education in 1985, completed an M.A. (Ed) in 1989 and worked overseas developing nurse/midwifery education programmes at certificate, diploma and degree levels. During the period of the research I was working as a nurse educator delivering post registration programmes associated with the 'Teaching, Learning, Supervision and Assessment ' of nurses and midwives.

4.10 The person studies: an introduction.

The next three chapters represent summary accounts and commentaries derived from the research experiences with the three participants. In addition to ad hoc or planned interviews, participant observation sessions comprised approximately 100 hours with both V and T and 30 hours with P. Additional supportive material is found in the following Appendices:

Appendix **6** summary account of V's development. Extracts A-F.

Appendix **7** analysis of V in relation to the 5 stage model of Dreyfus & Dreyfus.

Appendix **8** details of vignette 1 and other relevant extracts.

Appendix **9** summary account of T and relevant extracts.

Appendix **10** analysis of T in relation to the 5 stage model of Dreyfus & Dreyfus.

Appendix **11** summary account: P.

Appendix **12** analysis of P in relation to the 5 stage model of Dreyfus & Dreyfus.

CHAPTER 5

V, extracts from a person study.

First meetings

V struck me as a naturally effervescent and inquisitive person who appeared intrigued by the project, enthusiastic but naturally cautious. I outlined the study and we discussed the ethical dimensions especially anonymity, confidentiality and professional relationships/ethics. V was eager to ascertain what I was investigating and enquired whether she could have feedback on her development. I explained that this might influence her, however if she requested feedback in relation to specific events that may be possible. I sent her a modified copy of the research proposal (minus the explicit reference to intuition etc.) and an article by Titchen and Binnie (1993) which discussed the relationship between the researcher and the researched. Following this first meeting, my notes record:

> To what extent will V's knowledge and alertness influence me? It is going to be nigh on impossible to be the impartial observer, she is too eager to learn from the process herself! So, let's capitalise on this and hope she agrees! (October 1993)

This extract resembles *close observation* (van Manen, 1990) rather than traditional participant observation. In close observation the researcher is a gatherer of 'anecdotes' and seeks to recognise significant 'texts' from daily living whilst the research is happening, akin to the bricoleur.

V agreed to participate and confirmed that her ward sister, D, was supportive. I acquired formal consent from the clinical manager, met D to discuss the research, and organised an observation/familiarisation shift in V's absence. D considered that the research would be an 'important opportunity' for V, who should be able to utilise the experience. V was described in these terms:

- Being quick to learn; 'I only have to show her once.'
- 'She gets frustrated with herself', 'before she came we sat down to see what she expected and what I did: naturally they were similar, but she actually expects more of herself than we do'.

- There is 'something special about her': both personally and professionally, 'I could see her looking after a member of my family[1]'.

Another senior member of the nursing staff described V as being 'perceptive and bright'.

During the first shifts I familiarised myself with the layout and care delivery, endeavouring to 'blend in' through cultural awareness. I developed my skills in observing and compiling fieldnotes. From the first orientation shift, I noted 'looks', the 'reading of eyes,' and the use of metaphors. These early observations were the genesis of the subsequent analysis of *Le Regard* with its ultimate significance. Analysing these notes reveals implicit and explicit references to temporality, silence, space, responsibility, relationships between 'us', self and other. Nursing practices which aren't in the text book are observed:

> The student (nurse) had a query as to whether a particular patient could be rolled or not. The staff nurse stopped, thought and then went to clarify for herself. She went to get the X Ray, looked at it then checked with the houseman. They compared the X Ray with previous ones and discussed the situation, the staff nurse indicated that she wasn't happy to roll the patient. She verbally invited the ward sister's opinion, who agreed with her judgement. The ward sister then called to members of staff and students who were passing by to 'come and look at this'. This particular situation was not in the text books (first orientation day).

This extract indicates not only the *particular nature of each decision and case*, but the discursive manner through which judgements can be made and, for others, the opportunity for learning to occur. The dynamic of the 'similar to/different from' dialogue is evident. The patient is evidently a person who is both a focus and stimulus for learning.

Table **8** indicates the rich and challenging nature of the research. Just 'being there' in a uniform and as a person, invites and elicits responses from others. Thus as a *researcher, educator and nurse, 'me'*, I am occasionally perceived as a *resource* and frequently as a person with whom others engage.

[1]This is one of the finest accolades a nurse can receive from a fellow nurse. It is an informal bench mark used to assess students, namely the extent to which a nurse has sufficient trust in the person to leave them to care for a loved relative.

However there are times when I am 'invisible' to some in the field. This is usually associated with the perceived status as 'itinerant nurse'.

Table 8. Extracts from the fieldnotes: first orientation shift

1 My interaction with Mrs S [who has cancer] and her two daughters, non verbal knowledge, reading eyes, touching the person, blushing, eye contact, thinking the process through, the immediate relationship. I know they know I know, I used the word stricture: a tightening: I gaffed, but they merely acknowledged that which was not spoken of, but communicated. This indicates my thinking in action, is this the 'reflection in action?- the knowing that was operational? ... this illustrated the importance of silence and that I should have spaced and let them explain, I was in too quickly.... relational and emotional ties are ever present, everything is two way, separation is not going to be possible... My role as a resource, perceptions about me from two staff nurses who already know me...
2 A staff nurse, commented that 'you can give good nursing here because there is space'.
3 A student nurse, remarked that she 'learnt a lot here,' the 'best one for attitudes and feelings'. She became very animated about how good the ward was and how they were 'honest with the patients' and 'you learn that here'.
4 An indication of the natural curiosity of the staff is indicated by one who asked me what I was doing and then proceeded to try and discuss it with me! I replied using the expression 'learning and development of registered nurses in practice'. She enquires whether it is just about 'new' ones and I replied 'no'. She then asked: 'How will you do that?' and when I explain about observing and talking to the person concerned she interjected with 'but we also go on courses and read'.
5 My reactions are slow but accurate,... the nursing is in-bred in me so that I can make judgements even in the absence of information... the constraints on my performance are limited by my ignorance [of the local context] and heightened sense of responsibilities.

The research was generating material for dialogic/textual analysis[2]: its hermeneutic dimension. On a personal level, the reflection *upon* my language, phrases and actions provokes its own challenges, for example extract 5 includes the expression 'nursing is inbred[3]', which can be interpreted in a variety of ways. Including this expression is an exposure of self- at -that -time. It is tempting to omit it! Each comment and statement, whether composed in haste, deliberation, with energy or lassitude, reveals 'something' about, and to, the author/reader.

[2]In some respects often Socratic in nature.

[3]When reviewing this expression, there was a certain 'ouch' experience concerning the assumptions behind the expression.

The first shifts: months 1, 2 and 3

I entered the field on five occasions to orientate myself and to note V's early development. The familiarisation day was a reciprocal event in that the natural curiosity of the nursing staff and students led to demonstrations with the tape recorder and conversations about 'learning in practice'. The first shift with V involved further orientation with other members of staff and was focused in the high care area of the ward[4]. When demonstrating the tape recorder, V kept looking at a gentleman in an adjacent bed, she turned and said to him:

> V finish your tea in a moment: your sats[5] are dropping a bit... breathe deeply and easily.

V had learnt to monitor the saturation levels, but more noticeably, she recognised the patient's potential anxiety over this 'close observation' which generated a dialogue between V, the patient, another staff nurse and myself about equipment behaviour and the normal variations. There was a constructed nature to the conversation, in so far as dialogue and 'story telling' were being deliberately used to allay the patient's anxieties about the visual analogue scale which was revealing dramatic reductions in his saturation levels as he drank his tea.

> Learning is going on through conversation: it is almost imperceptible. The relationship and conversations which include the patients and the staff seem to involve mutual learning. Anecdotes are used to convey particular meanings [for example the conversation about the saturation levels] (notes).

During this first shift I was evaluating my role and actions and the extent to which I did/should engage in action. By the second shift I was able to concentrate more fully on V, her practice and development. Once again V's learning was stimulated/triggered by patient requests and queries:

[4]The ward layout was 'L' shaped constituting 6 bedded bays, a couple of single rooms and one 6 bedded bay designated as a high care bay. Here the acutely ill or most dependent patients were nursed. The bay was equipped with additional monitoring equipment and had a higher staff/patient ratio than the rest of the ward. This bay was of mixed sex, whereas the other bays were single sex.

[5]'Sats', refers to the extent that the blood is saturated with oxygen. Here the patient's 'sats' had dropped and he needed to stop drinking and replace his oxygen mask.

> A lady who was being discharged home in the midst of some diagnostic tests was enquiring how she would get to know the results and what might happen as a consequence. V didn't know, and so she went to enquire *in order to answer the patient's question*. It is unlikely that this would have been learnt if the patient hadn't asked and V hadn't been motivated enough to enquire... V could have learnt to prevaricate or make something up- which she didn't do - the sense of authenticity is very real.

This might seem a small and insignificant 'procedural' element to learn, yet its relevance to the patient was crucial and V needed not only to 'know the answer' but also to judge whether any 'additional' preparations might be required. V responded to the patient cues that she noticed (particularly those elicited through conversation), was an active listener and offered patients time to talk. Her organisation seemed good, although she had problems with timing and constantly had to readjust her work to cope. It was evident that she was unable to anticipate (but that also seemed problematic for some others on the ward). Her strong sense of independence meant that she was politely refusing assistance from colleagues, unable to 'see[6]' that they were trying to assist her.

V's knowledge and experience base facilitated some actions, but inhibited others. Thus, during shift 3, she was aware of the need to consider the administration of regular medications before giving a premeditation and was consequently referring to the doctor for the appropriate judgement. Whilst some discretionary judgements were being undertaken in relation to nursing actions, she acknowledged that her judgements weren't good enough (yet) for her to rely upon them. In consulting/seeking advice, she had been deferring to the medical staff on decisions as to whether a patient should be returned to the ward from the Intensive Care Unit. V had been 'in charge[7]' at the time and commented that she 'really shouldn't have accepted the patient':

V Next time I'll call the bleep holder.[8]

She considered that she had been 'thrown in at the deep end' and that in the future she would seek advice from a more senior nurse in these situations

[6]Meant quite literally.

[7]V had been the nurse responsible for the ward and nursing care on that shift.

[8]A senior nurse (ward sister level or above) who was 'on call' as an advisor/ manager for a group of wards.

(who by inference could be more assertive with the medical staff). In the account of this incident, V was describing her inexperience, how she learnt from it and was beginning to challenge the decisions of the medical staff. It is during this period that she comments upon the necessity to *listen to her instinct,* interpreted by me as being able to 'listen to herself'. However, other aspects of her practice showed clear gaps in her clinical knowledge and limitations in her capacity to 'see' clinical signs. Thus, whilst washing a patient, I noticed a swelling on a patient's side that she had missed.

> ..the significance of what she is seeing [and of course what she isn't registering] is still to be learnt... there is a lot of information that she hasn't acquired simply because she doesn't know about it -the Meno dilemma (notes).

Thus both the 'seeing', the 'registering' and the potential 'significance' are absent in this instance. A week later, this 'failure' to observe is reflected back to me by V, who was worried that she had missed it. Another aspect associated with these clinical signs, is learning which clinical observations to take and how often. At this stage V considers that she 'takes too many' which subsequently leads her to 'take too few' as witnessed in a key episode in month 4. This particular form of judgement has workload and clinical implications for the patients concerned and requires a balance between clinical knowledge and risk probabilities.

The potential relevance of information to *other staff* has also to be acquired and was observed through listening to, and being in receipt of, verbal 'hand-overs[9]'. During the second shift, V gave me details of a patient who had a potential carcinoma, yet she did not 'pass on' whether the patient was familiar with the diagnosis. Another obvious 'taken for granted' was that:

> ..it is of course unusual for a staff nurse to actually work with another person unless they are junior in rank or experience. There is a noticeable absence of working with people, the staff meet up for activities that need two, but primarily do not engage otherwise, thus it is difficult for someone to learn from another person if they are not together (field notes).

[9] An expression used to refer to the nurse literally 'handing over' a patient to another nurse. This refers to the verbal exchange of information which is accompanied by written records and sometimes involves interactions with the patient. The expression itself evokes the use of the 'hand' in nursing care.

Working in isolation inhibits learning through direct observation of others. V emulated others:

> She learns quickly, a patient was breathless with me and I was using relaxation/imagery to help the patient control her breathing. V came in and observed this and then later I saw that she was attempting the technique with the same patient (fieldnotes).

Inevitably perhaps, V is observing *me* and learning from my actions, one of the features of participant observation, yet a process which provides additional material for analysis. V's personal qualities of perseverance were witnessed when she assertively sought attention for the patient. There was an increasing recognition that 'handling the doctors' was something which V considered that she hadn't learnt as a student and yet was an important skill.

During these first three months V had been working primarily in the High Care area of the ward, some of her colleagues considered that this acute area was perhaps inappropriate for a newly qualified nurse. However, thanks to recent experience on the main ward she was beginning to *'see the ward more as a whole'*. By the third month, V no longer considered herself 'new', she felt more confident and a part of the ward team, able to contribute to ward based meetings. The benefits of her pre-registration community experience became evident when she outlined her suggestions for improving patient's discharge arrangements. However her increasing responsibility through 'being in charge' was generating new problems. This account of her growing sense of responsibility and the genesis of 'forward thinking' is revealed in this described incident:

> V mentioned spontaneously the issue of the tetracycline pleuredesis and the responsibilities of being in charge.... she didn't know how to do [it]. So, she had informed the house officer accordingly, realising that the next shift contained inexperienced staff and that they probably wouldn't know what to do either. One of the consultants came up to her and asked her how things were. She explained her problem to him and he said that it was the house officer's job anyhow! ... she had also learnt how to handle the house officer after the episode with the consultant: it was mainly she said, to do with 'having confidence' (notes).

There are evident uncertainties concerning the roles and responsibilities of different members of the healthcare team in that unit (and indeed one suspects from the house officer). From a DA perspective there are clear attributions of accountability, responsibility, and confused power/knowledge delineations, requiring definition and then 'confident' action. The *attributions of responsibility* are both for the present and for the anticipated future. V is indicating that the procedure could not be undertaken by the present shift, nor by the next one. Thus action was required in the present. Secondly, I note the attribution that 'handling the doctor' was associated with 'having confidence'. Interestingly, the fortuitous arrival of the consultant and her confident engagement with him led to the resolution.

V was also learning *'illness/disease trajectories*[10]*,'* or patterns through personal observation of patients with particular problems:

> V I have noticed that patients who have had oesophago-gastrectomy with part of the pancreas removed often don't *do well*[11].

Here she has compiled a general hypothesis from encounters with individual cases. This knowing was not overtly connected to particular physiological processes, nor related to explicitly learnt knowledge. It was a hypothesis which was learnt and evaluated through personal observation. So whilst V was 'missing' some aspects of clinical perception, she was acquiring others. Unfortunately she lacked a forum to debate and validate her interpretations.

V remarked that she was learning to do 'everything for the patient at once', rather than just going from 'task to task'. She gave the example of helping a patient to wash, doing their wound dressing or removing sutures. When doing these activities consecutively, she can talk to the patient continuously (asking them about their home circumstances for example) and by inference get to know the patient better, and 'do several things at the same time'. This clearly represents the capacity to **learn how to give holistic care**

[10]An expression used to refer to the way a 'typical' or 'individual' person may experience the progression of an illness experience.

[11]I have entered this italic to indicate a 'common expression' used in nursing.

rather than **knowing about holistic care**. She now knows what **holistic care is**. However this account also indicates a change in her capacities of concentration, she can now 'talk and do' in some circumstances.

It was during this third month that V experienced her first 'hospital' Christmas: a Christmas that the staff referred to as a 'sad one' partly due to the large number of patients who were 'unable to eat or drink'. V was feeling tired and 'not quite with it'. We discussed the strain of working over Christmas and trying to fit in one's own Christmas preparations. Here pragmatically was the dilemma of learning how to manage work *and* one's own personal life. It was during this period that V initiates moves to change her residence which occurs in month 5.

Month 4 - a significant event

During month 2 V's ward sister (D) who 'had been my support before', became seriously ill and her subsequent absence as a clinical leader and V's mentor had a marked effect upon the ward. When this began to impact upon the relationship between us, I adopted strategies to deal with it. A staff nurse who was *trying to be helpful* advised her to:

> forget what you have been told in college, forget what you have learnt from books- just get on with it.

This was directed without any explanation or indication of what 'it' might be! As a consequence of earlier discussions, V was now permanently 'on the outside' and rarely in High Care. She comments that 'I can't go on like this[12]' and determines to discuss her situation with one of the senior staff nurses. V had now learnt some of the routines and was actively seeking to discover what she called the *'little secrets'* of practice. In this example concerning the peccadilloes of a physician, she describes how she learnt from a fellow staff nurse:

> V I've got more into the routine than before.. first you have them all ready straight away- no matter what- because he [the doctor] calls for them out of order. It's little secrets like that you need to know, isn't it? [laughs]. But Z taught me that.

[12] Namely being tired and feeling unsupported. There was possibly a worry that she was facing some resistance as a member of the first cohort of Project 2000 diplomates and the 'buffering effect' of the ward sister was now missing.

The fascinating aspect is that V is learning how to survive and engage in a practice that is **not** an ideal scenario. The nursing staff are colluding in, indeed one could argue were subservient to, a practice which is not necessary and essentially not patient centred. Thus despite the previous articulation of learning holistic practice, it was also important to learn the routines which make life easier/ more comfortable. The consequences of the routine being disturbed became apparent during one busy evening shift that I observed, for as V described:

> V on a late at 1530, you go around and assess all your patients, but quite often on a day like today you get called away.

This break in the routine was an element in one of the most significant events in V's nursing development. For this reason, I shall describe it in detail, although the extensive notes and transcription extracts are found in appendix **8.**

Vignette 1. L: the professional 'sportsman'

> The patient, a young man L, was in a lot of pain. He had a pneumothorax [burst lung] for which a chest drain had been inserted into his chest. According to the morning X Ray his lung had recovered. During the course of the shift [1300-2100] V had been convinced that something was wrong and repeatedly went back to L to observe him, and then she would go to X [the nurse in charge] to express her concerns. Throughout the evening V persevered in her attempts to get L reviewed. Unfortunately, the house officer was dealing with an emergency in Intensive Care and was not seen on the ward until after V's shift had finished. At 2030, I decided to do a set of observations [V was giving handover] and discovered that L had a temperature of 39°C.

This episode was explored at length in a subsequent interview with V. I endeavoured to ascertain what she had been thinking, what she knew and why she had persevered to get attention for L. I had assumed that she was responding to the pain of L, but not to the other clinical signs. I also wanted to explore why she hadn't taken certain actions herself and to contrast her perspective with mine. The interview provides a comparison with V's earlier remarks in month 3 that she 'probably takes too many observations'. Once again the judgement of knowing which observations to take and when, remains an

essential aspect of clinical knowing. The episode was significant because it combined several skills which were necessary so that V could not only make sound clinical judgements, but also so that she could *act appropriately* in response to her judgements. The incidents revealed that:

- there are clinical 'facts' to be learnt whose presence or absence inevitably shape the judgements reached.
- These facts need to be observed (which may necessitate 'taking observations'), recognised, and their salience comprehended.
- The judgement involves a 'moral dimension' concerning what the nurse considers to be 'good/true/not right' i.e. the nurse's level of tolerance must be aroused.
- The relational tie to the patient and/or the knowledge of the patient provides its own parameter in respect to the anticipated 'normal' response.
- The nurse also need the requisite skills in 'presenting the case' both to her nursing colleagues and to the medical staff. The example demonstrates the nature of 'presenting the case'. It requires the factual bases outlined above, but also interpersonal strategies and mechanisms for providing accounts of events which subscribe to a particular format, so that they may be *legitimated and recognised* by others.
- The vulnerability of the comparatively inexperienced nurse is evident particularly in respect to her location within a hierarchy of power/knowledge and the vagaries of significant others within the context.

During months 5, 9 and 15, V relates specifically, and to some extent spontaneously, to this incident with L. In month 10 the response is elicited from a more generic query when she described how she learnt 'simple things like that'. Certainly, my perceived interest in specific instances may well have evoked subsequent reflection upon the incident.

V faced problems with colleagues, a busy evening, a difficult clinical situation and the limitations of her clinical and professional expertise. The

intensity of the shift led to several learning episodes, each one driven by a patient care requirement/ procedure. For example:

> A lady who was the most dependent patient that evening had a deep venous thrombosis (DVT) and possibly a pulmonary embolus. V asks me about the incidence of DVT's. I am surprised that she was not more familiar with this... in observing the patient's leg I considered that the circulation problem looked more arterial than venous.

V feels quite dispirited at this stage, at the end of the shift she comments that she remains 'very tired' and lacks support. She suggests that she could have been more assertive, saying 'No' to some of the workload that had been assigned to her.

Month 5

V had been unwell and was finding it difficult physically to adjust to night duty, speculating that her illness may be 'stress related'. V's consideration of her current state, no doubt the 'forced reflection' engendered by the discussions and interviews with me led to articulations of her development, perceptions and other influences upon her. The degree of clinical specialism determines that there is a lot for V to learn, and become:

> V one of those things... to find out at an appropriate moment.

The question arises as to when and what is the appropriate moment when there is so much to learn. There was a noticeable improvement in V's confidence, she was 'taking ward rounds' and openly discussing her needs with other members of staff. V starts to look forward in respect to her own development and manages to obtain agreement that she should have a mentor. She received support from one of the nursing auxiliaries, who was 'almost like a mentor'.

Others comment that:

- she is trying hard, she is liked, she tidies up
- she tries to do things as she has been taught - but that isn't always possible...

- she's had a hard time from some of the staff: this is attributed to her being a Project 2000 Diplomate and a particular individual.

V confronts the person who had been giving her a 'hard time'. She describes these first few months as a 'struggle', once again using the metaphors of battle and conflict. V is invited to participate in a group looking at the needs of newly qualified staff and this provides a focus for her to discuss 'mentorship needs'. She sought feedback from a senior staff nurse who says that:

> V there's absolutely nothing wrong with my nursing care, she's very pleased with that.

In discussion with a member of her family (Z), she recognises that she may appear more confident than she 'really is' and consequently not require help:

> V ... that's right, that's what Z thought. That I was giving the signal that I knew what I was doing... It's strange because as I perceive it, I feel that I'm not confident. I'm not confident at all... sometimes I'm a real jumble inside and yet I can't understand how I come across as being this person who is in control - which I obviously manage to do- and I'm not. My self awareness is perhaps very much low in that respect...

V's awareness that there are different ways to perceive things 'taught her a lesson'.

> V it's funny how you can see things, but they are not actually how they are. it (.) it's so (.) It seems such a small thing, but it isn't- it's quite a large thing. It's a sign of my insecurity in a way. (.) I still feel that there is so much that I don't know about... I can't think what I've got to do -it isn't coming naturally yet.

V recognises that she has to 'concentrate a lot', but it is 'coming easier' and that is something that she has learnt. Furthermore she can now concentrate on what she is doing whilst doing other things as well. Throughout the discussions, interviews and observation sessions in month 5, one notices the attributions to confidence, insecurity, struggles, beliefs about 'good practice' /rightness and V 's location in relation to Others (extract A. appendix **8**). By the

end of the month V was looking forward towards her own future and initiating actions to resolve some of her worries because:

> V As I said to Y, I felt that I've settled in... I've got over the newness and everything and I need to know how I am doing. I need feedback ... I've got to build my skills. And I want to know if I am employable at the end of the year... I was getting into a bit of a state and my confidence was getting knocked and I was getting lower and lower... It's got to be more positive... But I think people are afraid sometimes to give you that feedback.

V is taking the initiative herself, realising that 'others' contributed to some of the difficulties that she experienced.

Month 6

V is now much more cheerful and animated, she speaks with an increasing degree of fluency, delegates more, is better organised, her judgements have improved and she takes the initiative in respect to the outcomes of her deliberations. She is developing her own strategies and patterns of work. In some areas of practice there is very little hesitation and her liaison with the medical staff is more effective.

During this month V admits:

> "I enjoy having you here now, in fact I quite missed you".

V describes it as being 'really quite harassing' and 'traumatic at times'. Despite having achieved agreement to have a mentor (S), V outlines the problem that 'we don't actually work together very much', although she does 'go and ask her (S) things'.

> V She's very good at putting your mind at rest and saying 'well that's natural'.

Once again, 'being settled' and 'feeling part of the team' contribute to V's sense of well being and the acknowledgement when something is 'natural'. Her problem with X had been confronted and through V's assertiveness coupled with the intervention of a more senior colleague a more positive outcome was achieved, as she described:

V ... because sometimes I was quite worried. I really felt that on that occasion again, because she was the nurse in charge, it was actually a dangerous situation....

V described how the 'calmness' of others used to throw her.

V And I was getting quite frustrated because I thought you were ignoring me... And I know that if, if Y is not flustered, you don't need to be flustered... and I said: 'now I see it as it is', whereas I think I was misinterpreting it... I've tuned in a bit more as well.

Through V's increasing capacity to relate to, and to *read,* other members of the team, she is better positioned to learn from them, particularly the 'little secrets,' the 'trick of the way things have to be done' .These factors contribute to being able to 'work my workload':

V ..I came on and I learnt so much in that night. It was in a complete mess, and I think I've got more the trick of the way things have to be done. And able to work my workload now, coming to relate to it a bit easier. And that's thanks to Z [who] put me straight. Because I thought she's very organised- she's the one to go and see to get the advice.... She said: 'oh, alright then', she said. 'It's easy she said, you just sort of do this and store it all up here she said [V is pointing to her head and tapping it as she says this].. and then you'll be alright... I don't think she was so conscious of how much I actually learnt from her. I thanked her the next morning, I learnt a lot of little things. ... A bit more about suction the as well, about the sounds of suction. And when you know you've hit the spot that it's at. And you need to linger there a bit longer - which I had never known before. It's sheer practice isn't it?

These 'little' things/secrets include 'putting it up here' and the 'sounds' and 'feel' of suction as I outline:

M .. and I can remember one occasion when you were sucking him (a patient) out.. and he was chesty. And I could see then that you knew how to suck him out, but you didn't have the feel for it

V um there (pointing). That probably meant we hadn't done much recently..

M //and you can feel the spot

V yes

M //where you're suctioning

V //and hearing/ listening for it as well.. 'cos it's like in a plug isn't it?... I suppose that's a bit more pull on the catheter as well

The metaphors of 'clinical' discourse are interesting here, V is employing sound metaphors and I introduce touch metaphors. The flow of conversation is effortless with assumed understandings in the 'turn taking'. The development of these clinical discourses becomes more apparent in subsequent months. The 'seen as', 'similar to' expressions become increasingly evident. The connections between the intensity of the experiences and 'learning' are also clearly articulated. However the time intervals between actions can lead to a decline in function:

> V Z helped me learn something the other day though, she helped me to take out the tubes[13] and I hadn't done it for a little while, and I had to really think what to do.. tying the stitch and I'm absolutely fine with that. And we had one with a clot on, and I was panicking because there was this clot (.) and I was just sort of mesmerised by this. Terrible really because I couldn't think of anything else and I thought 'what's that? what have I done?' I thought it was something that I had done. And then she (Z) realised and she apologised afterwards - funny.

Here we note her experience of panic, the location of responsibility, and her inadequate knowledge which lead V to believe that 'she had done something'.

Months 7 and 8

Elsewhere I have analysed my role within the night duty observation. As the 'person in charge', V carried the responsibility for decision making. A characteristic feature of night duty is the judgement processes that are required in the absence of readily available support. Furthermore there are clinical decisions where risks and effects are balanced in order to promote patient comfort. For example whether patients should have observations undertaken which would wake them up. V's time management is greatly improved, she is

[13]Chest drain tubes.

more assertive and comments that others are not always prepared to 'stand up'. An illustrative example of her development would be in the management of patients commencing nasogastric feeds after oesophageal surgery. Whereas in month 4 V would defer any decision to others, in month 6 she learns to distinguish the types of problems the patient may have, would take action and then have it checked. In month 7 she initiates action, notices and responds to associated factors and accepts autonomous action in this aspect of care.

The cycle of development is thus:

- ability to recognise a potential change/problem/ issue;
- ability to report/record the problem to another;
- awareness/anticipation of the possible response (s) to be made;
- ability to defer the decision appropriately to another;
- ability to initiate appropriate actions;
- ability to make an effective judgement, have the capacity to make decisions, initiate appropriate responses and accept/take the responsibility for so doing;
- ability to appropriately delegate to others: whether actions, decisions, judgements or responsibility.

However in vignette **1**, she lacked the clinical knowledge and discernment to take assertive action. Her degree of proficiency is thus not only contextual, but is limited to her clinical knowing. These comparatively 'small' examples illustrate the complexity of becoming skilful in one aspect of practice and whilst there are similarities to other elements of practice (for example administration of intravenous fluids), transferability of skill and knowledge requires cognisance of both the similarities and the differences between the two aspects of practice.

During month 8, V was away on holiday and on further night duty. She had applied for another post in the same unit when her contract expired and was looking forward to the interview. In fact, when she was on night duty she had been asked to go on relief to the other unit, enjoyed it and felt that they may have been 'trying her out'. V phoned me and asked for advice about the interview and the 'current issues' in nursing. We meet and discussed the

possibility of 'scenarios' being used in an interview. V is happy for the research to continue in the new setting if they are agreeable. V is now referring more explicitly to 'working with me' rather than being 'researched upon'. During this meeting V's confidence was noticeably greater. She was reading and preparing for the future, weighing up possibilities, still with an ultimate goal to do community nursing. She deliberately consults with more experienced colleagues to gain as many perspectives as possible, I was one of them!

Months 9 and 10

The interview[14] had acted as a motivator for V, she continued to visit the library and explore aspects of the speciality, particularly in relation to the new ward. V is now responsible for assisting in the orientation of a new member of staff and this gives her a different role within the team. V comments that she might 'overload' the new person as there is so much to learn! She reflects back on the episode with L, how it taught her a lot and how she knew there was something wrong. Her narrative of this episode is now recalled with humour and drama. Her referral/ delegation skills are evident and senior colleagues obviously delegate more to her.

Once again it is the fluency, both in dialogue and performance, which seems to mark her capacity to recognise diverse threads. Similarly her relationships with others are more fruitful and constructive. I noticed that she was more observant of minor details of care and when she was confident in her knowledge and its accuracy she would make independent decisions. However, on other occasions she would note circumstances yet not act upon them. For example when observing one patient attached to a cardiac monitor, my judgement was that the monitor could be discontinued, yet V was reluctant to do so for several hours. V's increasing capacity to articulate her deliberations and consider potentialities in situations is evident.

She is in charge of the ward more frequently, particularly at weekends, and realises that she enjoys organising things. There were overt illustrations of V being more able to notice the performance of experienced

[14]She had been successful in the interview and it was agreed that the research could continue in this setting.

colleagues and actively 'modelling' some aspects of their practice. She considers that she has survived the first few months and that since her holiday she has taken 'some more steps'. She attributes going for the interview as making her 'think about things a bit more' and having had 'a bit more responsibility'. She remarks that:

> V You can become detached from the nursing because you have to.

Here we notice the importance of 'detachment', responsibility is making her plan, she is able to explain what she is doing and has a greater sense of liveliness, order and an ability to deal with situations herself. V tries to pass information onto others and to anticipate what may be required. She is working more automatically now. She is noticeably more inquisitive, and assertive with the medical staff thereby improving her understanding of their perspective. V's clinical knowledge is growing but inevitably still incomplete, she describes her ability to 'think things through and initiate things' as being:

> V ...due to experience. I think a lot of what I'm doing now is having seen somebody in a certain situation I sort of relate back to that (see extract B., appendix **8**).

V considers that this development was 'gradual' and is engendered by responsibility.

> V ... you know it's down to <u>you</u> and perhaps you take <u>steps</u> that um. (.) In case something does happen and then you know.

The analytical and evaluative way that V recounts her reflections upon her development is marked. Her speech is fluent, animated and evokes the interrelationships between V, others and responsibility. This responsibility and accountability *are growing*. The isolated nature of 'being in charge' generates responses from the individual in an attempt to 'control' and prepare for the 'unknown' but 'possible'. The 'between us' responsibility of nurse to patient and nurse to others. The importance of preparation becomes more essential, the need to anticipate and prevent difficulties. V identifies her growing knowledge and experience base and indicates changes in the way she is thinking:

V Yea and, I don't know, I'm doing a bit more revisiting of reading around what's going on as well to refresh my memory again. And maybe think about things, sort of think about things more carefully as to why such and such is happening.

Once again as the variety and number of patients that V has encountered grows, her repertoire of cases and persons, and persons as cases, from which she generates concepts of similarities and difference extends. In her account of patients with myasthenia gravis, the parameters of age, acuteness and weakness become focal points of sameness and difference.

M So how did you judge what was similar and what was different?

V Um, the acuteness of it was very different, although the weakness that they both suffered was the same. So therefore the acute stages could have developed with the second case if you see what I mean? (yes)

This was described as a rewarding activity. Another 'nice feeling' is associated with being able to 'pass on information' to others. Working with students and the new staff nurse enables V to realise[15] what she has learnt. When asked what could have been passed onto her, to help her develop, V replies:

V ... at the beginning of the shift, just making sure that I felt alright with looking after a particular person- whether I felt comfortable in taking that on, and did I understand exactly what I was looking for etc.. The bits of information that automatically 'click' to you. You're thinking 'Oh I should be watching his output etc. I should be watching his blood pressure' um, you know... giving some guidelines to work within, and I mean a lot of it. .... It's working out why etc. because when you are at the beginning of the shift you can't go and relate to a text book, you can't go and get the text book out, you can't sort of read away can you? (extract C., appendix **8**).

As the narratives continue, the contingency of situations is manifest, the importance of working out 'why', when there may not be a guideline or text book to help. The continual use of 'looking, watching, reading'. Once again the predominance of 'not knowing' and when something might be known, the

[15]Evocative of Socrates 'recollection'.

possibility for the 'unknown' or unpredictable to occur. The necessity to *anticipate* is conspicuous. A temporal change from the here and now to the possible future scenario. The ability to 'find out' gains a different relevance from her earlier 'need to know' descriptors. V continues after a further prompt:

> V Sometimes it's quite difficult to find out what you want to know. I think I've got hold (?). Also, I'm more confident to ask now as well. Although I always used to ask questions, I ask more now, that's strange isn't it?- because you feel more comfortable and you think it's good to discuss it.

This is a development from earlier statements when in month 5 wanted to learn how to 'stand back and debate'. Here she is indicating an acknowledgement of the importance of others perspectives which can be obtained by asking more questions and listening. Furthermore, this questioning and discussion *makes one more comfortable and is in the patient's interest.* Yet again, confidence is considered to be important. In this next episode V is commenting upon the relationship between some of the medical and nursing staff which 'at the moment one's going off one way and the others going off the other way and they are never going to meet':

> V ... I mean it's to the patient's detriment.. but hopefully with confidence growing and things like that, maybe I'd be able to do a bit more along those lines- I'll know what I am talking about, and (.) um can express concern.. because then you can get their idea back as to why they are thinking about something and then you know, it's sort of discussion isn't it? You're finding out what they are worried about and concerned about and they are hearing what you're concerned about and that might alter what they do.

The ability to stand confidently, be knowledgeable, listen to others, discuss and then act is articulated as an ideal goal. V discusses how there are always 'shades of grey,' some of which may be 'filled in' during her next six month contract in the adjacent unit. She acknowledges the importance of being able to 'pick up' information, 'grab situations' and become 'au fait' with technical things so that one can become 'confident'.

> V So that if somebody asked me to go and do it, I could go and say 'yes' and get on and know exactly what I am doing.

Because it's something I'm not very good at, at the moment. But hopefully X ward will fill that gap.

This account is similar to what Melia (1987) described as 'nursing in the dark', a term she used to describe how student nurses learnt to nurse in the absence of information and knowledge. V is gradually learning what to do and knowing who to call if she 'gets stuck'. V has also learnt what it means to 'put it up here':

V yes , you've got to think.. the biggest thing I use that for is analgesia. (//right) Um, sort of when I get there, I look at the charts and see where I am and think 'right, that's going to be due about (right). because otherwise it gets forgotten, particularly during the daytime'... I use it with others things as well.. then I think there is this time and this time I've got to look for, then think. And you think at 1030 I've got to come back and think that analgesia and then say at 1100 for this gentleman in here. And it does work, and you do look at the clock and you think 'Ah yes' and you go and sort it out.

M Yet it's um, how can I put it? It's not quite clock watching though is it? or is it do you think?

V No, no, not watching the clock, it's just you make a mental note which reminds you to go and see to it so that it's kept OK.

There were several anecdotes described and observed during this period which illustrate V's articulation and interpretation of the events she has experienced and anticipated. V and I could engage in lengthy discussions and 'shared narratives' about practice and the possibilities therein.

Months 11 and 12

During an evening shift, V is in charge, although a more experienced nurse was on duty in the High Care area. The 'hand over' I received from V is far more detailed, as is her attention to written records and other people's accounts. She notices omissions in the reports of others, whilst recognising that with experienced nurses you can hear expertise 'in their voices'. She is planning and thinking for the whole shift and takes advantages of opportunities to manage time and routines more successfully. V is now noticing inconsistencies or

anomalies in patient's accounts of their experiences/ expectations and seeks the underpinning reason. She remarks about a patient with a fever:

> V I don't know what it is but there is something about him that's not quite right.

Month 12 was the last occasion with V before her ward change. She prepared for the move by reading relevant clinical topics for the setting.

V is continuing to develop her skills as a shift leader, her dialogues with and about patients are more spontaneous and natural. With technical skills and procedures with which she is familiar her operation is smooth and effortless. Her deliberations are more overt as she calculates decisions and actions. The ward has been short staffed and V was eager to share the 'happenings'. She delegates work to me now and incorporates my presence in her decision making. At the beginning of the shift one can clearly see her priority identification, she orders her pocket notes and highlights key events. There is a pattern of activities which she initiates at the commencement of the shift, she does a round of her patients, checks charts and paperwork, clarifies where relevant medical and other staff are located. She arranges activity to try and ensure that she has control both for the expected and the unexpected.

Her increasing self assurance is witnessed with both doctors and patients. V was observed to be arguing more assertively with the medical staff, and not being satisfied with the competence of a doctor, she comments that, 'I always check his decisions'. An example of her acquired personal knowing was witnessed when she was engaged in a discussion with a medical representative who was demonstrating some new chest drain products. She commented spontaneously:

> I have noticed that the rubber tubes come out much more smoothly and with less pain than the plastic ones

V's colleagues agreed and I felt the edging of the two different tubes. The plastic ones were cut at a different angle and felt 'sharper' to the touch: here was acquired knowing from observation which is largely undocumented.

Month 14 new clinical area

During the first shift in the new area which comprised a six bedded High Care Unit, I quickly introduced myself to the clinical staff and undertook the usual demonstrations with the tape recorder. Due to the close proximity of the staff and patients, it was quite difficult to actually record in the unit. My first observation was how comparatively relaxed V appeared, even though she was new to this specialist area. Her capacity to pick up patient's psychological cues was marked, although again hampered by her restricted clinical knowledge.

V was acquiring the 'routine' and pace of the new area quickly and enjoying the higher staff to patient ratio required by the patients. Whilst her specialist knowledge is limited, V does have a range of experience and knowledge from her previous ward and when a patient reminds her of someone on the first unit, she becomes concerned. She 'didn't want this to happen to him', so she monitors him carefully and sought early interventions.

There was more interaction and dialogue between and amongst both the nursing and medical staff than her previous ward: information is shared more openly. V was learning from the numerous conversations about patients, their problems and the possible actions to be taken. This aspect to her learning becomes more noticeable in later months when V herself contributes more directly. However the experiences of being unprepared and untaught return.

> V .. and in the end I got her there.. and we had an arterial line to take out - and I had never seen it done and I didn't realise it was quite as straight forward as it <u>was.</u> But even if somebody had just said well this is all it involves, V, 'you'll be fine you know'- but that wasn't forthcoming.

One notices the remarkable similarity to the needs of the previous year, however V can now manage these situations and seeks support and advice, for example from X a senior staff nurse who is:

> V 100% **brilliant**. She let's you grow with confidence, you know really, brings you out, it 's **marvellous.**

V contrasts the styles of the senior staff, noticing how they work, support one another (or not of course!) and how through efficiency they can

actually appear intimidating. V is not as daunted as before, as she has learnt that there may be different perspectives to each situation.

In this new setting, there are different technical skills to acquire, patient experiences and illnesses to recognise and appropriate responses to develop. The intensity and dependency of the nursing required frequent decisions and judgements. Specific examples would include when and how to wash very tired and unstable patients. The contextual nature of each person demands decision making patterns which can incorporate both the generic medical problem and the specific characteristics of the individual person and their situation, e.g. titrating medications to maintain designated physiological parameters. The often 'unstable' nature of the patient's condition and the possibility of sudden emergency admissions determines that some shifts appear to be ever shifting sands where control of time and space is important. The skill of 'pacing' is essential.

Months 14 and 15

During month 14 the episode with Mr. S. is experienced. V and I met to review the research, to try and 'verify' the accuracy of some of my comments and accounts and to begin the process of closure (month 15). Appendix **8** contains some of the scripts and notes that I shared with V. However, I was surprised by the additional insights that V offered before the texts were displayed. Recurrent metaphors are 'being attuned', the acknowledgement that 'horrendous episodes' aren't so 'horrendous' any more and that furthermore, if they are, then one 'probably doesn't act as well' as one should. V authenticates the material and comments:

> V ..it's good to have a look at what's come out of it. I think it does fit in with my own thought process that things, I myself having improved in confidence, being able to act more autonomously and actually doing what I am supposed to be doing. And making a better job of it. And feeling a lot more comfortable with my role.

There are also discursive changes which become evident to V:

> V .. the way I am talking even is different. The way it comes across as well doesn't it?

V identifies other differences in her practice (see appendix **8**). Her increasing competence in managing various aspects of patient's fluid balance is witnessed several times, for example she comments about Mr.S.

> V I'm still reeling at the change in him, which is nice because it means that having now *looked after him,* and having been *involved with him* and *looking into the drugs* he was taking, about *his particular case*. That is knowledge I will take on again, because **he** was **something** I looked into... The reason I made the connection (about his depression) is that I was actually looking through all the drugs he was taking, that I didn't know- like Melleril. And that's how, it was there in clear print... Melleril interacts with the dopamine ... and also it made me realise as well -because he was taking allopurinol for the gout and I suddenly thought: 'well the renal failure may be worsened by the facts that his kidneys are not being perfused because of the problem with the valve'. And I suddenly thought he would not need, I wouldn't have thought, depending, to see how he goes. Now he will not need to be taking that as a long term thing- because hopefully er, the uric acid levels in his body will fall because they're being excreted wrongly... I think that is some thing that I am more able to do now because of the set up I am in. Really being able to home-in on a particular person, and that's quite a learning.

Mr.S. is perceived as *both a person and something* which she *looked into*. The learning derived from this situation is initiated by V's interest in him as a person and her interest in what was 'wrong' with him. She is able to *make connections* between various physiological, pharmacological and personal processes. However, even V was surprised at the change in him. She is learning how to 'home in' on someone.

In this interview, there were numerous examples of V's increasing confidence and capacity to make connections between her observations, her experience and theoretical knowledge. Towards the end of the interview V discussed her plans, she was now half way through her six month contract. She needed to establish whether she could continue in the unit and undertake a clinical skills course or whether she needed to look elsewhere. Whilst she seemed bright and motivated at work, she was most worried about what would happen when her contract finished.

At the end of the month, the day before I was due to work with V, she telephoned my home and left a message to say she was off sick and therefore I could not work with her. The following week I was away and then I had a nasty bout of flu. She rang in some state of distress one evening, at this juncture I knew that the research would soon be drawing to a close and I responded to her distress. Primarily there was a problem with the people she was working with. She had lost all confidence and was wondering whether she could actually stay there. I spoke to her about how she was feeling and tried to boost her confidence which I achieved. For some reason in the absence of positive feedback she had lost her confidence again, but when probed admitted that other 'D' grades were feeling the same way. She seemed brighter at the end of the phone call and so I suggested that she rang me the next week when we could meet. She rang later and said that she had decided to go at the end of her contract. We arranged to meet as she wanted me to help her with her Curriculum Vitae. She was going to move with her partner who was being relocated. I was preparing to gently terminate the relationship in the context of the research role: the boundaries were now inevitably blurred. We met again to complete the research and to undertake a 'closure' interview.

Month 18

Despite numerous attempts to work together, V and I did not manage it until the beginning of month 18. She had been trying to arrange interviews for posts in the country. Once again there were marked improvements in V's performance. She initiates changes in patient/nurse allocation. In one incident, she queries an observation with the senior registrar who let her talk through her own query. V was 'talking out loud', articulating her thoughts[16] to him, and he then probed further without giving her the answer. She then came to a conclusion, which she needed verifying, because it was not her decision to make. She came to the 'right conclusion' and the registrar initiated the actions.

Her cue recognition is greatly enhanced, for example she reported at handover that a patient's onset of hypoxia was noticed by him appearing

[16]Almost like a Socratic dialogue - Nightingale: and the doctor capable of eliciting the facts see chapter **9**.

'glazed' and a subtle behaviour change which she had noticed. V 'passed' this 'warning signal' on to her colleagues who acknowledged her observation.

The morning was busy and V acted fluently, appropriately adjusting her work pattern and referring to the more senior medical and nursing staff as necessary. There was considerable interaction that was non- verbal in origin and not articulated. 'Silent' team work, with unspoken acknowledgements as staff members interacted and responded to one another and their perceived perspectives of the patients.

During the few months that V had been on the unit she had developed markedly. Her confidence was assured, her actions fluent within the limits of her knowledge and experience. She was actively studying the clinical problems that the patients experienced, listening to conversations and being involved in decisions. The discursive changes were also noticeable in the oral context and through the recorded conversations.

Months 19 and 36 (interview only)

The 'closure' interview in month 19 was considered carefully. For the first time, I would actively use the word 'intuition' and discuss with V the research, her participation, consent and her feelings. I decided to ask her to write back to me with any additional comments to some prepared questions[17]. I hoped that this might give V a greater freedom of expression. V planned to see me at my home for lunch on her way back to the country. I formally thanked her and gave her a small gift as a 'thank you'.

V arrived late due to a traffic problem and we commenced with an informal chat over lunch, this part of the conversation is not recorded. However, when I began to summarise the focus of the research I obtained her permission to use the recorder, thus clarifying the boundaries of the research. At the end, there was also conversation after the tape had been switched off. Before we parted, it was arranged that V would return the questionnaire to me at her leisure, probably after her holiday and that we would keep in touch. I would eventually forward to her a copy of how 'her contributions' were being used and asked her to keep me posted with her address.

[17]This was not returned, although we met later.

During this wide ranging discussion, V was shown some transcripts and added further post- hoc thoughts about some of the incidents. She humorously commented upon my role stating:

> V I can see you seeing so much as well (laughing) it's not all one way you know! ... on high care especially you've been quite busy, I've noticed.

I asked her about one particular incident, whether she considered it was 'intuition' and she replied:

> V and that was intuition, it wasn't nursing learnt, it was a general way of life, dealing with people

With another example, she confirmed 'that it was', these examples are discussed in chapter **10**. It is probably noticeable by now to the reader, that the words 'intuition' or 'instinct' were rarely encountered in practice without a cue prompt! The oral discourse was more associated with 'knowing or not knowing'.

Most of the examples mentioned in this interview are analysed separately due to their content. V discussed at length however the impact of the short term contracts and the consequential effect of denying her educational opportunities. When coupled with a refusal to give her time 'off' to attend interviews she had become increasingly frustrated and annoyed. From her perspective 'there was no good will'.

V kept in touch during the next year, occasionally phoning to discuss career choices. She thoroughly enjoyed her next post working in community settings. We met again in month 31 when I showed her some more extracts from the fieldwork, together with my comments. V discussed how many of the original early episodes seemed 'all sort of negative things'. She has changed her perspective:

> V .. I think when I first read them back, I used to think this is because I am a new, new nurse (laughs). But I don't think that necessarily had any bearing. There's always things that come up that you <u>don't</u> know (// that's right) what it's all about...

M and that's one of the things I'm writing about- is this business of - you've got it there: the grey (pointing at the script and V's words)

V (reads out) and there all sorts of shades of grey, there are shades of grey (ironic laughter, quietly and softly)

This interview added fresh dimensions to understanding V's perspective with the passage of time. The manner through which she 'reads' the same examples is both similar and different.

Of course, whilst 'tales' are told and this appears to be the end of the story, there had been a developing 'between' us which emerged, changed and then was sustained. V keeps in touch on a personal level and eagerly awaits a copy of the 'final' product. Her permission has been granted for the use of the material. And so part of the Tale is Told.

CHAPTER 6

T, extracts from a person study

First meetings

I contacted T in the summer of 1994 through the auspices of R, a mutual colleague. T agreed to the research, providing it wouldn't involve her in any 'writing!' She had qualified 5 years earlier, working on a general surgical/urology ward before joining a palliative care setting. Knowing that T's clinical setting was engaged in other research activities, I ascertained that there would be no potential conflicts of interest or contamination between the research projects. T's manager agreed that the research could start as soon as practicable. To avoid unnecessary pressure on T, we waited a few weeks until her final degree examinations were completed.

During the period I worked with T, she undertook further clinical study and moved from hospital to home- based care. Whilst there were developmental aspects associated with these moves, the study represents different facets and dimensions to her knowing, rather than discrete, easily observed transition phases as evidenced with V. To preserve anonymity, I have sequentially used the letter of the alphabet to refer to patients/carers/relatives.

First shift: familiarisation

Arriving at 0645, it was rewarding to be both welcomed and expected. The environment was informal yet professional, the staff congregated in a staff room before moving to the 'office' for a patient handover from the night staff. I met the recently appointed ward sister. I explained that I was 'looking at how nurses learn in practice' and that T had kindly agreed to let me follow her for a period of about a year. The tape recorder was shown to those present[1]. The handover was informal and humorous. Friendly jibes were made about the presence of a 'school of nursing tutor'. After handover, the nurses reviewed their allocated patients before preparing for breakfast. During this phase the

[1]I wore the microphone but the not the tape recorder on this first occasion. This I felt would enable staff to familiarise themselves with the microphone and my presence without the 'worry' of the tape recorder. Indeed during the shift as people approached me for the first time and noticed the microphone they would hesitate before speaking. The presence of the microphone therefore enabled me to explain its function and gain trust without any fears of 'recording'.

primary nurses, like T, would outline and specify the care required for each patient.

Apart from the informality and professionalism, the most immediate and evident impression was the evident determination of the staff to achieve whatever was possible for patients and their families - even to the extent of 'rule breaking' when necessary. An example recounted during hand-over, indicated the 'cultural milieu' of the setting, where advocacy, confidence and assertion skills were demonstrated on a regular basis. The organisational structure was primarily open with clear delegation to the lowest level possible. An adapted form of primary nursing[2] was in use. Hierarchical structures were minimal and co operation and facilitative styles were evident.

'Death and dying' incidents inevitably permeated the study, including a recent episode where 5 patients had died in two hours and the portering staff had refused to come. There were 'dead bodies everywhere'. Whilst this dramatic narrative was revealed through humour, it exhibited a clear sense of purpose about the relationships between the staff and the porters, with T resorting to 'threats' in order to get assistance.

The complex nature of decision making was evident through the problems and challenges generated by the care of one lady, Mrs A. (see appendix **9**). This detailed account illustrates the continual and ever- changing nature of decision making which has to respond to unfolding events. There were problems with achieving a balance between effective pain control, the lady's state of drowsiness, and the route of drug administration given the state of her skin. I noted that:

> ... T was continually involved in making judgements and decisions. One can't say that great flashes or insights in the classical sense were being used, yet there was a continual degree of know- how which in most circumstances was being supported by 'know that'. Again, the growth of this knowing was from both the patient experience and also from dialogues

[2]A style of nursing organisation where nursing staff are organised in teams under the direction of a 'primary nurse'. The primary nurse, in this case T, would be the clinical manager for designated patients and took responsibility for their nursing care. Ideally, the off duty of the team would be arranged so that someone was always on duty to provide continuity of care. The primary nurse holds a responsibility in abstentia. In this unit the primary nurse would be responsible for a bay and side ward, about 6-7 patients.

> with the patient, the doctors and other nurses. A noticeable thing is the regular and continual rapport or gaze which takes place between us. For example, looks as we do things, the standing, looking, almost sizing up the possibilities or impossibilities (notes).

T described the day as 'bitty', having been off duty the day before, she was trying to organise and plan the care for the next few days as the primary care nurse. In the care of Mrs. B., T's skilfulness and the effect of my presence are evident.

> It was a pleasure to watch such skill at work. T recognised the fear and loneliness that existed, yet one could see that Mrs. B. couldn't quite accept the future as anything other than a rosy glow. It was also pertinent to note how my presence was being used by the patients as I am not there very often, I was being used as an intermediary by them. Information was passed to me in the knowledge that it would be related to the staff (notes).

The extract demonstrates that my role was neither innocent nor naive. The experience as *nurse* enables *me* to read situations in a particular way and indeed, elicits responses from the patients.

> So the interaction and knowing are all things to be done in relation to actual or perceived responsibilities... she (T) knew how to read the person to whom she was relating, in respect to both the tone of voice, the words to use and the action to initiate. T had feelings about the patients and also a knowledge of the possibility and the patterns that she thought might happen in respect to the patients' response- or indeed the relatives. Not only was T using this information to test out her communications but also as a strategy to help with developing the plan of care. She was prompting independence with help, yet she apologised sometimes to the patient in case she was a bit 'pushy'. The acknowledgement token given in return confirmed the appropriateness of T's actions (notes).

T delegates well to others. It is noticeable that she remembered things without note- taking: echoes of Nightingale's comments[3]!

Month 3

This extremely busy shift contained powerful emotive occasions, revealing the variety and complexity of professional knowing. Several key features emerged:

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[3]Chapter 3.

- that some expressions which may be considered evidence of 'intuition' are used as signifiers by the person to themself and to others;
- the handling of feelings;
- saying 'good-bye' to the dying;
- managing time;
- using opportunities;
- holding information;
- knowing through another;
- the spiritual dimension;
- confronting self/other.

Again humour was obvious and during the lull period whilst the patients were eating their breakfasts, ribald stories were being swapped concerning 'explosions' from various orifices. The references to socially unacceptable 'norms' and languages were evident. At the onset of the shift T referred to one patient, Mrs. C. and remarked:

> T she doesn't look so well & I can't put my finger on it.

Towards the end of the shift, when I asked T what she meant by this, she indicated a reference to the patient's *state of being* and a necessity for her to take action. My questioning technique revealed an increasing awareness of discourse through the use of 'think' and 'feel' probes:

> M ...you talked about Mrs. C,... you felt that you knew that there was something that you couldn't put your finger on [right]. And whether you still feel that at the end of the morning or, (.) whether you now feel that- think - you have addressed what you thought it was earlier?

> T I think, I suppose that she is generally less well and I think that she is generally deteriorating quite slowly. And because of that really. There are not really any marks or goal posts that she is reaching -even in a backward sense in a way-she's just gradually fading down there. And so it all becomes very woolly and I think probably that's what I meant by it, that she is generally just deteriorating really- and I still feel the same at the end of the shift.

The expression 'there's something I can't put my finger on', can assume a meaning as listener/reader that may not be shared or intended by the speaker. The function of the statement is to *draw attention* to something or someone, to the *invisible as yet* rather than necessarily to draw attention *to my intuition.* Later I explored T's skills in communication when dealing with 'difficult' issues and encountered the following dimensions:

- the 'timeliness' of intervention/ discussion, 'finding the moment' (perhaps karios?[4]);
- putting out 'probes;'
- noticing 'cues;'
- not to search too hard;
- giving permission;
- using appropriate language, knowing when to be directive.

The relational dimension is paramount, the 'between us' nature of care, but also the attention to the 'cues' which may be observed (see appendix **11**).

> T ...I think that um a lot of it is actually about finding the moment- um- if you search too hard you won't find it I feel, and that you can't sit down with somebody and say 'we're going to talk about you dying' (uh uh) or, 'are you going home?' or whatever.... And I think it's looking at their cues they are giving **you,** finding out what they do with that questioning.. It's just taking the cue really, because people aren't actually very overt... -they're on their mind- ... I think that comes through experience any way.

Later T expands this further...

> T ...another tell tale sign is probably just a silly one, but when you feel that you are getting somewhere, I quite often, then I go to sit down - I'm here to stay and this is time that I have allocated to you (um) and whatever... if they go like that [moving legs] and move their legs over -if they can -I always think that's like permission for me as well I know it's a stupid thing but I've noticed that.

Here in fine detail are descriptions of observations which have become cues and signs to the nurse, signs which are sensed and then read/ interpreted.

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[4]Karios (Greek) means 'right time'.

There were other noticeable features to this interaction, for example my use of silence and the continuity of the conversation.

The emotionally laden nature of practice was revealed with Mrs. D., a young mother who was being transferred home, by choice, to 'shortly' die in the care of her husband, friends and two young sons. Whilst washing her, she had asked us about how we felt. I explored this with T.

> T I think that um knowing her, knowing her, and knowing her history -she's actually a counsellor-. um and she, I **think**, she was probably doing 2 things (a) asking us because I think that she has a genuine interest in people and she has obviously thought about some of the impact this kind of work can have on her, because of what she does. Secondly I sometime just wonder if she is saying 'are you frightened of cancer?' as if to say 'um well I'm frightened of it I've got it can you normalise this' and asking something for normalisation... Yes, those bits which you just brush under the carpet, isn't it? but that was a very subtle way of doing it... It necessarily wouldn't always be what that patient wanted because you've got to look out for yourself as well. And I wouldn't perhaps if I had been feeling vulnerable I wouldn't have said to her about how I was feeling or whatever [voice quietens].

This extract reveals some of the 'difficult' things that can be 'brushed under the carpet', the 'stuff' of self. The *vulnerability* of both nurse and patient are exposed in the 'between us.' Both are dependent upon the 'other's' state of being and respond according to how such a state is interpreted. Skilful practice therefore *is concerned with knowing Self* and *the Self's capacity to* know, relate to and receive from, *Self and Other (s)*. The agency of practice can be highly contingent upon occasion, making its documentation problematic. The very selves of T, I and Mrs. D are confronted by her dying and (our) self.

As the interview continues, a discussion concerning uniqueness and generality arises as we analyse the 'dynamics' of the morning.

> T I think something like what we have experienced this morning, it's um, it **can't be LEARNT from a book**, you cannot put all that goes on this morning every dynamic- you know the dynamics of it -**you cannot put down in a book and tell people what to do**. It, it's not (.) **you are not going to be able to articulate it** - it, it's just about [takes a breath] (.) I don't know, I suppose it's **getting to know individuals and**

getting to know PEOPLE as er [voice is almost whimsical] en masse if you know what I mean? (um) Look at the workings of people and putting that into individual situations really, yeah.

M There were a lot of, of (.) little decisions which built up into actions this morning.

T Yeah, oh yeah, and they weren't necessarily the things that I had planned, I don't often plan - a few things I often plan to do, like I had to ring the district nurse, but that was my goal, but to start that I had to speak to N and that moves onto other things - and you end up wrapping another job into another job and another job. And **so you keep building up these circles that all interlink really** you know the ultimate goal. It's a good job you don't set yourself big goals really isn't it? [said with irony].

→M I think so [laughs]

T Quite often the simplest of things turns into the biggest job (yes that's right)...

This account demonstrates a clear and orderly sequence of events and factors which almost map out into a range of 'what if' possibilities to be reviewed in the process of action. The 'wrapping up' of one activity to another, the steering towards possibilities[5] and the consequential unfolding of situations are evident (episode with Mr. E.). In describing the emotion, the things 'touching little cords in your heart', and whether one 'replays' the shift, the subjective nature of practice surfaces again:

T ... Because it's so subjective, you can't put it - well you could put it down - but it would take you an awfully long time.

Thus in this praxis, the -ing-, the noumenon is ever present, it's intensity varies as does its temporality and space. Whilst chapter **10** analyses these issues, here I journey through selected accounts of *tiny* moments in dramatic, yet 'everyday', practice. Eraut (1985) drawing on McLuhan coined the expressions 'hot and cool action', yet neither representation reflects the situations described. Whilst Eraut describes the pressure for immediate action

[5]Another aspect of 'feedforwardness', 'intentionality' see Aquinas

where hesitation may cause the moment to be lost, here time is found in the midst of action so that the response is appropriate *and the moment is not lost.*

Having established that I was now akin to a temporary, visiting staff nurse, the next accounts will be drawn from months 6-9 prior to T's appointment as a home care sister.

Months 6, 7 & 8: Death, dying, afterdeath and the spirit?

Whilst this is not a thesis about these issues, they are significant intertextual threads to the tales. This next episode typifies the delicacy, sensitivity yet normality of many interactions.

> F was at sixth form college and alternated between being an adult and an adolescent, she would move down to fiddle with her trainers and then sit back up again. It was a very busy evening yet T gave no signs of being hurried, she enabled and sustained long pauses... The conversation moved from the initial 'how are you feeling?' to 'it must be difficult?' through occasions when F was sniffling and tearful, to moments when she cheered up. Lengthy pauses enabled T to pick up the appropriateness of interventional questions, reflecting back, but also ascertaining how far she could take the conversation... it took some time for T to ascertain that F had promised her nan that she could come home... there were problems at home between family members. F was anxious because this was the first death she had encountered and she wondered 'what would it be like?' For example, did people drown? She had noticed that the lady in the next bed was no longer there, had she died? F wanted to know whether there is a spirit- She was concerned about cremation- she would like to see a grave and know that her nan was buried there so that she would be able to go there and know that her nan was there... (month 6).

Judging 'how far to go' in these interactions becomes a skill for the nurse, the required agency involves:

- ascertaining the spiritual/religious /conceptual understandings the person has about death, dying and afterdeath;
- judging the moment;
- and judging how far to go - whether to facilitate 'breakdown' or 'maintenance'.

F had asked T about whether she believed there was a spirit, beyond death. T's response was appropriate for F who 'seemed pleased... and agreed that was what she thought' (notes month 6). Inevitably this 'spiritual' aspect of the nurse/family/patient relationship arises frequently and was witnessed on several occasions. Once more I notice T's postures and dialogue:

> T had sat patiently through all of this, not sitting near her, or holding her in a physical sense, but quietly challenging, reflecting and reitering the 'normality' of the emotions that F was experiencing. T gave options without forcing decisions, presenting useful ideas. The silences were lengthy but not strained and she would sit back focusing (notes).

There were several occasions when both T and I noticed 'cues' about patients, for example T when referring to F's nan said:

> T She has a flushed look- you know - cerebral.

Similarly, my notes record how in reaching for a book in a patient's locker:

> I noticed that it was a book about St Bernadette and I used that as an initiative to talk... I also noticed her rosary beads, so we talked a bit about Lourdes... her partner came in... I never did get to put the monkey pole up (notes month 6).

During month 7, another observed episode exemplifies skilful judgement in interaction.

> Mr. E was in a side room, looking out of the window to the garden, talking about his friends and avoiding our eyes. I sat beside T who sat there quietly exuding space. As Mr. E talked, he looked again and again at the garden. Eventually she stroked him, we discussed this later and she described how he 'gave her permission'- although not a word was spoken. As she stated, the 'intensity of looking'... it was another fine balance between the emotion and the strength that he would require. It was a lengthy period, with silences and as she remarked later it was difficult to 'judge how far to go'.

In discussion at the end of this shift, I ask T directly for the first time if she believed that she used her intuition, her response was:

T Do I believe that I use my intuition? Yeah, er well it's hard to use intuition. Um, I suppose intuition stems from something and that might be a little snip of knowledge that you have that you build on but you can't relate back to that. But you're thinking, just whirling round your head and then you think, 'ah yes, because of that'. But I suppose if you sat down and thought about it when you get home then you can probably relate back to something that you knew.

I then enquired how she used her knowledge with Mr. E.

T I suppose with Mr. E I did quite a bit of stuff, that is thinking things, picking up on things, is that what you mean?

M Yes, sort of how do you know what to say next?

T How I know what to say next, um, your next cue comes from the response you're given of the leads that you are given. And you learn them through experience of um knowing what kind of things makes people open up or gives people the opportunity to open up and go further. Um things about giving people permission to talk, er and um (.) just listening to people really. And um, it's all about the unsaid stuff really.

Here we have the 'unsaid stuff' almost discounted, yet it is 'between' people, possibly accompanied by 'cues' which need to be read and responded to. The description is about *doing* things yet my account and observation is about *doing silently* or *silencing* which contrasts with Beckett's (1995) description of being 'on- the run'. This next example involves the plurisensorial, T is making judgements 'by touch,' by 'looking,' as well as by 'conceptual knowledge'. Here, 'judging how far to go' has a different implication and connotation. T and I had gone to see Mr. F[6] because his urinary catheter was not draining well.

T looked at the swollen penis and catheter and wondered [articulated at the time] whether it was coiled, or not, in the right place... Once again the passing of looks was a key feature both between T and I and in a triangle with the patient: without a word being spoken... T tried deflating the balloon and changing the position of the catheter to no avail. I gently rubbed his abdomen whilst he was having a spasm and T tried to manoeuvre the catheter. It was difficult and T decided to try a

[6]Mr. F had a cancer of the intestines, with ascites of the lower abdomen.

stiffer one (i.e. a cooler one). The repartee between them was interesting because T had to hurt him in order to put the (new) catheter in, but he accepted that with some ribald humour (month 6).

In subsequently discussing this episode with T, the problematic of finding a discourse *between us* and *for the reader* emerged: the 'unsayable' becomes the problematic. Chapter **4** discussed the problems associated with analysing this next conversation.

→T Mr. F, um a lot of that wasn't about specific facts that I had learnt. I knew that... etc. But you manipulate that is, er um about um, it is not quantified experience - it's not experience- that I can say 'that is about learning as you go through your practice'. That is about knowing sometimes that if you do that, or if you do that, I have done that before and it has worked and therefore I have used it again and that was what that was. And like the oedema, um people usually panic when they see oedema 'Oh I can't get a catheter in, I can't get a catheter in'. But I **know** because I have squashed penises before [mutual laughter]. But they, they, reduce very easily, enough to get a catheter in and nobody has said to me that 'you know if you reduce that manually by squeezing it that will work'. It's just about experience and trial and error and picking up the bits that work for you...

When discussing how T had managed this and other 'untaught' situations she introduces the topic of intuition.

T You apply lots of um, I don't know whether you call it intuition, you apply um information from all different areas and you put them all together. I know fluid moves... [outlines the physiology]...

M So are you actually mentally thinking or are you explaining that now?

T No, I am explaining that now. I don't usually think it, just do it.

M And do you pass that on?

T Yeah, yeah, I do, yeah. People are quite impressed actually and they say, 'Oh how did you get that down?' It's not something that you are taught.

Here there is a recalled account offering a 'rationality' for the activities with Mr. K. when *during* the action being described, articulated thoughts were concerned with the mechanics of doing at the time and the *situation of the patient.* As we have demonstrated, when T and I tried to discuss the *tactile and sensory* aspects of the activities we struggled with discourse. This example resembles Macmurray's point that one can have an awareness of the unconscious as a constituent element of consciousness (1957: 99). He defines 'conscious behaviour' as an 'abstraction from action' in which the abstraction excludes rationality from the concept of action (1957:139). The distinction between an *a priori* knowing which can be recognised in retrospect and the capacity of conscious recognition of such knowing **in** the action is evident. However, this episode also illustrates that consciously aware knowing-in-action is *different,* because in this instance T *just did it.*

Thus, in-action knowing responds to the sensorial which may elude the retrospective articulated discourse. However, with probing, such a discourse can be elicited. T hints at this tacit 'knowing - in - action' which is subsequently considered to be recognisable in others:

T ... and you learn as you go along- because you are drawing from different things all the time, not mentally processing them, but they are there, in your head. It's very hard to articulate what aspects of it, knowledge, you are drawing on. But they are **there** even though you can't say what they are.

M Do you recognise them in others when they are doing it? [Pause]

T Um. (.) in different situations? Um yes, yes I think so. Because you get this fluency don't you? Um, not a fluency as in actions, but of thoughts- and in what you are doing. It becomes very fluent when you have got that experience. (.) Um, and you see that in people and you see (.) that cognitive processing involved, that you are not privy to in a way. And you can see that they have experience with that. Whereas, people who don't, you can see another kind of cognitive process going on, it's like

it's not connected- it's not fluency. I don't know, I'm not making much sense I? Do you see what I mean?

As the conversation continues, I attempt to clarify about 'thinking and doing' at the same time.

T ... but you can see that in people when they know what they are doing. It's not about **efficiency**, because I can be theoretically efficient, it's about this thing about- it's almost a confidence and a run on- and a process - a sequence of events. It's hard to articulate it... You're not aware of yourself doing it, but you can see it in others.

Ironically of course, I am striving to 'see, see in and through another' as the researcher, whilst T repeatedly comments that *it's hard to articulate it* and indicates seeing -in action as a possibility. On several occasions during this interview, T discusses the problematic of 'theory', how practice 'can exhaust it' and the possibility of developing new theory.

T Where do you go from there? You have nothing to build on, so **that's** when you go through the theory and you start building on it with experience. Know where to go from there, what in my experience has this shown before? Though it's not a conscious thing.

M Do you formulate new theory from your practice?

T Um, yes, I think you do. But it's not written down, it's a very personal thing. It's a very personal theory in all that you do (.)

This account apparently supports Eraut's discussion of knowledge creation in professional practice. Knowledge is being created through practice. Here the knowledge was expressed as a connectedness between the sensorial and the theoretical or disciplinary knowledge. Recognition of the clinical situation and the person have been identified as key features in professional skill. In this next illustration, we discuss a newly admitted patient, G, and compare my perceptions with T's. I had come to the same conclusion as T, but my sense of *priority* was different. This discourse is fluent, ordered and has rhythm.

> T ... I know what disease that man **had** um the um, Ca prostate quite often gets spinal bony metastases ... - sudden onset urological symptoms, and weakness in the legs - no other urological deficits- which may be it is, may be it isn't. But those are two trigger signs because I have seen them before. I have missed them before, Oh, that is the best way, you think 'oh shit' [I'm sorry] you think I've missed that, what could I have learnt from that? Learning isn't about getting it right, it's also about getting it wrong. And I have missed paraplegias before, although you know they are not entirely my responsibility to pick up, but I have seen things that I have not put two and two together. And if somebody had said to me at that time 'what um about the signs of impending paraplegia?' I could have sat there and said 'um well tingling, numbness, weakness, loss of balance, and loss of control and difficulty in bowel habit'. And I could be sitting there with that patient and I could be missing the lot of them, and I missed two vital signs of a patient once, so did the doctor and a lot of other people. When as soon as somebody said 'Oh he has got paraplegia' um 'O God, yeah' [she snaps her fingers] You immediately think [snaps fingers suddenly] 'How could I be so stupid not to pick up on that?' And now, because of that experience, I am more acutely aware that it is one of the few palliative care emergencies.

In this interaction there is an expressed difference between *knowing* the cues, signs and facts, *recognising* them, *interpreting* their salience and *responding* to them. Differences arise from our prior contextual experiences of the 'signs'. Furthermore there are marked attributions concerning:

- knowing the case and the signs;
- recognising trigger signs;
- learning isn't just about getting it right, it's also about getting it wrong;
- how getting it wrong 'makes one more acutely aware'- *even if it wasn't entirely my responsibility;*
- the rhythm inferred by 'snapping her fingers' when articulating some incidents.

It was during month 7 that T's natural curiosity prompted her to ask whether she could have feedback on the research, we discussed this and did so in month 12.

At the start of another shift, T went immediately after handover to Mr. H.

> We went to look at Mr. H who was dying peacefully. The night staff had said that he was comfortable but 'looks strong'. T said 'I have a hunch about him', a feeling, 'nothing to see' but 'we will wash him first' and then phone his wife. He had deteriorated but wasn't going to die just yet... (month 8).

Noticing small details and responding to them provided pleasure and comfort to many patients. Yet how did T know?

> Mr. J was very immobile... T had asked him if he would like a bath, he replied that he hadn't had one for two months so he was delighted.. he thoroughly enjoyed the warm water.. - moving his limbs well - something he couldn't do out of the water so well... So for Mr. J that day the bath was a luxury and it seemed a shame that he hadn't had one before... his pleasure was obvious and shared with other patients (month 9).

Another patient was admitted as an emergency from home and T immediately noticed his 'malignant hiccoughs' and that he probably wasn't well. Her concern for this patient was transmitted at handover, she had ensured that he had had a dose of morphine to relieve his discomfort. T was also becoming more motivated towards undertaking research herself, it was several months since she had completed her degree. T was particularly interested in action research, so I agreed to forward some relevant references.

A change in role: months 9-11

In month 8, T had applied for a post as a home care sister and been appointed to cover a defined geographical area. The staff agreed that the research could continue. This was an excellent opportunity to observe a stage of transition, but also practice in a community setting. On the first day, the weather was very hot and to celebrate the occasion I brought some cold drinks for the office (non alcoholic!). Following an introduction to everyone in the team of four, T explained how different this type of care was, ascertaining my experience in this setting. It was essential that my presence would not disturb the relationship between T and the patient, their family or other carers.

T had been working there for a couple of weeks and had been inducted to the location and the staff with whom she would liaise. T was also at the stage of building relationships with existing patients as she took over the patient list of the nurse who was leaving. Through observing the other nurses during the induction period, T had learnt from them and had been, as she put it, 'cherry picking' from their styles. Essentially, the nurses commenced the day at the office to confirm arrangements for visiting, to deal with new referrals and to deal with any administration which arose from the previous day's visits. A plan was then made to 'fit in' the visits according to geographical location, patient need and availability. Indeed toilet/break stops sometimes need to be planned. When away from the office, the nurses have a portable phone to enable them to respond to emergencies which were, on the whole, rare. The visits could last from half an hour to a couple of hours depending upon the patient/family need.

On a typical observation day, I would arrive about 1000H giving the staff time to deal with their own issues and administration. Depending upon the administration and the visits, we would leave between 1030-1100. Our packed lunch would be taken somewhere convenient, either in the car if it was raining, or if the weather was fine, in a convenient park, sea front etc. Indeed given the good summer of 1995 we enjoyed several breaks at the sea front. If the bleeper went for T, she would need to use a telephone, and so within her 'patch' she had identified convenient places to stop. Inevitably when visiting homes, discretion had to be used over the frequent 'hospitality' which would be offered otherwise we would be awash with fluid refreshment!

There was a wide range of administrative issues involved in the job, from a knowledge of social security provision for the terminally ill, to the limits and options available through health and social services. Similarly, a comprehensive understanding of the ethico - legal dimensions of specialist nurses working in relation to medical jurisdiction and terminal care was essential.

The morning pre-visit period was used by the team to discuss patient problems and a co- operative collegial approach was adopted. I frequently

witnessed 'brainstorming' episodes and experience narratives which were recounted to aid another's problem. Through this daily interchange, 'debriefing' was often occurring and the staff would share each other's load if someone was busy or had difficult situations to deal with. Medical/nursing liaison would also occur with other palliative care specialists. Within the inevitable ambience of group and personal dynamics, the fluid and open communications enabled quick, informal resolutions to daily problems. During the period of observation, the consequences of local Trust finances had an impact, with clinical decision-making occurring within the context of budgetary constraints and 'value for money' drivers.

Whilst the nurse's role is specialist, and apparently specific, due to the wide ranging, complex, contextual and individual nature of many patient's problems, the breadth and depth of required professional knowing is extensive. In contrast to the hospital based care, the home team work/operate alone in unpredictable circumstances sometimes requiring immediate judgements and decisions. The relational/emotional dimension of the work cannot be underestimated, for example in the week before my visit, there had been seven bereavement[7] visits.

The frequency of visits[8] is at the discretion of the nurse and made in collaboration with the family concerned. As T outlined, in each visit she tried to leave people 'in a good frame of mind', as she walks out they are still living with their situation. Her plan is to arrive cheerful, move into difficult areas, reaffirm what the relatives are doing and ensure that the visit ends on a good note.

The first visit, meeting people 'near the edge', maintaining and exploring boundaries of control.

Inevitably, given the nature of the care, T visits patients, their families and carers who are often as she put it, on or 'near the edge'. In comparatively short visits, the home care nurse has to establish a relationship through which the needs of all concerned can be expressed, analysed and responsive plans made.

[7]Once a patient has died, the nurse does a 'bereavement visit' and arranges follow up support if the family/carers desire it.

[8]At that time, the referral is normally through the community or hospital medical staff and located within the context of need/ funding arrangements.

Within the home of another, the health care staff are 'visitors/guests' and thus a trustful relationship is essential where 'mutual consent' is offered and received.

T seemed very relaxed and enjoying her new post, learning new things, as she put it, 'you learn all the time from the patients and their families, .. you learn from their descriptions'. Attending to the narrative accounts from the patients[9] provides information concerning their illness experience.

> Mr. K. seemed quite breathless at times and there were periods when T was trying to talk directly to him[10]... T took the opportunity to ask to inspect his legs and measure him for a new pair [of stockings], this took place in a another room at the back... Both of us noticed the bluey/white skin on his lower abdomen and legs, the jaundiced/anaemic rim to his eyes [in fact T inspected them later on](notes).

When the couple described the events leading to the diagnosis and the referral to the palliative care team, they recounted the way staff at their hospital had avoided them after the diagnosis had been given. The emotion of this moment was powerful and led to tears in the eyes of the wife. At this stage however, Mrs. K. did not wish to break down. She turned to me and expressed the importance of 'teaching the students' about this. Her struggle to retain control was most evident. T gave them time and space and kept the discussion on 'cognitive episodes' for a little while longer.

Eventually T moved the conversation towards pain control and the type of cancer that he had, and used the metaphor of the 'hammer and nail' to illustrate the importance of 'hitting the pain on the head' as soon as it started to arise.

> At this juncture the husband indicated non verbally that he understood this, and then he began to talk about his lower abdomen... he could 'feel things'... This led to a discussion about the gamble involved in taking chemotherapy... However the husband said that he 'knew' that it wasn't working, 'he could feel it'. And indeed so it had proved to be... (notes month 9).

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[9]For brevity's sake I shall just use 'patients' but this should include the relative/ carers as well.

[10]As I write this up, the visual image of their sitting room comes to mind, with the sun streaming in through the window.

This extract indicates how in this *first* visit, T covered a variety of topics and emotional depths judging 'how far' to go so that the couple retained their control- a need they had both expressed. 'Sensitive' subjects were broached and 'messages' exchanged. As T and I left this home, we shared our observations, in T's opinion the husband would not last long.[11] It had been a draining visit, requiring considerable concentration, technical knowledge and extensive relational skills.

In month 10 I attended T's graduation ceremony and we next worked together in month 11 following respective summer holidays. The hot weather spell continued. We commented upon how uncomfortable it must be for some of the patients and the staff remarked how difficult it was to concentrate at the end of the day.

Managing the pain relief medications

An issue that was observed on several visits was concerned with the patient's use of pain relief. Some patient's would be reluctant to take medications, especially pain relief and then the pain would escalate and take longer to bring under control. Fears of addiction and other worries (like euthanasia) acquired through rumour, the media,[12] other experiences and imagination could prevent effective use of the medication. Occasionally, these perceptions may have been gleaned from health care staff. The complexity and subtly of the interactions is illustrated in this next example.

> Mr. N. had recently had respite care for his wife who suffered from severe arthritis. The conversation was mainly about his pain control because T could see that he was tense. However he was reluctant to increase the painkillers... she used her hand graphically to portray hitting it [the pain] on the head... Mr. N seemed rather tense and after we had left T commented that she thought he would need respite care again soon (month 9).

Mr. N died between my visits in months 9 & 10. As T had predicted he found it difficult to accept medications and she had visited him one day to find him 'stiff as a board' and thought he was about to die. His pain was unbearable,

[11]Indeed, he died 10 days later.

[12]A few months earlier there had been a widely publicised TV film on euthanasia in Holland. In the local media, at that time, there was a case where a social services carer had been accused of giving too much morphia to an elderly woman.

however she managed to persuade him to take the pills and his pain was controlled. He began to feel so well that he subsequently returned to model making.

T's expertise was demonstrated through her narratives of previous experiences with other patients. Her skill was observed both in what she said, but also her postures and her use of pauses, direct and indirect gaze and questions. The topic of conversation would turn from the present, to the past, to the future and then to the present again.

Finding possibilities.

This ability to move between 'tenses' and to offer possibilities was revealed with two more patients, Mrs. P and Mrs. Q.

Mrs. P., an elderly widow, had a brain tumour and didn't like people 'looking' at her.

> I thus stayed silent until invited into the conversation by the patient, deliberately avoiding eye contact (notes month 11).

To describe the scenario would take an essay in its own right! The hot summer's day, T, anxious and hesitant before the visit. Mrs. P determined to stay at home, yet deteriorating and panicking when alone. The daughter willing yet not fit herself, a competent home social carer equally determined to ensure that the best should be done for Mrs. P. Local politics in care management lead T to take assertive action which might prejudice unknown future situations. As we left Mrs. P, I suggested to T that it was almost as if Mrs. P. had expected the events to happen, T agreed.

With Mrs. Q., T opened up the possibility of accompanying her husband on his trips to London to buy antiques for their business. This arose because T had invited her to discuss her feelings and then:

> she showed us some photos of the fairs in London ... T asked whether she felt up to going now. Mrs. Q had obviously not thought about it and one could see that the idea was attractive, T talked about how she could arrange her tablets to prepare for such a trip (notes month 11).

Once again finding opportunities, moments and possibilities enables T to assist and motivate the patients.

Gazing to find time and a bigger picture

Before the visits had begun that day, T had asked me how the research was going. I mentioned how I had observed her looking and seeing, how she seemed to use 'gaze'. She immediately replied and her face became animated as she commented:

> T I do use it a lot to pause and reflect... looking at what they are doing... getting a bigger picture... a whole picture gives time.

During the lunch break, T and I pursued this conversation on the grass at a nearby park. We discussed how T seemed to be able to look at someone and judge that they were going to die shortly (Mr. K. for example). The difficulty was that it could not be said to a person in case the judgement was wrong, as she described, 'it's more grey, not so definitive'. T remarked it is 'more tentative' because there are errors and the more you do the job, then the frequency of events will lead to errors occurring. With experience, dealing with a range of situations, certainty may be present about a decision/ judgement, yet at the same time there is an acknowledgement that the decision may be wrong. T distinguished between the judgement and the decision in respect to the subsequent action taken.

Handling the patient/family response

By the next visit (month 12) T seemed to have developed a wider repertoire of responses to a range of patient queries. She appears much more assured and comments that she doesn't actually 'think' she 'just responds'. Before departing for the home visits, there had been a lot of discussion in the office about bereavement visits- there had been seven deaths in the previous week whilst T had been on holiday. During the discussion the word 'love' was used on several occasions.

One of the anticipated visits was to Mr. R whose cancer had left him very deaf.

> T wanted to chat to Mrs. R who had previously expressed her worry that she couldn't convey her feelings to him. T had suggested that perhaps she might like to write her thoughts down to him... we discovered that Mr. R had died on the

> previous Sunday... T enquired about the letter, and it transpired that Mrs. R had written it and was considering placing it in the grave with her husband because she had not had the opportunity to give it to him... . The letter had been important to Mrs. R and in her way she had communicated with her husband.

Dealing with patients and relatives in a 'denial' state is a regular feature of the role. Concerns with Mr. and Mrs. S. led T to liaise with the district nurses at the health centre. When discussing another patient who had recently died, one of the nurses commented that he eventually 'had the will to die'. A fascinating discussion ensued as they explored people's 'readiness' to die, observing that sometimes people actually needed the 'will' to do so. Inevitably part of their role was to facilitate this move towards death.

During the lunch break, I showed T my folder of notes and she started to read sections, asking if she could see the rest. I left the folder with her, which she subsequently returned, commenting that it was 'just like everyday at work'. T identified some of the humorous movements and whilst she remembered the incidents, she had on the whole forgotten them. The review revealed how much she had done, how many people she had seen - and indeed how many had died.

Role boundaries and worrying about 'missing it'.

During month 14 I arrived to find everyone busy and apologising for the delay. It transpired that T had worked until 2105 the night before as a consequence of a couple of call outs. T was inevitably tired and her colleagues were obviously 'debriefing' her about it and trying to collectively establish how such a scenario could be prevented.

> T agreed that she wouldn't do it again, but it was all to do with decisions in moments...

One phone call to a GP illustrated the borders of the nurse's role where they are technically not able to prescribe, and so face the 'sensitivities' of the physicians. T needed to discuss a patient's sedation (Mr. U) and just before she rang the GP she remarked:

> T Let me think what I am going to say. I don't know, I'll make it up as I go along (month 14).

The call was handled diplomatically, revealing the skilful manipulation which was necessary so that T's advice would be both acknowledged and acted upon. The 'making it up as I go along' was the skilful capacity to be responsive to an unfolding dialogue. There were several episodes during the research when this role interface between physician and nurse was encountered. With the passage of time and experience one notices the increasing degree of manipulation and communication strategies employed by the nurse, in this case T.

This necessary interface between professionals in the management of patient care also provides positive examples of shared learning and development.

> The physiotherapists came into the office and asked about a patient who had a growth near the subclavian[13]... [There was a detailed discussion concerning the treatment and cause of the patient's swollen hand]. T then states: 'I was worried that I missed it'... T repeated 'that worries me' referring to visiting patients and missing important signs (notes month 14).

This attribution of responsibility for 'missing something' with its potential sequelae for the patient, evokes T's remarks in month 7.

There is another reference to 'knowing that someone is dying' which was discussed by the team. Someone remarked:

'He's dying, but I don't know why'

Another member of staff agreed commenting that 'the prognosis was better'. This brief conversation snatch indicated 'unexpected patterns' of dying which the nurses cannot fathom.

Learning how to cope with the nature of the job

As we departed for the first visit, an ambulance arrived bringing one of the patients that T had seen the day before and for whom she had arranged an early admission. T updated me about the patients from my last visit, nearly all of whom had died. In the last couple of weeks T had had nine deaths, most of which she described as 'comfortable'. We spent some time reviewing the patient

[13]A blood vessel in the upper region of the chest associated with the blood supply to the arm.

and talking about knowing the limits that people set down. T acknowledging that 'she couldn't do this job for ever' because you live 'in a world of death and dying'- even when you go home.

The unspoken meaning

The first visit was to a lady I had met before and who remembered me.

> ... there as an informal and open recognition that this lady didn't want to take any tablets ... in a sense it was a game they [T and the patient] were playing between them in which the short nature of the contract to take the tablets kept control with the lady, even if unconsciously there was a mutual recognition that T's 'for now' was probably 'for ever'... the conversation drifted to the lady's bloated abdomen. The abdomen looked rather hard through her clothes and eventually T asked to look at it and feel, she tested for the 'splash[14]' and explained this.... I was a triangle to the looks exchanged and the jokes which were acknowledging that the lady didn't want to take the pills but was nonetheless identifying a problem.... It was a matter of knowing the limits of the talk for each individual and the hope that you weren't getting it wrong... the lady needed to be in control... she was very fragile (notes, month 14).

Most of the visit was spent dealing with the 'unsaid' issues which were mutually acknowledged through a variety of non verbal and verbal exchanges, with humour serving its function as a means of raising issues. When discussing how she knew what to say, T again commented that:

> T I don't usually 'think' just respond.

The next visit was to another couple (Mr. and Mrs. W) I had met before, T was wary about visiting them because sometimes they would try and use her to spar off one another. On this occasion however they were on their 'best behaviour' according to T.

> ... There was a discussion about his anaemia and haemoglobin level [it had gone down as low as 4]. T had seen that he was very anaemic previously when the lab results had produced an error and seemed satisfactory. Consequently they had 'whipped' him in for a quick blood transfusion. Here again was T's power of observation, more accurate than the blood test! (notes month 14).

[14]When there is an accumulation of fluid in the bowel if the abdomen is felt and moved, one can feel the 'splash' of the fluid moving within the abdominal cavity.

We next met after Christmas during month 16. In the office I again noticed the metaphors used when the nurses communicated with one another, the use of euphemisms, for example:

'he's not so good', 'not so bright', or 'in a muddle'.

T discussed how she sometimes noticed death in the patients, for example with Mr. X.

> T I knew when I saw him, he was euphoric, as if 'I'm OK, nothing is touching me'.

T had a particular interest in the depression which often accompanies the terminal illness, she has read widely and shown me some of the books. It was often difficult for her to get a psychiatric nursing referral for some of her patients (and their families). Indeed one of the visits was a 'follow up' to Mrs. Y. who had been diagnosed as having cancer the previous summer and suffered a severe depression as a consequence. She had been suicidal and during the Christmas period T had thought she 'might go down'.

> It was a difficult visit, T first went to establish whether she would be well enough for me to come in. T went to the door and after making her assessment, I was beckoned in... Mrs. Y could quickly dissolve into tears and T would use cognitive techniques 'to bring her back'. There was a lot of structured talk from T, repetition of previous discussions as well as enquiries about the present (notes month 16).

T addressed the problematic issues and then once again departed on a positive note. She had emphasised that Mrs. Y hadn't expected to survive Christmas and thus 'there was a landmark' to the occasion.

During this and a subsequent visit in month 17, T's skills were noticeable, every word and non verbal movement was important. As T subsequently outlined:

> She, she's her body. I always know from the way she answers the front door, how she greets me. You know, it's like you make an assessment in the first, kind of like the way she speaks to me, the way she opens the door, the way she looks at me - whether she turns away from me. Loads of things really. And then **my** heart sinks or goes up (month 17).

Here one notices a fluid expression of the observation of another's body which is embedded within seconds of greeting 'at the front door'. Furthermore, this assessment may challenge the practitioner emotionally.

Another dimension is handling a multiplexity of pre- existing family problems. Mr. Z, was a man in his early forties whom T had visited for the first time the week before. On that occasion Mr. Z had been informed that his grandfather had died. The family had had a series of 'bad crises' over the past year.

> T was concerned about Mr. Z's mental state, during the last visit Mr. Z had used words like 'feeling dark/black'. T spent some considerable time apparently aimlessly talking about a variety of issues before addressing how they felt... Mr. Z wanted to 'get back to work', but the unspoken was that maybe he wouldn't. One of the children was at home and said 'hello', but didn't want to talk to T as yet. Whilst there was open discussion there was also fragility and moments when both Mr. and Mrs. Z were on the verge of tears.

Through close attention to the metaphors used by the families, T establishes their state of being and picks up cues. The 'feelings of darkness' were thus an important cue and once again, it was essential to explore, yet not to go beyond the 'borders of control' of each family member. Maintaining regular contact with the family at this 'crisis' point was essential and T noted the funeral date, encouraging the family to contact her.

Sometimes it was medical colleagues who had difficulties managing, and indeed that is one major reason for the existence of the home care team.

> A GP had phoned the office earlier in the morning in a 'pickle, stammering and incoherent' about Mrs. A who was in another 'patch' covered by a colleague who was on holiday.

In this episode, it was technical knowledge which was being shared and the development of confidence within the daughter.

> Mrs. B was in bed and still in some pain. It took T quite a while to ascertain exactly which medications she had been taking and how they had been changed. Mrs. B had obviously been tolerating quite substantial pain and the GP had been trying to manage.

The complex pharmacological understanding was noticeable, T endeavoured to establish a very comprehensive understanding of Mrs. B's condition, her recent illness history and the pattern of the GP's interventions. The crucial importance of interprofessional communication and knowledge sharing was evident throughout the day.

The last visit during month 17 included another visit to Mrs. Y. T had continued to visit Mrs. Y on a regular basis, she had managed to get her to adopt a diary approach before Christmas to monitor her feelings and progress. T had also arranged for Mrs. Y to have a visitor from the hospice as she 'felt that she was quite lonely'. T gave a detailed description of how delicate it was and the importance of finding an appropriate lay visitor 'very carefully picked for her qualities'. Thus T had initiated several interventions: the diary, the lay visitor, staged responses from the couple, details of a pendant alarm.

I asked T:

> M ... What led you to think that she would actually write up and use the diary? Was it a gamble?
>
> T A complete gamble, and um I just said to her 'if you can't write, or you don't want to, just write one incident down. Um you know just forget 10 a week, just write one for each day'... then we talked about that incident and she seemed to have an understanding about, what had happened to- about it. And I think she saw the benefit. And then she wrote a few more, it's got less since Christmas... It's worked quite well really.

T described how 'we were doing the kind of diary only orally', over a particular incident and Mrs. Y 'suddenly it was... like it was dissipated with her gaining insight into what's happening'. Through the diary and T's visits Mrs. Y realises that 'she **is** actually improving'. T outlined the tremendous energy it takes to persevere with someone like Mrs. Y. For example after a visit lasting an hour, where one is concentrating intensely, it is physically and emotionally exhausting. In discussing Mrs. Y in detail, T articulates some of her 'theories in action':

> T she's a very complex lady, and she' like **all** people and **all** things when there is a crisis in their life- then a lot of what has

gone before is um retold as well. Looking back on her... the relationship with her husband... it's all about compromises...

As we discussed some of the visits that I had made with her, T commented:

T It just goes to show how many have died and I don't remember!

Mr. U had died, as had Mrs. A and Mrs. B. As we drove past one house, I reminded T, she couldn't place the family at first:

T it just goes to show ... what you forget. Most people if they went and somebody had just died, they would remember that for ever (chuckles).

In meeting death and dying every working day, the practitioner has to learn to 'manage' and thus one questions whether they can possibly retain all the memories and 'afford to remember?'

This was the last formal visit with T enabling several aspects of practice to be revisited. We had worked together over a period of 18 months, incorporating over 100 hours of observation.

And so, another Tale has been told.

CHAPTER 7

P, extracts from a person study.

Introduction

P was a very experienced accident and emergency (A & E) nurse, who had worked in both the UK and USA. I was already acquainted with P and thus directly contacted her to ascertain whether she would participate in the research, fortunately she agreed. We both acknowledged that A & E was a vulnerable setting for research due to the unpredictable nature of the environment[1]. I discussed with P's manager the ethical issues and my role in the department. Due to the nature of the setting the use of the tape recorder might prove to be inappropriate. Whilst there was a change of nurse manager during the observational period, I was able to undertake observations during a span of sixteen weeks (4 shifts totalling 28 hours) before P moved to another post. I explained that I was looking at how nurses learn in practice and what they know when practising. The research was delayed and interrupted due to P's ill-health.

However, although the total observation period with P is markedly less than with T and V, the data is very rich. P was more established in her field of practice and was operating at 'expert' level according to both the Benner and Dreyfus model. It was through the observation work with P that the key significance of *gaze* became most apparent to me. Similar to the partnership with T, I could contrast my experience of the clinical situation with hers and explore the epistemology of practice with less concern about influencing professional development. To some extent, P's experience enabled me to be a genuine 'learner/apprentice' on many occasions.

The setting

The layout of the unit was significant because nurses were assigned to different sections for all or part of a shift. Ambulance admissions entered straight into a 'stretcher bay area', whilst non - ambulance admissions were assessed in another area by a 'triage[2] nurse' who classified them according to the nature of

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[1]Whilst BBC's 'Casualty' is an extreme manifestation of daily life in A&E, it nonetheless conveys the unpredictable and dramatic dimensions to A&E.
[2]From the French *trier* meaning 'to sort'.

the problem. The department had its own resuscitation (resus.) rooms, minor operating theatre and plaster rooms. Upon arrival the staff would be assigned to one of the three areas, with the span of duty as triage nurse being of restricted length to prevent observer fatigue and consequent error. During the day medical staff were always present.

First Visit -month 1 of observation

This first visit coincided with the six monthly change of junior medical staff who were requiring supervision and monitoring from the nursing staff. Handover between shifts included not only the patients in the department, but also significant events from the previous 24 hours should queries arise. Following handover, I was oriented to the department and then joined P as she commenced the normal 'checking routine' of equipment for the shift. P was in charge of the ambulance bays, so before we started this checking procedure, she assessed each patient and then delegated staff accordingly.

The resus. room was reviewed first, this enabled me to be familiarised with the layout whilst P and I discussed how she allocated staff and how the unit operated. Within the resus. room, R would pair up a junior inexperienced nurse with an experienced one so that the junior could be supervised and learn. It was also important to have a senior person not on resus. duty so that the rest of the department could be kept operational: it wasn't unknown for there to be two people requiring resus. at the same time.

P outlined the criteria she used to determine whether to put a patient in the resus room. This episode reveals her skills:

> Mrs A was admitted with a cardiac problem and was being cared for by another nurse. P assessed Mrs A. and suggested that she be moved to the resus room. As P outlined, by locating her in the resus room the lady's condition would be labelled 'severe'. Furthermore, monitoring is easier... P was subsequently found to be right in her judgement, the lady deteriorated, her blood pressure dropped and she had more chest pain. The lady required more active intervention which was facilitated by her being in the resus. room.

P described the 'high dependency' bed as being another important place to position patients so that they were automatically identified as 'needing

monitoring'. P spoke fluently, in an organised manner, it seemed quite natural for her to articulate what she was doing on this occasion- perhaps indicative of her ability to teach students. Throughout the shift she monitored both the other staff and patients, checking whether people needed assistance and making clinical judgements/decisions. As the morning proceeded and more patients were admitted, P would assess each one and then delegate a nurse to be responsible for the patient. Occasionally this would happen automatically as a nurse would be freed from dealing with previous patients.

There was a protocol of action for 'types' of patients and for the general admission process. During the shift there were several occasions when P's skills were sought, some were technical, some clinical and others a combination of the two. Thus:

> A staff nurse had difficulties getting the blood pressure machine to work properly. P was called, she checked the blood pressure manually and was concerned about the patient's condition- suggesting the move to the resus. room. P was calm and collected throughout, but she was noticeably watching and checking, indeed she left the screens slightly ajar so that she could observe the patient as she walked past. P identified the requirement for an intravenous infusion and an increased frequency of observation.

P's capacity to anticipate that there may be problems is interesting. It is obvious that she had tremendous experience and her 'repertoire' and *experience* of 'cases' was extensive, this enables her to *envisage* and *anticipate.* She was continually monitoring, checking and anticipating situations. At the bedside, the need to make instantaneous relationships with patients was essential, not only to reassure them, but also to glean accurate information about what is, or might be wrong. Her skill in gaining accurate information from the patients was apparent.

The fluency of P's action was evident in the 'typical ' response to a patient admitted with a head or spine injury. Standard procedure is to ensure that the patient has a neck collar applied and that they are treated as if there is a spinal injury until proven otherwise. In such a circumstance the patient is 'log rolled[3]' and their clothing removed. The activity was required several times

during the course of the morning, not only was P fluent in an effortless manner, she was an able delegator and supervisor of the activity. During the roll, P would be continually observing looking for movement, response, injury and monitoring the 'roll' technique of those present.

During this first shift I was utilising my own 'dormant' knowings and learning new techniques from P. This first shift drew immediate attention to P's continual surveillance and fluency in practice. She reminded me of times as a ward sister when I 'just stood and looked'. Her continual state of 'ready alert'.

Month 2

P had been unwell again and this delayed this visit. The key points from this shift were:

- patterns to the dialogue, sequence and content;
- vigilance;
- continuous, often unobtrusive, observation;
- attending to nuances and small details.

On this occasion she was assigned to triage from 1300-1700 (staff do four hours at a time in order to maintain their vigilance). The role of the triage nurse was to assess each person on a rating scale of 1-4 with 4 being the least serious. The nurse also monitors the waiting room to ensure the patients do not deteriorate unnoticed. There were set parameters to the nurse's role which was restricted to experienced nurses due to the potential for error in assessment.

> Throughout the time span in triage, there was a steady trickle of patients with the waiting time for non urgent treatment ranging from half an hour to two hours later. This later delay was due to an emergency arriving by ambulance at 1420. P demonstrated to me what she did and whilst mindful of the patient, she talked me through everything that she did. She was a skilled observer who would watch the patients (and their escorts) from the moment that she saw them, both coming in and out of the room. P attended to every nuance of the person's body, as well as their accompanying talk. This was often done unobtrusively when the patients might consider themselves 'unobserved'. P did not assist a patient to undress unless she judged that they needed intervention. She was thus able to watch and observe the extent of their discomfort, signs of deformities or pain etc. This quiet

[3]A way of rolling the patient keeping the spinal column in alignment. This procedure involves 4 -5 people depending upon the circumstances.

observation provided her with the opportunity to observe, and the patient with the opportunity to act at their own pace if they were in discomfort. If she noticed an inconsistency she would note it and then seek an opportunity to verify it, usually through unobtrusive observation (notes).

There were also 'patterns' to the dialogue with the patients/relatives, for example P had a particular content and sequence in informing them about the waiting time. This repertoire or 'script'[4] was well rehearsed and although modified to meet the individual, the content and sequence remained unaltered. Continual observation, gaze and vigilance were the most noticeable features of P's actions.

Preparing for a change in post - month 3

During the next visit, P was assigned to the ambulance bay where she was in-charge. Later in the day, she had an interview for a new post. P was now recognising that it was difficult to obtain a senior post in A & E, in some respects she was almost too senior for the post she held. She was ready for more challenge and trying to make her self 'visible' for any opportunities that may arrive. Whilst P did not obtain this particular post, she acquitted herself well and subsequently acquired a different position.

The noticeable features of this shift were:

- the immediacy of thought and action;
- rhythm, pace and tempo;
- searching for clues and cues, fitting them together;
- looking and gazing;
- something not being 'right';
- feeling 'uncomfortable';
- operating at the boundaries of the hierarchical role;
- positioned in relation to the medical staff.

As we commenced the shift checking the resus. room, she practised some of her preparations on me! P highlighted concerns about the checking procedures, for example the use of the cardiac needles. This led to the

[4]See Hunt, 1992.

following discussion which revealed the deliberation processes involved in clinical situations.

> P→ We had a gentleman in, I couldn't work out why he had his pedal pulse ... He looked as if he was tamponading[5] initially- and that's in fact what happened- tamponade. But, he had also a rupture of his er -um- no- what he had done was he had ruptured his aortic graft due to a deceleration injury... and it had tamponaded and compressed the heart... and I could remember thinking this through and thinking 'I'm not too sure it's a good idea' and saying it to the surgeons as they were putting it [cardiac needle] in and 'whoosh,' out came all this blood, 'Oh dear' [ironic laughter] (notes).

Whilst continuing with the checking routine we discuss the organisation of A&E departments, and P exhibits particular positions which she can and has argued with others.

> P ... I have had a big argument with X over this, because s/he turned round and said 'No, they need stabilisation before they go into theatres'. My argument is stabilise the patient then in theatres, you cannot open someone up so easily in resus./reception. I gave up then... When you are in a resus. situation, the interpretation of that information and the data that you are actually collecting. You are going to pick out the data that is necessary and interpret it and feed that back to the correct people. If you have the information about the patient's condition and all the things that can effect that patient. Now I say to you that an untrained nurse cannot do that- I have got the skills to actually do that- unless they have had some formal training and input they can't understand the whole range of conditions that effect that person.

When discussing something known as the 'lighthouse effect'[6], P remarks:

> I can identify with that - particularly with the resus. room. I have very set dum dum dum dum [clicks her fingers as she says this with each 'dum'] and if that' s not ready then I am very uncomfortable. And I can't deal with the patient as well as I would like to until that is set up...

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[5]Cardiac tamponade is where there is bleeding into the sac surrounding the heart, as there is limited room for expansion, the heart is 'embarrassed' and there are specific changes in the blood pressure, heart rate etc.

[6]Refers to the visual scanning pattern of air traffic controllers.

We are interrupted and then P initiates a conversation about sixth sense.

> P You tend to find that you're em your set way for the way you deal with something comes like your automatic way. But then you see things that flash[7]-out- because that's an automatic process- but overriding that is looking for something deeper than that and going through the processes of 'Right OK we'll do this but what, you know- sort of, (what) else can be occurring there'?... To me, I think that has an element of sixth sense, what they talk about the sixth sense coming in. It really is, um, I have that organisation in the brain of how you look at [it]//

A medical consultant overhears this conversation and interrupts remarking with good humour (not disparagingly):

> → You can always tell when people have got it, they leave their broom sticks outside, Staff Nurse P.

The similarities to T's accounts are marked and are discussed in chapter **10**. Whilst dramatic anecdotes are recounted in this conversation, unlike those of V, they do not evoke the 'horrendous'. There is a relational 'sharing' implicit within the accounts which leads to further anecdotes and analysis. This example reiterates the tempo and pace of action:

> P I remember one particular day... the nursing auxillary turned around and said, 'Well I don't know that patient seemed to have developed a runny nose- he must be having a cold' and [she] handed him some tissues. And this patient had a head injury and had got a smack on his nose and had been a bit dazed, but not unconscious. Couldn't see anything on the X Ray and he was going to go home. And it was like 'bing, ah' [snaps her fingers]- CSF[8] from the nose. And it was just through a flippant comment that she actually made... it was the CSF coming down.

P's assessment skills were often ahead of the medical staff. In this next episode she anticipates what is required, but is not 'allowed' to proceed.

> An Australian tourist having just completed a cruise from Australia to the UK. was unwell. He had severe flu type symptoms, we [P and I] assessed him and it seemed to be rather similar to a pneumonia type infection which wasn't responding

[7]The word 'flash' may be consequential to our earlier conversation.
[8]Cerebral Spinal Fluid - which is running and straw like in colour -exuding from the nose is a classic sign of intracranial problems following a head injury.

> to the antibiotics prescribed by the ship's doctor. The gentleman also had some chest pain and P suggested an e.c.g[9]. This was stalled by the doctor until he had examined him, and then stated that the patient should have one! (notes).

P's experience and skill is again in the possibilities that she considers and the consequences she attempts to forestall.

> A young man C was admitted following a car accident- there was a suspicion that he had damaged his neck. Not long afterwards, a young woman was admitted giving a history of a car accident rather similar to the young man's. P put two and two together speculatively and tried not to locate them next to one another in case they were the two drivers from the same accident. Her speculation proved to be correct. P had ascertained this possibility from the description of the accident first given by the male, even though the receptionist had not connected the two admissions (notes).

The combination of P's prior experience with the present scenario leads to an investigative approach and an almost continual search for 'clues' and 'cues', making the apparently invisible or unconnected *visible*?

Gazing and looking

On several occasions during this morning when new ambulance patients came in, I would notice P apparently 'stop and think.'

> -almost as if it were a moment in stillness in the midst of action[10], during this period she seemed to look around at the board, at the bays and at the people, she would then make a decision. It also seemed important that she was not interrupted, as she was internally weighing up the situation. A classic example of this was when there was another car accident which involved a lady driver, two children and a young baby... P looked at this motley, noisy crowd of people arriving and put them in two adjacent bays (notes).

The fragmented nature of A&E activity meant that there was often a problem ensuring continuity, especially with the medical staff and treatment. Hence the logic and coherence of happenings was difficult to establish. P would often just apparently 'wander' around checking what was happening to each

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[9]Electrocardiogram.

[10]See chapter **9** for a discussion of the *gaze*.

person and then taking appropriate action to ensure that care management was progressing.

Month 4

P had been unwell again, however she had achieved secondment to another section of the hospital. The unit was very busy and we had been assigned to the stretcher area to relieve the night staff. Whilst there were further examples of P's expertise, this shift demonstrates the impact of puzzling situations and the importance of sequence and diversity in enquiry.

The department was extremely busy and the usual checking procedure couldn't be implemented straight away. The morning remained busy with P supervising and taking responsibility for the area. The variety and depth of P's professional knowledge was illustrated throughout the morning, the way she applied her skills of observation and questioning to enable her to assess the situation and the persons involved. P seemed to have repertoires of enquiry which she would employ as she constantly 'scanned' the individuals and the department.

There was a wealth of opportunities in this shift concerned with knowing, 'faulty knowing' and the importance of sequence in diagnosis/assessment. The learning which occurs on, and in, the job is considerable. Short illustrations include the questioning techniques used by the medical and nursing staff in assessment. The trail of events and evidence which the staff try to ascertain, the watchfulness of staff, discussions between them about what is wrong, the relationship and relevance of the observations and the questions demonstrated by senior staff as they supervise and question their juniors.

Knowings are observed which are based upon expectations and experiences, concepts of norms and the stereotypes of templates which seem to emerge when 'cases' or instances are encountered or re-counted. The concept of *not knowing* is as important as *knowing* when situations 'don't add up' or don't seem right. Two particular examples from this shift illustrate these points.

An incomplete and puzzling situation

The gaze and looks that P employed were at both a surveillance and interpersonal level. In this next example, we observe the depth of her probing, but also the *withholding* of gaze. P considered that the patient, Miss S. did have pain but that something else was 'aggravating' the situation, which was 'not right'.

> Miss S. had a long standing back problem. She had collapsed at home and finally been admitted... The orthopaedic registrar had examined her and was satisfied that she could go home. She had been given analgesia ...we were awaiting transport to take her home. Miss S. was adamant that she should be admitted. Her father arrived, looking sprightly and stated that he felt she could go home in their car. P agreed to assess her to see if she could manage. We went over to give Miss S. a hand and assess... she indicated that the pain was still bad, there was a lot of grimacing and re-articulated fear about going home, and the pain causing her to pass out. P was quite firm and avoided eye contact with Miss S. when she was outlining her fear. Miss S. sat at the side of the trolley and wouldn't move, there were no signs of anxiety from her father.. she grimaced and pulled faces, exhibiting spasms of pain which did not look to me as if they matched up. I noticed that P wasn't being soothing, she was encouraging her to take her time and move with our support... Again and again P reiterated the moves to make... P asked her if she would like to see the doctor again as it was not her provenance to alter the discharge arrangements... the moves and physical signs of distress did not seem to match the expression on her face... P went to the medic. and suggested some form of sedation and asked for her to be seen again. Whilst we were arranging the medication, Miss S.'s father found us and indicated that she did have pain, but a lot of it was 'up here'- pointing to his head.

This complicated situation which lasted over several hours culminated with Miss S. being admitted. Both P and I had expressed moments of uncertainty about Miss S. Neither of us were satisfied with the information being presented to us, the picture did not fit, but we were unable to resolve it. Both of us used similar criteria based upon experience and knowledge. This was not a denial of the pain being experienced by Miss S., but a concern that the non - verbal signs were not commensurate with our expectations of the 'normal' responses. Miss S.'s reasons seemed illogical and inappropriate given

the situation, especially when her father offered his perceptions and said 'I know my daughter'. Unfortunately, neither of us learned the outcome to this situation. Once again P and I were interpreting signs together in a non verbal 'between us' . I was avoiding eye contact with Miss S. so that she couldn't use me as a counter point to P.

Getting the sequence wrong, asking questions in an appropriate sequence: the registrar knows best.

> Mr and Mrs T with their toddler and other son were on their way home from a camping holiday. The child Jim, accompanied by his mother, was admitted by ambulance with a completely swollen face with bumps , his eye was rapidly closing over and there were concerns that there could be an airway problem... Mrs T was pale and in shock. The junior medical officer did not elicit the information from Mrs T carefully enough and consequently arrived at the wrong conclusion. As she was asking the questions, I could hear the incomplete nature of what she was doing. Fortunately, she offered the correct treatment. Mrs T's accounts was neither sequential nor ordered due to the manner in which the junior doctor asked the questions. In contrast when the father arrived, about the same time as the senior doctor, the chronology of the story was elicited in a different manner. The registrar's questioning enabled greater detail to be elicited. The junior doctor had focused too quickly on one solution, whereas the senior had 'backtracked' the story further and asked a wider range of questions.

Whilst this example was primarily an observation of the medical staff, it revealed that some of the junior doctor's difficulties were similar to those of V, namely that assessment skills rely not only upon accurate physical observation, but also the capacity to offer breadth and depth to the range of possibilities that may exist. Sequence, observation and diversity are crucial ingredients to the interaction. This was the last occasion when I worked with P, she transferred to a different area where it was inappropriate to research.

And so, another Tale has been told. In this Tale the significance of the 'not known', the contextual, the importance of silence and gaze, rhythm, tempo and pace, feature as noticeable ingredients within the ongoing activities of action. Actions are often focused towards the unknown future moment rather than the present.

CHAPTER 8

JUSTIFYING THE ACTION AND GARNERING THE TEXTS?

8.1 Introduction

The person studies have demonstrated that it was necessary to reappraise some of the traditional methodological stances associated with participant observation, ethnography and discourse analysis. Whilst no single existing perspective was found appropriate, interrogation of the Discourses of others enabled a selective acquisition of insights which facilitated the researching. It is argued that the (D)discourses explored through this study incorporate both the polemic, closed modernist genres as well as the postmodernist traits of being open to new possibilities and intersubjectivities. This argument is developed by stating that:

- the study *is* hermeneutical[1] because it has defined text as 'any written or spoken product of (D) discourses';
- from an *intentional*[2] perspective, I *used* both participant observation and DA as tools, rather than method;
- the study was not an ethnography in the 'disciplinary' sense outlined by Hammersley (1992, 1996);
- the study assimilates material from other Discourses rather than from a single defined Discourse perspective;
- in 'the grey' of researching, the normal and historically advocated role, expressions and forms of engagement can be transgressed;
- whilst researching as bricoleur, I developed an analytical perspective which may 'mirror' aspects of the nursing context.

These claims lead me to disagree with Hammersley's recommended stance for the researcher, i.e. that primacy is accorded to particular manifestations of the researcher's *state of being at the time of the experience/ observation*, where the 'objective' positions in Table **9** are preferred.

The appropriateness of a rigid adherence to *either* set of parameters is questioned. Denying the opportunities which may emerge from the 'subjective' parameter prevents the researcher exploring 'new possibilities' and denies validity

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[1] Derived from the Greek: Hermes, the messenger of the Gods.

[2] Hammersley (1992) challenges this premise, considering that people can be wrong about their intentions.

to material gleaned from concurrent and post hoc reflexivity. Thus whilst I disagree with Hammersley, I do not privilege positions labelled 'subjective', rather I apply the principle of *equifinity* suggested by Parker (1997). The appropriateness of a stance is determined by its transparency in relation to context and intention.

Table 9. Contrasting stances of the researcher 'In the Field'

Recommended stance: 'objectivity'	Recommended stance: 'subjectivity'
outsider	insider
not being at home	being at home
stranger	friend
foreigner	being familiar/native
marginalised	socially committed
lay/novice	expert
naive/innocent	experienced
intellectually distanced	intellectually involved
not surrendering oneself	surrendering oneself.
engineering	not engineering

Hammersley (1992) clearly distinguishes between 'ethnography' as method and ethnographic activities as tools, where the former is preferred because it attends to (1) the generic rather than the specific; (2) the concept of fallibility (after Popper); and (3) the role of the research community to which the researcher belongs. These respective stances indicate the problems which arise when adhering to clearly defined research traditions which are Disciplinary or Discourse bound. These Discourses engender antithetical debate, representing 'black and white' arguments, for example Van Maanen (1988: ix) prefaces a seminal text with the remark that:

'This book is about culture in black and white'.[3]

Van Maanen and Hammersley exemplify the importance of contrast, comparison and dualism in ethnographic and cultural studies. The *status* accorded to the research and the information acquired is determined by the community or culture to which one reports. From such perspectives, it *is* important to classify the nature of the empirical work, for example its claims to be ethnography or, an activity which uses participant observation. The chapter will now explore the

[3] When discussing the 'grey' this is worthy of note.

contribution of hermeneutics, (D) discourse analysis and participant observation to the study. Interestingly, early nurse researchers have distinguished between interaction which is 'generally used to refer to the study of actual behaviour' and the nurse patient relationship (Pearsall, 1965). Indeed, Diers and Leonard (1966) drew attention to the potential connections between discourse/ attitude/ interaction and relationship.

8.2 A hermeneutical approach

O'Collins and Farrugia (1991) describe hermeneutics as the theory and practice of understanding and interpreting texts, biblical or otherwise. In the attempt to understand and interpret, hermeneutics seeks to locate texts within their historical, situated context, striving to convey the 'meaning' to contemporary society. In so doing, hermeneutics recognises that a text 'can contain and convey meaning beyond the original author's explicit intention' (O'Collins and Farrugia, 1986: 90). Inevitably, the role of the interpreter (translater/reader) is pivotal. The metaphor of the dialogue has been used to describe the conversational relationship between the interpreter, the text and by inference the original author (s). This dialogic nature of hermeneutics, the 'hermeneutical circle', arises from the works of Heidegger, Gadamer and Bultmann. Furthermore, by considering experience as text (Usher 1992b), the hermeneutical dimension may be applied to the reading of experience, as well as the reading of texts in a literal sense. 'Reading' is thus a metaphor of action. The study sequence has been designed to enable dialogic interaction between its constituent texts. Representations of Self/Other, Agent/Agency, Subject/Object have been shown to be significant contributors to the person studies. Selective appropriation of elements from DA enables these various texts to be analysed in a particular way.

8.3 Appropriateness of DA and relational concepts

Approaching discourse analysis as a somewhat eclectic and naive nurse educator, Disciplinary Discourses with their respective boundaries and restricted codes were often, at first encounter, 'strange' and 'provocative'. The process of interrogation challenged these constructed boundaries, their discursive influences and their relevance to this research process. The approaches considered were firstly, the action oriented styles of Gilbert, Mulkay, Potter, Wetherell and Edwards; secondly

the structural perspectives offered by Foucault; and finally the multidisciplinary and social outlook of Fairclough. Table **10** summarises those influences which have contributed to the construction of this bricolage.

Table 10. Influences from DA and Relational Proximity

Point	Influence	Source
1	(D) discourse can be both 'text and talk' and studied as topic and resource;	Gilbert & Mulkay, 1984. Potter & Wetherell, 1987.
2	DA is not restricted to the cognitive dimension, it can be plurisensorial;	Gilbert & Mulkay, Woolgar, 1988.
3	Sample size is determined by the process rather than inherently valuable by its size;	Gilbert & Mulkay, Potter & Wetherell 1987.
4	Accounts of lived experience may include the four existentials of lived time, space, body and relation;	van Manen, 1990
5	There may be interpretive variability generated by context, action and belief which may apply to all participants;	Gilbert & Mulkay.
6	Potentially different repertoires may be encountered;	Gilbert & Mulkay.
7	The possible existence of 'collective consensus';	Gilbert & Mulkay, Gadamer 1993.
8	To consider evidence of changes in discourse/ knowledge and to consider whether particular classes of discourse maybe have precedence, or be stages in practitioner development;	Gilbert & Mulkay.
9	Texts may be evaluated in respect to their *doing* component; their *descriptive* element and the potential *conventions* associated with the texts/ accounts: i.e. seeking the action orientation;	Austin (cited Potter & Wetherell, 1987).
10	There may be indicators of accountability, responsibility and their attribution;	Edwards & Potter 1992.
11	Consider the portrayal of *fact and interest;*	Edwards & Potter 1992.
12	Explore links between the mode of action and the mode of representation and pertinent issues which arise in respect to the language functions of 'identity', 'relationships' and knowledgeing/ believing;	Fairclough 1992.

cont. Table 10. Influences from DA and Relational Proximity

Point	Influence	Source
14	Attend to the possibilities of 'silent murmurings' & 'intertextual' threads, the 'not said' and 'unsayable';	Foucault (1972: 27).
15	Recognise the import of power/knowledge influences, but not at the expense of ignoring hegemonic, reciprocal, or covenant relationships i.e. consider the nature of the relationship;	Foucault. Bradshaw 1994. Schluter & Lee 1993.
16	Acknowledge how persons are recognised, positioned and relate to each other.	Foucault. Schluter & Lee 1993.

Discourse analysis currently supports a diversity of methodological and theoretical origins recognising the ongoing development of this realm of study (see Van Dijk, 1985, Edwards and Potter, 1992, Fairclough, 1992). As Van Dijk (1985:3) discusses, there is an assumption that there are both individually constructed realities and collective understandings which can be revealed through talk. Potter and Wetherell (1987) contend that there is no *method* to discourse analysis, rather a 'broad theoretical framework' and a set of suggestions which are summarised in appendix **13**

The relevance of the sixteen points identified in table **10** is now explored.

Point 1: text as topic and resource

Considering (D) discourse and text as both topic and resource enables the literature review, the observations, experiences and narrative accounts to be analysed. This provides its own dilemma: the text producer has to recognise when to 'leave the field' for as Atkinson (1992) comments, an aspect of the field is the text itself! Potter and Wetherell's model of analysis offered many insights. However, unlike their recommendations, I included myself as researcher, participant and text producer as a data source. Similarly, whilst transcription conventions were employed, full coding was limited to particular accounts, rather than every utterance. Verification was achieved with key episodes when practicable, generating further material for analysis (see vignette **1**).

Point 2: the plurisensorial approach

Given the fieldwork experiences and the observations concerning seeing, looking, silencing and 'between us' activities, an analytical approach which incorporated the

plurisensorial was necessary. The extension of discourse analysis to include texts rather than just accounts of dialogue was evident in Gilbert and Mulkay's seminal work (1984), with subsequent analysts including the visual and the pictorial in their investigations (e.g. Woolgar et al., 1988). Hence the plurisensorial nature of data was considered, albeit in the written form. The articulatory struggles to adequately convey these dimensions indicates discursive tensions and the necessity of ameliorating strategies.

Point 3: sample size

That sample selection should be determined by the research question rather than size is commensurate with a DA approach and is argued by Potter and Wetherell (1987). In this case, the sample size is small (3 participants and myself) yet the data source is rich and 'overwhelming'. In relation to the research question, detailed descriptions and analyses were required rather than numerical instances.

Point 4: lived experience

The study addresses concepts of reflexivity, temporality and space, offering evidence of the problematics encountered when nurses learn nursing. Woolgar (1988) debated what Ashmore described as 'disengaged' or 'post hoc' reflexivity where such a reflexivity is separated in *time* from the research itself. Attempts are made to reveal contemporaneous and extemporaneous thoughts and reflections as source material. There is a claim concerning evidence of an 'immediate' kind as well as that which is through time disengaged from the process itself and yet may interact with the past. Indeed as Usher (1991) discussed, revealing the practical (in this case the in -action) may lead to an increase in theory. From a phenomenological perspective, the notions of 'lifeworld existentials' feature in and through the fieldwork and textual accounts. van Manen (1990) refers to four existentials which he considers to be useful 'guides for reflection in the research process', namely: *lived*[4] *space* (spatiality), *lived body* (corporeality), *lived time* (temporality) and *lived human relation/ other* (relationality or communality, which is also considered as 'lived other'). However as Usher (1996) debates, there may be a danger that one focuses on the 'subject' at the expense of the 'other', and indeed vice versa.

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[4] The use of 'lived' is an interesting concept, conveying a particular emphasis to the experience. Yet surely the experiences, just by definition, have been 'lived', otherwise they are 'dead' or 'not experienced' by the actor?

Whilst the texts alter and are shaped by these existentials, the unifying effect within the lifeworld should not be overlooked. van Manen discussed how these four existentials can be differentiated but not separated (although for the purpose of research they can be temporarily studied independently). Handling these existentials poses particular difficulties when writing and constructing the textual account. Manning (1995:250[5]) suggested that the validity of the experiential dimension within an ethnographic report may be judged by whether it:

i appreciates the fundamental perversity and *unpredictability* of human conduct;

ii encourages the systematic and perhaps intertextual integration of the natives' and the observer's *perspectives*;

iii recognises that social *spaces and times* can be valued;

iv considers whether there is sensitivity to the *image* of reality that constitutes the *experience* of the other;

v articulates expectations concerning intuition, insight and knowing, the *unsayable.*

Whilst Manning inadvertently privileges the novel and strange, these dimensions are incorporated within the study and its reporting.

Point 5: impact of context, action and belief

Recognising the potential impact of context upon discourses draws attention to both variability and constancy. One example is the extent to which I was a 'constant' element determining or shaping the discourse responses elicited by the participants. Paradoxically, as one who could herself generate different voices, the constancy of my influence is itself questioned. The person studies seek to address these issues through attention to the context and retrospective analysis. Fairclough (1992) points out that texts are shaped, determined or influenced by social, economic and material conditions. Thus the generic nursing context, the particular fieldwork episode and the numerous interactions, e.g. nurse/client;

[5] Manning 1995, Chapter 9 *The Challenges of Post Modernism* in Van Maanen 1995.

nurse/nurse; nurse/others are noted. In record keeping, the nature of the process determined a more varied accumulation of texts and greater inclusiveness than Potter and Wetherell (1987) would advocate. However, the nature of DA acknowledges such contextual variability.

Point 6: encountering different repertoires

Where Gilbert and Mulkay identified the two repertoires of 'empiricist and contingent' and revealed the tension which existed when they were in close proximity, Fairclough discussed the potentialities for articulatory struggles of both a homogenous and heterogeneous nature; and the varying 'scales' of interpretation. Fairclough (1992: 224) notices the many facets of discourse analysis, concluding that whilst his model is hegemonic, other models should not be rejected, rather they should be appraised for their utility in different domains. Where Potter and Wetherell sought variability, the contextual nature of the various 'interviews' in which I was engaged differed. On some occasions variability was sought and on others apparent consistency. For example, some interviews were informal 'chats' and 'convenient occurrences', whilst others were planned to include structured questions combined with opportune probing. Attention to the discursive practices enabled identification of the 'It Cannot Be Said' phenomenon associated with some attributes of knowing/not knowing.

Point 7: the collective consensus

Given the contemporary nursing discourses which discuss the intuitive, attention to potential collective consensus was essential. Gilbert and Mulkay examined the construction and deconstruction of consensus. Their research led them to criticise the 'supposedly collective phenomenon of cognitive consensus', maintaining that participants can use their interpretive repertoires to construct a realm of collective phenomena. This hypothesis is particularly useful when considering the concept of 'intuition' as a collective phenomena. (D)discourses about intuition may then be perceived as part of a collective phenomena where individual accounts are apparently constructed to 'fit' the assumed/constructed model yet may in 'reality' be 'radically different'. This perspective concerning 'accounts of intuition' has been applied to the literature review itself. However DA is but one of the activities of action and thus a collective phenomena may not be *solely* cognitive in nature should

it exist. In order to investigate how participants create the appearance of shared belief and construct their solutions, Gilbert and Mulkay suggested that three problematics should be addressed, namely:

i that the person claiming consensus has identified all those who are pertinent members of the group about whom 'consensus' is claimed;

ii the person can correctly attribute the cognitive belief to each individual member;

iii the cognitive content of the consensus can be accurately specified and proven to match the views of the members.

Thus, if I were to advocate that intuition was a collective phenomena, I should respond to these three criteria. This differs from the perspectives of **Sensus Communis**[6] outlined by Gadamer (1975). Gilbert and Mulkay concluded that within a given field, at a particular point, 'for the purposes of sociological analysis' it cannot be said there is a specifiable degree of consensus.

Point 8: evidence of (D)discourse changes

In seeking to educe any particular classes of discourse which may or may not be analytically prior, one enters the realms of intertextuality. Thus whilst Gilbert and Mulkay would advocate that no class of discourse should be seen to be of itself analytically prior, I speculated that there may be some classes which might be prior in the learning and development of the practitioner. Chapter **9** will discuss these developmental dimensions with the Discourses of intuition. In contrast, Fairclough (1992:8) argues that there is a *relationship* between (D) discourse and knowledge. Thus, a change in discourse practice may itself reveal an alteration in knowledge, social relations and identities.

Evidence of changing perspectives through discourse was evidenced in the fieldwork and is supported by the work of Benner et al. (1996). For example, when looking at transcripts of earlier interviews, V remarked spontaneously:

> V Yes, I was going to say that to you Mary, the way I am talking even is different, the way it comes across as well isn't it?

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[6] See section 9.5.4

M um (.) can you see that in the [hesitation], the examples as well? (//) [referring to the transcriptions being examined]

V Yes, yes (.) and maybe even NOW 'horrendous episodes' I probably (.) I wouldn't find them so horrendous now. And becoming more attuned (.) to everything, (.)It concerns me that I used to see them as horrendous episodes [said with irony]. I think as well (.) because (.) if you regard them as horrendous episodes then I would say that you probably don't act as well as you may do (V month 15).

Chapter **5** demonstrated how V acquired these patterns of discourse.

Point 9: evaluating the doing and descriptive elements

Potter and Wetherell (1987) drew attention to Austin's observations concerning the different classes of sentences namely, the performative and constative. *Performative* sentences actually do something, rather than just describe a course of events whereas *Constative* sentences primarily describe something, and in so doing, reveal a state of affairs. Potter and Wetherell point out that whilst these two distinctions became less clear with the passage of time, the significance of Austin's work is that sentences may **have a doing** component; a **descriptive** element; and that there are **conventions** that connect the utterance with the social activity. Applying Austin's work to the analysis of discourse, indicates that it is possible to identify the **action doing (actioning)** orientation; the conventions which may be linked with the sentence and the descriptive nature of the text. For example (superscript numbers refer to the order of sentence):

V [1]He's apyrexial, but I don't know if that is the paracetamol. [2]I don't know if they are aware of that. [3]There's something I can't put my finger on about that man (Month 11).

In the third sentence, V is indicating *worry and an acknowledgement that there is something else to know* when she remarked:

[3]There's something I can't put my finger on about that man (Month 11).

Performative sentences like this one, require *Felicity conditions,* (conventions) which have to prevail in order for the performative to be successfully accomplished. In this example, the discourse was contingent not only upon someone (Me) making an enquiry, but also the condition that V was concerned

about the patient. The first sentence offers a description of empirical data (apyrexial) which is accompanied by remarks which indicate queries and reveal the *uncertain state of affairs experienced by V.* The necessity for subsequent action indicates a possible performative function:

> [1]He's apyrexial, but I don't know if that is the paracetamol. [2]I don't know if they are aware of that.

Point 10: attributions of accountability and responsibility and
Point 11: the portrayal of fact and interest

These themes were derived from Edwards and Potter's (1992) conceptual schema known as DAM: the discursive action model. The model articulates three dimensions, action, fact and interest, and accountability. Attention to these elements facilitated the analysis of many episodes, particularly the focus upon the primacy of action. Edwards and Potter's psychological stance relates to the action orientation of talk and writing in respect to the social action or interactional work performed by (D) discourse in an epistemological sense. Edwards and Potter investigated the 'realm of fact construction' where accounts may be 'garnered' to manage dilemmas of presentation.

Table 11. The DAM model, adapted from Edwards and Potter (1992:154)

Action: The focus of analysis is concerned with action. What is reported is the product of remembering and attribution and the accounts are situated in activity sequences which refer to what people and groups do.
Fact and Interest: Each individual is faced with a *dilemma of stake or interest* which influences the production of their reportings. Reports are constructed accounts which portray facts in various ways. These reports may be rhetorically organized to undermine alternatives. Elements within this section include: category entitlements, vivid description, narrative, systematic vagueness, empiricist accounting, rhetoric of argument, extreme case formulation, consensus and corroboration, lists and contrasts.
Accountability: Reports attend to the agency and accountability discovered in reported accounts and the speaker's action whether contemporaneously or historically.

Edwards and Potter address *accountability* which has special relevance to the activities of this research. They demonstrated that within participant's accounts there are levels of attribution of accountability which may at one level be concerned with attributing responsibility for the events, and at another level concerned with

the actual accountability of the speaker. The interaction between these two levels is shown to be managed according to the context, for example:

> →V She [the relative] wanted me to sort of reassure HIM and I thought well next time, I'll probably say to the person: "No,(.) I can't lie for you. I can't answer your query." [put in laughter]. It's not, not just how you actually deal with the patients, it's their relatives as well [ironic laughter] (V month 5).

In this decontextualized extract, there are several layers of accountability/ belief perceived, and inferred, through V's account. As speaker, V is stating that 'I can't lie for you', she indicates the contrasting accountabilities (responsibilities) she perceives and experiences between relatives/ patients and herself. Shortly afterwards in the same interview she explores this theme of conflicting responsibilities:

> V ... You never get out of the conflicts, the weekend I was working on X ward ...

V continues immediately with two narrative accounts of situations which are *subsequently* described as occasions when I 'used my intuition'. Consistently throughout the fieldwork, issues of accountability, and responsibility echo as 'voices' influencing the participants, others and myself, evocative of Edgar's (1993) comments concerning the moral tradition of nursing. Such notions are difficult to restrict to the 'cognitive dimension' alone, particularly as they interact with the situation in orienting the action. Different *forms* of the empiricist and the contingent repertoires interact. Acknowledging that accounts can be 'garnered' has relevance to the practitioner learning to 'garner' the case so that it can be 'presented' appropriately.

Point 12: explore links between action and representation

Two perspectives were helpful, Edwards and Potter's model previously outlined and Fairclough (1992). Edwards and Potter remind us that activities occur in a sequence, a sequence in which the psychological concepts like reward, compliment, blame, invitation and responsibility etc. reside. Furthermore, like Sampson (1993), they recognise the 'intertextual collective' other (s). This example refers to 'others' who are silently present: T, the grandmother 'nan', F[7]'s parents, the 'other lady who had died' and myself:

> ....F wanted to know how quickly the end may come. T described the fact that for most people there was a warning signal ... At this point F commented upon people 'going yellow' and wheezing. This in fact transpired to be the yellow colour of her nan, which T explained was due to her liver. The wheeziness was what F had observed from the other patient who had died. T managed to respond to these enquires and seemed to be able to locate the contexts. This was one where I couldn't locate the context because I hadn't seen the lady who had died (notes with T, month 6).

Whilst this extract describes an aspect of 'everyday life' of the staff in the hospice, namely responding to the needs of relatives *who have questions to ask*, it is followed by an account of the activities that were taking place during the interaction:

> F alternatively looked at the two of us. I found myself actively trying to work out where to put my eyes, sometimes she would look at me and I would avoid F by looking at T, or I would smile and reinforce what was happening, or just nod. It was an intriguing position and as the observer, my presence was automatically becoming involved in the 'between us', I could not 'fade'. I could actively retreat, affirm, be still, or focus on them differently. I noticed that I seemed to be naturally emulating T's postures quite significantly (T month 6).

These excerpts echo T's previous remarks concerning the *dynamics of a morning*. In analysing such data, it is important to incorporate the *intensity* of this action as represented in the recalled account (in writing this sentence I note a 'stated belief' of my own).

Point 13, 14 : consider the simultaneity and the intertextual threads

It is Foucault (1972: 27) who draws attention to the:

> ... silent murmuring, the inexhaustible speech that animates from within the voice that one hears, (to) re-establish the tiny, invisible text that runs between and sometimes collides with them.

In order to discover the silent murmurings, or indeed the significance of the 'not said', one is advised to heed the 'formations, positivities, knowledge, discursive practices' that reside within/between the (D) discourse. Foucault claims that 'there is always a secret origin, so secret and so fundamental that it cannot be grasped itself'.

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[7] F is a sixth former whose grandmother, 'nan', is dying of cancer. T was conversing with her in a secluded sitting room.

He challenges the premises of certainty and the linear unifying progression of historical accounts. Foucault advocates the recognition that events have 'movement, spontaneity, and internal dynamism' and thus traditional 'history', which seeks continuities, should incorporate these possibilities into its analysis. I argue that through participant observation one attends to the 'movement, spontaneity and internal dynamism' of the event/episode but its analysis requires consideration of the 'continuities and possibilities' present through the others' influence (e.g. power, knowledge, hegemony) and the product which is the text.

To avoid confusion with previous word use, Foucault coined the expression 'Discursive formation' to describe either the recognition of a defined regularity which appears to exist between statements, or the recognition that between these statements there is a system of dispersion (difference). *Rules of formation* are the conditions which are discovered within a given discursive division. ***Discursive practices*** are recognised by the enactments within a formation of Discourse. Foucault identified practices associated with the Discourse of clinical medicine. He defines the discursive practice thus:

> .. it is a body of anonymous, historical rules, always determined in the time and space that have defined a given period, and for a given social, economic, geographical, or linguistic area, the conditions of operation of the enunciative function (Foucault, 1972:117).

Foucault expands upon the notion that Discourse is <u>more</u> than the use of signs to designate things. In other words (D) discourse is <u>more</u> than the utterances and language of which it is constituted. This may appear to resemble the 'Gestalt' concept in psychology, except here the difference or 'value added' appears subsumed and not recognised. Foucault indicates that the 'more' should be revealed and described (1972: 49); the search for the 'invisible visible'; the premise that 'everything is never said'. This leaves the problematic of establishing, ignoring, or denying the presence of the 'everything' the 'muchness?'

> '.. and they drew all manner of things - everything that begins with an M - .... and muchness - you know you say things are 'much of a muchness' did you ever see such a thing as a drawing of a muchness?' (Carroll, 1987: 63, Dormouse to Alice).

It is necessary to emphasise that Foucault (1972:55) does not concentrate on the 'speaking individual subject,' rather he outlines a 'totality' through which the subject is dispersed across various sites. It is this denial of the impact/ presence of the 'speaking subject' which has been criticised by others (e.g. Fairclough), and prevents my total subscription to Foucault's position. Foucault ignores the problem raised by the question:

How does one connect the participant's discourse with their sense of being?

Foucault's reflections on the connection between power/ knowledge[8] and discourse are seminal. His legacy is that attention should be afforded to their impact upon the constitution of public Discourse within a group, and the reminder that one should remain open to the possibilities which may emerge from that which is not (obviously) present.

Foucault distinguishes between the emphasis in scientific domains towards connaissance, and the discursive practice which explores the savoir. The empirical work in this study indicates a tension between the savoir and connaitre in the actioning of practice. It is important to acknowledge Foucault's account of the relationship between his notion of 'archaeology[9]', savoir, connaitre and science.

It is from these 'structural' perspectives that Foucault's concept of Discourse Analysis differs from the 'individualised' approaches of say Potter, Wetherell and Edwards. In extending Foucault's terms to a more wider domain, for example to the definition of (D) discourse, there is a greater richness in analysis, enabling consideration of the *simultaneity* of the present with the *simultaneity* of the past: the archive. The simultaneity of both heralds the potentialities for the future (intended act), reminds us of *feedforwardness* (Beckett, 1995) and the *application* described by Gadamer (1975: xx):

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[8] In translation one has to distinguish between knowledge as *savoir*; *knowledge in general,* the totality of connaissances and knowledge as *connaitre: a corpus of knowledge, a particular discipline*. According to Sheridan, Foucault considers *connaissance* to be the relation of the subject to the object and the formal rules which determine it, whilst *savoir* refers to the conditions necessary in given situations for that object to become connaissance (see page 15).

[9] Archaeology is Foucault's term to describe 'discourses as practices specified in the element of the archive' (p131). The archive incorporates both that which appears as self evident in statements, and that which is the system of its functioning: the mode of its occurrence of the statement -thing.

> that meant that again there is a mediation between the past and the present: that is, application.

There is scope therefore to engage with the dialogic impact of the Self texting with the texts of others. This may occur with the archive of literature, the Discipline or the oral/ written record. This dialogue may reveal my understanding 'which belongs to the being of that which is understood' (Gadamer, 1975: xix). I note the word 'being' which infers existence, temporality and space in presence and presencing. These statements also indicate the inadequacy of a purely structural approach and appear to link the noumenon and the phenomenon.

Fairclough (1992) sought to overcome the apparent deficiencies in previous Discourse traditions, developing a multidimensional approach which is textually oriented, whilst incorporating the abstract: hence Fairclough's abbreviation T.O.D.A. (Textually, and thus linguistically, Oriented Discourse Analysis). Foucault's structural perspective contributed significantly to Fairclough's position adding the dimension of power/ knowledge formations to the linguistic influences. However, as Fairclough points out, Foucault did not specifically address the analysis of spoken and written language, but rather scrutinised the Discourse of the human sciences as witnessed through historical documents.

Fairclough drew on Foucault's insights that (1) Discourse is constitutive of social life; (2) discursive practices are defined by their relations with others (intertextuality or interdiscursivity); (3) there is a discursive nature to, and of, power (4) there is a political nature to discourse and (5) the discursive nature of social change. Fairclough explored the deficiencies of Foucault in respect to his neglect of the textual discourses; the absence of 'practice' and an exaggeration of power at the expense of the Gramscian notion of hegemony and active struggle. Fairclough defines practice in this context as the 'real instances of people doing or saying or writing things' (1992: 57).

Fairclough attends to three dimensions of discourse: discourse as text; discourse practice and discourse as social practice. However, his use of the terms 'text and discourse' is restrictive and does not match the working use I employ in this thesis. To Fairclough discourse is a 'form of social practice, rather than a purely individual activity or a reflex of situational variables' (1992: 63). Fairclough views

discourse as a mode of action as well as a mode of representation and that there is a dialectical relationship between discourse and social structure. Fairclough distinguishes three elements of the constitutive nature of discourse which in turn correspond to three functions in language namely the 'identity', 'relational' and 'ideational' functions. Awareness of these functions aided interpretation and analysis.

Bias may be elicited through attention to the intertextual and texting. Sanger (1995) argues that the researcher often fails to appreciate bias in the 'language, rhetoric and modes of transcribing' used to represent social realities. As Denzin (1994:507) argues, 'all texts are biased, reflecting the play of class, gender, race, ethnicity, and culture' and the author should make clear to the reader the moral biases which organise researching. Thus attempts are made, often through post hoc reflexivity, to expose bias/stance, albeit perhaps falling prey to the ironies of distortion discussed by Parker (1997).

Point 15: recognise nature of the relationship

Point 16: explore the recognition and relationship of persons.

Whilst Schluter and Lee's (1993) work is not within the domain of DA, their relational profile offers a useful adjunct to the contextual analysis of DA. Schluter and Lee propose that relationships contain two aspects, namely *quality* (which refers to how 'good or bad' the relationship is perceived to be by the persons involved) and *structure* or *relational proximity* (which refers to the extent to which the persons know one another). Whilst the quality of the relationship is essentially immeasurable, relational proximity may be quantified in terms of five indicators which constitute the closeness of the relationship. I found these indicators useful points from which to reflect upon the relationship between the researcher and the researched, in this case between myself, V, T and P. Inevitably the person studies traced an emerging relationship with each participant which was subject to the factors mentioned by Schluter and Lee.

Table 12. Five Dimensions of Relational Proximity

Indicator	Description
Directness	Refers to the amount of face to face contact one person has with another.
Continuity	Refers to the length of time one person has known the other and the regularity of contact.
Multiplexity	Refers to the various settings in which the two persons meet and the associated role sets. The variability of these settings increases one person's knowledge of another. This dimension is obviously connected with role theories (e.g. the work of Goffman 1971, and Ruddock, 1972).
Parity	Refers to the level of mutual respect between people. Whilst this may be influenced by factors like status, intelligence or wealth, this is not necessarily so.
Commonality	The dimensions of relational proximity are thought to be necessary, but perhaps not sufficient, pre conditions for the development of a good relationship.

As the study demonstrates, the sixteen points acquired from DA informed my stance as researcher and significantly challenged the usual premises accorded to the researcher's role as participant observer. Pearsall (1965) argued that researchers often fail to clarify whether they had *analytically* employed participant observation as technique, role, or methodology. In this case, participant observation was used as tool not method in the attempt to search for the concepts and matters under review.

8.4 The Participant Observer 'In the Field'.

Chapter **3** outlined the rationale for my use of participant observation. Table **9** has identified the traditional preferred 'rules of engagement' which are encountered in the literature on participant observation/ethnography. These traditions privilege *difference as the means of interpretation /representation.* Research analysis implicitly involves notions of sameness and difference through its reliance upon contrast as a means of verification. Woolgar (1988: 19) highlights the assumed notions of difference/ distance 'embedded in practices of argument which maintain the distance and exoticism of the target of study'. Woolgar, like Polkinghorne, attends to the potential implications of ignoring the 'other' antithetical dimensions. The pervasivness of this 'exotic' dimension is seen in a nursing publication in which

the prospective student is advised to present 'an interesting story' (Johnson, 1995). This discussion will indicate possibilities that may have been opened or closed if I had undertaken the fieldwork adhering faithfully to the advocated descriptors of ethnography. Some research activities and outcomes were enabled through manifestations of *sameness* whilst others gained from manifestations of *difference*. Reed and Proctor (1995:10) contrast the nurse researcher's role as 'outsider' or 'insider', introducing the term 'hybrid' when the researcher undertakes research into the practice of other practitioners in an unfamiliar setting (to the researcher). Reed and Proctor acknowledge the oversimplification of their analysis recognising that researchers 'move backwards and forwards' through a range of positions during a study. This is a more realistic appraisal of researching. Their work indicates the recognition of a different situatedness for the nurse researcher (see **8.5.3**).

8.5 Participant observation or ethnography?

This debate arises from both an analytical and pragmatic perspective. To define the study as an ethnography carries with it particular connotations which, it is demonstrated are not consistent with the development of the research. For example to what extent does one consider that the three practice settings were three distinct cultures, or merely three aspects of one culture? Indeed, although I was located in the settings, was I studying culture? I do not propose to enter a debate concerning cultural definitions. The point is whether the study of a person within a culture, is *itself* the study of culture and if so, to what extent are its findings *generalizable to the culture*. If the empirical work is focusing on individuals, then the extent to which the individuals constitute a group and share a given culture determines whether the study is 'cultural' and thus ethnography. Laugharne (1995) questioned whether a ward setting necessarily represents a cultural group. Savage (1995) overcame this dilemma by using the term 'mini ethnographies' to refer to her study comparing two wards. Neither solution applied to this study.

Traditionally, participant observation has been clearly associated with ethnography, being frequently defined as such and considered a method. For example Hammersely & Atkinson (1983:2) define ethnography as being the *same as* participant observation, a position echoed by Spradley (1980:50) who remarked that the central aim of ethnography is to 'understand another way of life from the

native point of view', emphasising that ethnography enables people to learn from one another.[10] To Van Maanen (1988), ethnography is concerned with the manner in which one culture (or a selected aspect of a culture) is portrayed in terms of another; residing on the premise that the social reality of another maybe represented through the analysis of one's own experience in the world of these others. From these illustrative (but I would contend fairly representative) definitions, one can identify that essentially participant observation *as* ethnography is concerned with focusing on *difference* in order to 'present phenomena in new and revealing ways' (Hammersely 1992: 13). From the researcher's accounts, theory may evolve and new or different conceptions of 'reality' emerge, theories which are derived from:

- acquiring aspects of the lived experience of the other;
- engaging with the other's accounts of their experience;
- interpreting these accounts and observations in the context of a direct contrast to/from the 'culture' of the observer.

The written outcomes of these activities is the ethnographic text, shaped by the traditions from which it is launched and as Van Maanen (1988) outlined, the impact of four issues: (1) the assumed relationship between the culture and the observed; (2) the experiences of the fieldworker; (3) the representational style(s) used to construct the account of the research and (4) the role of the reader. In discussing these connections between fieldwork, culture and ethnography, Van Maanen graphically portrays 'the way it is done' as well as the way it is reported. Van Maanen perceives ethnography as being the tie which knots the fieldwork and the culture together. In producing this 'knot', the ethnographic text is formed, with its own style (e.g. Confessional, Impressionist and Realist), and genres (e.g. literary, critical, formal).

This encounter with the mores of ethnography and participant observation illustrates the methodological knots into which one can quickly descend and indicates the dilemma presented when one seeks to classify and delineate the research method. So far, the debate has centred around the concepts of culture, ethnography and participant observation. Let us now examine the characteristic

[10] There is a subtle irony here in that whilst it is suggested that one should acquire the 'native point of view', traditional ethnography asserts that one shouldn't 'go native'.

features of participant observation *as* ethnography in relation to the researcher's activities 'In the Field'.

Ethnography is typified by the exhortation to 'strenuously avoid feeling at 'home' in order to prevent a loss of 'strangeness' which may allow the 'escape of one's critical, analytical perspective' (Hammersley & Atkinson: 1983: 102). This warning is accompanied by the recommendation that, whilst there may be moments when there is a necessity to engage in social interactions for pragmatic and social reasons rather than research ones, it is important:

> ...never to surrender oneself entirely to the setting or the moment. In principle, one should be constantly on the alert, with more than half an eye on the research possibilities that can be seen or engineered from any and every situation (1983: 103).

I challenge some of these remarks, raising concerns about the 'engineering' advocated in this extract. Savage (1995) when admitting her anthropological stance, discussed how she excluded some data which had been acquired during social interaction *after work*, commented that:

> This goes against the usual practice of many anthropologists who might view this kind of informal interaction as the key to understanding informant's world views. However, I felt that I did not have informed consent to carry out my research in this sort of context (p21/22).

Whilst I share her concerns about the acknowledged jurisdiction of consent, her remarks demonstrate the mores of the anthropological community and implicitly indicate how they conflicted with the mores of 'friend' or 'nurse' culture. Let us examine some of the assumptions underpinning these views of ethnography.

8.5.1 Being at home as....

There is no doubt that research possibilities were open to me simply because I *could* 'be at home'. In order to be metaphorically and literally 'behind the screens,' as an active participant, there were occasions where to be functionally safe, I needed to be 'at home' and 'familiar' i.e. to some extent 'embodied' as a registered nurse in that situation. Where Savage (1995) commented that she held the stance of a beginner and did not engage in technical procedures as an observer, this contrasted with my overall position as an 'experienced' general nurse. I propose that *certain*

aspects/perspectives to research in clinical settings become accessible only when one is 'at home' and 'functionally safe'. I challenge the universal assumption that 'being at home' diminishes one's capacity to be critical and analytical. Whilst I do not contend that this may and does occur, I have difficulty accepting the presumptions about the virtues of 'objectivity' which underpin these remarks of Hammersley and Atkinson. Furthermore, I note that Hammersley and Atkinson suggest that if one is feeling 'at ease', then perhaps the fieldwork is completed, or one is just being lazy! These are possibilities, but not universals, residing on the premise that analysis is only achieved through being separate, dissociated, noticing difference and contrast.

There is no doubt that the observation work undertaken with T in home settings required a degree of clinical expertise and personal adaptability that may not have been possible from a lay person or inexperienced nurse. It is unlikely that I would have been able to enter some homes where patients experienced complex problems. For example, the potential as observer to do 'damage' to one particular patient with a mental health problem was significant. Similarly, with P, if I had not been able to handle some clinical situations, I probably would not have observed so clearly her 'sweeping gaze', nor provided evidence concerning the content and quality of my own 'knowings' when operating behind the screens in the emergency department. Several other aspects of the fieldwork would have not been exposed to the 'researcher's eye', if I had not been able to 'blend,' 'be at home' and 'respond' to the clinical situations. This discussion revisits the *intentions* of the researcher. I am proposing that it is the extent to which the researcher can simultaneously manage participation and analysis at two levels, namely clinical analysis and performance in respect to patient safety, and secondly research analysis and performance in relation to the situation occurring. As others have noted, this 'double' requirement demands a degree of concentration which hastens the onset of fatigue and observer vigilance. However, such considerations also provide data for the analysis of professional practice itself, whether as researcher, clinician or educator.

Hammersley and Atkinson (1983) suggest that the researcher should *engineer*[11] the research possibilities: such a term holds the negative connotation of

[11] Engineer: a skilful or artful contriver: Oxford English Reference Dictionary (1995).

being highly manipulative and constructive. One does not deny the researcher's capacity to 'look' for opportunities and readily grasp them as they occur, but this account seems to undermine the advocated position of 'naturalness', inferring that the researcher is actively intervening in the situation. If this is so, there appear to be inconsistent claims, however if one ignores the potentially pejorative connotation of 'engineering' then the comments may more closely resemble the consequences outlined when being an active participator. The exposition of these possibilities reside in the researcher's account, where the decision making and judgement processes should be revealed.

8.5.2 Lurking

The traditional activity of 'lurking' or 'hanging about' (see Roy (1970) in Burgess: 1984) should also be challenged. In clinical settings one is operating in a milieu of negotiated relationships in which a 'professional' is accorded a role with attendant expectations/privileges. Certainly, there were times when I lurked, hovered, wondered etc., however I was doing so within the 'front[12]' of a registered nurse. For a variety of ethical, practical and safety[13] reasons, one cannot 'lurk' in a clinical setting without some perceived legitimacy. Indeed, in a patient's home, 'lurking' would be positively impertinent, disrespectful and could damage the ongoing therapeutic relationship between the practitioner and the patient. The notion of the 'free spirit[14]' floating in the breeze has its boundaries of place, manner and appropriateness. To paraphrase Woolgar (1988:21), one is debating the extent to which the character of that which is studied, should shape the nature of the investigation and thus the nature of the representation. However, in a complementary manner, 'lurking *as a* practitioner' provided other opportunities open (literally) to the researcher's eye as this extract indicates:

> The ***SHO*** [junior doctor] attempted ***to put a line*** [into a neck vein] in the neck, so I stayed by his [the patient's] head, I was now caught pragmatically in the middle by accident... By now I was literally trapped up beside the patient, next to the registrar [senior doctor] who was going to ***position the scope*** [fibreoptic imaging device]..... Around the patient [who was very sick], there were plenty of looks that were exchanged between me and the patient, between L and I,

[12] After Goffman 1971.

[13] Hospital settings are comparatively open institutions where vulnerable persons are susceptible to threat, theft or, in the case of infants, abduction.

[14] See Burgess 1984 citing Roy 1970.

> and then between the doctors [whose preoccupation with what they were doing led them to be generally unable to converse with the patient]. S understood it[15], there was a lot of silent team work going on in the background... the unspoken acknowledgement that it was better for me to ***be with the patient***... (V month 18).

In this example, it was my position at the patient's head (which incidentally was frequently at the patient's eye level, not from a standing position) which enabled me to observe the glances and looks. Whilst assisting in the care, I was 'making mental notes' of the scene as a clinician and researcher, literally enacting Hammersley and Atkinson's advice to 'keep more than half an eye' on the possibilities. This particular episode contributed to my deliberations on the concept of Gaze and Regard.

Hammersley (1992) when discussing the merits of the practitioner as ethnographer asserted that:

> In short, I do not believe that being a participant in a situation provides access to valid knowledge that is not available to an outside researcher (1992: 145).

Whilst I would not deny Hammersley's assertion that these activities could have been observed by a non participant, given the restricted space around the bed, it is unlikely that there would have been the physical room for the observer to be 'at the patient's head' as a non participant/ non practitioner. Perhaps a video[16] may have elicited such moves, but I doubt its capacity to 'follow the looks'. Certainly, I cannot exclude that non participation may have achieved similar observations, however the interactive nature and my physical position enabled me to observe, receive and participate. Hence, these variations offer the potential for different and similar perspectives to be undertaken. It is perhaps not an issue of the *validity* of the information gleaned, but rather the *opportunity* to obtain such knowledge and the fidelity of the account. Hammersley (1992) recognises the plausibility of the claims that practitioner ethnography may hold, yet does not accord these claims particular respect. Furthermore, Hammersley assumes that the practitioner as researcher is researching in their 'home' location and his criticisms are largely addressed to the

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[15] An illustration of Jefferson's discussion regarding 'shared moments' and acknowledgement tokens.

[16] The recent 'abuses' of the use of patient videos has led to requests for research involving the videoing of hospitalised patients to be careful scrutinised and avoided where possible.

Teacher *as* Researcher movement (after Stenhouse, 1975). I thus challenge the privilege that Hammersley accords to the 'non practitioner'. It is in the analysis of *parity* that one determines the appropriateness of the research activity and the knowledging which may be generated from such actioning.

8.5.3 Surrendering oneself: Going native? Being Familiar

Another ethnographic tradition is to advise the fieldworker against the danger of 'going native' (Hammersley: 1992). The maxim to maintain a 'more or less marginal position' with the assumed sense of insecurity, stance of intellectual distance and the social position of stranger, engenders not only emotional and physical responses to the researcher's role, but also assumes that 'marginality is a virtue of ethnography': a claim made by Hammersley and Atkinson. Surrendering oneself to the situation implies that the researcher is so immersed in the 'here and now' that analysis is unreliable or impossible. Another argument arises when one considers theories associated with skilfulness, expertise and competence. The capacity to 'be deeply involved', whilst having the capacity to 'quieten the analytic' mind, is a characteristic of the expert (Dreyfus and Dreyfus, 1986). The polarities of native/ stranger, lay/ expert need to be more fully explored in the context of other Discourses and evaluated within the roles of researcher/ practitioner etc.

Tables **13** and **14** summarises the relative merits of participant observation in respect to the parameter of 'familiarity as a nurse'. The tables demonstrate how these varied role expressions influence the nature of that which is observed, experienced, and interpreted.

Table 13. Observation studies: advantages to being 'familiar' as a nurse

Participant observation: advantages	**Study**
reduced culture shock	Pearsall 1965, Ashworth 1980
sufficient understanding not to impede nurse work	Ashworth 1980
acceptance	Ashworth, Kratz 1978
personal experience in prolonged vigilant observation	Ashworth 1980
can notice the presence of 'omitted actions'	Kratz 1978
knowledge of the native language, categories, rules & behaviours	Macleod Clark 1982
can focus & make explicit that which is unconscious or tacit	
direct experience gives one valid knowledge of the phenomenon	Hammersley 1992

cont. Table 13. Observation studies: advantages to being 'familiar' as a nurse

Participant observation: advantages	Study
reduces time required in order to understand the situation and context	Hammersley 1992
practitioners may be able to test theoretical ideas in situ.	Hammersley 1992
Non participant observation: advantages	**Study**
knowledge of the basic acceptance and tolerance levels of nurses	Wells 1980
ward routine acceptable to observers	Jones 1975

Table 14. Observation studies: disadvantages to 'being familiar as a nurse'

Disadvantage	Study
cannot assume a naive pose	Kratz 1978
respondents have expectations	Kratz 1978
confusion and doubt through a different clinical environment	James 1984
observer effect (through knowledge and presence)	James 1984
not doing enough study of the observer effect	James 1984
oversight of assumed language meanings	Spradley 1980
being culturally bound	Spradley 1980
experiences are immediate and subjective	Hammersley 1992
focused observation	
overlooks items because they are no longer perceived	Pearsall 1965
social and intellectual distance cannot be maintained	Hammersley & Atkinson 1983
diminished capacity to be analytical and critical	Hammersley & Atkinson 1983
divided loyalties	Hammersley & Atkinson 1983
self knowledge does not imply validity or accuracy	Hammersley 1992
experience privileges particular kinds of knowledge	Hammersley 1992

8.5.4 The visiting cousin?

I could be labelled as the 'occupational practitioner' (Hammersley and Atkinson), or a 'native' from a similar tribe who was primarily focusing upon individual practitioners. It is analogous perhaps to being a visiting cousin from another village who works as an occasional worker whilst studying in depth one member of the tribe. In this study the research participants are encountered in several intermittent instances of action and interaction. Whilst I may have been 'unfamiliar' with the setting or the latest technique, because I was a 'practising nurse and educator', I was neither lay person nor novice, yet alternately 'experienced or not'.

The possibility of 'sharing' with the research participants was noted by Williams (1989) who discussed how her experiences 'mirrored' those of the participants and vice versa. The nature of the mirror, 'Through the Looking Glass' becomes its own focus for study: the reflexive and reflective dimensions previously noted which may reveal dimensions of nursing practice and its acquisition. It is the relationship between the 'knower and known,' the observed and the observer, which Van Maanen considers the most problematic aspect of ethnographic interpretation. It is through the dynamics of this interaction that variations in role expression evolve. The researcher's personal challenge is to adjust and be responsive to unfolding situations whilst not abusing people and their relationships.

8.6 Summary

I have demonstrated that the concepts of Role, Self, Agency and Other have emerged as significant participants within the research process. Through comparisons with traditional models of ethnography and participant observation I have shown that the researching involved a dynamic movement of responses across the 'subject/object', 'sameness/difference' divide according to situation, action, interaction and belief. Participant observation was used as a *tool* not method. The research engagement represents a bricoleur position transgressing modernist and postmodernist positions in an hermeneutical endeavour.

The debate has questioned whether observation in the 'natural state' is ipso facto an accurate/ faithful representation of the phenomenon /nounmenon. Gilbert and Mulkay (1984) challenge the premise that through solely observing actions the analyst is able to 'avoid, or at least reduce to an acceptable minimum, any dependence on participant's potentially variable interpretive accounts'. They argue that 'social action is not 'directly observable' in that what is observed may not reveal the purposive nature of the action...' Awareness that the researcher is a major *instrument* in data collection draws attention to the researcher's own values and personality which may influence the study (Lipson: in Morse 1992). This foregrounds *intentionality* which applies to researcher and 'others' alike.

With the benefit of these perspectives drawn from DA, relational concepts and ethnography, the study now proceeds to interrogate the Discourses of the 'Unsayable'.

CHAPTER 9

ORIENTING AND SEARCHING FOR SELF/OTHER

Intuition/Reflection/thinking/knowing in action in the context of the learning and development of registered nurses in practice.

9.1 Introduction

Locating this literature appraisal *after* the fieldwork accounts enables a hermeneutical dialogue between the literature and empirical work. Whilst preliminary literature reviews were constructed *prior* to entering the field, they were reconstructed following the fieldwork experiences and exposure to DA. Consequently 'new' and 'particular' readings of the existing and emerging literature were generated.

The literature review had two major foci. First it analysed the (D)discourses associated with the tacit, intuition, reflection, thinking in action. This review acknowledged and questioned the representations of these 'unsayable', 'inexpressible', 'invisible' and elusive concepts. In addition, fieldwork encounters with 'seeing, looking and gazing', and the Discourses of the body and medicine, stimulated consideration of Foucault *(La Clinique),* and Nightingale. The second focus, which has been explored in chapter **3**, addressed the epistemological aspects of professional practice related to the learning, development and skilfulness of registered nurses.

Whilst several writers (e.g. Lumby, 1991), suggest that intuition, reflection, thinking and knowing - in- action are at least equivalent terms, if not synonymous, others question their very existence. Certainly the interchangeability of the terms was most evident, causing inevitable confusion and the investigation dilemmas previously addressed. The fieldwork inevitably considered :

> What is it that the competent practitioner knows when s/he engages in practice and secondly, how has s/he learnt whatever it is that s/he knows?

Let us proceed to examine these concepts mindful that there was an apparent dearth of 'natural' examples in which participants or others in the field, uttered explicit discourses which referred *either* directly to the concept of

intuition, *or* indirectly through the articulation of associated words like 'hunch', 'instinct', or 'gut feelings'.

Whilst these 'unsayable' concepts are singly worthy of individual analysis, their examination is restricted to the *in -action* dimensions pertinent to nursing practice. Whilst reflection *upon practice* is an inevitable companion to all facets of the study, it is not itself the major focus. This chapter will scrutinise the tacit, connoisseurship, skilful doing, intuition, reflection and knowing-in-action. The chapter commences by analysing the impact of the Cartesian legacy and the implications of Macmurray (1957, 1961) and Shotter's (1975, 1993) claims that knowledge and movement are integrated in action. I shall propose the processes of *actioning and silencing.*

9.2 The Cartesian legacy

The Cartesian legacy has created a divisive discursive problem which linguistically separates the mind/ body, subject/object, noumenon/phenomenon, knowing/doing, theoretical/ practical. The tension between the theoretical and the practical will remain so long as the theoretical is not conceived as being within action. This theoretical/practical problem has been exacerbated by the privilege accorded to the theoretical, disciplinary forms of knowledge and 'knowing why' rather than 'knowing what/how[1]'. Indeed Walker[2] (1988:64) remarked:

> our knowing, and the belief in that knowing is grounded in knowledge based systems of thought which are themselves constituted in bodies of knowledge.

Both Macmurray (1957, 1961) and Shotter (1975) draw attention to the implications of shifting perspectives to the "I Do". Macmurray (1961: 24) argued that we should change our stance to commence from the standpoint of action, which is the 'distinguishing characteristic of the personal'. The Self is Agent, an existing being, a person, who operates in relation to Other. Action is primary and thought is within the activities of action, hence thought can be perceived as a form of embodied action. Shotter (1975) describes this shift as moving:

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[1] A distinction attributed to Ryle (1949)
[2] In Woolgar 1988

> ...first from thought to action, and then from an egocentric to a social standpoint- a shift in standpoint, from one in scholarly reflection to one in everyday social practices (1975:23).

Thus, one stands in action and views from, and in, action (where action is itself plurisensorial). The significance of a failure to achieve this shift in perspective is evidenced in the literature and the fieldwork. For example, the concepts of intuition, reflection, the tacit and thinking are historically located within either a Discourse of 'mind' or a Discourse of 'body'. It can thus be argued that resistance to determining the concepts exclusively within one of these poles may be a struggle not against the 'mind' or the 'body', but rather a struggle against the discursive practice which constitutes this dichotomy. The significance of 'cannot articulate' may be a manifestation of this dilemma possibly compounded by privileges accorded to the 'mind ' or 'body' stance. Interestingly, Kant distinguishes between Intellectual and Sensible intuitions (Rorty, 1967). The former facilitates knowing reality in itself and may be used for dealing with 'immediate knowing' associated with concepts, theories and formal relations. Sensible intuitions are related to sensorial knowledge where sensing is a form of knowing which may be inexpressible.

Attempts to manage a discourse of person/ intuition which link cognition, behaviour and 'affect' are problematic. Several (D)discourses on intuition illustrate these dilemmas through metaphors like 'gut feelings' which connect bodily associations with knowing. Other indicators of contrasting stances are represented by the 'male /positivist/scientific/cognitive' models and the 'female/artisitic/feeling' claims. These tensions illustrate socio- cultural and historical influences representing particular paradigms/positions which are themselves the focus of hegemonic struggles in (D)discourse & practice. Fischbein (1987: x) indicated these tensions when he referred to the 'dramatic struggle of the scientific mind against intuitive biases'. These debates construct antithetic metaphors. Terms like 'simultaneity', 'wholistic', the 'unsayable' and the use of verb forms suggest discursive strategies which try to integrate not only the mind and body, the subject/object, knowing/doing, but also the temporal and spatial via discourses of intuition, reflection- in- action, embodied knowing, deciding and judgement. Another consequence of the

enlightenment was the gradual supremacy of the visual sense (Macmurray, 1961 and Foucault, 1973). This has relevance to fieldwork accounts of 'gazing, looking and seeing' and 'reading' the text. Through reference to the works of Foucault and Nightingale, it is evident that British nursing arose at a time when the deficiencies of the medical gaze were already apparent.

In attempting the reformulation suggested by Macmurray (1961) and Shotter (1975), one becomes uncertain of the outcome. Intuition becomes an aspect of action, and due to the problem of discourse, talk about it reveals the purposes and functions of an aspect of, and within, action. The consciously aware thought or intuit may appear to be either a process of abstraction which originated from action, or as an attempt to *inform* action. Given the discursive nature of a thought/intuit, as Macmurray (1961) commented, abstraction may be a rhetorical activity.

9.3 Seeing and Knowing.

Learning description and learning to see become crucial aspects within the practitioner's development, as V demonstrates. Foucault highlights this necessity 'because it means giving the key of a language that masters the visible' (Foucault 1973:114). Foucault explored the genesis and development of positivism through a fifty year period of medicine in France, outlining a *medical regard* which created a power/knowledge difference expressed through a form of discourse and gaze. This product of a 'speaking eye' would be both the 'servant of things and the master of truth' (p115). Implicit within the expression 'speaking eye' is the concept that the eye engages in communication, here as the speaker to the Other's listener. If the Speaker is the Agent, then the Other may once again be Self, Object or Person. This analogy is also one of master/ servant, or master/novice dependent upon the context and associated suppositions. The person studies revealed different Gazes and discursive practises.

Foucault describes the 'unravelled mysteries' and the neglected aspects upon which the enlightenment has overlooked its own epistemology, the importance of death. Yet if practitioners can see death in life (as T indicates), then the connections and creation of (mutual) knowledge (knowledging/

knowings) are more elusive than the living or dead corpse. Seeing (within[3]) the person, to a concept wider than the disease is an oft stated goal of nursing practice. Nightingale (1969:125) confronts the gaze (predominantly medical and male) which perceives the body *as a reservoir* or a *curious case.* As Foucault discussed, from this perspective the patient is only that through which the text can be read. It is interesting that Nightingale's original text was published in 1860, whilst Foucault dates 1816 as the final constitution of the medical gaze as being able to confront a sick organism and a particular way of seeing with the accompanying emergence of pathology. Forty years later Nightingale (1969:133) is questioning the limits and consequences of this very anatomical/clinical positivist model when she ironically comments that:

> Pathology teaches the harm that disease has done. But it teaches nothing more.

Nightingale (1969:123) offers a conception of observation and experience which is wider than the medical gaze: an observation which includes the situation of the sick person as well as a knowledge of his[4] individuality. The distinction is made between the focused and limited observation of the physician (apperception) and the potential 'powers of observation' of the 'non scientific person'. As care returns to the home, then one must question whether it is returning to the 'natural locus in which truth resided unaltered' (Foucault, 1973: 109) or whether it is being rendered into the modern version of the 'neutral domain, one that is homogeneous in all its parts and in which comparison is possible and open to any form of pathological event'. Contemporary political discourses which seeks to further 'rationalise and scientise' the practice of medicine may be an attempt to extend the gaze into new domains raising the status of this 'pure gaze'. However, it is nursing practice which deals with what Lawler describes as the problem of the body: somology. So if medicine offered to positivism the discourse for dealing with death, it is argued that nursing can aid in the construction of an 'incomplete' discourse to deal with 'the grey', the 'living', the 'embodied' and the 'invisible'.

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[3] The Latin origin of intuition is *in+ tueri*, meaning to gaze upon, tueri = to look at. *Intuitio* may also mean a contemplation.

[4] I acknowledge the stereotypical use of the male gender to represent the patient!

Belenky et al (1986:18) observed the ' tendency for women to ground their epistemological premises in metaphors suggesting speaking and listening is at odds with the visual metaphors (such as equating knowledge with illumination, knowing with seeing, and truth with light) that scientists and philosophers most often use to express their sense of mind'. This study notes the recurrent verb forms of 'seeing', 'looking', 'knowing' and 'doing' within the practice of nursing.

9.3.1 Learning regard/gaze

Foucault argued that the medical gaze cast a veil over alternative (and in some cases earlier gazes[5]) to become the determining gaze of the physician's examination. Not only was a power and knowledge difference created between the person, the body and the physician, but a classification and hierarchy of medicine and medical gazes arose representing the dominant forces within each epoch. Today, technology serves the gaze, becoming a focal point for the physician away from the body itself, yet representing the underlying pathology through visual imagery created by machines, chips and instruments. Gaze may seek to discover that which is apparently invisible, its location and nature. Where sovereignty exists, the look is not empowered to invite reciprocity, it transmits acquiescence and passivity. Foucault assumes a reciprocity with the live body which is subservient, this has been noted with the nurse as well as the patient. The 'speaking eye' has to acknowledge the knowing and information emanating from the Other who is in trans/ interaction.

Having noticed from both Nightingale and the fieldwork the use of 'gaze' by nurses, one questions how is this gaze used? Indeed is the gaze a constituent element of intuition? Within nursing practice gaze has to contain the capacity to accept responses from the Other (s). The moral aspect of nursing demands that the gaze should be respectful of the person and their position. Both Macmurray and Shotter emphasise the person as a moral, socially responsible and intelligible agent. Whilst gaze can generate a power/knowledge status, it is silent and accompanied by a language which needs to be understood. Hence in the silence of the gaze there is action and

[5] Appendix **14** outlines Foucault's references to Gaze in La Clinique.

transmitted, or received, meaning. The novice has to learn the language to present the case as seen by V in vignette **1**. In this instance, the **regard** (gaze) is fused but unspecified, it is an untrained gaze which has not yet learnt the range of actions nor the significance of that which is perceived. The signs become confused in interpretation and the symptoms are not manifest nor elicited. Yet the gaze of compassion and 'rightful action' demands a nursing response to the situation. Macmurray and Shotter clearly articulate the community dimension of the Person, whose relation to the Other engenders meaningful action. Kirkpatrick (1991) in the preface to 'Persons in Relation' explores the connections between Gilligan and Macmurray, namely, both emphasis heterocentricity, mutuality, engagement, relations/connections and community. As Kirkpatrick discussed, for Macmurray, friendship means community and the full expression of a relationship between persons:

> all meaningful action is for the sake of action, and all meaningful action for the sake of friendship (Macmurray 1957:15).

As this chapter develops there are further references to these themes, the role of 'meaningful action' and its attributed elements. The review of the 'unsayables' continues with 'tacit knowing' a term attributed to Polanyi (1966) who claimed that it is 'an essential component to human knowing'.

9.4 The nature of the Tacit: Polanyi's contribution (1958 and 1966)

Polanyi proposes and validates a perspective on human knowledge which emerges from a 'harmonious view of thought and existence, rooted in the universe' (1966:4), albeit constrained by a cognitive discourse- no doubt a consequence of his own situatedness within a scientific and philosophical community of the 1950s- 1960s. To Polanyi, the personal participation of the knower is essential in all acts of understanding. Knowing is a skilful action requiring an active comprehension of the known, (1958: vii). It may require effort, attention, indwelling, the establishment of a meaningful relationship between previous experience and the present. This relationship incorporates the 'shaping or integrating' tacit power 'by which all knowledge is discovered and, once discovered is held to be true' (Polanyi, 1966:6). I note the 'orienting' and searching nature of the tacit.

Polanyi's explanation and discussion of two kinds of mutually exclusive knowing within the tacit (the focal and the subsidiary), offers a partial explanation for the problematic of the 'unsayable.' The focal is that to which we focus our attention, whilst the subsidiary is that which is subsumed within the total awareness. Thus, when focusing on the adjustment of an intravenous drip rate, I have a subsidiary awareness of the feel of the switch in my hand. In moving my attention to the switch I lose focus on the drops. Polanyi suggests that objects held in subsidiary awareness, like an external tool, may become an extension of self enabling the person to achieve or signify something (Polanyi, 1958:61). Thus, 'we know the first term only by relying on our awareness of it for attending to the second' (1966:10). Similarly, it is possible that the nurse in focusing on the patient may not recognise the tacit knowing which is employed in so doing, where:

> Our conceptual imagination, like its artistic counterpart, draws inspiration from contact with experience (1958:46)

This interface/ interaction between experience and the conceptual imagination is no doubt a potential component of the practitioner's ability to generate something new, but also mirrors the impact of the mind/body discourse split. The relational dimension to nursing practice contains two images from Polanyi (1958:65) which are particularly relevant: the act of hope and the 'striving to fulfil an obligation' expressed in the universal intent of personal knowledge. Polanyi likens this commitment to *love.* The person studies revealed episodes where the presence of hope and perceived attributions of responsibility drive nurse actions. Acts of hope (e.g. T and Mrs Y.) may involve experimentation, or lead to a new possibility. The sense of commitment may be to a person or thing, whether patient, relative, self, profession, colleague etc., that is to people, theories/beliefs or institutions/ organisations.

9.4.1 The Skilful Performer and the role of tradition

Polanyi states that skilful performance[6] is achieved by adhering to rules which are not known as such to the performer. Whilst the performer may be

[6] Polanyi is referring here to the art of 'doing'.

cognizant of 'rules of art', these rules can only guide the performer if they are 'integrated into the practical knowledge of the art' (1958:50). However, until the art can be specified in detail, it cannot be transmitted by prescription, only by 'example from master to apprentice' through tradition. In such transmission, the apprentice has to submit to authority, placing trust[7] in the master and emulating his practises. The analogy with nursing is apt, especially when the art is 'essentially inarticulate'. Dreyfus and Dreyfus (1986) draw on Polanyi's work, discussing the need to:

> decide in which areas it can tolerate mere competence and in which areas it wishes to practice old fashioned training and apprenticeship so as to preserve old fashioned expertise (1986:188).

However, where the transmission of knowledge involves the 'little secrets[8]' and is within a strong oral culture, then Polanyi's conclusion that 'the transmission of knowledge from one generation to another must be predominantly tacit' has profound implications for the development of practitioners (1966: 61). The role of apprenticeship is not questioned lightly given the well documented defects of apprenticeship training within the institutional bureaucracy of the N.H.S.

To Polanyi, connoisseurship, an art of knowing, like skilful performance 'can be communicated only by example, not by precept'. Interestingly, one of Polanyi's example of connoisseurship is that of the physician recognising heart sounds. In describing the personal knowing of the physician, Polanyi overlooks the necessary requirement to be a skilful performer in the *use* of the stethoscope. The skilful performer is one who sets personal standards which the self evaluates, whilst the connoisseur values entities through standards which he has set 'for their excellence'. Polanyi considers that through the personal 'coefficient', the commitment to universal standards transcends the individual's subjectivity and thus 'bridges the disjunction between subjectivity and objectivity'.

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[7] Schon describes the 'follow me 'relationship between coach and student.

[8] V

This brief examination of Polanyi's work has indicated several dimensions to the tacit and skilful acts of knowing/ doing namely:

- The tacit contains inarticulate and unspecifiable elements.
- Examination of these inarticulate and unspecifiable elements may be possible.
- Where skill is predominantly tacit, it requires transmission from master to apprentice.
- That awareness may be focal or subsidiary.
- That concepts like 'hope', 'commitment,' 'obligation' and 'responsibility' are associated with personal knowing.
- Skilfulness and connoisseurship may involve 'indwelling' and different evaluative components.

Let us examine the 'intuitive'.

9.5 The tacit, intuition and the intuitive

Intuition is a term which means many things to many people (Westcott, 1967). Does it mean to 'see within?'[9]

Intuition and its properties has been analysed from several perspectives including those of theology, philosophy, psychology (especially cognitivism), skill acquisition and development, professional education, feminism and nursing. It is not surprising that Fischbein (1987) referred to intuition as being a 'highly controversial concept in science and philosophy', whilst Kenny (1994) asserted that 'there are no words at the present time to describe it'[10]. Bastick's (1982) survey of the literature on intuition concluded that there were no precise definitions, but rather there tended to be descriptions of associated properties, twenty of which were considered to be common (see Appendix **16**). Westcott (1967) suggested that in both philosophy and psychology the differences concern the issue as to whether there is a reality to be discovered rather than multiple realities to be constructed: however even this distinction ignores the premise that **both** may coexist. Westcott (1967) contrasted three philosophical stances towards the phenomenon, namely: the Classical, the Contemporary and the Inferential positions (see Appendix **19**). Westcott

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[9] Intuitio.

[10] From a DA perspective one asks what is the function of this statement that 'there are no words to describe it?'

(1967) reminds us that throughout history, intuition has held a special place and that 'whatever the nature of ultimate reality and whatever the nature of intuition, the former is to be known through the latter'. Claims about intuition are thus shaped by perspectives concerning the existence, nature and location of ultimate reality.

Rorty (1967) defines intuition as 'immediate apprehension', where apprehension refers to disparate states like sensation, knowledge and mystical rapport. Whilst Rorty (1967) suggested that 'nothing can be said about intuition in general' he proposed four principal meanings of which he considered three philosophically significant. The first un- controversial meaning which is philosophically not significant is the *hunch*: 'unjustified true belief not preceded by inference'. The second meaning is 'immediate knowledge' of a truth, where 'immediate' is not a temporal concept: it refers to knowledge which is not preceded by inference. The third meaning is immediate knowledge of a concept, where the knowledge is not accompanied by an ability to define it. The final meaning is a 'non -propositional' knowledge of an entity where although knowledge is a necessary condition for the intuition of the entity, it may be sense perceptions, intuitions about universals and mystical or inexpressible intuitions. Rorty assumes the existence of an adjudicator who has determined that the belief is neither true and/ nor justified[11]. Reading these distinctions I was struck by the atemporal attribute of 'immediate' discussed by Rorty. Reviewing the literature, it is clear that this understanding of 'immediate' has been construed by some to refer to 'sudden in onset/ time' (e.g. Paul and Heaslip, 1995). In many papers, it is difficult to establish which interpretations have been employed.

Analysing varying perspectives on intuition, one notes the contexts from which the authors deliberate: contexts which may explain the paradoxes encountered. Appendix **17** summarizes studies reviewed in this study, the author's disciplinary backgrounds and, where significant, characteristics of the research/study participants. One problematic is the extent to which definitions/commentaries on intuition are actually discussing aspects of *similar*

[11] These remarks are evocative of Plato's distinction between right opinion and knowledge.

phenomena expressed in varying contexts, or, qualitatively *different* features. Westcott (1967: 40) argues that accounts of intuition represent similar phenomena 'although designated by various names and approached from very different positions'. Bastick (1982) attributed some of the investigative difficulties to the impact and legacy of the 'mystical' overtones associated with intuition. He argues that this association with the 'unknowable' has hindered research into the phenomena, particularly in the West. This recurring concept of the 'unknowable' is significant.

For example, intuition is conceived as a 'day to day/ common experience' or a rare 'insight and creative thought/action' documented in both nursing (Rew and Barrow: 1987, Blomquist: 1985, Gearhart & Young: 1990, Davidhazar: 1991) and non nursing literature (Wertheimer: 1961, Bastick: 1982, Dreyfus & Dreyfus: 1986). Bastick (1982) claims that intuition is pervasive in the 'whole spectrum of human endeavour', a view contested by those who consider intuition to be an imaginative universal or restricted to particular forms of thinking/ behaviour. Dreyfus & Dreyfus (1986) consider that intuition is synonymous with 'know how': the 'understanding that effortlessly occurs upon seeing similarities with previous experience'. From this perspective intuition is the product of deep situational involvement, recognition of similarity and as an 'everyday' experience implies a 'sameness', a 'reproducible' nature, a 'commonness' or 'le bon sens[12]'.

Some nursing Discourses consider that intuition is a part of the oral practice tradition of nursing practice, a component of the female paradigm associated with care and warmth: the antithesis to both the biomedical approach (Shraeder and Fischer, 1987) and empirical, rational factual knowledge (Young, 1987). Rew and Barrow (1987) articulated the concern that the use of intuition by women, particularly in nursing practice, has been 'ignored, denigrated or denied', thus eliciting a quite different response to the 'insights' or 'intuitive leaps' described in the more male dominated fields of mathematics and science. In these fields, intuitive leaps are not only well documented, but seem integral to the stages of creativity, e.g. scientists like

[12] Gadamer cites Bergson's (1895) description of *le bon sens*, the sense that has a moral element and is the 'good sense' which governs our relations with persons.

Einstein (Wertheimer, 1961). An increasing (or regained) legitimacy accorded to intuition and subjective knowing is found in Benner (1984), Watson (1985), Meleis (1991) and Street (1991). Integrative approaches are articulated by Paterson and Zderad (1976) who claim that the ability to combine intuition and analysis **is nursing's methodology**, being both subjective and objective; and Pyles and Stern (1983) who suggest a Nursing Gestalt' which is a 'a synergy of logic and intuition involving both conceptual and sensory acts' related to timing, accessibility and an effective mentoring relationship.

Physiological data suggests that intuition encompasses both right and left hand brain activity thus incorporating both the cognitive and affective dimensions (Davidhazar, 1991). Right brain activity is associated with sensing, intuitive and affective capacities whereas left brain function is associated with intellectual and cognitive skills (Holmes, 1996). This association with mental processes is discussed by Meleis (1991) who considered that intuition is part of the philosophical process, the mental labour which is central to the process of developing theories.

From this review intuition could be defined as whatever *the experiencing person says it is, existing whenever s/he says it does,* providing a symbolic discourse referring to a 'state of being'. This latter approach reflects the suggestion that intuition may be an aspect of the 'sensus communis' in which 'feelings or intuition' have an established 'something' with common significance (Shotter's analysis of Vico, 1993:54). According to Shotter, Vico's **sensus communis** (common sense) arises from socially shared identities of feelings in which an experience/event/circumstance has generated a shared sense with a subsequent 'imaginative universal'. The phrase 'feelings or intuitions' is itself significant indicating that perhaps:

- feelings are intuitions;
- feelings are not intuitions rather, intuitions are an alternative to feeling;
- the word intuition is the imaginative universal.

Langer (1967) discusses the philosophical challenge presented by 'feelings' in so far as the effects caused by feelings are physically describable, yet the feeling of them is not. Langer contends that feelings are fundamental to

the act of knowing. This argument links the cognition, its accompanying 'feeling' component and the behaviours which may be consequent to the 'intuition'. Schraeder and Fischer (1987) describe intuition thus:

> The sudden inexplicable feeling that something is wrong, even if medical tests cannot confirm the patient's altered state.

This is similar to the cognitive perspective where 'intuitive knowledge' comprises the 'self evident statements which exceed the observable facts' (Fischbein, 1986:14). Extending these definitions, several fieldwork accounts would be classified as being 'intuitive' and even more would qualify if the term were rephrased thus:

> An embodied Knowing that some thing/person requires attention in the absence of expressible evidence at that moment.

This definition reinforces the searching and orienting nature of processes 'named' intuition. Support for this 'searching and orienting' dimension is found in Fischbein (1986:12), who described the function of intuition as being to:

> create the appearance of certitude, to attach to various interpretations or representations the attributes of intrinsic, unquestionable certitude... to offer behaviourally meaningful representations, internally structured, of intrinsic credibility, **even if these qualities do not, in fact, exist in the given situation** (Fischbein, 1986:12.)

Intuition is thus a necessary strategy to deal with overwhelming amounts of sensorial data; to organise and make meaningful the situation in which s/he is situated; and to acquire certitude. Bastick acknowledges the importance of intuition to learning when he argues that 'intuitions are basic to the educational process' (1982: 100).

9.5.1 Learning to 'see as': Perceptions and Intuition

Sensorial and social perceptions are key elements in an individual's ability to 'see as'. Bronfenbenner et al (1958)[13] identified three theoretical categories as being essential for the skill of social perception, namely: social sensitivity; predictive skill; role taking, including both imitation and responsiveness;

[13] Cited by Westcott (1967)

interpersonal sensitivity and sensitivity to the generalised other. These features highlight the significance of 'being able to relate' and are similar to Shraeder and Fischer's characteristics of intuitive thinking (1987).

According to the Gestalt psychologists, physiognomic perception is the 'seeing of emotional qualities in peoples' expressions, works of art, or physical objects' (Bastick, 1982:63). Bastick contends that physiognomic perception is part of the intuitive process which

> ...involves empathy and projection in that the mention and perception occur together and are so interrelated that one feels it is possible to imagine how the moment of the perception feels (1982: 68).

Physiognomic perception is undoubtedly an essential feature of nursing assessment, involving both empathic projection and kinaesthetic empathy. This view is supported by Benner and Wrubel (1982) when they describe nurses 'skilled in recognising and discriminating among aspects of outward appearances'. However, the extent to which this skill becomes tacit and attributed as 'intuitive' contributes to the debate concerning the *a priori* nature of intuition.

9.5.2 Learning to be intuitive: Intuition in the naive/ novice

The role and existence of intuition in the novice is a contentious issue. Fischbein argues that intuition is contingent upon *a priori* experience of knowledge and is the product of personal involvement in a certain practical or theoretical activity. diSessa (1983) proposed that intuition (as P -Prims or Phenomenological primitives) changes from having an *explanatory* effect with the novice to a *heuristic* outcome for the expert. Whilst Fischbein and Bunge contend that intuitions cannot be changed or transformed, Bunge (1962) argues that beyond the pre-systematic stage, intuitions lose their specificity and cease to be intuitions. Expert nurses argued that the deliberation required to analyse intuitive decisions/processes no longer makes them 'intuitive' (Orme and Maggs, 1993). Benner attributes intuition to expertise, whereas Ruth- Sahd (1993) argues that the novice has intuitive aspects through 'knowing the person'.

diSessa proposes that the novice's p-Prims may be high priority naive phenomena which need radical restructuring in a cognitive priority structure in order to allow expert -like understanding: a move from 'common sense' to scientific reasoning 'which is not so much the character or even content of knowledge, but rather its organisation'. diSessa discusses the role of interpretation upon recollection of previous events, in particular the impact of existing 'knowing' upon the recollection. For example, present experience may be evaluated in the light of association with a past experience which is accompanied by its conditioned emotional sets. The consequences of such evaluation may lead to a change in the process.

Blomquist (1985) stated that 'valuing intuitive thinking and encouraging its development should be a component of education for clinical proficiency and faculty development'. Citing the work of Bruner, she suggests that intuitive thinking may be fostered through role modelling, sensitivity to the use of intuitive thinking, varied clinical experiences, teaching problem solving methods, encouraging guessing and developing self confidence. The connections between 'intuition', risk taking, conviction, confidence and knowing are discussed by Jenny and Logan (1992) in their study of patients being weaned from ventilators.

9.5.3 Intuition in nursing (D) discourse

The pre (or sub) verbal nature of 'intuition', was probably first documented in nursing literature by Nightingale:

> I have often seen really good nurses distressed, because they could not impress the doctor with the real danger of their patient; and quite provoked because the patient 'would look' either 'so much better' or 'so much worse' than he really is 'when the doctor is there'. The distress is very legitimate, but it generally arises from the nurse not having the power of laying clearly and shortly before the doctor the facts from which she derives her opinion, or from the doctor being hasty and inexperienced, and not capable of eliciting them
> Nightingale (1969 :125)

Crucially Nightingale's analysis raises several points, namely that:

- the nurse cannot articulate: specifically to the doctor;
- the nurse might not know the facts;

- the facts may be there but are not recognised by either the nurse or the doctor;
- the doctor may not know how to elicit the facts from the nurse;
- there may be other reasons why the nurses cannot 'impress the doctor with the real danger of their patient;'
- the facts are difficult to articulate;
- that the opinion of the nurse may be similar to the 'right opinion' 'of the Meno, and is not as yet 'tethered' and thus cannot be considered as knowledge.

Since Nightingale, nurse writers have discussed intuition within the clinical context, referring to it in terms similar to Young (1987), namely that it is a process where the nurse knows something about the patient that cannot be known, is verbalised with difficulty, or the source of the knowledge cannot be determined. Benner and Tanner (1987) define intuition as *understanding without rationale*. The view that intuition may play a specific or unique role in nursing recurs in recent nursing (commencing in the US and now in the UK) literature. It has been suggested that within nursing, any unique characteristic of intuition may be derived from the concept of 'knowing the person/patient' (Pyles & Stern 1983; Schrader and Fischer 1987; Benner 1984; Jenny & Logan 1992; Benner et al. 1996). Gerrity (1987) proposed that where sensing is the preferred Jungian mode, nurses should be encouraged to learn to 'cultivate' their intuitive abilities so that they may be trusted. Whilst this reflects the argument that certitude is a feature of intuition, 'trusting' intuitions infers the concept of probability and 'rightness', otherwise having certitude becomes equivalent to trusting. Schraeder and Fischer (1987) claimed that when nurses act and respond to cues and gut feelings that things are 'just not right', it may be inferred that they have a strong belief in themselves and can master clinical practice. Vignette **1** questions this assumption as it demonstrates that clinical mastery may not be a necessary pre requisite to an individual's response to that which is perceived to be 'not right'. It is perhaps rather the identification in the person's terms that things are *not right* that initiates action, action which itself may be inadequate in the *patient's terms*. Fieldwork vignettes support the

importance of 'learning to trust my intuition (instinct); 'learning to 'present the case', and 'handle the doctors'. Gerrity speculated that when nurses learn to trust their intuitions they may be become frustrated if the physician does not attend to their intuition: the dilemma Nightingale described. Both Nightingale and Gerrity attribute this difficulty to the physician seeking 'hard facts' or evidence.

Easen and Wilcockson (1996) conclude that intuition is a non-conscious, irrational process which has a rational basis. Intuition is speedy, effortless and can be validated, involving sound, rational and relevant knowledge in familiar situations. King and Appleton (1997) limited their review to nursing literature, identifying the intuitive experiences of students arguing that intuition occurs:

> ... in response to knowledge, is a trigger for nursing action and/or reflection and thus has a direct bearing on analytical processes in patient/client care.

Both these papers indicate a growing acceptance in nursing Discourse that 'intuition' exists, is associated with prior knowledge/experience, has a relational dimension, and performs a crucial role in professional practice.

Exploring concepts of intuition one identifies that issues of context, Discourse, meaning and definition are infrequently challenged, investigated and tested *across* disciplinary boundaries. Chapter **10** will appraise these claims attributed to the phenomenon and questions the existence of a universal noumenon. The *orienting* nature of activities attributed as 'intuitive' has been discussed and the associations with judgement noted (see Smith, 1988).

9.5.4 Judgements

Westcott notes that work on intuition and judgements arises from two traditions, namely: those undertaken in abstract, non interpersonal, problem solving or concept formation studies; and those involving areas of complex behaviours which are frequently social or interpersonal. The ability to 'come to a conclusion/ decision judgement' is an oft described outcome of intuition. The descriptive vocabulary includes terms like insight, inference, creativity and intuitive leap. Gillimore (1993) suggests that 'insight' is associated with

intelligence, intuition and wisdom, claiming that insight is gained 'through competence, communication, and flexibility', whereas Boreham (1986) considers insight to be the ability to go beyond the information given and to construct possibilities and constraints out of previous experience. Boreham's study suggested that expert judgement required a high degree of prowess in all three modes of cognition, namely intuition, sensing and logic with each mode being interdependent upon the others for success: intuition is quite clearly located within the domain of cognition. Westcott argued that for a conclusion to be defined as being 'intuitive', the thinker must ordinarily **not know how** the conclusion was reached, or at least it must be obscure to a sophisticated observer, and that there is a distinction between 'intuition' and inadequate explanation. The implications for my role as observer are that **if** I were 'sophisticated', for an event to be labelled intuitive, ***I*** would ordinarily be unable to discern the evidence. These perspectives where intuition is seen as a separate entity to reasoning/ logic are extensively discussed by Bastick (1982).

The role of intuition in expert clinical judgement is illustrated by Benner et al. (1996) and Orme and Maggs (1993). The practitioners in Orme and Maggs' study constructed a definition which indicated the orienting nature of intuition:

> A state of heightened perceptual awareness which emanates from sub conscious thought. It influences behaviour and therefore influences the decision making process (Orme and Maggs, 1993).

Furthermore, for an intuition to be valued, it required 'pre -existing knowledge' which was appropriate and relevant. Gadamer (1975, 1993) links the development of judgement with that of sensus communis. Judgement is described as a capacity to subsume 'a particular under a universal, recognising something as an example of a rule'. As Gadamer points out, this cannot be logically demonstrated. Gadamer (1993: 39) asserts that judgement cannot be learnt theoretically 'because no demonstration from concepts is able to guide the application of rules', rather judgement can only be 'practised from case to case'. The significance is that whilst judgement is about individual cases, albeit

influenced by universals, judgement cannot be logically proven and its explanation may present the individual with discourse problems.

9.6 Acting Intuitively and Doing

Young (1987) found that intuitive actions were in many instances inseparable from the cues themselves, indicating that there was a *simultaneity* in the two phases of the judgement process, i.e. their study participants, like T, P and myself, described knowing something about a patient whilst simultaneously doing something. Young indicated that subjectivity was pervasive in the decisions associated with intuition and that because of the complexity of the cues and situations, she inferred that subjectivity was 'represented' in many nursing decisions. Young proposes that five attributes/conditions facilitate intuition: direct patient contact; self receptivity, experience, energy and self confidence.

Bastick discussed the works of De Grout (1965) and Scott & Davis (1971) who argued that intuition was triggered or activated by situations which themselves triggered specific experiences whether real, imagined or visionary. Fischbein identified mechanisms which are thought to 'participate' in the process of generating intuitions: overconfidence, dramatisation, premature closure, primacy effect, factors of immediacy, including the sub category of visualisation. These mechanisms are very similar to the six aspects of intuitive judgement described by Dreyfus & Dreyfus (1986).

Beckett (1995) distinguishes between 'prolonged' episodes of practice, when it is possible to deliberate upon the outcome of the action in advance, and the series of sub- episodic moments of judgement which form part of the trail towards the planned outcome. However, some episodes are so brief or spontaneous that there is little, or no, time for anticipatory deliberative intention. In doing, one tries, as Beckett argues. Shotter (1975) discussed how individuals learn how to try in a manner that makes sense to others and, citing Dreyfus, he reminds us that the process of trying enables one to know how to try. Beckett distinguishes between acting *intentionally* and *acting with an intention* (Beckett, 1995:136 citing Wittgenstein).

Shotter (1975:110) describes how persons come to *act intentionally* when their actions are informed by 'their knowledge of what they are acting on' and that persons can 'come to act intending meanings' in their action. Shotter (1975:31) argued that the person is 'faced' with the challenge of acting intelligibly and responsibly rather than just intelligently. This dimension of acting *towards* an outcome is echoed by Beckett when he debates the extent to which reflection endorses rational action. Beckett's conclusion is that there is no such thing as Schon's reflection-in action. At the sub episodic level there is judgement, judgement which is associated with trying towards achievement and is accompanied by a series of actions. Whilst there is a dynamism between the episodic and the sub episodic, it is not reflective, rather it is reflexive. Beckett suggests that the notion of *feedforwardness* changes 'the nature of the accomplishing'. Maranhao's concept of *steering or orienting* is similar to feedforwardness, with the three concepts inferring intentionality:

> ...participation or interiority does not welcome guesswork, but only steering, and steering precariously (Maranhao 1991:244).

In other words, intentions are mediated by other beliefs and contexts, and to paraphrase Shotter (1975:91), human action is constructed by the interplay between the individual's attempt to realise their 'projects, goals, enterprises or ideals'. If we consider aspects of nursing knowledge to be *pragmatic knowledge*, then its evaluation is proportional to the extent to which it:

> ...functions successfully in guiding human action to fulfil intended purposes... a pragmatic body of knowledge, thus, consists of a collection of examples of action that have worked to bring about desired ends (Polkinghorne, 1992:151).

Residing within this premise are considerations of what constitutes the desired ends and the role of intentionality and rationality. To Beckett rationality is the retrospective justification for action (1995:120). Munby and Russell's (1989) analysis of student teacher Nancy, demonstrated how her 'seeing as' perspectives changed as a consequence of action. This insight has

particular relevance when considering the impact of responsibility upon the learning of the practitioner.

It is appropriate to consider the contentious concept of reflection-in-action where two activities 'knowing and doing' are conceived as being different yet connected.

9.7 Reflection -in- action

Eraut (1994), amongst others, has commented upon the difficulty in establishing a definition of *reflection-in-action* because Schon, the major proponent, did not use sustained argument but employed metaphor and example. Indeed, Eraut (1994:148) proposes that 'it is necessary to take the term 'reflection' out of his theory, because it has caused nothing but confusion'. Eraut concludes that he would prefer to consider Schon's work as a theory of meta-cognition during skilled behaviour and deliberative processes. However, Eraut limits analysis to the cognitive dimension.

Schon (1983, 1987) argued for a model of professional practice in which the 'artistry, intuitive and creative' dimensions of practice were valued (see Appendix **18**). Schon describes knowing-in-action as the 'characteristic mode of ordinary practical knowledge' whilst 'reflecting- in- action' refers to the common sense notion that 'we can think about doing something while doing it' (1983:54). During this process, the practitioner may evolve a way of doing it. Reflection-in-action is considered to 'hinge on the experience of surprise' (1983:57); 'act as a corrective to overlearning' thereby enabling one to 'make sense of uncertain situations' (1983: 61); it involves a form of action research; and is coached rather than taught. Reflection -in- action can be seen in the performance of practitioners who demonstrate 'professional artistry.' However, the paradox is that if an 'expert' increasingly acts through 'knowing in action' and is 'not surprised', then presumably s/he reflects *less* in action. Schon goes so far as to equate this with boredom, rigidity and a deteriorated service to the client group.

9.7.1 Claims about reflection- in- action

The following claims have been made about reflection- in- action, namely that it can:

- generate paradigm cases for learning from practice;
- link the artistry of nursing with the science of hypothesis testing so both can be united (Conway, 1994);
- considers theory and practice as inseparable, includes thinking, thereby adding to theory whilst the action is occurring (Powell, 1989).

Schon's perceptions of thinking/knowing/reflecting- in -action demonstrate the influence of Polanyi; the 'ordinariness' of thinking whilst doing; that the *knowing is in the action*, i.e. knowing is a constituent of action; that reflection on knowing is often accompanied by reflection in the present; and the emergence of what Schon (1991) subsequently describes as a 'reflective conversation' with the matters in hand. Beckett (1995), describes Schon's reflection- in -action as the:

> hot and immediate slice of practice within which the professional can make a difference then and there (1995:104).

Beckett analyses 'time' within the slice (or episode) of practice, arguing that the practitioner seeks to achieve that which is 'right' and consequently that which is providential. He points out that reflection -in -action is problematic because it is difficult to:

> conceptualise an epistemology of occurent action which leaves the power of human purposes intact. We act because we *want* (that is desire) to. But we also act because we *have* to (1995:114).

Like Eraut, Beckett questions aspects of Schon's concept, especially the phenomenon known as 'reflection-in-action'. Beckett demonstrates his criticisms through reference to two points, first through analysis of trying/anticipation and secondly through references to intentionality. Greenwood (1993), Lauder (1994) and Beckett (1995) challenge Schon's conception of reflection- in-action, arguing that Aristotle's practical syllogism and practical wisdom may be more apt, a claim supported by Benner et al. (1996). Thus reflection- in- action is a concept whose existence is disputed. It is appropriate to return to the earlier debates and consider how verb forms

may assist the problem of the 'unsayables', 'inexpressibles' and the Cartesian legacy of dualism.

9.8 Moving the Discourse towards the verb forms: 'actioning'.

Nursing[14] is known by the verb form. It is argued that several extracts from this study appear to support 'actioning'.

> Actioning is a process /state in which the individual engages with various activities of action[15] like cognition, abstraction, activity and movement and that this engagement *creates/ generates action which is oriented* towards the Other.[16] Actioning is the process through which the Self creates action for the Other. Through such actioning, the person's sense of agency may be perceived and manifested in particular ways.

In some respects this concept of 'Actioning' incorporates the 'Action Present' described by Schon. Issues of temporality and space dwell within Actioning. In the *doing* of practice one encounters a diversity of activities melded by the individual in her attempts to 'make sense' (in the Schon context) and respond to the unfolding situation in which she is located. The repertoire and subsequent interaction of the activities is potentially as complex as the repertoire of practises which are the observed outcome of 'Actioning'.

I have found the term *actioning* a useful way of coping with the coherence problem one encounters when attempting to respond in a non-dualist manner. I have drawn on the work of Becker (1991), Maturana (1988, 1991), Maranaho (1990, 1991) and Usher (1991), in adopting the verb form *actioning*. For example Becker (1991) described how Ortega, Maturana and Varela used the verb languaging to distinguish from the noun language: a distinction between ' *language*, a description produced by an observer, and *languaging,* an act experienced in *statu nascendi'*. In a similar fashion, Usher (1991) uses the term 'knowledgeing' to acknowledge the manner in which the process of research constructs knowledge. Becker argued that because our

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[14] Nursing is like teaching- another predominantly female occupation in the UK.

[15] According to Macmurray, action in the form of its actuality is as 'unity of movement' where movement and knowledge are 'inseparable aspects' of action referred to as *dimensions* of action to ensure that these are considered as 'the indivisible unity of knowledge and movement in action' (1957:128).

[16] The 'Other' may be the referential Self, Another or an object, thus the statement applies reciprocally.

memories are different, 'languaging is *orienting* us differently' (p228/229). As the participant observer, I engage with both the noun and the verb forms of language/languaging, knowledge/ knowledgeing and action/actioning. Indeed Foucault when claiming that 'knowledge can gaze', completely separates the person from the activity, demonstrates the activity of abstraction and the instrumental properties of gaze.

From this perspective, intuition may be conceived as being of actioning, facilitating the person in the *orienting* of their action. Hence intuition may be the term used by the individual to refer to those 'indescribable' activities which enabled them to orientate their action towards/ from particular activities. Intuition may be conceived as a function of languaging whereby the noun conveys meaning to the Other. The activity to which the language of intuition refers is intuiting and is associated with knowledgeing[17]. Through the knowledgeing of this study, to paraphrase Becker (1991:230), I create my world which is not 'created by me alone but rather by my recurrent and multiple interactions with other'. Through languaging with numerous others the knowledging of this study becomes an element within its actioning.

Becker (1991) discusses the problematics associated with translating between languages which are conceptually different and where the 'domain of distinctions itself is different'. Becker describes the tension caused when one introduces 'alien ways of knowing into one's description' (p 226). Similarly nurses are faced with introducing 'alien ways of description' into public discourse. Knowings established from different disciplinary or cultural backgrounds may appear foreign to the novice who is expected to acquire these 'new' Discourses. Atkinson (1996) demonstrates this clearly within the realms of medical talk and procedure. As Becker suggested, languaging 'works' by obscuring differences in the linguistic domains that we experience whether interpersonally or interculturally (p230). Becker referred to Oretega's two principles within his 'New Philology' and adding the third axiom as his own:

1 Every utterance is deficient - it says less than it wishes to say

2 Every utterance is exuberant - it conveys more than it plans

[17] Indeed intuiting incorporates knowledging, its outcome may lead to knowing.

3 Everything said is said by someone

Thus the novice needs to learn the textual and subtextual implications of the first two axioms. However another dimension arises when what is observed is *nothing being said*[18] in order that 'something can happen'.

9.9 And it happens in Silence?

The person studies illustrated occasions when the relevance of silences and an associated gaze were observed. These connections between silence and language offer a particular emphasis to the study. Becker for example, cites Ortega:

> And each language represents a different equation between manifestations and silences. Each people leaves some things unsaid *in order* to say others. Because *everything* would be unsayable. Hence the immense difficulty of translation: translation is a matter of saying in a language precisely what that language tends to pass over in silence (Becker 1991: 226).

One problematic has been to deal with not only the 'unsayable' but the 'inexpressible'. In so far as I am the translator of the plurisensorial nature and text of the fieldwork, I face the issues outlined by Ortega at two levels: the *particular* aspect arising from the situated context and the *generic* aspect of English culture and language. In order to translate the silence, the person must be able to read it, and have a recognisable signifier to convey its meaning to the other (or at least provide a sign which may be interpreted by the other). Foucault concluded:

> A hearing gaze and a speaking gaze: clinical experience represents a moment of balance between speech and spectacle. A precarious balance, for it rests on a formidable postulate: that all that is *visible* is *expressible*, and that it is *wholly visible* because it is *wholly expressible* (1973: 115).

> A new alliance was forged between words and things, enabling one *to see* and *to say*. Sometimes, indeed, the discourse was completely 'naive' that it seems to belong to a more archaic level of rationality, as if it involved a return to the clear, innocent gaze of some earlier, golden age (1973: xii).

[18] Although paradoxically something is received non verbally.

Reference to the 'archaic, innocent and earlier age' is intriguing. Did/does such a gaze exist, and if so is it located within nursing discourse? Where Foucault mentions the 'moment of balance', I question the extent to which this occurs in silence. However Foucault raises the issue of the 'formidable postulate' which connects visibility and expression. This study reveals discourses which challenge the postulate because the discourses privilege the contextual, the contingent and acknowledge the *inexpressible.* However, let us return to the analysis of silence.

van Manen (1990:112) discusses silence in respect to its limit and the power of language, he outlines three categories of silence operating in 'human science research generally and in hermeneutic phenomenology particularly'.

Literal silence: the absence of speaking.

Epistemological silence occurs when one faces the unspeakable. van Manen cites Polanyi's tacit knowing[19] 'we know more than we can tell' as an example of this.

Ontological is considered to be the silence of Being or Life itself. van Manen describes the 'fulfilling silence of being in the presence of truth' and the 'dumb -founding sense of a silence that fulfils and yet craves fulfilment' (citing Bollnow, 1982)

van Manen distinguishes between epistemological silences caused by the individual's linguistic competence (i.e.. the 'other' may be able to describe for 'self'[20],) and those which arise because a specific discourse cannot (adequately) express the 'something'[21]. van Manen discussed how the capacity to express may be related to 'moments in time'. Hence today I struggle to find words which tomorrow may flow with ease: the situatedness of silence.

In their examination of **women's ways of knowing**, Belenky et al (1986:3) identified five different perspectives 'from which women view reality

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[19] Polanyi (1958) describes three characteristic areas where the unutterable occurs, i.e. where the area is too great for description in words. The first is where the tacit is such that articulation is virtually impossible, the second is where the tacit is co extensive with the text of which it carries meaning and the third occurs through the degree of sophistication.

[20] For example where you/the other have the vocabulary to supply a signifier for me/the self.

[21] Here Lawler's assertion that there is no discourse of the body would be applicable.

and draw conclusions about truth, knowledge and authority'. These five epistemological categories were named 'Silence, Received knowledge, Subjective knowledge, Procedural knowledge and Constructed knowledge'. Those women described as 'silent' were literally silent, being 'mindless and voiceless subject to the whims of external authority'. When women acknowledged that they could learn from others, they became passive receivers of knowledge. Subjectivists perceived knowledge as personal, private and subjectively known or intuited. In this category women learn to listen to the 'voice inside' which is trustworthy and reliable. Procedural knowers invested in learning and applied objective models in the acquisition and communication of knowledge, they listened to the voice of reason. Procedural knowers acknowledge that individuals have different 'ways of looking' (p97), state that communication may be difficult, yet could be achieved by rapport and intuitive understanding. Women who viewed knowledge as contextual were labelled constructivists, valuing both the objective and subjective ways of knowing, recognising that they can create knowledge themselves. I wonder whether the primacy accorded to intuition in nursing Discourse represents a degree of collective 'procedural knowing' within the nursing group.

The epistemological aspects of silence present a different perspective which may be a feature of learning. If silence (i.e. silencing) is a movement of actioning, possibly occurring contemporaneously with other activities like Gaze and Intuition, then if the latter two serve as activities which orientate and search within the silence of languaging, then the capacity to achieve and read 'silence' is essential to the practitioner. During the fieldwork practitioners frequently said that they 'just do it'. Why is it that practitioners refer to 'doing nursing?' Maguire (1995) discussed the importance of 'just doing it' within teacher education. Thus to the practitioner, the thought may not be separated from the action, it is within. This evokes Macmurray's argument supporting the primacy of action and contingency.

9.10 Summary

This chapter has discussed the diversity of perspectives from which the tacit and intuition, thinking, knowing and reflection- in -action have been analysed.

Polanyi acknowledged the unspecifiable nature of personal knowing, valuing concepts like 'hope' and 'commitment' and recognising the place of the objective search within knowledge creation and evaluation. Recent debates concerning reflection- in -action were spurred by Schon, whilst Eraut proposes the removal of 'reflection in action,' supporting the merit of metacognitive processes and the time episodes of practice. Beckett argues that reflection- in -action does not exist, rather greater attention should be accorded to anticipation, trying, and intention within the practitioner's conceptions of 'rightful action': phronesis. Nurse writers have largely subscribed to the banners of others, and in some cases added the claim that reflection- in- action is the 'bridge' (Conway 1994) between theory and practice, artistry and science. Johns (1995) accords 'reflective personal knowledge' the status of being:

> the most substantive form of knowledge and should properly constitute the body of knowledge of a practice discipline.

Belenky et al (1986) and Gilligan (1993) suggest that 'different' voices may be used by women representing not just potentially different ways of knowing, but rather different attributions to the significance and relevance of the known. Gilligan's work highlights the relational and in the context of moral judgements, attributions of responsibility and the person's conception of self. Earlier chapters discussed how the absence of a consensual perspective concerning these -in- action dimensions left the empirical work in a unique position. It was a potential search for that-which-might- never- be-found or acknowledged.

The dialogic interaction of fieldwork experiences with the texts of Becker, Foucault, Maranaho, Nightingale, Usher, and van Manen has revealed a potential *nursing regard.* In addition, the study has encountered discursive strategies to deal with the problem of dualism as they relate to the tacit, intuition, reflection, thinking and knowing- in- action. Within the context of the study, it has been proposed that silencing, gaze and intuition may be facets of actioning. It has also been suggested that elements of nursing practice resemble postmodernist features similar to Polkinghorne's analysis of the

practice of psychology. Chapter **10** will now develop these arguments as the study approaches the end of its hermeneutical journey.

CHAPTER 10

WINNOWING

(Journey's End: Or Which Tale(s) to Tell?)

10.1 Introduction

Chapters **8** and **9** have debated the conceptual and pragmatic issues which underpinned the study. This chapter weaves the various strands together in an endeavour to produce a grand narrative. Whilst chapter **11** will indicate possible future tales, literary closure[1], determines that further travels are temporarily suspended. The bricolage re-emerges from the guiding narrative:

> **Intuition/Reflection/thinking in action in the context of the learning and development of registered nurses in practice.**

T aptly remarked, it is impossible 'to put it all down in a book'. Ely et al. (1997) discuss the processes of winnowing and whittling which enable the researcher to produce a collage -like text of requisite proportions. In this case the process involved:

- *recognising* material associated with the original tales;
- *selecting* material which supported or questioned the tales;
- *deciding* which tales to tell;
- *'letting go'* superfluous material irrespective of affinity;
- *balancing material* from different sources, episodes and tales;
- *texting* the bricolage.

Chapters **1, 4** and **8** discussed the influences which shape the bricolage, emphasising the relevance of attending to both similarity and difference. In this chapter, the Tale emerges through an analysis of the study findings. This is achieved by examining two interactive threads, namely:

1: Did I 'find' intuition/reflection/thinking in action? (sub plot, what did I find?)

2: Contrasting the person studies with the Dreyfus model in relation to learning, development and professional practice.

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[1] Parker, 1997.

Through analysis of these strands and their associated sub plots, the study:

- concludes that there is no evidence to support the presence of a unique, identifiable, universal reality, 'intuition';
- confirms the orienting nature of alleged intuitive activities;
- reveals the searching processes of gazing (*regard*), looking, and silencing;
- acknowledges an epistemology of the grey/rainbow;
- encounters five discourse types and languaging practices;
- elicits an It Cannot Be Said Device.

The chapter now collates the threads which have led to these conclusions.

10.2 Have I 'found' intuition/reflection/thinking in action?

(sub plots: Could I make sense of/ identify thoughts, knowing in action? What did I find?)

During the field work phase which spanned two and half years (1993-1996), the most noticeable feature was the few occasions when words associated with 'intuition' (e.g. instinct, gut feelings, hunch , insight) were encountered naturally. The person studies confirmed that variants on the word 'knowing' were used as a prompt for both dialogue and selective attention in the field. My memos repeatedly questioned whether I had 'seen ' intuition, for example:

> My thoughts today [with V] were that the issues seems to be more about knowing than it is intuition. Can I honestly say that I see *intuition* being used? What I do observe is a lot of interactive communication and sensorial knowledge in which that which is seen in some way forms the focus for a similar to, or different to, event... when I worked with T, there I saw the looks that sized up the situation, provided clues to possible actions (month 14).

My conclusion is that I have **not** found a universal, isolated, noumenon to be labelled 'intuition'. The person studies clearly demonstrate that I **did** encounter reference to an orienting process which involves the Self indicating, through plurisensorial discourse, something which the Self *knows or doesn't know* to the Other and vice versa (where the Other may be the referential Self). These challenges led to a reappraisal of the Latin root,

'in-tuitio', to 'gaze upon', which conceives intuitio as process, not an object noun. Intuition *is thus the action* of striving to 'see upon/within'. Explicit attributions to intuition/ instinct revealed a searching, orienting, signifying process which contributed to a judgement or decision. This process is acquired by first learning to look, see and, if possible, recognise salience. Secondly, during the searching when a '(not) knowing with some significance' becomes apparent, it should be listened to by the self. Thirdly, what is known/signified should be trusted, if possible, it should be followed. Practitioners recognise that they should discern when to listen to the 'instincts' of others. For example:

> The junior house officer asked for the [chest] drains to be removed. V didn't think that the drains should be removed. She described looking at the enrolled nurse 'we looked at one another', but neither acted. The consultant was subsequently 'cross' that the drains had been removed. V in discussing this said: 'I'll follow my instincts next time' (V month 3).

In this instance, one function of 'instinct' is to orientate future and present activities. Learning to listen to instinct is associated with an individual's capacity to listen to Self as the Other and subsequently to realise the reliability and validity of the intuits. With experience, practitioners acknowledge that their intuits 'may be wrong' or based upon incomplete information. Consequently, they should prepare for that possibility. In V's example, neither participant responded to what their respective Selves were saying. Their subsequent actions exhibited deference to the Other (medical officer). In silence they 'looked' and 'heard' but did not act upon their assumed common understanding. In hindsight, their 'knowings' were validated by the consultant. This example of intuiting occurs in the silence and manifestations of actioning, the stage of 'received' knower (Belenky et al., 1986). However, unlike Benner et al. (1996), there is no evidence to support the premise that alleged intuitive processes are restricted to 'experts'.

P, when discussing her 'sixth sense', attributes her skill to the 'organisation' of 'how you look at it' and her ability to search (month 3). Her account reveals feelings of discomfort and a signal of something *not right* or

not known yet: a consistent feature of other attributions of 'intuitive knowing' which indicate both the *a priori* and *anticipatory* nature:

> P ... And there is something there that is flashing at you and that doesn't add up [voices changes pitch]. 'There's something about that person, I don't like 'em, but I'm not sure ... I don't know what it is'... you just feel uncomfortable and you haven't quite pin pointed why that is.
>
> V ...it wasn't nursing learnt, it was a general way of life, dealing with people.
>
> T ...it might be a little snip of knowledge that you have that you build on but you can't relate back to that [inferring 'at the time'].

Additional examples of 'intuition' are identified if one includes references to:

> Believing that something is wrong in the absence of expressible evidence *at that moment*- or
>
> The sudden inexplicable feeling that something is wrong, even if medical tests cannot confirm the patient's altered state.

In these instances, fieldwork references reveal common attributions concerning the function of this 'intuitive' state of being, namely it:

- is indicating a need to be alert or ready for something (to self/others);
- is indicating the necessity to search for something *invisible as yet*;
- may be accompanied by discomfort;
- is possibly associated with a degree of conviction, confidence, trustworthiness or fallibility;
- may evoke an awareness of past experience/knowing;
- is indicating a need to communicate.

As chapter **9** discussed, these characteristics are typical descriptors of intuitive episodes. However, applying Westcott's criteria that to be defined as intuitive the thinker must ordinarily **not know how** the conclusion was

reached, or at least it must be obscure to a sophisticated observer, I struggle to find *any* examples of intuition. Interestingly, T describes post hoc rationality:

> ..if you sat down and thought about it... you can probably relate back to something that you knew (T and Mr.E.).

Analysing *my* 'seen as' experiences questions the extent to which the 'flashbacks and associations' were my own models or metaphors used to give shape, context and meaning. Alternatively, these experiences may be the outcome of a 'search' which enables Schon's framesetting to occur. This speculation does not explain why a particular 'seen as...' came to mind. For example:

> [One feature]... was the extent to which my 'thoughts' in action generated memories of previous situations within my experience (at this point the 'remembered' person/situation and its associated present 'match'). These recall moments echo Schon's description of the practitioner evoking 'seen as' experiences from their professional repertoire. The 'researcher' in me found it interesting to note which 'memories' were evoked by 'present' situations. These recalled situations were themselves specific, and seemed to 'appear' as if from 'nowhere' and were patient specific - to the extent that I could visualise the patient concerned (May 94 notes).

These situations triggered powerful images and memories which included recall of the patient, their response, their 'illness management', the relational context and in some instances the accompanying feelings. Whilst it could be argued that these 'recollections' were the 'tacit intuitive' model of Fischbein, or Boreham's 'template' for the current situation, the purely cognitive nature of these models is an inadequate representation. The unfolding references associated with vignette **1** indicate that with hindsight V questions why she 'hadn't seen' signs before: a comment also reported by T (with patient G). The person studies of V, T, P and myself record memories supporting the presence of connected prior experience/ knowing. I thus find **no** evidence to support the *absence* of *an a priori* in the attributed and observed/experienced accounts of *knowing in action*. Paradoxically, contemporary nursing discourse seeks to legitimise 'intuitive' knowing, acknowledging 'understanding without rationale' (Benner & Tanner, 1987). However, I propose that what is being

referred to is a rationale which is *unknown to the person at that time or not articulated consciously* rather than simply *not known.* Certainly for T, P, M, and latterly V, the experience of 'incomplete knowing' leads them to actively *search* for that which is currently not visible. It was during these episodes of searching and orienting themselves to other actions that I noticed aspects of gaze, silencing and personal characteristics like perseverance, ability, and confidence. Furthermore T, P and V acknowledge the important of being open to possibilities, even when they have a degree of confidence and certainty in their actions. It is this dimension which bears similarities to contemporary Discourses of postmodernism (see Polkinghorne: 1992, Parker: 1997). These Discourses are themselves pre- dated by Nightingale and are inadequate explanations of practitioners' knowing.

Recognising and accepting a searching process in the Other acknowledges the initial postulate, 'whether I could make sense of/ identify thoughts in action'. With the benefit of hindsight I realise that this statement is inherently Cartesian and assumed (rather like Foucault's accounts) that thoughts are disembodied and act independently. The person studies have demonstrated that T, P, V and I all 'admit' to recognising 'processes', expertise, discourse and experience in an other and Self. With V however, this capacity to notice was more evident about 6 months after qualifying.

> T ... and you see that in people... (month 6)
>
> V ...the ones who have done the course, you can hear it in their conversations can't you? (month 10).
>
> P ... you see more junior staff thinking why, and you know they haven't developed that flash-point. It's not up to that level is it? (month 3).

10.2.1 Learning the 'little secrets'

The fieldwork elicited some of the 'little secrets' in clinical practice, the tacit of Polanyi. For example from one shift with V (month 4):

> Giving people test drinks following endoscopies.
> Checking the efficiency of the heparin pump.
> Only giving 500 ml at a time to prevent accidental overload.
> 'Getting on with it'.

Learning to say 'no'.
Getting more into the routine.
Have them all ready straight away- no matter what.
Forget what you have been taught.

The recording, investigation and transmission of these 'little secrets' is a crucial pedagogic issue as Polanyi and Benner have articulated. Learning these secrets relies in the capacity to 'trust another' and the availability of suitable opportunities. The study has demonstrated the importance of recording and articulating these secrets.

In addition to the tacit and intuitive, the study explored episodes associated with 'thinking/reflecting- in- action'.

10.3 Thinking/reflecting- in -action

Chapter 9 discussed how thought may be conceived as an activity of action. When the Self dialogues with the Self as Other (dialogic rhetorical device), then recalled/ focally aware 'thoughts'[2] occurring contemporaneously with movement activities become components of actioning. These movement activities may be elements of *regard*, or components of 'just doing'. The person studies evidence both these forms of investigative signalling to self. 'Thinking on one's feet' is an activity of actioning, where the Self is consciously searching/exploring meaning in a process which takes time. Similarly when 'just doing', the searching process may involve a dialogic engagement with other senses. This engagement may be embodied and/or embedded within the subsidiary awareness.

'Reflecting- in- action' is thus a redundant and somewhat contradictory term. Reflecting **is** action. As Macmurray (1957: 165) argued:

> ..if we start from the 'I think' there is no possibility of arriving at action; whereas it is possible to derive the theoretical from the practical if we affirm the primacy of action.

Reflecting *is* doing (i.e. doing knowing), and an activity of action. Abstraction assumes a disengagement of the Self *from* the action and knowing. This is another manifestation of dualism and conflicts with attributions within the person studies. The person studies indicated episodes where particular movements of the Other were read as states of being

[2] Consciously aware linguistic dialogue with Self?

associated with moments of searching, deliberation and judgement. Analysis of the between us revealed attunement[3] and the possibility of collective 'shared thoughts' or 'shared movements and moments'. These activities were subsequently confirmed through silencing, implicit or explicit acknowledgement tokens.

10.4 Looking, gazing, silencing, dealing with the body

Chapter 9 explored the use of verb forms, the significance of 'seeing and looking', between us and illustrations of nothing being said[4] in order that 'something can happen'.

> The other noticeable thing is the regular and continual rapport or gaze which takes place between us (with T month 1).

The use of 'quieting' (Rew, 1987) and 'silencing' to enhance a searching process was evidenced by P:

> ... P would stop and think... moments of stillness, in the midst of the action. During this period she seemed to look around at the board [placement of patients], at bays and at the people. She would then make a decision. It also seemed important at this stage that she was not interrupted, as she was internally weighing the situation up. [Indeed if others were around her they would hold back and not interrupt, as if they were recognising the importance of the moment] (P month 6).

These activities which involved searching/orienting gazes of discernment, and the creation (or koinia) of time to search through 'silencing', were associated with the experienced practitioners. This contrast with a medical gaze was apparent (V month 18) when the doctors were so preoccupied with the machinery and finding the diagnosis, that they were unable to look at, or converse with, the patient: their gazes were completely focused upon the machinery. Meanwhile, the patient, myself and another nurse were 'exchanging looks' which conveyed a knowing of the person and the situation which was one of 'sharing' rather than one of difference. Chapter 9 discussed how the medical gaze and discourse has expanded to enable the visual metaphor to be seen, read, interpreted and judged. In so doing, the

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[3] Shotter, 1993:148 and fieldwork accounts.

[4] Although paradoxically something is received non verbally.

tactile may appear to have diminished in power and necessity, yet can be used with great skill. For example in the scenario just mentioned, touch was used as both a comforter (by the nurses) and as a means of enabling the medical gaze to look directly inside the person (illustrated by the insertion of the fibreoptic scope). The generation and reading of these gazes offers a different potentiality: one which simultaneously offers certainty whilst traversing beyond certainty to the 'unknowable' (as yet). The concepts of time and space interweave here as the 'I do' outlined by Macmurray is necessarily temporal, 'for all doing takes time' (1957:132). Hence the gaze can at once be temporal, in so far as it is within action and is an activity of purpose, yet the focus/ abstraction of the gaze may involve a referent Other, as Foucault described. This latter gaze may be more spatial than temporal and is certainly plurisensorial.

Table **15** attributes a few examples from the person studies which are evocative of *non pathological* gaze(s) in Foucault (1973).

Table 15. 'Gaze' comparisons.

References to Gaze (Appendix 14 Foucault, 1973)	**Comparison with Gaze in the person studies**
Gaze of hope & benevolence p41	T with F, Mr. J.
What is given only to the gaze p51	V month 10, 18
The constant gaze p54	V month 10, Mr.S.
Gaze of discovery p61	V Mr.S. T month 1, P Miss S.
One observes p61 A language which owes its truth to the gaze alone p69	T month 3, P month 2.
Open naive gaze p65	V upto month 10
Gaze and silence p107	V month 18, T Mr. K, P month 3.
Learning to see and know p114	Vignette 1, V month 10.

The study indicates that these gazes arise from a variety of influences within the relationships between person to person, or person/ object.[5] The constituted relations are not just of power and knowledge, whether as savoir or connaitre, but rather they may be extended, as Macmurray and Polanyi argue, to encompass relationships involving concepts of love, compassion, rightful

[5] Indeed Schon refers to the 'reflective conversation' with things.

action and responsibility. These relationships may include the constructions of gaze as represented by the medical gaze; but not necessarily in an exclusive manner.

Analysing aspects of 'gaze' tends to resemble a jigsaw puzzle where one is required to isolate, recognise and collate individual pieces so as to construct the picture. Metaphorically, one grasps the whole, sees the picture, separates the metaphor and the visualisations and looks for the clues. In solving a jigsaw one literally, by touch, 'fits the pieces together'. It is through the integration of various activities (e.g. speech, movement, touch and sight) that the links may be revealed which enable coherence. Although Foucault identifies the 'gaze of compassion' and the gazes turned towards the sick person with their 'vital force of benevolence and the discretion of hope', this dimension becomes lost in the analysis of text. By juxtaposing Foucault's *Visible Invisible*, one can expose the 'others' implicitly present. It is proposed that the concepts of *regard* and *discursive practises* applied to the researching of the study, reveal the 'personal' evocative of Macmurray and the concept of gaze as *engagement* is propitious.

It is argued that elements of nursing practice operate within the 'invisible' space where alternative gazes are encountered and located. These gazes are difficult to describe as *text* except through the medium of metaphor, imagery or dialogue. Where language cannot encompass, articulate or adequately describe 'experience', then a process is required through which the 'unsayable' can be handled. When the 'unsayable' is assumed to be common within a group, then the group may construct mechanisms for conveying meaning associated with the 'unsayable'. At this juncture, symbols or signifiers assume a 'sensus communis', whether restricted to a working group in close proximity, or across the professional group. It is proposed that talk about intuition is one such signifier. However due to the context and culture the import of the signifier will vary (hence the many different definitions of the term intuition outlined previously).

Where Foucault described the manner in which the foundation and constitution of experience was changed so that one could show by 'saying what

one sees', talk about intuition (intuition as a concept) could be an aspect of 'showing something particular that **I** see/ feel and know'. It may be an attempt to reveal an aspect of **I, that which is between us, or the Self as Agent communicating to/with the Other**. There is also an acceptance of the 'unknowable' or the 'grey' which philosophically alludes to a noumenon which is not known in its entirety: the 'unknowable real'. As Macmurray (1957: 63) suggests we need to move beyond Critical Philosophy and come to the 'central and revolutionary conclusion that reason is primarily not cognitive but practical' and to continue beyond Kant to 'a formal reconstruction which would start from the primacy of the practical, take up into itself the theoretical as an aspect of the practical' (p69). But there is a problem with the 'thing in itself' because that represents the object and thus the noumenon needs to offer some sense of its own relation to the phenomenon. It is at this juncture that the discursive struggle becomes acute, a desire to link the subject/object requires a process vocabulary. Apart from signifiers and verb forms, it is difficult to find *in English* a linguistic device to solve this problem.

If signifiers become essential for the group, they may hasten the legitimacy of text and narrative (in the latter case often expressed in the aphoristic genre). In order to respond, a form of communication is required which enables transmission of *that which is perceived or apperceived* to another. From this (mutual) recognition, response, whether as action or interaction, is possible. This communication may become restricted to the group, as Foucault argued happened with medicine, or it may open to a variety of others. Nonetheless, each individual, as V has shown, *has to learn the language of the discursive*[6] *practices associated with their role (s), time and place* if they are to be an active participant rather than subordinated to the practice.

The intriguing pedagogical challenge is how to facilitate learning the various forms of **regard** and silencing. The evidence drawn from comparing the fieldwork with the Dreyfus model offers some possibilities.

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[6] The medieval Latin origin of discourse is *dis +currere* meaning to run different ways and *discursus,* argument: a running to and fro.

10.5 Learning nursing and the Dreyfus model

Having established useful parameters from the Dreyfus and Dreyfus model and Benner's adaptations, I duly compared the observation notes with the 5 Stage model[7] (see Appendices **7, 10** and **12**). This work was contextualised within the sub plot:

> What is it that the competent practitioner knows when s/he engages in practice and secondly, how has s/he learnt whatever it is that s/he knows?

To ease mutual understanding, I consider plurisensorial embodied dimensions of 'knowing' - not just the cognitive. The person studies confirm that due to their expertise and experience, the analyses of T and P represent more static descriptors than V. Collectively these findings are contrasted with the Dreyfus model in table **16**.

Key differences include those indicated by Eraut (1994), namely the potential significance of concerns about error and the influence of others. However Eraut, Dreyfus & Dreyfus and Benner apparently articulate a cognitive or metacognitive process via the discourse of the mind/body separation. Analysing the material as text with a DA frame, one encounters discourse practices which indicate integration and attempts to meld the binary opposites through metaphor or expressive articulatory problems. Table **16** demonstrates the varying modes revealed by the person studies. The effect of experience/expertise is noticeable. The involvement of the whole person, the *embodiment* is more comprehensive than a simple reduction to modalities of cognition associated with terms like inductive/ deductive, rational, irrational and arational.

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[7] This study examines 4 nurses during various time spans, whereas Benner et al. observed 3 episodes of practice with 48 nurses, obtaining narrative accounts through group discussions. The initial education and clinical settings of the nurses is different, reflecting the transatlantic gap.

Table 16. Similarities and Differences to the 5 Stage Model

Parameters	Similarities	Differences
Components	Context free and situational	Primacy of Learning the 'grey'
Recognition & Concentration	Both patterns are observed- learning the little secrets, the rules, the patterns. Intense concentration of the inexperienced.	T &P can employ both strategies at will. Aware of fallibility. Focal & subsidiary awareness operate. Pace, tempo and rhythm relevant. Searches for the absent, inconsistent.
Approach	Deductive & holistic are used by T & P according to situation. V committed to holistic practice.	Analysis involves searching, looking and gazing. It is plurisensorial, can be embodied with experience. Selectively given or withheld.
Salience	Salience is/can be combination of the universal and the contextual and time. Limited by knowing/experience.	T, P, M recognise that salience/ interpretation may be wrong - from a different perspective to V's earlier awareness. Salience in/to others is recognised and actively sought. Potential unknown salience.
Response	Response proportional to knowing/experience/expertise, the here and now, and to future anticipated. Response person centred.	May be bodily 'reflective', responds to 'not right'. Plans for the unexpected. Judges moments. Involves searching. Time /tempo contextual.
Rationality/ Deliberation	Conscious and careful in less skilled. Risk grows with confidence. Learning to stand back and debate.	Contextual, intentional. Conscious and unconscious. Responsibility influences risk taking & preventing risk. Questioning.
Performance	Stages similar. Discourses change.	Controls/exudes patterns of tempo. pace, rhythm, space, stance-embodied. Deals with the unsaid. Performance related to personal vulnerability.
Judgement	Acquired universals and then 'little secrets'. Some universals are 'local'.	Judgements may be *embodied*, due to sensorial data. Influence of others and capacity of self.
Perspective	Experience incorporated.	Perspective involves personal standards/values. Selective and focused according to situation.
Decision	Priority identification problematic for the inexperienced.	Commitment to people, ethics, impact of/relation with others influence decision. Employs 'search' strategy. Includes feelings. Not knowing is as important as knowing.
Commitment	Marked attributions of responsibility/accountablity of self and others	Professional role has public responsibility. Personal responsibility for self, others, the 'rightness'. Having courage.
Locus of Control		Alters with role identification and working alone. Locus of control is recognised as situational. Inexperienced may exaggerate inside control.

cont. Table 16. Similarities and Differences to the 5 Stage Model

Parameters	Similarities	Differences
Awareness	Monitoring and absorption noted	Experienced switch between modes, but maintain monitoring level when absorbed if situation demands. Others recognise state. Being 'attuned'.
Self Evaluation	Evaluated in relation to patient outcomes.	Performance evaluated in relation to attributions of personal standards. Collective standards and patient outcomes.
Teaching/ Learning	Apprenticeship and monitoring important. Needs help with prioritising and learning 'secrets'. Learning through 'testing', 'others' and their accounts.	Learning the grey, the different discourses and presenting cases and persons to different audiences. Learning strategies of silencing, searching, gazing. Relational. Learning through teaching and 'passing on'. Triggers for learning are often patient centred.

Benner et al.'s analysis of Intensive Care Nurses (1992, 1996) demonstrates significant similarities to the fieldwork evidence. For example their discussions concerning:

- the acquisition of socially embedded knowledge, skills and ways of being through discourse, learning collective wisdom, emulation and experience;
- the importance of touch, pacing and attunement as skills acquired by expert practitioners caring for clients in critically ill situations.

Each person study has similarly identified collective and personal wisdom. V's articulated development bears the hallmark of Advanced Beginner to Competent stages in relation to the parameters of perception and seeing; management of the situation and performance; safety/comfort/control; and temporality. However there are marked differences within the domain of judgements, decisions, self in relation to others, and agency. Whilst Benner (1984) identified competencies within the work role, this focus is upon learning and knowing. In particular 'the routine' has been studied as well as the 'unusual'. Interpretation of events which bear face similarity has thus been different. Two illustrative examples are highlighted in table **17**.

Table 17. Comparisons with Benner et al. exemplars.

No	Benner example	Fieldwork example
1	Exemplar 2, 1984:148/9 'How did you remember the tomato juice? You seem to keep a lot in your head' (advanced competency)	V 'It's easy she said, you just sort of do this and store it all up here' [V points to her head] (month 7) 'No, no, not watching the clock, it's just you make a mental note which reminds you to go and see to it so that it's kept OK (month 10). M I work to a clock!.. I seem to be able to recall the fixed points, not just of the ward but of the patients (month 5 with V)
2	Exemplar, 1984:142/143 'I also said I was calling because I wanted a doctor NOW'.	V 'I said "go and look at this man NOW"... there are times when I get it right' (month 5)

10.5.1 Exemplar 1: 'Co-ordinating, Ordering, and Meeting Multiple Patient Needs and Requests: Setting Priorities'.

This exemplar is exhibited by a nurse who demonstrates the ability to remember numerous details in an ever-changing situation. In V's case, a comparatively inexperienced nurse learns how to 'make a mental note' so that she can remember the numerous things to be done in relation to *time*. The pedagogic application is enabling nurses to learn how to 'make mental notes', not just to learn how to prioritise. Making a mental note is a tacit skill, reminding us of Nightingale and Street. It may be a constituent of the 'wrapping up' skill mentioned by T, illustrating a capacity to be non linear and open to managing 'shards and fragments' in unfolding situations where salience and priority change. Connecting activities (including knowings) is another essential component. Nurses produce embodied bricolage. Practitioners learn how to make mental notes, to 'wrap one job into another' and thus respond to emerging and un-predicted situations with less effort, greater fruitfulness and productivity. Through observation of ongoing development, the location, interpretation and nature of this competency within the stages of skill acquisition is questioned.

10.5.2 Exemplar No. 2: 'Getting Appropriate and Timely Responses from Physicians'.

Benner describes this competence as requiring skills of presentation, knowing the physicians idiosyncrasies, knowing when to be assertive and knowing which

physician to call. Timeliness is knowing *when* to call the doctor. Certainly there are numerous fieldwork references which document the problems in achieving this goal. However, whilst the nurse has to learn the language of the physician, justice demands reciprocity. This point is omitted by Benner et al.'s analysis which proposes that the skilful negotiation between the two is a function of the nurse's clinical grasp, knowing the physician and skill in making the case. The transmission of *salience* and 'worry' are key features in constructive inter and intra disciplinary practice and are neglected by Benner. The dialogue between V and I (appendix **8**) illustrates how incompatible discourses can lead to inadvertent confusion and potentially inappropriate patient management. Learning the nature of these various discourses and repertoires appears to be a neglected area of nursing pedagogy. Whilst comparisons with the work of Dreyfus, Dreyfus and Benner undoubtedly aided the theoretical development of this thesis, the points of departure are significant. Unfortunately a detailed discussion is beyond the remit and scope of this study.

Whilst acknowledging the conceptual and linguistic dangers of closure, the bricolage is now becoming visible. The negative is fixed and the image is revealed through the components of actioning; the representation of doing and the primacy of the contingent; the discourses encountered and *regard.* These threads culminate by acknowledging *in-tuitio*: learning to gaze within and upon.

10.6 Actioning

Chapter **8** defined actioning as:

> As a process/state in which the individual engages with various activities of action like cognition, abstraction, activity and movement. This engagement creates/generates action which is oriented towards the Other. Actioning is the process through which the Self creates action for the Other. Through such actioning, the person's sense of agency may be perceived and manifested in particular ways.

Figure **2** represents the components of actioning, illustrating the integration of the 'whole' embodied experiences of knowing/feeling/doing.

Figure **2** incorporates the Self/Other relationship and the evaluation of personal standards or co-efficient discussed by Polanyi. Figure **2** adapts van Manen's (1990) life world existentials to illustrate the embodied and between us nature of actioning. Figure **3** links actioning to judgements and decision making. These representations of actioning indicate its sophisticated nature, some ontological and epistemological dimensions to learning and the potential attributions of knowing as 'intuition'. The elements identified through both figures reveal some of the dimensions of practice which are currently neglected in the articulated discourses of 'learning nursing'.

Figure 2. Diagrammatic representation of the components of actioning

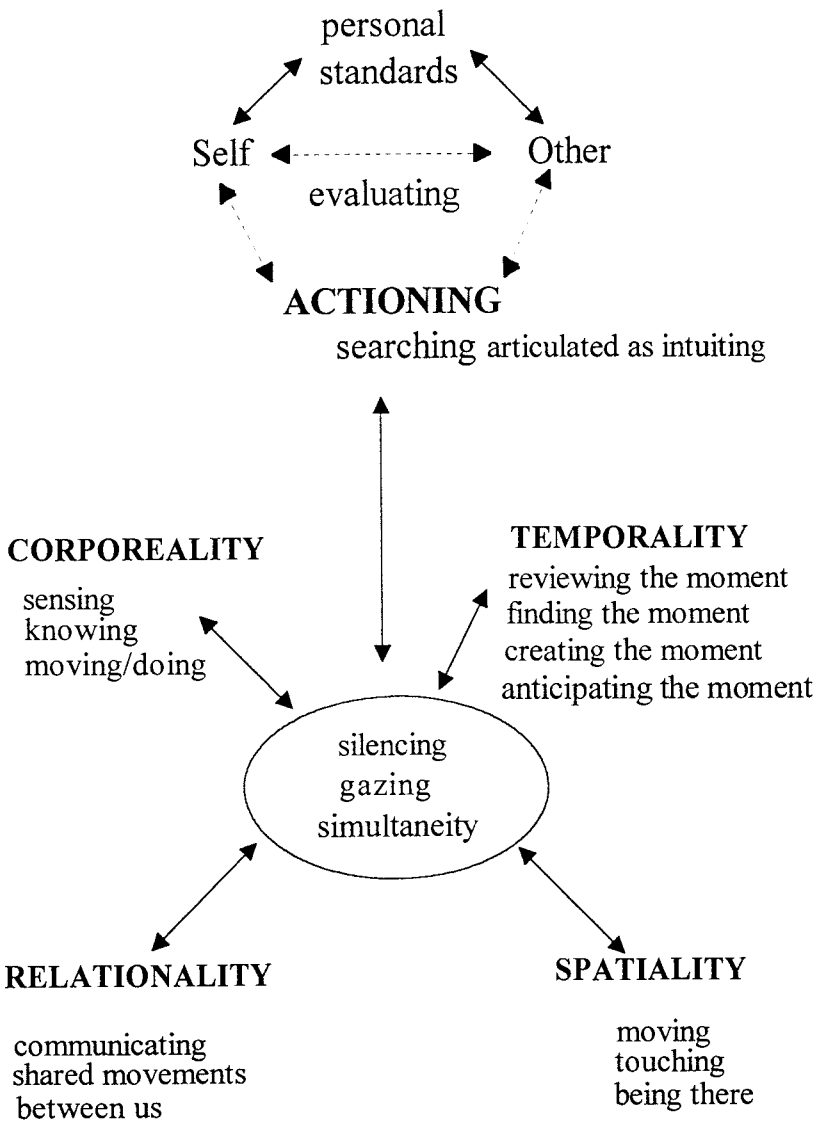
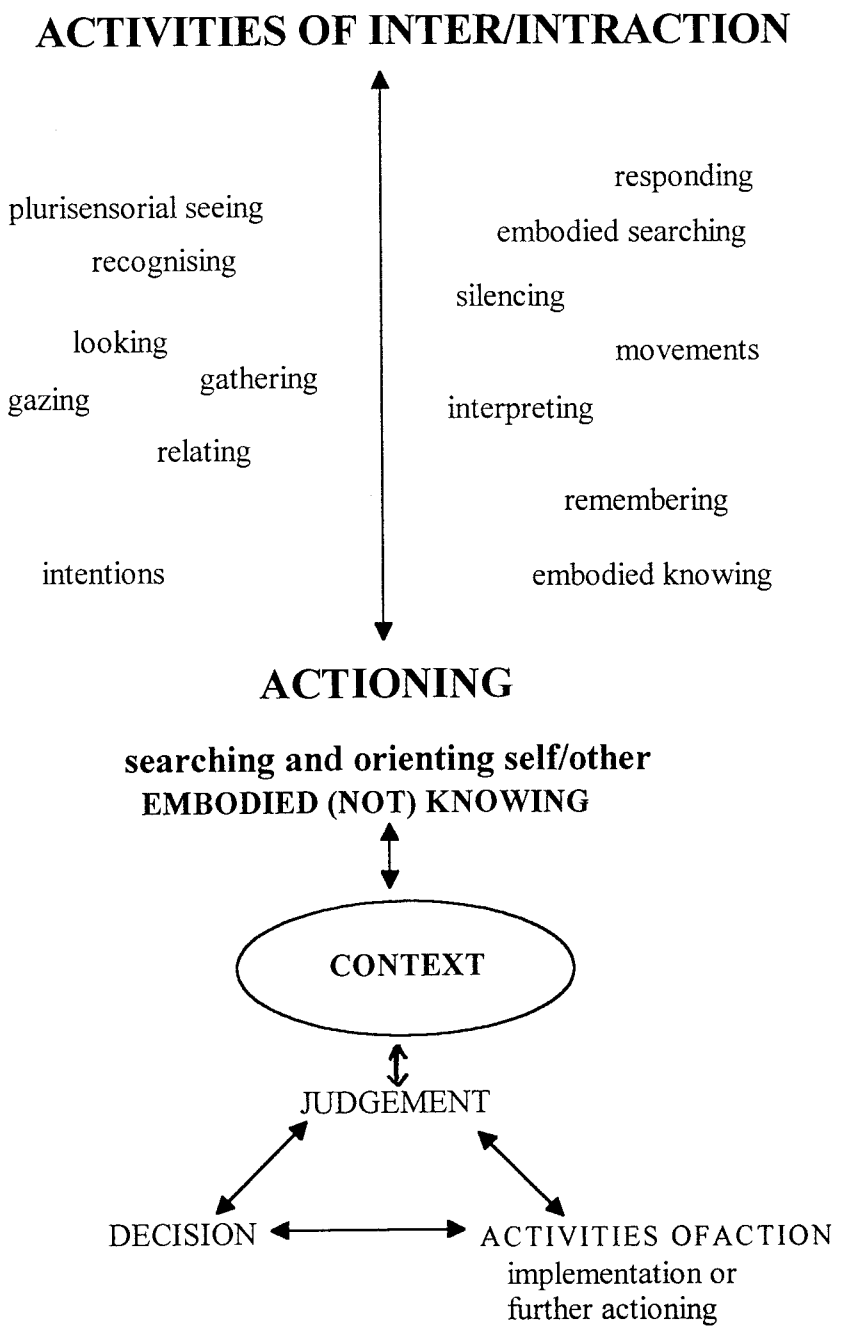


Figure 3. Relationship between actioning, judgement and decisions



10.7 Primacy of the Contingent: Doing

During the person studies there were many attributions concerning the role and usefulness of theory (e.g. T month 4). Sometimes the contingent is given precedence over the empirically based 'theory'. T for example commented that 'the books can't give you (all) the answers' (when you need them). According to this discourse, the role of general, context free theory becomes secondary to the unique/situated present and/or anticipated future. However, the disciplinary Discourses are still recognised as a useful *tool*. It is apparent that the so called 'theory/practice' gap is in fact a tension between the 'empiricist/universal' Discourse and the 'contingent/particular' discourse. A more challenging postulate is that this tension arises because there is no discourse to commence from the standpoint of Action. Indeed the descriptors used as the ideal model of the professional practitioner exacerbate the dualism, inferring that professional practice involves two separate functions of thinking and doing, rather than actions which are the outcomes of plurisensorial embodied knowings/doings. Criticisms that the recent changes in pre-registration education and the moves into Higher Education have led to a neglect of the doing component within practice have led the ENB (1996, 5.7) to assert that: 'institutions must have an assessment strategy for each programme which:

a) reflects a curriculum in which there is an inter-relationship between theory and practice

b) ensures equal value and accreditation is given to assessment of both theory and practice

c) requires the student to demonstrate competence through the achievement of learning outcomes in both theory and practice. Separate pass criteria for theory and practice are required'.

Whilst these comments reflect an attempt to 'value' both knowledge and experience, they illustrate a discursive theory/practice split. This discursive 'anomaly' aggravates a theory/practice division by reinforcing two distinct and separate entities which require integration. It would be more useful to strive towards (D)discourse which acknowledges the primacy of action,

where context and situation determine the blend of activities required for appropriate practice.

The evident primacy accorded to the action and contingent indicates that whilst anticipatory planning may be limited, there is intentional planning. Furthermore, there are indications of embedded subsidiary planning which is not required at a focal level.

10.8 Learning a variety of (D)discourses

The person studies reveal a mixture of (D)discourses and the interactions between them. For example with T (month 4), there is a cyclical and interactive attribution:

learning about people en masse (the general)

learning about particular people (the specific)

learning about the relationship between the two (i.e. the general and the specific).

Constant comparisons, similar and different to, become integral components to the practitioner's capacity to 'do'. These apparent combinations of general and specific, the person, the case and 'it' are gradually acquired and recognised through discourse. Vignette **1** illustrates V struggling to learn the case, learn about people, learn about types of people en masse and the little secrets of practice. One difference is noted here:

V .. **he** was **something** I looked into... (month 14/15)

These examples remind us of Gadamer's analysis of judgement and Nightingale's discussion concerning the 'facts' and 'observation'. Table **18** demonstrates emergent discourse as V's early strategies for learning how to search, look, assess, present and interact are revealed.

Table 18. Example: Learning a nursing regard and its presentation: V

V **Month 4** (direct quotes)	V **Month 10/11** (direct quotes)
Actually give them a good look over	Having seen somebody in a certain situation. I sort of relate back to that
Doing everything like their temperature right away	I look more thoroughly at all the information on the charts
Doing that	Then I look at them look at their circulation and breathing pattern... deterioration. I'm doing it more automatically, more aware..
Go armed: -with my information -to do battle -with facts & figures that somebody can't ignore	I go through what I think is going on then have some suggestions.
Get your case Prepare your case Present your case	Go and look Get my information If I need go to the doctor
I need more experience- things are more indicative than you think. If I have noticed something not quite right, I ask them to come and look with me. I know then I'll learn.	This is a big step to learn, it's to do with responsibility. Taking steps [in case something happens]

It is proposed that there are at least five forms of Discourse[8] which accompany facets of gaze, namely: a Discourse of case, which contains elements of the medical regard and other Discourses; the Discourse of person; a mixed Discourse which is person as a case of people; a discourse of relationships (personal and interactional), and a discourse of responsibility (includes ethics). These forms may be located within the frames of the empiricist, the contingent and the It Cannot Be Said Device, exhibited as the 'grey', or the 'unknown'. These five discourses may be shaped by any discourse of context (for example 'dying'). It was beyond the resource of this study to explore the extent to which a study of the discourse of context may represent/reveal **the** or **a** Nursing Discourse. Figure **4** overleaf represents

[8] Interestingly, McCormack 's study (1992, 1993) reveals similar descriptive accounts. However my conclusions differ, primarily due to my use of discourse analysis rather then McCormack's use of concept mapping to scrutinise the data.

these discourses, whilst figure **5** illustrates the impact of substituting 'discourse' for *regard* as 'seeing' which is an active response process. The connections between 'seeing', 'languaging' and practice are evident. Indeed, perhaps 'sensing' may be a more appropriate expression.

For ease of presentation, I have employed the upper case D in discourse. I acknowledge that the small case 'd' in discourse may be more appropriate in some circumstances. Similarly, I conceive the word 'case' to represent a Disciplinary bound Discourse, thus according to context, the Discourse or discourse of case may originate from a science (perhaps the physiology of shock) or the arts (perhaps the stages of child development). Examples could be:

pulmonary oedema is manifest by frothy sputum

hospitalisation can cause regression in a child's development

Hence clinical discourses concerning a child with pulmonary oedema may include both Discourses in the representation of 'knowing and seeing' this case. Perusal of the person studies will further exemplify the modes of Discourse and gaze outlined in figures **4** and **5**.

Figure 4. Knowing and Discourse

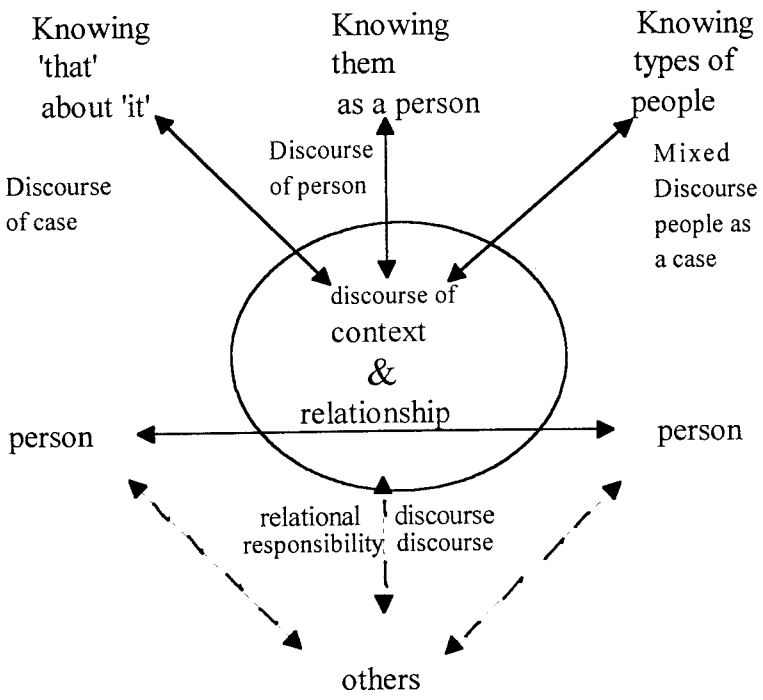
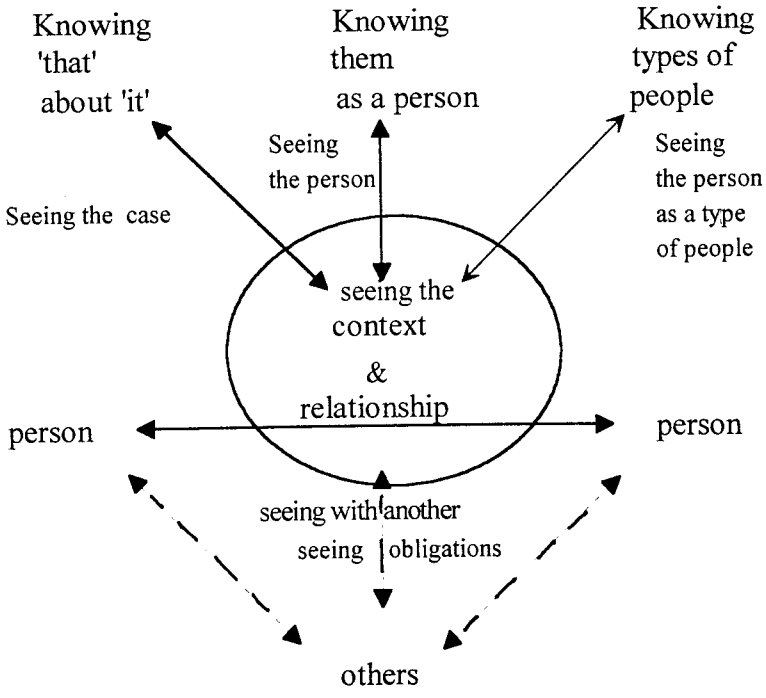


Figure 5. Knowing and Seeing



10. 9 Learning the case

Vignette **1** focuses upon the problems of learning, seeing and articulating the case. It contains an 'empiricist' repertoire of factors/facts which are acknowledged to be objectively measurable/observable and a discourse of responsibility. The exemplar demonstrates learning the facts of the *medical case* outlined by Foucault, i.e. learning how to perceive the body as object; an appreciation of underlying pathology and its potential manifestations as signs, cues, indicators of deterioration, improvement, and representative of 'typical' responses. As V indicated the case has a *content, sequence, and a particular way of being represented in discourse*. When the facts are presented in a way that *cannot be ignored*, they become legitimated, self evident and elicit their own responses. However, in presenting this case there is an inherent *relational* issue manifest here as *accessing* others (doctors) through *intermediaries* (senior nurses). At each stage a particular 'presentation of case and the self is required'. The contextuality and contingency of the situation is most evident, *who* is available and how they respond. In retrospect, V describes two facets to presenting the case, *knowing how to use others (including the doctors)* and *having the confidence to go (and use them)*. Other attributions of accountability and responsibility include the capacity to receive and acquire responsibility. The doing is responsive, in that it is connected with *being able to do something for someone*. A failure *to do* is expressed by feelings of inadequacy. Doing is within actioning and emerges from it. The fluency, pace and rhythm of discourses change and the activities required to anticipate, plan, judge, decide and act develop with experience, knowing and responsibility.

10.10 Acknowledging In-tuitio: learning to gaze within and upon?

This journey which originated as an exploration of the tacit and the intuitive quickly recognised the plurisensorial, embodied knowing/doing of practitioners. This knowing is not conceived in terms of the isolated thinker of modernism, but as actioned by practitioners in a 'holistic' manner through the incorporation of tacit or recollected embodied knowings emerging from their:

- concepts and intentions towards perceived 'rightful action'. These activities are derived from the interaction of the moral tradition of a given nursing community and the personal standards/beliefs of the individual;
- previous experiences;
- relational knowings of individuals or categorised persons;
- capacities of observation and recognition whether of a particular or generic nature;
- capacities of imagination, recognising possibilities or anticipation.

Within any given situation, the fruitfulness of (embodied) knowing relates to that required to 'cope/deal' with the particular instance. Consequently, dealing with 'not knowing' may be more significant than 'knowing'. The experienced/skilful practitioners exhibit their expertise by their ability to employ strategies which investigate and manage 'that which is needed to be known'. In so doing, practitioners may articulate a manifestation of the 'It Cannot Be Said Device' and engage actioning, silencing, or gazing processes.

It is evident that nursing practice operates within contextual continua of the predicted/unpredicted, seen/unseen, general and particular. An epistemology of the rainbow/grey is exhibited when practitioners acknowledge the 'black and white' and the hues of the 'shades of grey'. In this study, practitioners seek knowledge of the polar discourses/positions of modernity *and* the open contextual possibilities and intertextual nuances evocative of postmodernism. The It Cannot Be Said Device addresses both the visible invisible and the invisible visible, admits the presence of silent murmurings and future unknown- as- yet possibilities which are accompanied by varying degrees of certainty.

Learning nursing involves learning pragmatic embodied knowings and strategies which search for connections between these interacting (D)discourses so as to resolve or ameliorate the pressures emerging from situational temporality. Whilst practitioners acknowledge that their embodied

knowing may be partial, its evaluation is judged fruitful when it enables movement towards the desired intentions, be they focal or subsidiary (see Polkinghorne, 1992). Thus, in vignette **1** useful actions were initiated in the *absence* of accurate clinical knowledge, whereas other exemplars exhibit the presence of subsidiary embodied knowing retrospectively articulated. The evaluative criteria of utility suggested by Polkinghorne (1992) is perceived according to the practitioner's state of agency and which/whose interpretation of 'fruitful outcome' is employed. The discourses of responsibility/ accountability indicate criteria of deontology and personal standard **in addition** to those of utility. Modernist epistemologies privilege particular stances and representations within the binary constructions of dualism. In so doing, they acknowledge 'black and white', difference and opposing forces. Whilst postmodern epistemologies seek to expose hierarchical positions and question tendencies towards universality or globalisation, they fail to address the 'between' phenomena and the search for the 'edges' of embodied knowing/doing (see T). Whilst knowing is interpreted and constructed, the recognition and responses to shared movements revealed in the person studies indicate a satisfactory degree of assumed meanings and moments. Secondly, in learning embodied knowing practitioners require an applicable universal so *that I learn to do something for the other.* Increasing responsibility, whether actual or perceived, leads to changes in agency. Whilst a postmodern epistemology of nursing practice appears superficially appropriate, we need to look beyond it to the absent (D)discourses and future tales of an epistemology originating from action and 'just doing'. This (D)discourse would conceive knowing/doing as one.

10.11 Summary

This chapter has summarized the study findings. It has demonstrated how the Cartesian legacy generates discursive problems for a nursing practice which involves integrated embodied knowings/activities and the capacity to learn from others through narratives, observation and interaction. It is proposed that intuition is a signifying discursive strategy to deal with (1) the It Cannot Be Said problematic and (2) the necessity to draw attention to

something/someone. In analysing the data we have identified actioning, silencing and gazing. Discourse analysis has revealed five interrelated yet distinct forms of discourse which incorporate the Discourses of others. To represent the primacy of action and the reading of activities as text, it is perhaps more appropriate to refer to 'languaging analysis' rather than (D)discourse analysis. This may aid the analysis and representation of a nursing activity which concerns people, the body, life, death, illness, health and that which *cannot be said, but might be communicated, between us.*

Whilst the person studies revealed individual responses to learning within the context of practice, they consistently revealed the powerful learning tool of 'patient triggered learning'. From V we observed the development of an individual struggling to care with 'good' intention through the first 18 months following qualification. In so doing, V developed different discourse patterns, acquired new perspectives in relation to her sense of agency and that of others, learnt to 'listen' to herself and to present the cases of 'case and person' to others. T demonstrated how the subtle acquisition of knowledge and experience 'meld' into fluent, intentional action within hospice and community settings. She discussed 'just doing', anticipation and 'feedforwardness', characteristics shared by P who revealed the importance of silencing/gazing in the midst of a hectic emergency department. Each participant exhibited 'attunement', pace, tempo, sequence, patient triggered learning and movement in their practice, offering some challenges to the Dreyfus model. Encounters with aspects of nursing **regard** have demonstrated elements which resemble those rejected by medicine (according to Foucault) and others which are derived from medicine or other Disciplines.

Analysing the fieldwork through reference to the works of Benner et al. (1996) and Dreyfus and Dreyfus, it has been shown that nursing practice involves a range of discourses and discursive practices which indicate 'beyond the postmodern' characteristics which predate the category 'post modern'. Learning nursing also requires a tacit acknowledgement of the polar extremes of modernity combined with an awareness of the open possibilities, perhaps unknown as yet, evocative of postmodernism. Where nurses seeks to define

nursing, to ascertain the foundations of practice, the 'little secrets', the 'edges' of practice and claim caring, holistic, humanistic practice as their 'virtues', they follow the trails of modernity. V's early development documents this search for the 'truths' and 'cultural norms' of practice. P's quest for the 'real' problem behind Miss S.'s pain is another illustration of this acknowledgement of a 'reality' which is thought to be manifest in the presenting phenomena. In contrast, when P and M in the same example accept a silent, or hidden possibility, despite the certainty within the given situation, they reflect a postmodern and neopragmatic stance. Past experience provided each participant with personal knowings which guided and/or required evaluation in the situation at hand. Nonetheless, the admission that duties and responsibilities drive actions assumes either a compliance to a privileged more, or the representation of personal belief and standard. It is not surprising that nurses appear to employ both modern and postmodern features in their practice as the analysis of Nightingale indicated. Furthermore, the discursive struggles to establish and thus privilege the *unsayable* and *personal* may be considered as a tacit acknowledgement of a premodern vestige, or, a move to a discourse beyond the constraints of dualism. The study may well have strayed into the 'sixth moment'[9] in its search for the unsayable discourses of nursing practice. As Lincoln and Denzin discuss, the irony is that the 'sixth' may be an adapted form of earlier moments echoing 'ghosts from the past'.

Unlike Polkinghorne (1992: 156), I do not accept the 'common sense' contention that:

> the articulation of an epistemology of practicing knowledge must be based on the processes of expert practitioners, not the deliberative procedures and theoretically derived rules that constitute the practicing knowledge of novices.

This argument does not consider the embedded cognitivist privilege accorded to the expert. This study has demonstrated that however 'expert' the expert, and 'novice' the novice, *both* contribute to the development of *an* epistemology of embodied knowing/doing.

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[9] See Denzin and Lincoln, 1994: 284.

In conclusion, it is argued that nursing practice is inherently a bricoleur activity, it 'cobbles' together shards and fragments, known and unknown (as yet) in its attempts to create and manage action for the other- the construction of an embodied bricolage.

Inevitably, learning nursing as a registered nurse involves *learning in action for action* with people. This learning relies upon a tacit pedagogy of searching for action.

CHAPTER 11

THE EPILOGUE: FUTURE TALES?

11.1 Introduction

Journey's end determines that I should reflect upon the processes and outcomes of the study and suggest possibilities, implications and recommendations for the future. This will be achieved by first evaluating the research process. The thesis will then conclude by discussing the potential relevance of the study to the learning and development of registered nurses in practice.

11.2 Evaluating the research process

The study has demonstrated the problems experienced when researching as a bricoleur, constrained by Cartesian and bounded Discourses. In an attempt to facilitate dialogic, hermeneutical interactions between and within the constituent texts, a different format was adopted for the construction of the thesis. Acknowledging that some readers might find this format 'messy', I appeal to the works of Marcus (1994), Ely et al. (1997) and Parker (1997) who have encouraged me to 'break the mould', albeit in a constrained and tentative manner.

This methodological stance sought to represent the primacy of action; investigated the contested and unsayable; selectively appropriated elements of DA and was informed by the ethnographic tradition. It could be criticised for producing Morse's (1991) 'sloppy mish mash'. I dispute this claim, arguing that the possibilities which emerge from researching in *different and same* ways extend the corpus of the (not) known and recognise the complexities and nuances of epistemological research in the field. Chapter **8** demonstrated that the research engagement transgressed the modernist and postmodernist positions in its hermeneutical endeavour. In so doing, it identified the benefits to be accrued from researching according to context and situation, especially when the domain studied is itself undefined. Whilst Parker (1997) discusses the irony of reflective approaches which seek to analytically justify issues of bias, distortion, validity and reliability, I have endeavoured to appropriately reveal those factors which influenced the study's design and implementation. It is facile to argue that the study would benefit from more 'detailed' research with

greater numbers involved: this is not disputed. The study has established the relevance of investigating the 'unsayable' discourses in practice and the use of observational methods to record and analyse the developmental dimensions within professional practice.

Whilst the study has appealed to established canons to justify its processes, it has also exposed the importance of critically appraising their applicability to different contexts. Perspective and fruitfulness become criteria for evaluation. With the wisdom of hindsight, I would recommend that a future study would acknowledge the possible benefits to be accrued from:

- researching both 'sameness' and 'difference' whether in respect to the researcher's biography, the setting, or the research participants;
- new technologies which might facilitate recording in practice;
- extending the research participants to include other health care professionals thereby establishing any situatedness of the findings;
- exploring the oral culture and its impact upon the recall and transmission of practice;
- focusing on discourses which *struggle*;
- attending to interdisciplinary discourses;
- analysing the formal and informal teaching (D)discourses of practitioners and educators;
- acknowledging that, despite the Meno dilemmas, one *can* endeavour to investigate the unsayable, tacit and unknown through attention to action, interaction and discourse. However, the outcomes may well be subject to a contentious validity.

In acknowledging that the texting of this bricolage is a product of the interaction between self and others, its value is similarly judged by self, others and readers. As the author, I have confidence in the applicability of the findings, albeit from such a comparatively 'small' and 'subjective' sample. I have acquired new perspectives from which to investigate and explore practice. I

trust that should the reader find potential new readings for, and of, practice then the 'worthiness' of this expedition is evident.

Chapter **4** acknowledged that the method of investigation was neither innocent nor naive. The reader may question whether my pre-givens or role manifestations led to a self fulfilling narrative. This is a dilemma of both participant observation, being a semi-insider and producing a bricolage. Chapter **1** discussed the intention to question the impact of my role and (tacit) assumptions through the process of a reflexive reading of my own discourse and experience as text. Whilst I am satisfied that the theoretical constructions of the thesis either emerged from, or were confirmed by, fieldwork experiences, I acknowledge that they are *my* constructions. The tales are not complete, but they do expose different dimensions of practice for analysis.

It could be argued that I did not 'discover' intuition because it eluded my observations. This point can only be challenged by the subsequent evidence of others. Similarly, one questions whether the *developmental progression* noticed in the research participants, especially with V, is an accurate linear portrayal. Whilst there is little doubt that the changes occurred, it is reasonable to argue that what is reported is (1) the participant's perception of change and (2) the date when I noted the episode (or others in the field). It *is* possible that some observations may have been present at an earlier juncture. However longevity in the field tends to inform such judgements.

From this evaluation of the research process, it is timely to consider the potential relevance of the study to educational practice.

11.3 The potential relevance of the study to the development of nurses in practice settings.

The study has demonstrated that the heuristic processes of actioning may incorporate activities of *regard,*[1] *silencing and embodied knowing/doing* in the pursuit of rightful or 'best' action. The study reveals the gradual acquisition of (D)discourses, different repertoires and mechanisms for conveying 'worry' and 'the invisible as yet' to others. Significant factors which impact upon learning in nursing practice include:

[1] I hesitate to state a *nursing regard* because that infers that the gazes are privileged to nursing.

- the absence of oral and written Discourses concerning the body (Lawler, 1991);
- the little 'secrets' of practice;
- the crucial need for a (D)discourse which commences from the standpoint of action and which may lead to an increase in the use of verb forms;
- the importance of responsibility, accountability, authority and agency within the perceived and actual experience of the practitioner.

There is little Discourse for many of these elements, yet the drive to establish a bounded knowledge claim for nursing persists and may, unchecked, hinder the situation of embodied knowing/doing. Nursing practice and its study require an epistemology of possibilities which includes the 'fixed points', has a language of action served by embodied knowing/doing and employs a variety of (D) discourses, including the Discourses of others. As argued in chapter **10,** perhaps the adoption of the term *languaging analysis* may facilitate the study of these dimensions in the future. Languaging includes attention to the silent, the non verbal and the various forms of discourse/text which can be communicated and interpreted.

These arguments have profound implications for the educator, raising questions concerning curricula, pedagogy and communication. First, there is a paucity of literature and espoused educational practice which addresses a contemporary curriculum which incorporates a pedagogy of learning associated with gazing (upon and within); silencing; different (D) discourses. Certainly there is a neglect of the connections between (D)discourses types and the strategies required to manage them when they occur in juxtaposition or sequence. Whilst there is a burgeoning literature concerning the 'intuitive' and 'reflective practice', Chapter **9** revealed that this literature has a tendency to appeal to rationality and cognition, rather than exposing the intertextual elements within the 'learning and doing' of practice. Recognition of these pedagogical concerns raises challenging questions about the most appropriate location for the learning of these neglected dimensions of practice, e.g. the

practice arena, the educational institution or a staged combination. Could practitioner development be enhanced through an increased attention to observation, stance and connections *in practice*?

To reconstruct existing pedagogy requires a shift beyond the goal of the 'critical, reflective problem solving thinker' towards the embodied actioner whose searching and knowing/doing strategies incorporate a range of activities across the epistemological rainbow. These processes include the capacity to dialogue with the discourse of others and to elicit and analyse detailed descriptions of clinical discourses. The practitioner is then empowered to learn the 'secrets' in practice, their evaluation and transmission. Accompanying these activities is embodied expertise including stance, movements, plurisensorial actions and reactions. A curriculum constructed from this stance would foreground; the oral, the hidden and the unknown. It would employ verb forms and the *current or future tense* rather than the *past* in its aims and values. Furthermore, it would both reflect, mimic and potentially reconstruct practice if its origins were the 'doing' of nursing, the intentions of practitioners and their embodied knowings whether of a focal or subsidiary nature.

Educators would acknowledge that whilst the corpus of the known may increase, there will remain open possibilities and invisible visibles requiring an It Cannot Be Said Device (ICBSD). The recognition of the It Cannot Be Said Device is not a mystical 'cop out', rather it is an acknowledgement that 'not all can be spoken', yet 'something' can be communicated. This 'something' can be partially elicited, valued and appraised. Analysis of the ICBSD reveals key dimensions within professional practice, whether of power, knowledge, hegemony, struggle, the visible or the invisible.

Inherently, nursing articulates a person based practice which recognises the individual who is to some extent similar to, or different from, one previously known. Through a return to the root of the intuitio- to gaze upon / within- one seeks strategies to facilitate the practitioner's capacity to 'see', 'action', and communicate across multidimensional (D)discourses and frames. The nature of practitioner knowing/doing is thereby reconstructed, challenged and open to debate. But what of the Dreyfus' claim that there can:

> be no clinical *knowledge* as Plato would define it, but there can and must be clinical *understanding*. Thus, in caring, as in the case of the *application* of medical theory, one finds a practice requiring involvement for which there can be no theory.... Thus, nursing has an even more privileged place among western skills than that of providing an outstanding example of the essential place of practice and intuition in a theoretical discipline. Nursing is also - and this constitutes its total uniqueness - a domain which shows forth clearly that in some human areas there is no place at all for abstract, objective, universal theory, nor for analytic rationality. Besides being the perfect model of a craft (*techne),* the caring practices of nursing provide a paradigm case of skills that have no theoretical component at all (1996:47).
>
> .

Whilst acknowledging an intention to legitimise the particular situation of the expert caring nurse, what is overlooked is the *attribution* of theory and its role by the practitioners. Theory is considered to have partial or incomplete utility, new theory is created in practice, and is sought by the practitioner. Caring is *thus informed by theory, although explicit theory may not always be a necessary prerequisite*. From a standpoint of action and belief, Dreyfus' claim is thus challenged and *is* challenged by the evidence of the person studies. The tether of nursing opinion is one of constructed retrospective analysis, akin to Beckett's definition of rationality[2]. Nurses 'knowing' is always partial, but it may be sufficient to resolve the situation at hand. The educator facilitates the practitioner's development of searching strategies, to prepare practitioners for changing stance, agency and discourse. Nursing as an oral, aphoristic tradition requires space for the learning, analysis, interpretation and transmission of its oral genres within the context of expanding and emerging Disciplinary knowledge claims.

11.4 Conclusion

Chapter **10** concluded that nursing practice involves learning in action for action with people. A nursing pedagogy should, by inference, focus upon the facilitation of learning actioning. This search for intuition has culminated in a quest for linguistic devices which may aid the learning and development of nurses in practice. Languaging analysis in, and of, nursing practice offers the

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[2] 'The retrospective justification for action' (Beckett, 1995:120).

potential to reveal the *plurisensorial* discursive struggles which accompany embodied practice between people. Developing strategies to facilitate searching practises **in** practice may promote the acquisition of embodied, discursive expertise. This would be an embodied pedagogy, languaging in an epistemology of the rainbow whose focus is that which is morally appropriate between us. However the journey to establish this pedagogy would face its own discursive power/knowledge struggles, for all cannot be spoken, yet *something* may be communicated between us.

Rainbows of course lead somewhere, and they are quite beautiful to behold, but no one seems to find the end of the rainbow. This is the paradox of nursing practice.

Interpretation of the terms employed by Dreyfus and Dreyfus (1986) for the purposes of analysis.

FEATURES	DESCRIPTION
COMPONENTS/ ELEMENTS	The components or elements of a situation which can be recognised. Rule bound or holistic, template matching.
RECOGNITION & CONCENTRATION	What is recognised in a situation, how it is recognised and the degree of effort required. Rule guided and isolated to holistic, intuitive and contextual. From non discernment to discernment.
APPROACH	Refers to the capacity of analysis. Decomposed and deductive to holistic and inductive.
SALIENCE	The extent to which salience/relevance is recognised.
RESPONSE	The way in which the individual responds to stimuli and situations. From stimulus response to intuitive and on going response. Refers to the capacity to prioritise and order. Presence of risk taking behaviours.
RATIONALITY / DELIBERATION	The extent and manner in which the person 'thinks or deliberates', whether conscious, arational, transitional or deliberative.
PERFORMANCE	Refers to observed behaviour and degree of skilfulness, both cognitive and behavioural.
JUDGEMENT	Interpretive ability: from rule governed and non discretionary and non interpretive decisions to those which are consciously considered and then automatic.
PERSPECTIVE	From having no particular perspective to having a selected perspective and then one which incorporates experience.
DECISION	Capacity to order, be detached, analytical, intuitive, inductive and holistic. Decisions can be prioritised.
COMMITMENT understanding deciding responsibility	Refers to the commitment of the individual towards their actions and the subsequent outcomes. From rule guided behaviours with little responsibility to involved actions with detached decisions and acceptance of responsibility.
LOCUS OF CONTROL	Whether internal, external or a combination: the focus for the control element residing within, between, or external to the person [from their perspective].
AWARENESS	Capacity to be aware of the surrounding situation and themselves, from a monitoring role to total absorption in the situation.
SELF EVALUATION	From evaluating one's own performance in the context of rules to evaluation in respect to outcomes and processes.
TEACHING & LEARNING IMPLICATIONS	The methods through which the person tends to learn and the methods of teaching which may aid development.

DREYFUS & DREYFUS: 5 STAGE MODEL OF SKILL ACQUISITION

(adapted & derived from Dreyfus & Dreyfus: 1979, 1982,1986.

FEATURES	NOVICE	ADVANCED BEGINNER	COMPETENT	PROFICIENT	EXPERT
COMPONENTS	Context free. Acquisition of rules. Relies upon information processing.	Context free & situational.	Context free & situational.	Context free & situational.	Context free & situational.
RECOGNITION & CONCENTRATION	Recognises relevant objective facts & features. Requires intense concentration and focus.	Begins to recognise elements by their presence 'similarity in experience'.	Sees situations as a collection of facts. Maybe overwhelmed by volume of elements recognised	'Holistic similarity recognition'. Recognition without conscious thought; 'sudden noticing'. Deeply involved in the task, although concentration maybe broken in order to deliberate further .	'Holistic' & 'intuitive'. Hardly aware of the situation unless crisis/ challenge is encountered. May operate with some part of the mind 'aloof, detached and open to alternatives'.
APPROACH	Decomposed	Decomposed	Holistic	Holistic	Holistic
SALIENCE	None	None	Present	Present	Present
RESPONSE	Responds to: stimuli & features	Recognises facts, according to learned features.	Needs to develop a sense of order & priority: may chose a plan. Implies notion of risk taking.	Plans, anticipates, modifies, evolves.	Does what normally worked Intuitive "I am". Usually non reflective and ongoing.
RATIONALITY/ DELIBERATION	Conscious Calculative Rational	Conscious Calculative Rational	Conscious deliberation: degree of risk, depends upon perspective. Abstract, analytic & contemplation Calculative Rational	Unconscious Deliberative Transitional	Unconscious. When challenged becomes involved in critical reflection and will deliberate on own intuitions. Deliberative. Arational.
PERFORMANCE	Operates within specified parameters according to rule governed behaviours. Context bound	Improves to a marginally acceptable level after sufficient exposure to 'real' situations.	Can simplify & improve performance. Begins to plan. Selects issues of 'perceived salience'.	Rapid, fluid, involved. Handles situations in a new and flexible way.	Same as proficient.
JUDGEMENT	No	No.	Requires conscious deliberation .	Manner that defies description .	Manner that defies description.
PERSPECTIVE	None	None.	Chosen.	Experienced.	Experienced .
DECISION	Analytical, detached, 'Breaks down' environment into component parts	Analytical	Analytical	Analytical, intuitive know how, know that & expectations. Wholistic	Intuitive, can use 'monitoring' usually non reflective. Analysis and verbalisation can get in the way.
COMMITMENT a) understanding b) deciding c) outcomes	a) detached b) to some extent responds to recognised 'stimuli' c) little responsibility for the outcome	a) detached b) to some extent responds to recognised 'stimuli' c) little responsibility for the outcome	a) detached b) involved c) involved: emotional responsibility	a) involved b) detached c) process and intuitive	a) deeply involved, mature and practised b) some sense of validity in intuits c) product of her understanding
LOCUS OF 'CONTROL'	Outside	Outside	Inside	Inside	Inside
AWARENESS	Monitoring	Monitoring	Monitoring	Monitoring	Absorbed
SELF EVALUATION	Through how well rules were followed				According to personal standards
TEACHING/ LEARNING IMPLICATIONS	Learns through facts, principles, rules and contexts. Requires instruction and experience	Needs exposure to real, concrete situations with some degree of contrast. Needs experience .	Needs exposure to real, concrete situations with some degree of contrast. Needs experience. Needs hierarchical orders/ procedures. Requires human tutors.	Needs exposure to real, concrete situations with some degree of contrast. Needs experience. Requires human tutors. Apprenticeship mode and experience. Has to acquire the ability to 'quiet the analytical mind' Experiences are vivid. Needs to unlearn the learning habits which first made the proficiency possible	Needs exposure to real, concrete situations with some degree of contrast. Needs experience. Requires human tutors. Apprenticeship mode and experience. Has to acquire the ability to 'quiet the analytical mind' Experiences are vivid. Needs to unlearn the learning habits which first made the proficiency possible

APPENDIX 3

ANALYSIS OF INTENSIVE CARE NURSES (DERIVED FROM BENNER ET AL 1992)

FEATURES/ASPECTS	ADVANCED BEGINNER (n=24)	COMPETENT	PROFICIENT	EXPERT (n=43)
Perception and seeing 'views of the clinical world: noticing and responding to different directives for action'	Perceptual work is to recognise 'concrete manifestations of clinical signs and symptoms'. Excited about 'seeing'. Unlikely to notice variations, situations are seen as an 'instance of the general category.' Begin to 'match' theory with practice	Has difficulty with 'seeing (changing) relevance.' Structure inhibits recognition' of actual signs. Recognises the need for synthesis and the need to see as a whole. Trying to read the situation in relation to past situations.	Marked by increased skill in seeing changing relevance: direct recognition through association'. Recognises shifts in priorities or requirement to 'reframe' the situation. sense of salience is 'not infallible.'	Normally 'grasps situations immediately and smoothly'. Reading the situation based on expected changing relevance and action. Practical grasp of other clinician's perceptions of the situation. Open to the situation.
Management of situation and performance	Difficult to manage the simultaneity of competing stimuli. Constantly working at the 'edge of their knowledge/ skills'. Accomplishing tasks & miss nuances of the situation. Lack flexibility and clinical know how in unstable situations.	Beginning to plan and structure the day. Sets goals, makes plans to achieve them. Prepares for the unexpected. Becomes competent as a consequence of a crisis of confidence, but also through learning from the clinical situations and the actions of others. Takes more responsibility than is realistic'	Recognises situations: 'takes on new experientially based possibilities in order to 'recognise new' issues/salience. Set priorities from unfolding situations. Confident in their ability to notice the salient and important.	Fluid, skilful manoeuvring: direct access to action. Can manage rapidly changing circumstances. Confidence leads to advocacy and making a case.
Judgements and decisions	Use 'learned procedures' to make clinical judgements. Believe they can rely upon these procedures: develop a 'naive trust'. 'Acutely aware of the patient's current status'	Beginning to question the judgements of others, leads to an obligation upon themselves. Uses checklists. 'Believe complex theoretical understandings and sophisticated goals' will guide them.	'Based on procedural knowledge and protocols' with 'flexible recognition in particular situations, the relationships with numbers and the way the patient looks and responds.'	Has better and different grasp of the situation than other clinicians -e.g. urgency and salience. 'Guided by direct apprehension of the action Required by the situation at hand, .. documentation follows the action'
Safety/comfort/control	Feel 'unsafe and distressed' when they lose control of the environment. Feel secure with standard practices.	Try to order the environment and the tasks. Tries to limit the 'unexpected'. Copes by becoming more vigilant- 'usually as a result of a disaster or 'war story'.		Usually know when they have a 'good grasp' of the situation. 'Feel uncomfortable when they don't.'
Temporality	Focus on here and now rather than future.	Focus on time management, predictability and consistency.	Analytical problem solving and anticipation	Anticipates /projects patient's likely progress: this shapes response
Self in relation to self/others (including as found in narrative) **Agency** 'determined by the perceptual grasp of the situation'	Aware of self as one deliberately taking on the role of nurse. Accepts limitations, knows they need to address their 'knowledge deficit' through reading, consulting or to 'delegate up their concerns'. Situations are referred to in the way they affect the nurse (rather than the patient). Notice ease and flow of others. 'Experience complex agency' in relation to their feelings and attributions of responsibility. Do not feel full responsibility for planning, but accept responsibility for completing tasks and orders. Feel a 'remarkable sense of responsibility to perform'.	Self is ever present and critically reflective. Ever developing sense of integration within the health care team. Can experience 'excessive sense of responsibility' due to the crisis of trust in others and the 'rules'. 'This vision of performance and agency is institutionally rewarded'. Beginning to recognise that being a 'good nurse' does not necessarily mean following plans and orders. As the experiential base is missing, 'agency is (partly) based on explanation and interpretation' of situations. 'Anxiety is now more situationally attuned'	Accounts reveal situations where actions 'overturned expectations' recognises lack of experiential knowledge in others. Free from excess responsibility as they no longer have to deliberate to notice stimuli. 'Transition from analysis and interpretation to direct understanding'. 'Attunement increases to the point that emotional responses signals.. changing relevance.'	More realistic sense of agency and responsibility for the patient. 'Coaches others to see the situation in the same way'. Handles physicians. Keeps track of the less experienced. Responsive to patient and family concerns in complex situations.

APPENDIX 3

FEATURES OF THE PRACTITIONER'S DEVELOPMENT (DERIVED FROM BENNER ET AL . (1996)

ADVANCED BEGINNER	COMPETENT	PROFICIENT	EXPERT
Clinical World	***Clinical World***	***Engaged Reasoning***	***Clinical World***
• requirements for action	• incremental development	• practical reasoning engaged in transitions	• clinical grasp and response based practice
• clinical situation as a source of learning	• improved organisational skills	• practical grasp open to correction	• embodied know-how
• clinical situation as ordered and regulated	• improved technical skills	• skilled emotional and ethical responsiveness	• seeing the big picture
• as a test of personal capabilities	• focus to near future: anticipatory	***Emotional attunement***	• seeing the unexpected
Clinical Agency	• disillusionment	• gaining embodied know how	***Moral Agency***
• procedural practice	***Organising their work***	• role of emotion in recognition and salience	• skill of involvement
• reliance on the experience and judgement of others: delegating up	• more fluid, co-ordinated, understand team and their work, anticipatory planning, sequencing	• actions guided by reading situation	• managing technology
• learning the skill of involvement	***Developing clinical understanding***	• attuned to patient/familiy/carers	• working with and through others.
• agency within the health care team	• identifying significant clinical signs and symptoms	***Recognising Changing Relevance***	• acknowledgement of boundaries, limits and possibilities
	• gaining a more holistic grasp	• recognition and response to changing relevance	***Features***
	• anticipating future possibilities	• confidence in capacity to note context and significance	• certainty may not be possible.
	• reconciling standardised and individualised care	• response time faster	• timing and pace of expert practice
	The Role of emotions in clinical and ethical learning	***Socially skilled sense of agency***	• temporal grasp of relating past, present and future
	• as a source of perceptual awareness	• salience improved	• emotional attunement
	• developing the skill of involvement	• confronts implications and limitations of responsibility	
	Agency	• practice guided by good outcomes	
	• coping with hyper responsibility	***Improved and differentiated skills of involvement with patients and families.***	
	• negotiating clinical knowledge learning to make a case	• learning how to confront anxiety in face of suffering etc.	
	Experiential Learning and Coping with Failure	• managing self and vulnerability	
	• limits of elemental and scientific knowledge and the need for experiential learning		
	• crisis in confidence in other's competency		
	• confronting the moral conflicts		
	• confronting crises in societal caring		
	• institutional breakdown and its impact on practice		

7 Domains of Nursing Practice and associated competencies* (Benner, 1984)

◆	**The Helping Role** Creating a climate for and establishing a commitment to healing; Providing comfort measures and preserving personhood; Presencing; Maximising the patient's participation and control; Interpreting and managing pain; Providing comfort and communication through touch; Providing emotional and information support; Guiding patients through emotional and developmental changes.
◆	**The Teaching- Coaching Function** Timing: capturing readiness to learn; Assisting patients to integrate problems with lifestyle; Eliciting and Understanding patient's experience; Interpreting patient's understanding and giving rationale for procedures; Coaching in relation to culture and context.
◆	**The Diagnostic and Patient Monitoring Function** Detection & documentation of significant changes; Providing early warning signs; Anticipating problems; Understanding the particular illness, anticipating care; Assessing patient's potential and capacity to respond.
◆	**Effective Management of Rapidly Changing Situations** Skilled performance in extreme cases, rapid grasp of problem; Contingency management; Managing situation until physician arrives.
◆	**Administering and Monitoring Therapeutics Interventions and Regimens** Managing IV therapy; Safe medicine administration; Combating hazards of immobility; Promoting wound healing.
◆	**Monitoring and Ensuring the Quality of Health Care Practices** Providing backup for safe practise; Assessing what can be omitted/added to medical orders; getting appropriate and timely responses from physicians.
◆	**Organisation and Work Role Competencies** Co-ordinating, ordering and meeting multiple patient needs and requests: setting priorities; Building and maintaining a therapeutic team to provide optimum therapy; Coping with staff shortages and high turnover.

These domains were generated from 31 competencies that Benner's team identified from descriptions of 'critical' incident patient care episodes.

* The competencies have been summarized for brevity

Summary extracts from the fieldwork relating to V's development and other general observations.

Summary of the first shifts.

This summary account of these early shifts illustrate aspects of learning, knowing and development associated with the following issues:

- learning in response to patient queries/problems
- learning (or not learning) to observe, 'see' and interpret.
- learning 'what' to pass onto others
- learning when and how to accept help/consult/refer with and from other
- learning to acquire the judgement necessary to establish the nature and frequency of patient observations
- learning how to cope with feelings
- learning how to cope with other members of staff
- learning to challenge the (clinical/professional) judgements of others
- working alone
- the 'cueing' of one person to another, and the 'reading of looks'
- her perseverance to obtain help for patients
- confidence
- beginning to locate the responsibility for the present action to the future
- learning how to deliver holistic care
- learning how to do 'everything' /'several things' at once

As these points indicate, the concepts of self and self in relation to others combined with the nature of clinical/professional knowing were essential features.

Months 1 and 2

- orientation period in the field
- learning which happens through conversation
- the relationship and conversations between and amongst the patient and staff seem to involve mutual learning

Month 3

- familiarity with the patients, but lacks the extended awareness of information to pass it to other nurses (e.g. including me)
- organisation good, but fiercely independent. Kind, gives patients lots of space to talk, an active listener who picks up on their cues
- she needs to learn how to accept help from other members of staff
- has already learnt to make decisions about the discretionary use of pre medication drugs
- once again the interactions with patients stimulate learning. It is unlikely that she would have learnt x if the patient hadn't asked.

- confesses to probably taking too many observations. She is being allowed a certain amount of discretionary judgements, yet she is aware that her judgements are not yet good enough for her to rely upon them
- she has still to gain an awareness of the potential implications/outcomes of signs/ indicators. The significance of what she is seeing (and what she isn't registering) is still to be learnt
- still learning how to cope 'when you don't know enough when caring for a patient'
- learning to challenge the professional judgements of others and to be assertive for oneself on behalf of the patients
- she learns quickly, observed me using a relaxation technique with a patient, later I saw her repeating it.
- referral techniques good, she perseveres for patients
- learning that can't take place because that which is seen is not registered for its relevance or meaning and thus unaware of the potential unknown/hidden possibilities that may exist. 'Seeing the work'
- needs to learn how to give and receive help from others
- working in isolation, temporality is lost
- thinks through her care carefully
- slow pace
- needs to learn how to relate to doctors
- learning how to deal with 'not enough being done for a patient'
- learning about demands of the job upon one's social life, feeling tired
- learning the roles and expectations of others
- learning to have confidence with the doctors
- learning through personal observation
- beginning to do 'everything' for the patient at once rather than just going from task to task
- more confident in bringing issues upto the attention of the ward team

Month 4

- incident with the footballer
- needs help to structure her day
- she is responding to her knowledge and beliefs, but not yet to the significance or otherwise of the clinical picture, she needs to blend the two
- she is now tending to leave the observations
- she is learning more about how to relate to people, most of her major problems stem from working with people, not because she is difficult, far from it. It is do with the need to 'manipulate communications' in order to 'get things done'. The 'games people play', but no one is there to explain the games
- she is beginning to break out and challenge what is happening
- the lack of clinical knowledge is astounding in some ways
- learning some of the 'tricks of the trade' and the 'fixed points' to the day
- learning that she is often not alone with her problems

Month 5

- identifying skills she needs to learn and arranging to have 'tuition' from more senior staff
- has been unwell, ? stress related she says, difficulty adjusting to night duty
- asking me lots of questions now
- beginning to check up on the doctors
- moving home, it will be a busy month for her
- upset by changes in off duty without consultation
- describes one of the auxiliaries as being 'almost like a mentor'
- A staff nurse, comments that V is doing well, works hard but tries to do things the way she has been taught and that it isn't always possible. Speaks of V with affection and respect.
- V seeking a staff nurse as a mentor as the ward sister has been on long term sick leave
- V learning to present the case
- learning to do other things as well, like a conversation
- getting the best out of the person you are looking after
- realising that others perceive things differently - it's 2 way
- asks for feedback
- getting better at taking more poorly patients
- still worries about not working fast enough
- realising that what you don't get done you hand over
- recognising a lot of us feel frustrated.. unable to give idealistic, holistic care
- learning the language of the speciality of nursing
- having the knowledge to anticipate what they are saying (meaning the medics)

Month 6

- feels more accepted as a member of the team
- problem with Nic comes to a head
- understands where some of the more experienced nurses are coming from. Realises she had been misinterpreting their response
- 'I've tuned in more as well'
- 'more the trick of the things have to be done'
- 'able to work my workload'
- learning more about suction
- recognition that she is not the only one finding things difficult
- taking out the tubes
- planning for the next shift occurring
- much more organised
- delegates more assertively
- initiating action more frequently

Month 8 (night shift)

- time management much better
- more authoritative

- increased decision making and confidence especially when she had the appropriate knowledge
- extent to which knowledge was and wasn't known by the staff
- judgements of risk and effect
- initiating more actions herself

Month 9

- trying to sort out about the end of the contract goes for the interview for another ward in the unit. 'couldn't concentrate after the interview ' worried about her next post, 'gap between the two contracts.
- colleague helps her to prepare for the interview
- has become an informal mentor for a new staff nurse
- aware of overloading the new comer with too much information. Planning how much supervision/ support to give.
- has now settled in her new residence
- notices the expertise of others:
- working more automatically now
- feels she has taken some more steps since she came back from holiday
- applying for the other job has helped her to focus
- feels she has 'got through', I've survived.. but there's still a bit of surviving to do'
- has had more responsibility and sees this as contributing to her learning/development
- being in charge of the whole ward now, especially at week ends (when the wards are usually quieter)
- aware that you can become 'detached from the nursing' when in charge. Contributing to corporate decisions and team meetings. She is assisting in the design of an orientation plan
- the interview prompted her to go to the library
- responsibility seems to be making her plan,
- more fluency in her actions; she is clearer and able to explain what she is doing
- more sense of order and a liveliness, an ability to deal with situations without having to look further
- has learnt from another staff nurse, role modelling is noticeable
- she now attempts to pass things on and is quicker noticing cues
- some clinical knowledge is still weak
- her actions are flowing one into another
- other senior staff are leaving her to do things
- she pursues information when she needs an answer

Month 10

During this phase there are noticeable recurring threads to the accounts:

- learning and its attributions/connections with responsibility, challenging situations and experience
- the contingency and complexity of events and patient care: 'shades of grey'
- that 'minor things' contribute to the 'whole thing'
- the anticipation of a change in clinical area and its motivational influence

- evidence of changes in discourse accounts and the location of 'time'
- the sudden and obvious recognition to V that learning and development has occurred.
- others comment on how she has improved and is more confident
- she is delegating
- thinking quite significantly on her own
- asking questions of the medical staff
- thinking through the process of delegating work, considers what might need to be done and what might not
- now has a fixed place in the team, but at the same time seems outside the 'knowing' group
- extracts more experience
- more aware of the facts that she knows and might need to know
- attributes learning etc. to responsibility (including night duty) and having another staff nurse to induct
- reading more and revisiting things
- thinking more, asking why
- applying information
- clinical knowing and recognition
- recognises that it is necessary to have help to learn the bits of information that 'click to you'
- has the desire to master the more technical skills like monitoring
- discusses what she calls the shades of grey
- 'picking up that sort of information' more aware of 'grabbing' the situation in order to learn
- 'I'm having to do more and that's a growing experience and I'm getting au fait with who to call if I get stuck. Sort of realising the other not just ward based things but unit based'
- 'running around more, I seem to be sorting out the complicated bits, not actually getting in to do the patient care'
- able to do a bit more along those lines
- finding out the patient's worries etc.
- 'it might seem a minor things it is still something that contributes to the whole, the whole thing'
- now knows what 'putting it up here means'
- 'you do look at the clock and you think 'ah yes' and you go and sort it out'.
- making mental notes
- 'the learning is um experience and becoming used to the routine and taking advantage of that and it's also um just sort of getting the book out and having a look as well'
- relating to people who have experience
- 'it only dawned on me today'
- outlining rationale
- first time she decided to move someone independently. 'Things are quite complicated'
- starting to read books in preparation for transfer to the other ward, interested in the clinical skills course

Month 11

- V in charge of ward
- gives a detailed handover which illustrates the extent to which she has developed over the last year
- more aware of timings and routines
- still finding it difficult to be assertive with the doctors
- able to articulate her decisions
- the one's who are doing the clinical skills courses, you can hear it in their conversations

Month 12

- delegating has improved, uses me to look after a sick patient!
- She has her priorities identified at the beginning of the shift, orders her notes and highlights key events
- clinical knowledge more spontaneous to stimuli and events
- she has the job in high care
- permission granted to give informal feedback to the unit manager and the ward sister
- seeking to learn technical things, definitely studying, considering studying for skills course of a degree
- prepared now to argue for things, she almost 'harasses' the doctors and doesn't apologise for it.
- she checks the decisions of new doctors
- she has a sense of timing, her thoughts are forward looking
- she anticipates times and events
- she now discriminates with decisions and decides whether to follow the doctors order or not
- she would now make referrals herself: 'carrying through the responsibility on my own
- the sequence of her actions would be different
- she now recognises that there are times when she KNOWS things
- that she can now challenge in a more informed way
- that sometimes the protocols may not be appropriate
- that other colleagues should be listened to, their perspectives recognised, but that it is a personal decision eventually. Signs can be misread by anyone.
- V recognises that she is now 'making connections'

Month 14 (new clinical area)

- sensitivity to picking up psychological needs has improved although she still lacks the detailed observation to identify clues to the client
- concerned about a patient because he reminded her about another patient from her previous ward
- the memory of the previous patient was stirring actions with her
- focus for learning the patient's condition
- feeling 'held back' by circumstances
- impact of the short term contract is worrying her
- V reading a book about reflection

- V learning a lot from people, she asks questions frequently, learning through her desire to be able to understand what is required for the patients some of this is triggered by the nurse handover
- making judgements, the parameters and context
- her skill as a communicator is noticeable
- still needs reminding to delegate to others sometimes
- the shift as a period of shifting sands, yet with fixed parameters and actions to the day
- learning through looking at X rays' or ecg's, asking questions of the doctors, or the patients,
- everything is do with checks and balances and risks and actions and convictions

A week later this patient's care is discussed by V in an interview.

Month 15

- show her the fieldwork notes of the footballer (see extracts)
- 'the way I am talking even is different isn't it?' She is aware that signs can be misread, easily mis- read
- still trying to sort out the clinical skills course
- challenging in a more informed way

Months 16 & 17

- both V and then I am unwell, telephone conversation where she rings me in some distress one evening.

Month 18

- initiating changes in patient / nurse allocation
- V does some regular observations and notices an anomaly, the senior registrar let her talk through her own question , she is actively talking out[1] loud and articulating her thoughts to him, and then in the process of coming to a conclusion which she then needed verifying, because it was not her decision to make. She came to the 'right conclusion' and the registrar initiated the actions.
- her cue recognition is greatly enhances, 'she reported at handover that a patient's onset of hypoxia was noticed by him appearing 'glazed' and a subtle behaviour change which she had noticed.

Month 19 (interview only)

- I can see you seeing so much as well (laughing) it's not all one way you know! on high care especially you've been quite busy, I've noticed
- and that was intuition, it wasn't nursing learnt, it was a general way of life, dealing with people

[1] almost like a Socratic dialogue.. Nightingale: and the doctor capable of eliciting the facts...

Extract A. Month 5, wanting to 'stand back'

V I think it's very difficult. I'd like, (.) I think difficult, I it's like sometimes I'm ITCHING, itching to sort of get that more experience to to be able to sort of (.) stand back and debate um, and I think if it's something that I know that I am right on I might. Like that gentleman I was CONVINCED he needed a chest drain. I was CONVINCED that his pain was probably a pneumothorax and I'd probably look now to see if there was anything. But er um I actually had to basically tell Doctor X to actually GET UP and go, and go and look at this man 'he's in too much pain'. I said 'go and look at him NOW, it's no good putting it off, I need you to go and look now, you've got to go NOW'. And he was actually very good and later on that night he came back to me and said 'thank you'. There are times when I get it right..

And there was another time when a gentleman was very confused and in danger, and actually he's actually managed to pull his catheter out and we were going to take his venflon out, but he ripped it out before we got there. And he (the doctor) would NOT remove it. We were going to the consultant because he (the patient) was in danger. .....

... 'Come and look at him now, he's pulling his chest drain out, he's a real danger to himself and you need to sort it out now'. They actually came and sorted it out. It's awful isn't it?

M You think they don't listen?

V I don't know, I don't know if it's because they, perhaps, I think, It was a situation THEY couldn't face .That's what it was. (//)

M How did you handle that?(//)

V I er I can be quite confronting at times, they've got to COME. 'I'm sorry but you're coming and I'm not going away until you do'. I don't know what they think of me for that, but I'm not really that bothered because I know that I am right and that I would push for it.

Extract B. Month 10: learning to look more thoroughly and 'horrendous episodes'

M I was noticing how you were able to initiate things now and decision making. You seemed now, more comfortable with the sorts of decisions that were (.) needed (//um yes). Obviously thinking things through sort of(.) at the time.

V I think most of that is due to experience. I think um (.) a lot of what I'm doing NOW is -having seen somebody in a certain situation -I sort of relate back to that and I LOOK more thoroughly at all the information that I've got there on the charts etc. And then I actually look at THEM and look at their circulation and their breathing and what's it like .And also noting MORE CAREFULLY the change in people as well, whether they have deteriorated, particularly with their breathing pattern. I think I'm more aware of it more AWARE of it without it being so um (.) I'm, not I'm fully aware that I'm aware of it if that makes sense, I'm doing it automatically I think, which makes things easier and then I go through what I think is going on and then perhaps have some suggestions go and LOOK and get all my information and then if I feel the need to I can go to the doctor and I think that having learnt THAT is quite a big step and I never picked it up in my training and I don't know why. Keep wondering now WHY it took me so long to get there.

M Did it feel as if it happened all of a sudden or was it a gradual thing do you think?

V I think it's a gradual thing, I think, [deep breath], I think the fact that I'm taking on more and more responsibility, it's more down to YOU as well. It's more that sort of sense of accountability is growing as well. Particularly when you're on the night duty as well, you know it's down to you and perhaps you take STEPS that um (.) in case something does happen, 'cos then you know that you are in the BEST situation to so something about it. Because I have had a couple of horrendous episodes where I haven't been properly prepared and I think now I do more to GET prepared does that make sense?

Later in the same interview:

M .. and because you were suggesting that last time you thought that having somebody with you with the students made you suddenly realise what you HAD acquired.

V Yeah,(.) [faster] and I don't know I'm doing a lot more, um, revisiting of reading around what's going on as well to refresh my memory again. And maybe think about things sort of think about things more carefully and as to WHY such and such is happening and WHY that treatment is being given. And I think, that actually having DONE IT now and actually LOOKING AFTER looking after different people with different situations, the knowledge is growing, my knowledge is growing. In particular I noticed this week thymectomy and myasthenia gravis. All the information before looking I was able to use again looking after a young girl this time. And it does it makes it easier you're more I think you're more confident to go and deal with that person because you have a greater understanding of perhaps what's going on

M is that theoretical knowledge do you think, or was it that you were remembering the (.) how, can I put it, was it sort of um I now know MORE about myasthenia or, was it the memory of the previous person, or was it a bit of both?

V A bit of both I think, (.) a little bit of both

M And was the second person DIFFERENT from the first one?

V VERY much different(//)

M (//)So how did you judge (//)

V because it wasn't so acute

M (//) what was similar and what was different?

V (.) Um the ACUTENESS of it was very different, although the WEAKNESS that they both suffered was the same , so therefore the acute stages could have developed with the second case if you see what I mean?

M yes,

V because of that weakness there, but um but also being able to give them some information that it WOULD take a long time for them to actually feel the benefit of the operation and it is also very difficult because he was a man in his seventies and this is a young girl who is 14-15 (.) so that was quite different.

and later

Extract C. Bits of information that 'click to you' (month 10)

M ... what sots of things do you think that people perhaps should have passed on? that you can know identify, or ways that they could have helped you?

V I think that um one of things say could have been at the beginning of a shift just making sure that I felt alright looking after a particular person. Whether I felt comfortable with taking that on and did I understand exactly what I was looking for etc. . The bits of information that automatically 'click' to you and you're thinking 'oh I

should be watching his output etc. I should be watching his blood pressure ' um you know and just pointing our perhaps and giving some guidelines to work within and I mean a lot of it. I don't think that you can teach everything, some things have to be found out for somebody on their own. But given those guidelines to help ease you through your 'Oh I've never looked after somebody with this before, What's going to happen?' 'Oh why am I doing this?' or am I rather that I am I just doing it because you're doing it It's working out why etc. because when you are at the beginning of the shift you can't go and relate to a text book you can't go and get the text book you can't sort of read away can you?

M No that's true. Did you find you had to do a lot of that, or wasn't it in the text books what you wanted to find out anyhow?

V Sometimes it's quite difficult to find out what you want to know. I think I've got more also I'm more confident to ask now as well. Although I always used to ask question, I ask more now that's strange isn't it? Because you feel more comfortable and you think it's good to discuss it. It's good to see how someone else sees it and perhaps take on boards what they think about it and then um it's healthy. discussion

Extract D. Shades of Grey (month 10)

V ... But the other side of it I'm quite looking forward to learn a bit more because if I went back to ... surgery I would have a lot more information they re closely interlinked

M Oh yes

V Because there are some sorts of shades of grey. There are always shades of grey, but there are quite a few sorts of shades of grey. I feel that if I had the six months in High Care that would sort of be filled in. I'm quite looking forward to sort of picking up that sort of information. And more of the high tech. things..

References to Pace, rhythm

V I worry about not working quick enough

V I've tuned on a bit more as well.

V I 've got more the trick of the way things have to be done

References to silence/not spoken about

M Now people say you should plan these things, but then I think it was planned but not articulated.

V (interjects) Yes it was done, but not spoken about.

Extract E. Different perspectives, the clinical language (month 5)

V talking about the ward round and a particular patient....

V yes, I don't know if you heard um when we were talking about the ng feed not being tolerated? and X said 'What do you mean it's not being tolerated?', Well, I said 'It was bubbling and it just wasn't being absorbed', and he said 'What do you mean?' and I said 'well it wasn't being absorbed so it was dropped back down again because it just wasn't being absorbed'. I had to get quite assertive.

M Can you imagine, can you think if he said 'bubbling' what do you think he thought it could have been? because if you describe bubbling to me and I'm a thoracic surgeon, what might I think it would be ?

V chest drain?

M yes, there's a nasogastric tube in somebody who has had the surgery that Mr S has had OK? And feeding them fluid through a nasogastric tube which is presumably in the stomach somewhere..

V it's below the stomach

M duodenum

V um

M Right, and the nurses are telling you that when you put the rate up/ below a certain level he starts bubbling?

V I suppose you could think about not pulmonary oedema? Is that what you are thinking?

M Well you're sort of half right

V Well he's sort of aspirating it, I suppose.

M Um That might be why he was saying to you 'What do you mean, bubbling?'

V Ah, I didn't think about it but it's very difficult because that's what J handed over

M So next time you hear that, then you'll probably ask a bit more about what she meant by 'bubbling?' because bubbling to a thoracic person is a chest bubbling.

V Um I hadn't thought of it like that (laughing)

M or, it could be, because you weren't talking bubbling of a chest, or were you?

V Well I took it to mean

M And you had to repeat yourself twice in order to say he wasn't tolerating it, so was he being sick with it, or was he regurgitating it So if her was being sick with it or regurgitating it, it's going in, but if it is being bubbled from the lung, then for some reason he is inhaling it.

V I took J to mean that he wasn't tolerating it, not taking it down and absorbing it, actually that's what I did say to him, I mean well absorbing it, that's what I said.

M and then he stopped hassling you?

V Yes, that's right! yes he did. Right (laughing) So don't say bubble to him ever again (laughing).

M I mean it when it went up to 50 he did cough with it. I noticed that this morning. We turned it down and it may be that if it's going down a bit quickly it's making him cough because if it's going through

V It's because he has got that problem with his vocal cords.

V Um it's having the knowledge isn't it to know to anticipate what they re saying, B's got a world of knowledge

Extract F. Month 36

V looking at the section about the chest drains:

V Yes, listen to the voice inside saying. Well we were **told** to take the drain out. We thought [softens tone] um . I don't think we should really, and we should err on the side of caution. Well I remember all that went on actually.

V's DEVELOPMENT: parameters adapted from Dreyfus & Dreyfus
Month of research

FEATURES	MONTHS 1 & 2	MONTHS 3 & 4	MONTH 5	MONTH 6
Components/ Elements	Mixture of context & situation free			
Recognition & Concentration	Recognises some objective facts within limits of knowledge base. Concentrates intensely	'Learning looks' from others. Noticing patterns in 'types' of patients. Sometimes recognises that 'something is wrong': but may not know why	'I find I have to concentrate a lot' beginning to talk whilst concentrating 'it was staring me in the face. why couldn't I see it?'	Some elements now recognised with ease level of concentration varies with situation
Approach	Committed to holism yet level of professional knowing inhibits performance		'The constraints inhibit giving 'holistic care"	
Salience	Within limits of knowing recognises salience	Significance of observations limited	'When something is wrong'	Salience recognised according to degree of knowing
Response	Responds to person queries /identified *problems as well as recognised facts*	See vignette 1	Learning to give a 'good look over' 'what I've got to do isn't coming naturally yet'. Important to 'gather facts' and 'go ahead'	'There were things I wasn't sure about'
Rationality/ Deliberation	Conscious deliberation	Careful deliberation. Unable to identify consecutive inputs	'Itching to stand back and debate'	'I hadn't done it for a while and I really had to think about it'
Performance	Adequate and safe. Operates within the context of previous experience and current understandings of workplace norms	Tends to work in isolation. Pace slow. Lacks the ability to 'see the work.' Clinical knowledge remains deficient in many areas. Learning to say 'no'. Trying to do things simultaneously. Clinical situations sometimes beyond her level of expertise	Operating the way she has been taught. still rule bound. Learning to present the case, the language of the speciality and context. Has problems 'taking on' some of the staff.' 'Getting better at taking poorly patients'	Able to manage her workload with better time management and order, planning ahead for the next shift, delegating. More assertive when she perceives things 'to be wrong'. Initiates actions more frequently and independently
Judgement		Discretionary judgements occurring in some situations/ practises. Beginning to challenge the professional judgement of others. Beginning to risk take	Beginning to anticipate the medical staff	Judgements in 'known' situations are confidence and acted upon
Perspective		Becoming increasingly holistic in operation. Aware of need to learn 'whole perspective' beginning to 'see' this	'There's so much I don't know' doing'	
Decision		Does not yet rely upon her own judgements. 'Follow my instincts next time'		Beginning to rely on her own judgements
Commitment understanding deciding outcomes	Responds to notions of 'rightness.' Accepts emotional and cognitive responsibility for actions: involved		'I feel as though I let him down' 'part of getting involved really -getting the best out of the person (i.e. patient)'	
'Locus of Control'	Internal and external- depends upon context	Realisation that some problems are due to 'others'.	Realises that others may perceive things differently: 'a sign of my insecurity"	Appreciates that experienced colleagues can seem 'so calm' and 'now understands where they come from': this influences her control
Awareness		'Not new anymore'	Asking more questions. 'I feel a jumble inside -but may look more confident- I've got over the newness'	Feels more accepted as a member of the team
Self Evaluation	Evaluated in the context of patient outcome and her role in this	Appreciates that she is not alone with her problems. 'Important to be confident'. Learning to cope with the 'demands of the job'. Matching work and private life.	Able to identify skills she needs to learn. 'I worry about not working quick enough'. 'I want to know if I am an employable person at the end of the year'. Finds working with students 'rewarding'	Actively seeking help to learn: 'people are being out in danger' 'I've tuned in more', 'Able to work my load'
Teaching/ Learning Implications	Learns through: patient cues and queries, conversations observation and role modelling. Needs assistance to acquire clinical knowledge and methods of coping with other staff members. Trying to learn the rules.	Unable to learn because relevance and salience not understood. Learning: confidence with the medical staff; through personal observation; how to relate to others; the 'tricks of the trade'; to 'see'	'I wanted to work with someone with more experience'	'Learnt the trick of the way things have to be done'. Needs to know what is 'natural', so she can have her mind 'put at rest'. 'I learnt a lot of little things' Learning from people
Other Comments				

V's DEVELOPMENT: parameters adapted from Dreyfus & Dreyfus
Month of research

MONTHS 7 & 8 (night shift)	MONTH 9	MONTH 10	MONTHS 11 & 12
		Aware of the context: 'shades of grey' making connections, things 'lead on'	
Significance of clinical cues varies with clinical knowing	Operating 'unconsciously' for routines. Quicker at noticing cues. More precise in recognition details. Recognises there are 'more and more' things to learn/do. Still limited by clinical knowing	Recognising a greater range of clinical situations. Repertoire of cues more extensive/ explicit. Picking up cues but not necessarily their significance. 'I look more thoroughly at the information' developing strategies	Timing is a feature of recognition. Clinical knowing is more substantive and spontaneous: this knowing is cognitive and plurisensorial
		Thinking beyond the confines of the ward More global/holistic	Monitoring more overtly, including the work of others
If recognised then salience variable		Recognises information which needs to 'click' Salience of night duty 'there are less of you there'	Present within limits of knowing. Anticipates potential salience
Assessing 'risks and effects' e.g. whether to turn people or not identifying priorities	Within limits of knowing, plans, anticipates, considers options	Priorities more evident. Clinical repertoires not yet complete. 'Relates back' to previous situations. Acquiring sequences of action 'doing it automatically.' Takes steps 'in case something happens.' Tries 'more to get prepared': work patterns altered as a consequence	Anticipates timings and events. Priorities identified at the beginning of a shift and subsequently adjusted. Responds to recognised stimuli and events. Confident delegation. Organises for control
Calculative within limits of knowing	Aware than when one is in charge one can become' detached from the nursing.' Able to explain her actions. Considering wider options. Beginning to speculate	'I ask more questions now', making mental notes. 'It only dawned on me today' 'thinking through'. Considering options. Retrospectively analysing events and trying to establish more effective ways of doing things 'you think ahead', 'it just leads on doesn't it?"	Forward looking
Time management improved, more authoritative	Gaining fluency, more ordered and lively. Speed improved and sequencing of actions. Increasing independence in decision making. Others delegate more to her. Managing complex situations. Developing an action plan for others	Much more articulate in descriptions of practice. Others mention her confidence and improvement. Clear delegation 'you look at the clock and sort it out' 'more confident to go and deal with the person' Questioning medics. Established place in the team 'I'm having to do more now'	Clinical knowing more spontaneous. Gives more informative handovers. More assertive and confident with patients
Initiating judgements with increasing confidence	Making considered responses. Increasing ability to defer to others for advice. Anticipation of decisions, yet not always confident enough to implement	Improved delegation and referral skills. Growing knowledge base and experience of situations. Explaining decisions associated with safety and ability to monitor the situation/patient	Can hear 'expertise' in conversations of others. Checks the decisions of new doctors
Gaining greater breadth	Holistic and focused on corporate activities 'passing on information'	More global and holistic, sorts out the complicated issues first. Eager to considers the roles of other professional groups 'to hear their ideas'. 'Minor things.. that contributes to the whole thing'	Gives detailed handovers which indicates breadth of perspective
More confident when knowledge base supports this		'Decisions are complicated' applies information, listens to other perspectives.	Can articulate decisions. Discriminates when to follow medical orders or not
Responsible for a new staff nurse	Very involved in the outcomes and process of care	Outlines rationale responsibility & accountability influencing actions	
	Beginning to recognise the difference between locus of responsibility, i.e. self or other 'I have more responsibility now'	Internal. Importance of 'grabbing the situations.' Taking advantage of the routine 'sometimes it's difficult to find out you know'	Argues with medical staff. Tries to control the situation
Aware she can 'overload' a new member of staff with too much information	Noticing the expertise of others 'she's got a lot of experience.. an it shows' going for a job interview increases her self awareness	Realisation she has learnt through mentoring another staff nurse. Recognises that the 'unexpected can always happen'. 'you are there and it's upto you' can now ' put it up here'	Still has difficulty being assertive with doctors, yet actively pursues them to get things done'
	Aware she likes 'organising 'things	Asks more questions of herself and others realises the need to learn more technical things 'I seem to be sorting out the complicated bits'	
	Responsible for a new staff nurse, this is making her plan. 'I feel I've taken on more steps', 'learning more rapidly' Learning through talk and discussion	Relating to people with experience. Attributes learning to 'experience and responsibility' Reading and 'revisiting' things 'I went home and looked it up'. Would have appreciated guidelines at beginning	Studying more, using text books. Seeking to learn technical skills
	'It's been a traumatic year'. 'I've survived it.. there's still some to do'	'it's nice being able to pass it on' 'it's more spontaneous'	looking to her future career

V's DEVELOPMENT: parameters adapted from Dreyfus & Dreyfus
Month of research

MONTH 14 (new clinical area)	MONTH 14/15 interview	MONTHS 16 -19	MONTH 32 (interview only)
Attending to parameters and (new) contexts	Very situational		'There's always things that come up that you don't know'
Picking up more complicated psychological cues, yet misses other subtle ones. Lacks some clinical knowing/skills in new context. Patients remind her of someone seen before in a different context	Increased clinical knowing. 'Actually knows' things now. Recognises issues of similarity and difference: the 'weakness' was different	More specific cue recognition, alert to variations and subtle changes in patient. Non verbal recognition between staff. Notices early onset signs	Learning to present the case never stops -'you have to learn it again'
Present in relation to the fixed parameters of the day	Is also an issue of salience in respect to professional colleagues	Not just of features but of potentialities	
Connections with previous patients/knowledge in different contexts. 'Didn't want this to happen to him' Initiated actions and decisions. More proactive in practice and reporting. Clear planning	Sequenced and structured responses which consider specific variations.. Knows how to gather the case and present it. Clear plans of action. Fluency in action where skills are known. 'Making connections,' both physical and psychological	More fluent, responding to staff and patients in an anticipatory and flexible way 'I can see you seeing them'	
Considers 'checks and balances'	'Thinks things through'. Speculating about possible problems and outcomes 'That is knowledge I will take on again.' Cues picked up between nurses and doctors- need to read each other		
Communication skills noticeable still needs help to delegate to others. More fluent in relation to doctors: engages in detailed conversations about patients; asks more focused questions. Delegation skills are not operational here yet	Gained her confidence back since changing clinical areas. More informed about what is going on	More confident interacting with medical and nursing colleagues in a discursive manner. Seeks assistance when needed. Time and person management better. Articulates the case fluently to doctors	
Considers other options and range of possibilities before making decisions. Continually making judgements throughout the shift	Wider range of possibilities considered Challenges others in a 'more informed way.' Knows when 'it was wrong.' Aware that you can 'misread the signs'		'Yes, listen to the voice inside'
			'Do they still find that they were still learning to present a case and it never stops?'
	'but if it ever happens again, I'm going to be more challenging, because it was wrong -I know it was wrong'		'whereas now if I wanted to see the doctor, I would go and get the doctor - that's the difference'
Deeply involved, often cannot manage several items at the same time	'Now I can carry through the responsibility on my own'		'It's having the courage of your convictions as well'
Medical staff are 'easier to relate to here'			
	Reflects back to month 9 & the process of becoming more 'attuned to everything'		
	Knows how to use doctors to help her. 'The way I am talking even is different' realises that her perceptions have changed 'feeling more comfortable with my role now'. Doing a 'better job', acting autonomously		'I suppose it's how a moral works isn't it? It's there as your guide'.
Trigger for learning is patient's condition, reading text books, learning from: members of staff and me. Conversations with others and attending to their discussions. Learning about and from the medical case.	'He was something I looked into': learning through interest in the patient/ management. 'It was something I kept meaning to look into- looking through all the drugs that he was taking-'		'It's not just what you are taught in nursing, it's what you bring as person to it'
Being held back because she needs to 'have a few tips' and know what to 'look for'	'I'm really able to home into particularly one person and that's quite a learning experience'. Had lost confidence as a consequence of the move but has now regained it		

V and Vignette 1:

Version 1: The description of the event from my fieldnotes (month 4).

L, the professional sportsman is recounted elsewhere. However he has a *tension pneumothorax* [not initially recognised at his club], *chest drain was now off suction and he was receiving bupivicaine.* ***Omnopon was written up for him.*** He was ***stiff as a board*** and spent most of the time lying with his eyes closed and *supine*, which is not the ideal position for a thoracic patient.

Eventually when I ***did his obs. his temp was up***. The night auxillary ***sat him up*** and I **inspected the wound**. there was no problem. I **checked the drain** and it was OK, as was his breathing. Some small quantities of blood draining from the drain. He tried to get up and felt woozy.

Jottings

L, the professional sportsman who V was worried about: ***stiff as a board*** at times. *Analgesia given but not effective*. NIC [nurse in charge, X] **not listening to** V: *Chest drain OK*: apparently: he was thought to be *asleep but easily roused* and lying flat. Eventually at 2030 I ***did his temperature*** and it was 39C. Night auxillary ***took the reading***, next thing X **called the doctor to see** the patient [the Dr.] who by 2230 hadn't arrived because of a pt [patient] in ITU. This incident must be picked up in interview in order to ascertain what V was thinking, I suspect she was responding to the pain of L, but not to the other clinical signs

X was responding not to the pain but to the absence of physical signs [I asked her away from V]: like the chap is OK breathing wise, no cough, no change in chest drain, the *lung has probably come up* and therefore it must be his ***tolerance level*** [this is X's perspective]. Later on she comments it maybe that he has a *focus for infection*: because he has a sputum plug stuck somewhere or the lying down has caused it. I suspect there is some labelling to do with his being a professional sportsman [why did V not sit him up?]

2100 I take the BP, it's OK, I take the pulse and a normal tachycardia for the temp. However his pulse is normally low [40-50] : probably due to his fitness [I had noticed the 'muscles' and subsequently discovered that he was a professional sportsman].

I feel that V is not used to looking for the clinical significance and no one is teaching her this..

The ward had been very busy and V's routine had been disturbed and she said at the end of the shift:

> V on a late at 1530 you go around and assess your patients, but quite often on a day like today you get called away.

Version 2: summary account and queries

> The patient a young man L was in a lot of pain. He had a pneumothorax [burst lung] for which a chest drain had been inserted into his chest. According to the morning X Ray his lung has recovered. During the course of the shift V had been convinced that something was wrong and repeatedly went back to L to observe him, and then to X to express her concerns. Throughout the evening she persevered in her attempts to get him reviewed. Unfortunately, the house officer was dealing with an emergency in Intensive Care and was not seen on the ward until after he left to get L reviewed. At 2030, I decided to do a set of observations [V was giving handover] and discovered that L had a temperature of 39C

> This incident was picked up at interview in order to try and clarify what V had been thinking and why she had persevered to get attention for L. I had assumed that she was responding to the pain of L, but not to the other clinical signs. I also wanted to try and explore why she hadn't taken certain actions herself. In this section of the interview, V is responding to my enquiry about the care of L during that shift. 'She' refers to X, the nurse in charge.

Analytical Notes

> This example seems to indicate that V had an 'instinctual' feeling that 'something wasn't right', a something which she was unable to support with evidence: 'the facts'. What is interesting here is the presence of V's instinct which occurs in the absence of <u>contextual</u> experience and in the presence of inadequate theoretical and clinical knowledge. From V's perspective, and my observation, it was apparent that she lacked Schon's repertoire of cases which might provide the resource for the 'seen as' experience. However following this experience she had increased both [although sadly did not receive a comprehensive picture of the theoretical and clinical background underpinning the patient's possible medical problem].

> It is interesting to question here the extent to which this 'early feeling' of 'instinct' is similar to, or different from, the intuitive phases described by Dreyfus. It is worthy of note that during the clinical observation of L, I felt that something else was wrong: reflection however makes me challenge the extent to which I was also responding to V's persistence, but I was feeling exasperated by the absence of simple interventions

which **may** have extended the field of data and dealt with my personal curiosity which was then aroused. My experience led me to consider what else as wrong, and for that I had a repertoire of investigative actions to explore. Eventually at the end of the shift I initiated these actions because I was not clinically satisfied [taking the observations and doing my own check of the patient]. It was this set of observations that led to the identification of the temperature.

My desired set of observations were: observation of the wound and drainage tubes, respiratory pattern [touch, sight, sound] oxygen saturation levels, temperature, pulse/heart rate and blood pressure and a description of the pain.

My thoughts were that it was unlikely to be a recurrence of the pneumothorax, but this needed to be excluded. V's observations were that L was in pain, his oxygen saturation levels were fine, he wasn't right, but she didn't know what was wrong, and felt that NIC wasn't listening to her, as V put it 'crossing that barrier was hard'.

The interview also contrasts with V's comments two months previously when she remarked that 'she probably takes too many observations' (field notes month 3). This infers that the judgement of knowing which observations to take and when, remains part of their clinical learning. This episode proved to be a 'significant' learning experience as it combined several features necessary to establishing and implementing clinical judgement:

- being able to ensure that other members of staff listen and respond to one's opinions
- gathering and presenting the 'appropriate facts'
- being aware of the 'appropriate facts'

Other references to this vignette, including recorded conversations in informal settings.

This next extract is from an interview with V about 2 weeks after the events described.

V I don't think I know how to read, look at the X Rays and interpret the X Rays properly. That's something I need to find more about. Look at the X Rays and interpreting them (.) and that sort of knowledge that I've got to get a little bit more (.) Things like (.) I never really realised that a pneumothorax when its reverting and the lung's expanding , that causes a lot more pain (.) and to read that properly

M That was when that sportsman, wasn't it? (.) that was a conflicting story....

M You were reading things weren't you?

V I knew, I knew that it wasn't just because the lung was expanding, and I was trying my best to get through that barrier [referring to the nurse in charge], I , you know it was quite hard.

M Could you see what, how it it was going?..

V It .. I got the feeling that she wasn't interested (.) She saw that it was the lung expanding and that's what it was and not worry about anything (..) which surprised me because she actually saw him herself on two occasions and she went to give him some analgesia. And she actually came to give it at 1730, but she didn't actually give it, (.) but then she said that she wanted to get the doctors to come and have a look at him (.) She was still pretty reluctant to until we found his temperature was high...

M Looking back on it now, with him (.) If I was interpreting you correctly (.) you felt there was actually something wrong that wasn't just his lung (.) but you weren't sure what you saw?

V NO [spoken as assent, i.e. interpreted as 'No, I didn't know what I saw']

M If you were going to be with similar patients is there anything you would do differently?

V I think something, I don't know really, that up until the last sort of few months is (.) actually giving them a ***a good look over*** and ***doing everything*** like *their temperature* and things like that straight away. Doing that BEFORE then I'm **going armed** with my information. **Going armed to do battle**. It's so awful that it should be like that, but **going armed with the facts that somebody can't ignore**, things like **getting your case, preparing your case, presenting your case.**

M um

V I suppose that what you are technically doing there is um the houseman whether he had been there (.) I think very often that the situation would have been different if there hadn't been a problem[1] in ITU because he would have come and had a look at him straight away. In future I think I would *look at him more thoroughly* and **go armed with my facts and figures** and Oh I suppose its being new and ...

[1] Intensive Therapy/ Care Unit

because it's more isn't it? because I feel as though I let him down. And that would have been em I think it was um the circumstance again em with the person in charge. I had presumed that the, the houseman had left the calls through the person in charge and I wasn't making any headway there.

M Is that [??]different from what you would have done before? ... (?)

M And are you getting the sort of information together that you know that you might need in order to have enough facts, the appropriate facts?

V I think I need a bit more experience for that really. I think that I you know I would see whether he was in any pain but obviously then I'd get something effective and then I obviously would look at that and I think now I would always do somebody's temperature as well because I think that tells you a great deal. Definitely his oxygen saturations, but then I did his oxygen sats to see whether because I wanted to see if the lung was collapsing again. That's what I thought it might have been.. I definitely looked at that, but um, but obviously the pulse rate. I'm beginning to see now that they are more indicative of things than of what you think they might be indicative of I suppose.

V subsequently used the word 'instinct' to describe what it was that led her to persevere with this situation.

Month 9

V initiates a return to the scenario mentioned above, she was recalling how she had recounted the episode to a senior nurse (P), describing her problems with nurse X.

V The um confrontation that I had with X, it's amazing she's quite different now.

M It was quite significant, it effected you very significantly really didn't it?

V yes it did, didn't it? Looking back on it, do you remember that football player from Y? I can't remember his name now, I was telling P about that yesterday and she was standing there [gives a mimic of P's astonishment]. I could tell her now because X had moved on.

V It taught me a lot as well didn't it?

M I won't forget you standing there sort of saying 'Well I knew' (//)

V [laughs at the memory]

Month 10

M .. to try and focus now on what exactly is being learnt and how you're sort of thinking as you are doing things-if possible//

V The learning is um, it's experience and becoming used to the routine and taking advantage of that. And it's also um, just sort of getting the book and having a look as well

M although as we were saying earlier, it's not always on the book!

V (//) NO [mutual ironic laughter], it's not helpful and sort of relating to people who have experience and ..

M .. some of the things that the patients seem to experience aren't written anywhere which is (//)

V Um simple things like if the lung's expanding it causes much more pain than if it's not expanded. Simple things like that isn't it?

Muses and analysis month 10

V initially learnt that in order to present a 'case' to a doctor or a more experienced nurse [who may or may not be responsive] it is important to:

1 give the patient **a good look over** which involves **doing everything like their temperature, oxygen saturations, pulse, whether they had pain**

2 to **go armed with the facts and figures to prepare the case and get the case**

3 to **present the case**

Whilst V recognises that there is 'more to it than that' she hopes that 'will come with experience'. She is also aware that 'things are more indicative' than they might seem:: thus she demonstrates an openness to future possibilities and meanings. The experience of caring for this person was accompanied by a

strong sense of Knowing, what she called instinct: V *knew* that something was wrong, she could *exclude* a recurrence of the pneumothorax but could not *speculate* on what else it might be.

This early knowing was possibly a response to the person's pain or a 'relational knowing. At this point I write that it was not due to her clinical knowledge: a point verified through interview and observation at the time. In direct contrast some 5/6 months later, V reveals how this 'theory in use' has been further developed. V acknowledges the role of experience which enables her to 'relate back' to 'having seem somebody in a certain situation' She then distinguished between looking at **them** [the person] and looking at 'all the information' [the facts?]. This information is available through experience and through knowledge concerning the sorts of information to ascertain. During the process of looking and acquiring the information speculation is occurring. Discernment is evident, the ability to identify **when** to go to the doctor 'That' is a 'big step' and its acquisition is a puzzle at one level *Why did it take me so long to learn?* and yet 'that' is attributed to increasing responsibility and experience. Responsibility leads to an awareness of the need to be 'prepared' for 'potentially horrendous episodes.'

In **month 15** V refers to these encounters slightly differently when shown the transcripts containing the above example.

> M Just to show one example which is one we have talked about before, which was going way back. And how it has been connected up. Now this is the story of the sportsman- the 'famous' one
>
> V Oh yeah, I remember that one
>
> M ..that's straight from the transcript when we were talking about it.
>
> V Did I really say that? [laughing].. that's probably because that's how I felt it was. And I remember saying all those things and that was quite an important lesson along my road (//right) and then.....
>
> V .....before you go on Mary, something in hindsight I'm aware of that also was stopping me there then. Two things, firstly knowing how you can use the doctors to help you, actually getting access to them

(//right) and secondly, having the confidence to go (//right) [then laughing]

V ..Did I use that term 'good look over', or is that your term?

M No the terms in(//)

V What I actually said (//)

M (//) the words in bold are the things that you actually said (//)

later on:

V Yes, I was going to say that to you Mary, the way I am talking even is different, the way it comes across as well isn't it?

M um (.) can you see that in the [hesitation], the examples as well? (//) [referring to the transcriptions being examined]

V Yes, yes (.) and maybe even NOW 'horrendous episodes' I probably (.) I wouldn't find them so horrendous now. And becoming more attuned (.) to everything, (.)It concerns me that I used to see them as horrendous episodes [said with irony]. I think as well (.) because (.) if you regard them as horrendous episodes then I would say that you probably don't act as well as may do. (V month: 15)

M So looking back at that first one, if I had interpreted you correctly, how you did have a conviction or something, about that particular gentleman or er you knew something was wrong you had you knew

V yes

M How do you now perceive that sort of 8 months or not quite a year later?

V One thing that would be definitely different is that I would be taking on the course of referral by myself independently I wouldn't need to go through the nurse in charge on that shift. I could be more and carrying through the responsibility on my own which I think would have brought about a different result

M What did you think you knew then?

V In what sense, Mary?

M When you were relating to him that particular time and you said that you used your instinct and you knew that there was something wrong or not quite right

V I think that was the first, if I remember correctly, actually looking after that gentleman and being told I had never been aware of the fact before that before when the lung was inflating expanding and actually sticking to the chest wall that it would cause discomfort *but there was more discomfort there* and I think it was triggering it. *There was something else at the bottom of all this. He shouldn't be in this much discomfort* it was quite evident he was thrashing around he and I suppose without *I didn't actually check his temperature but I suppose I saw it for myself and I remember his skin being shiny and more looking at the basic things rather than (.)* The thing that is different now is that automatically you would do everything that I realised that I hadn't done at that particular time. To, to go and, you know the, I think the problem was that I think *I didn't know how to present my case properly.* So therefore I was relying on the nurse with the more experience to help me do that -but that wasn't forthcoming - and *I didn't manage to recognise on my own what I should have been doing-* whereas now there would be no need to include her at all- I 'd go through the channels on my own, I could you know.

M Um (.) Do you have those similar times now though? Where you feel you do know things and yet you don't (.) or you (.) and yet they are coming together?

V (.) Ye:s, I suppose there was an incident a couple of weeks ago and a gentleman was actually suffering from *pulmonary oedema and we were* ***watching the amount of fluid he was taking on board and his urinary output fell*** *and rather than treat with frusemide to extract the fluid off (.) er they were treating him with* ***IV maintenance fluid*** *and* **I was arguing against that** and I didn't want to put the ***IV Maintenance fluid up.*** But I actually **referred to the person in charge on that particular shift and spoke of my** *feelings*, **they put forward their case, how they saw it and said that 'No that was the *right* thing to do',** but again I was in this situation of **actually knowing this time,** actually knowing that it wasn't the correct thing to do but (.)(//)

M How did that turn out?

V Well it did make him ***positive*** slightly, but I can't remember by how much and **I've got a few (.) um** [laughs], it's very difficult to describe a few sort of *looks* of '*you did that*?' when I was *handing over* the next morning...

Month 36: reviewing the research

V ..can I ask you, do the other girls, did they still find that they were still learning how to present a case and it never stops?

Later in the interview: M discussing with V vignette 1.

V It effected all my practice really, (.) perhaps

.....

V reads accounts

V Yes, yes it is isn't it? You go through on your own, that's right. I was saying I would get her to back me up before, whereas now I would go and bleep the doctor. I would go and get the doctor. That's the difference, I would go. It's having the courage of your convictions as well.

M absolutely and that is one of the changes that you see coming through, but with it is the way you described things.

Summary extracts from the fieldwork relating to T and other general observations.

Months 1 and 2

- orientation period in the field
- use of humour
- rule breaking
- cultural milieu of advocacy, confidence and assertion
- moments of judgement involve looking, the 'best I can do'
- know how from patient experience, dialogues with others
- regular and continual rapport of gaze
- skill in focus, listening
- responsibility: for when she is not there
- agendas in interaction
- use of my presence by patients
- remembering without making notes

Month 3

- handling feelings
- use of signifiers
- saying good bye to the dying
- managing time, timeliness
- using opportunities
- holding information, knowing through another, giving permission
- spiritual dimension, between us
- confronting/knowing self/other: using appropriate language
- putting out probes, noticing cues, reading
- using silence
- vulnerability
- unsaid stuff

Months 6,7, 8

- handling death and dying and the spirit
- judging how far to go
- postures, dialogue, between us
- clinical language- cerebral
- use of intuition
- doing and doing silently
- unsayable discourses
- tactile, sensory
- just doing it
- contrasting salience in priority
- rhythm of practice

Months 9, 10 & 11

- change in role
- learning from observation of others
- coping in the community
- operating alone

- agendas for interactions
- relational/emotional ties
- meeting people near the edge, maintain and exploring boundaries of control
- learning from families and their descriptions
- presence of another
- giving time and space
- exchanging messages
- pain & symptom relief management
- use of metaphors
- finding possibilities
- gazing to find time and a bigger picture
- the grey, errors

Month 12

- wider repertoire of responses
- 'just does it'
- more assured

Month 14

- role boundaries
- worrying about missing 'it'
- learning to be assertive with other staff
- noticing the 'unexpected patterns' of dying
- coping with the job
- unspoken meaning, dealing with the unsaid
- skilled observation

Months 16

- metaphors
- skilled use of techniques
- 'she's her body'
- close attention to patient/family metaphors
- handling medical staff
- complex pharmacological knowledge

Month 17

- taking risks
- use of energy
- forgetting
- skilful planning and concentration

Mrs A. **Month 1**

Mrs A was a very large lady, and thus turning her was difficult, requiring the use of the hoist. The bed area was cramped and this made it even more difficult. To resolve this problem, T decided to move her bed to the opposite side of the bay where there would be more room... We noticed first thing in the morning that her catheter was leaking and so we changed the sheets and returned later to wash her. At this time, T tried to deflate the catheter balloon to see if there was a fault there. The process was extremely painful and so T went and obtained some lignocaine for the urethral opening. There appeared to be nothing wrong with the balloon and so it was repositioned as all seemed well. However when we went back later to sit Mrs A. up for lunch we noticed that she had pulled the catheter out- balloon and all. This posed an immediate problem (at lunch time) and it was at this juncture that we moved the bed. We changed the sheet only to find that the hoist was tangled around the bed wheels and we had to move things again. We rolled Mrs A. over and were removing the sling when we noticed that she was faecally incontinent. What to do at this point? We were interrupted and asked by one of the doctors to give the lady in the next bed some analgesia immediately. So, we removed the sling, quickly rolled Mrs A., removed the soiled napkin, cleaned her and applied a fresh napkin. We were then back to trying to sit her up! We tried the 'sheet pull' technique (my suggestion) which certainly got her up the bed but not upright. By this point we were both as exhausted as the patient. T decided to leave her at this juncture. The whole process was checks and balances there are not necessarily 'rights and wrongs', but rather the 'best that I can do in this situation' (notes).

Month 3

M ... you seem able to um (.) select moments.... you seem able to say that which might be difficult to say to someone -(um um).. how have you managed to acquire that yourself?

T I think that um a lot of it is actually about finding the moment- um- if you search too hard you won't find it I feel, and that you can't, never sit down with somebody and say 'we're going to talk about you dying' (uh uh) or, 'are you going home?' or whatever. I think that um you can put little probes out and people will either take those up and/or they'll say thanks very much or good-bye- in lots of different ways. And I think it's looking at their cues they are giving **you** finding out what they do with that questioning or just that subtle question that you do or things that they come back with you to (um). It's just taking that cue really because people aren't actually very overt -you find out that people, or very few people, um are very overt in um asking to talk about things- they're on their mind -but they need that push just to say it's OK to open up. Almost like it's a permission before you can step in. I think that comes through experience any way

M yes sort of judging the moment when you can (um yeah) go in because in some respects it seems isolated and (yes) and yet it's it's [silence]

T I, I think you would find the moment if if, if, you screwed up and you've got it wrong, you would definitely know that because people would just cut you off, not in an unpleasant way, but they would suddenly say something totally unconnected or they would look away or they would some of them would say 'oh I know don't you worry about that' or 'just no thank you' [continual mutters from M]

M yeah that was something I have noticed over several- you know the few times that we have been working together. um in some respects to me it might seem as if you suddenly went to talk to someone and yet obviously [silence]

T //[interjects] there's thought behind it

M [in relief] yeah and um because and I was registering that these were quite directive sometimes (yeah) comments that (yeah) that the person was responding to (yeah) and so (.) there was a precursor there somewhere [lightly spoken]

T another tell tale sign is probably just a silly one, but when you feel that you are getting somewhere, I quite often, then I go to sit down - I'm here to stay and this is time that I have allocated to you (um) and whatever and another thing I have noticed is if people move their legs they want you and if they don't and you are grappling at their feet I always think well they don't particularly want me and if they go like that [moving legs] and move their legs over -if they can -I always think that's like permission for me as well I know it's a stupid thing but I've noticed that.

Analysis of T using parameters adapted from Dreyfus & Dreyfus
Month of research

FEATURES	Month 1-3	Months 6,7,8,	Month 9- 12 a new setting	Month 14-18
Components/ Elements	Situational, all modes used.		Taking opportunities Noticing death.	
Recognition / Concentration	All modes used. Notices states of being.	Cue recognition can be contextual or non specific.	Wider range of repertories develops in new setting.	'Worries about missing it'. Unspoken meaning.
Approach	Analysis involves searching, looking & gazing. Holistic. 'Filling in the picture' 'Looking for cues' & 'tell tale signs'.	About the 'unsaid stuff'. Involves all senses. 'Just do it'.	Function of the gaze.	'She's her body.'
Salience	Salience recognised. Connected with empathy, signs & experience.		Learning salience in other staff -new setting.	
Response	Risk taking, anticipatory. Stimulus response & automatic. 'Finding & judging the moment'. Apparent 'sudden' movements are intentional. Uses silence. Depends upon personal vulnerability.		Giving time and space. Descriptive repertoires. Finding possibilities. Responds to unfolding situation.	Dealing with the 'unexpected patterns of dying'.
Rationality/ Deliberation	Anticipatory. Intentional. Searching for possibilities.	Connection between the sensory, & theoretical can be sudden.	'Just responds.'	Increasingly purposeful.
Performance	Fluid, intentional and competent. Delegates, monitors others. Able to confront others. Dealing with their 'stuff' and my stuff.	Exudes 'space'. Effortless and deliberative. 'Fluency in action and thoughts.. sequence of events'.	'More you do the job, more errors' 'Crossing the borders of control'.	Strategies more deliberative. Dealing with the unsaid. Requires energy.
Judgement	Incorporates risk assessment. All modes used. Adjusts to ongoing situation. 'Getting to know people and individuals.'	'How far to go?'	Incorporates awareness of self.	Taking gambles. Dealing with compromises.
Perspective	Both selective and focused according to situation.			
Decision	Incorporates feelings and cognitions in decision making which uses varied modes according to situation. 'Wrapping one job into another.'		Cyclical plan to management of home visits.	Contextual, confident. Handles the risk.
Commitment understanding deciding outcomes	Responsibility for self and others. Both involved and detached			
'Locus of Control'	Combination according to situation.	Responsibility for getting it wrong varies.		Responsibility heightened through working alone.
Awareness	Total absorption combined with awareness of surroundings.			Learning how to cope with the job- emotional: living in a world of death/dying.
Self Evaluation	Evaluates self in respect to both rules, outcomes, processes and personal standards.	Recognises value of hunch/feeling.		
Teaching/ Learning Implications	Learning through 'testing' personal hypotheses; through dialogue with others.	You learn 'through doing'; 'putting it together'; as you go along' & 'getting it wrong.'	Learning through others. Learn from 'their descriptions'.	
Other Comments	Use of humour. Non-verbal skills. 'Between us' interactions.		Collective debriefing and sharing. Completing an oncology course.	

Summary extracts from the fieldwork relating to P

Month 1

- orientation period in the field
- monitoring others all the time (staff and patients)
- talking and doing with ease
- judgement criteria are concerned with patient *and* impact upon junior staff
- fluent, organised anticipates
- instantaneous relationships
- state of 'ready alert'

Month 2

- patterns to dialogue, sequence and content
- vigilance
- continuous, often unobtrusive, observation
- attending to nuances and small details
- gaze

Month 3

- immediacy of thought and action
- rhythm, pace and tempo
- searching for clues, cues, fitting them together
- looking and gazing
- something not being right
- feeling 'uncomfortable'
- operating at the boundaries of the hierarchical role
- positioned in relation to the medical staff
- assessment skills
- stop and think

Month 4

- scanning the department
- knowing, 'faulty knowing', sequence in assessment
- 'between us'
- capacity to offer breadth an depth to the range of possibilities

Analysis of P: parameters adapted from Dreyfus & Dreyfus
Month of research

OBSERVED FEATURES	MONTH 1	MONTH 2	MONTHS 3/4/5
Components/ Elements	Both context and rules.		
Recognition & Concentration	Discerning. Notices early cues. Extensive experience. Actively seeks cues and clues.	Attends to nuances and small clues.	Searching for 'what else can be there?' Search for consistency and inconsistency in relation to context and 'rules'.
Approach		Mixed forms of analysis. Gaze and vigilance.	Can override the automatic. Gaze is interpersonal, monitoring . Selectively given or withheld.
Salience	Salience recognised & if not searches for it.		
Response	Quick, both modes used. Prioritises. Takes risks.		Immediacy of thought and action. Yet stops and thinks.
Rationality/ Deliberation	Seeks to prevent risk.		
Performance	Fluent, organised, able to articulate as she performs. Fast. Monitors others. Delegates. Continual state of 'ready alert'.	Patterns to dialogue, sequence and content.	Rhythm, pace and tempo. 'Dum, dum, dum'. Operates at the boundaries of hierarchical role. Controls time. Performance geared towards the possible future scenario.
Judgement	Anticipatory. Envisages. Prioritises All modes used.		
Perspective	Incorporates all modes.	Draws on previous experience.	
Decision	According to time available. Both modes.		
Commitment understanding deciding outcomes	Committed to personal standards and positive outcomes for patients/carers.		
'Locus of Control'	Selectively mixed.		
Awareness	Monitors and absorbed dependent upon context.	Continuous, often unobtrusive monitoring of self situation and that of surroundings.	
Self Evaluation	Has personal standards.		Fully aware of skills and limits.
Teaching/ Learning Implications			Learning influenced by inadequate data. Learning in and on the job. Learning through discussions of the case and person
Other Comments			Not knowing as important as knowing.

Summary of Potter and Wetherell's (1987) 10 stage model of analysis in discourse

1	Research Questions: where the participants' discourse is treated as a topic in its own right.
2	Sample selection: the determinant is the research question, size is not necessarily an issue.
3	Collection of records and documents: predominantly of interaction, not the researcher's participation.
4	Interviews: here it is advocated to seek variability rather than consistency, with structured interview guides rather than open ended less focused approaches.
5	Transcription which is appropriately coded.
6	Coding which is as inclusive as possible, including variances and contradictions.
7	Interrogation of our own presuppositions and our unexamined techniques of sense making'. Analysis which should include a 'critical (p168) and focuses attention on the constructive and functional nature of discourse.
8	Validation should include consideration of the four techniques of coherence; participants' orientation; new problems and fruitfulness.
9	The report should include the entire reasoning process from the discursive data itself to the formation of the conclusions (p172).
10	Application: here the potential relevance of the report should be discussed and where possible the verification or consultation with the participants may be advantageous.

References to the *Gaze* in Foucault's 'The Birth of the Clinic'

(from the Sheridan Translation, 1973)

Page No	Description
13	qualitative
15	penetrating
23	in some sense diacritical
25	multiple gaze ... where gazes meet
29	unity of the medical gaze
38	the new requirements of the gaze
39	unimpeded empire of the gaze.. the gaze that sees is the gaze that dominates
41	the gaze that is turned upon it by those close to the sick person has the vital force of benevolence and the discretion of hope
41	the gaze of compassion
42	there is a gaze that does not distinguish it (disease) from, but re-absorbs in into, all the other social ills to be eliminated; and a gaze that isolates it, with a view to circumscribing its natural truth.
48	the way in which one directed one's gaze and the way in which it was trained did not overlap
49	knowledge is spontaneously transmitted by the word and the word that contains most truth prevails
51	what one did not know was how to express in words what one knew to be given only to the gaze. The Visible was neither Dicible nor Discible
51	a gaze armed nonetheless with its privileges and qualifications
51	The great myth of the free gaze, which in its fidelity to discovery receives the virtue to destroy; a purified putrefying gaze, which free from darkness, dissipates Darkness
54	constant gaze upon the patient
61	to discover by means of the gaze
61	the language of knowledge remains silent, and one observes
64	a way of teaching and saying became a way of learning and seeing
65	bright, distant, open naivety of the gaze
68	It is a question, in the absence of any previous structure, of a domain in which truth teaches itself, and, in exactly the same way, offers itself to the gaze of both the experienced observer and the naive apprentice; for both there is only one language: the hospital, in which the series of patients examined is itself a school
69	a language that did not owe its truth to speech but to the gaze alone
70	'read little, see much, and do much'
83	object of a gaze
84	the doctor's gaze is a very small saving in the calculate exchanges of a literal world
89	the sovereignty of the gaze, gradually establishes itself, the eye that knows and decides, the eye that governs
89	the clinic was probably the first attempt to order a science on the exercise and decision of the gaze

89	gaze not content to observe what was self evident
101	medical certainty is based not on the completely observed individuality but on the completely scanned multiplicity of individual facts
105	a domain of clear visibility was opened upto the gaze
107	privileges of a pure gaze those of a gaze equipped with a whole logical armature
107	The observing gaze refrains from intervening: it is silent and gestures less. observation leaves things as they are; there is nothing hidden to it in what is given.
107	the purity of the gaze is bound up with a certain silence that enables him to listen
109	The clinical gaze has the paradoxical ability to *hear a language* as soon as it *perceives a spectacle*
109	One can, therefore, as an initial approximation, define this clinical gaze as a perceptual act sustained by a logic of operations; it is analytic because it restores the genesis of composition; but it is pure of all intervention insofar as this genesis is only the syntax of the language spoken by thing themselves in an original silence. The gaze of observation and the things it perceives communicate through the same Logos, which, in the latter, is a genesis of totalities and, in the former, a logic of operations.
114	To describe is to follow the ordering of the manifestation, but it is also to follow the intelligible sequence of their genesis; it is to see and to know at the same time, because by saying what one sees, one integrates it spontaneously into knowledge; it is also to learn to see, because it means giving the key of a language that masters the visible
114	over all these endeavours on the part of clinical thought to define its methods and scientific norms hovers the great myth of a pure Gaze that would be pure Language: a speaking eye. ..... This speaking eye would be the servant of things and the master of truth
115	A hearing gaze and a speaking gaze: clinical experience represents a moment of balance between speech and spectacle. A precarious balance, for it rests on a formidable postulate: that all that is *visible* is *expressible*, and that it is *wholly visible* because it is *wholly expressible*. .
120	And, by reciprocity, the clinician's gaze becomes the functional equivalent of fire in chemical combustion; it is through it that the essential purity of phenomena can emerge: it is the separating agent of truth.
120	One can see now that the clinic no longer has simply to read the visible; it has to discover its secrets.
120	The clinical gaze is not that of an intellectual eye that is able to perceive the unalterable purity of essences beneath phenomena. It is a gaze of the concrete sensibility, a gaze that travels from body to body, and whose trajectory is situated in the space of sensible manifestation
121	the glance is silent, like a finger pointing, denouncing.
122	The glance is of the non verbal order of *contact*, a purely ideal contact perhaps, but in fact a more *striking* contact, since it traverses more easily, and goes further beneath things. The clinical eye discovers a kinship with a new sense that prescribes its norm and epistemological structure; this is no longer the ear straining to catch a language, but the index finger palpating the depths. Hence that metaphor of 'touch'
129	the surface gaze

134	In order to overcome the firsts series of objections, there did not seem to be any need to modify the structure of the clinical gaze itself: was it not enough simply to observe the dead as one observes the living and to apply to corpses the diacritical principles of medical observation: the *only pathological fact is a comparative fact?*
135	the medical gaze must therefore travel along a path that had not so far been opened to it: vertically from the symptomatic surface to the tissual surface; in depth, plunging from the manifest to the hidden; and in both directions, as it must continuously travel is one wishes to define, from one end to the other, the network of essential necessities. The medical gaze, which, as we have seen, was directed upon the two dimensional areas of tissues and symptoms, must, in order to reconcile them, itself move along a third dimension. In this way, anatomo- clinical range will be defined.
144	It is no longer that of a living eye that has seen death - a great white eye that unties the knot of life
158	Death, which, in the anatomical gaze, spoke retrospectively the truth of disease, makes possible its real from by anticipation.
162/3	The clinician's gaze was directed upon a succession and upon an area of pathological events; it had to be both synchronic and diachronic, but in any case it was placed under temporal obedience; it *analysed* a *series*. The anatomo- clinician's gaze has *to map a volume*; it deals with the complexity of spatial data which for the first time in medicine are three dimensional. Whereas clinical experience implied the constitution of *mixed web of the visible and the readable,* the new semiology requires a sort of *sensorial triangulation* in which various atlases, hitherto excluded from medical techniques, must collaborate: the ear and touch are added to sight.
163	Four thousands of years, after all, doctors had tested patients' urine. Later they began to touch, tap, listen. Was this result of the raising of moral prohibitions by the Enlightenment?
165	But we must not lose sight of the essential. The tactile and auditory dimensions were not simply added to the domain of vision. The sensorial triangulation indispensable to anatomo -clinical perception remains under the dominant sign of the visible: first, because this multi-sensorial perception is merely a way of anticipating the triumph of the gaze that is represented by the autopsy; and ear and hand are merely temporary, substitute organs until such time as death brings to truth the luminous presence of the visible; it is a question of a mapping in life, that is, in *night*, in order to indicate how things would be in the white brightness of death.
165	Thus, from the discovery of pathological anatomy, the medical gaze is duplicated: there is a local circumscribed gaze, the borderline gaze of touch and hearing, which covers only one of the sensorial fields, and which operates on little more that the visible surfaces. But there is also an absolute, absolutely integrating gaze that dominates and founds all perceptual experiences. It is this gaze that structures into sovereign unity that which belongs to a lower level of the eye the ear and the sense of touch. when the doctor observes, with all his sense open, another eye is directed upon the fundamental visibility of things, and, through the transparent datum of life with which the particular senses are forced to work, he addresses himself fairly and squarely to the bright solidity of death.

165	The structure, at once perceptual and epistemological, that co from it, is that of *invisible visibility*. Truth, which, by right of nature, is made for the eye, is taken from her, but at once surreptitiously revealed by that which tried to evade it. Knowledge develops in accordance with a whole interplay of *envelopes*; the hidden element takes on the form and rhythm of the hidden content, which means that, like a *veil*, it is *transparent* [45].:...
169	It is no longer a question of correlating a perceptual sector and a semantic element, but of bending language back entirely towards that region in which the perceived, in its singularity, runs the risk of eluding the form of the word and of becoming finally imperceptible because incapable of being said . to *discover* therefore, will no longer be to *read* an essential coherence beneath a state of disorder, but to push it a little farther back the foamy lien of language, to make is encroach upon that sandy region that is still open to the clarity of perception but is already no loner so to everyday speech - to introduce language into that penumbra where the gaze is bereft of words. An arduous, delicate work; a work that *reveals*, ...
170	Language and death have operated at every level of this experience, and in accordance with its whole destiny, only to offer at last to science perception what, for it, had remained for so long the visible invisible - the forbidden, imminent secret: the knowledge of the individual.
172	The Gaze that envelops, caresses, details, atomizes the most individual flesh and enumerates its secret bites is that fixed, attentive, rather dilated gaze which, from the height of death, has already condemned life.
190	henceforth the medical gaze will be directed only upon a space filled with the forms of composition of the organs. The space of the disease is, without remainder or shift, the very space of the organism.
190	The medicine of diseases has come to an end; there now begins a medicine of pathological reactions, a structure of experience that dominated 19 Century, and, to a certain extent, the twentieth, since the medicine of pathogenic agents was to be contained within it, through not without certain methodological modifications.
191	Everything in Broussais ran counter to his time, but he had fixed for his period the final element of *the way to see*. Since 1816, the doctor's eye has been able to confront a sick organism. The historical and concrete a priori of the modern medical gaze was finally constituted.

PROPERTIES OF INTUITION AND INSIGHT

(Bastick, 1982 and Fischbein, 1987)

BASTICK (1982:25, TABLE 1.3/1)
quick, immediate, sudden appearance
emotional involvement
preconscious process
contrasts with abstract reasoning, logical and analytic thought
influence by experience
understanding comes by feeling-emotive not tactile
association with creativity
association with egocentricity
intuition need not be correct
subjective certainty of correctness
recentring
empathy, kinaesthetic knowledge of other
preverbal concepts
global knowledge
incomplete knowledge
hynogogiv reveries
sense of relations
dependence on environment
transfer and transposition

FISCHBEIN (1987)
self evidence and immediacy
intrinsic certainty, high intuitiveness implies the combination of a strong feeling of evidence with a high level of confidence (p200)
perseverance
coerciveness
theory status
extrapolativeness
globality
implicitness

PERSPECTIVES ON INTUITION
(derived from Westcott 1967)

Nature of Reality	Nature of Intellect/ Reason	Nature of Intuition
1 Classical Intuition **BERGSON** prime reality (the perpetual happening) is normally masked from human knowledge -in dynamic flux	• shields the perpetual happening and patterns, organises the perpetual happening • enables survival management • is a conscious activity	• enables man to recapture/ contact prime reality & to directly experience the perpetual happening • third kind of knowing • difficult to communicate • not usually pertinent to everyday life • artistic intuition is the ability to indwell in the uniqueness of an object thus enabling expression through art • pure perception intuition, is the intuition of perceived sensory experiences • intuition of truth • ultra-intellectual intuits: synthesis of intuits gives rise to a conception • intuition is private to the intuiter & rarely has observable or communicable consequences • instinct is the unconscious automatic knowingness characteristic of lower animals present in man
SPINOZA consists of a 'whole' 'unified' does not exist in parts provides unity with other manifestations or knowledges the 'whole' may be 'God'	• reason enables knowledge of abstract • not necessarily true or accompanied by certainty • maybe improperly used	• brings about knowledge which is special/ mystical • it is knowledge which is not *a priori* is without rationale • knowledge of supernatural/ God • knowledge of the essence of a particular /concrete case • brings conviction of truth with it • elaborate intuitions may occur after utilisation of reason • not directly communicable • experience of contact with reality
CROCE beauty is the experiential representation of the reality of the external world	• gives knowledge of the relations among things implies conceptual knowledge	• is an expression • stimuli of beauty as perceived as impressions which are synthesises: the process of intuition • the expression of this process may lead to an experience of beauty (ugliness) • gives knowledge of individual things

STOCKS 1939 an external reality to be known some truths are self evident, i.e. they are not deduced/deducible	• critically dependent upon intuition	• critically dependent upon reason which enables intuitive judgements • intuition of self evident truths is direct and immediate apprehension
EWING 1941 as above, identical to Stocks	• reason depends upon intuitions which by their intrinsic nature must be true • reason can be utilised to support intuition	• immediate knowing of truth, without proof and without the possibility of truth • conviction associates with this knowing • primitive premises & art of deducing must be seen as true intuitively • criticises the durability of 'self -evident truths' & therefore its implications for intuition & inherent subjectivity • linked to inference • a basic process which enables reason to infer/ deduce
2 Contemporary Intuition **BAHM: 1960** positivist some elemental truths exist	• intuitions enable deduction/ induction	• immediate apprehension: self evident • object of intuition determines the type of intuition: (1) objective infers the apprehension of an external object (2) subjective infers the apprehension of self (3) organic infers simultaneous apprehension of object and subject • error may occur due to conflicting 'intuits' • truths exists when there is 'wholeness' • based on a priori knowledge & experience
3 Inferential Intuition **BUNGE 1962** dismisses notion of fundamental and certain truths		• 'nonsense': suggests that feelings of certainty are but a confusion psychological state and are confused with the certainty of rigorous proof

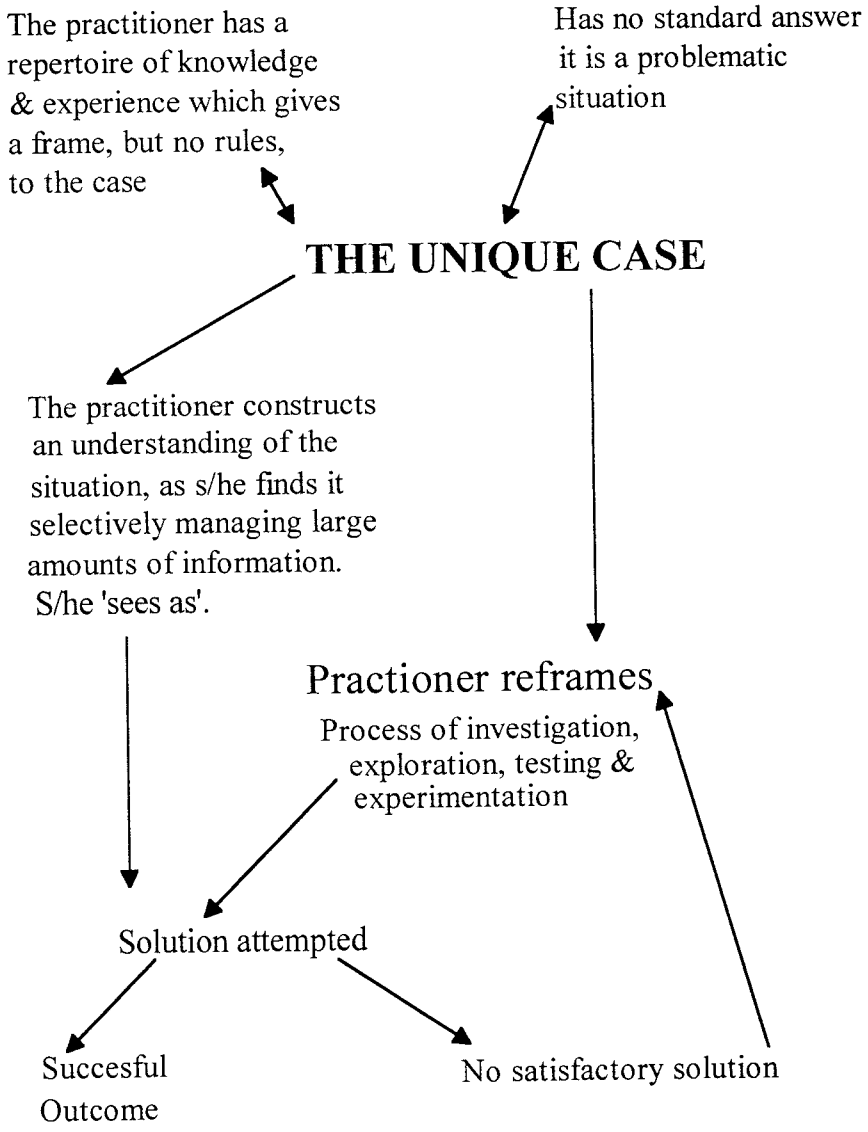
SUMMARY OF PERTINENT STUDIES ON INTUITION

AUTHOR	PERSPECTIVE	STUDY DETAILS
Pyles & Stern, 1983	US critical care nursing	Adult, female nurses sample of 28. In depth interviews associated with early diagnosis.
Gerrity, 1984	Holistic. US Nurses.	Adult, gender not specified Data from Myers 'Briggs Type Indicator of 3103 nurses data collected between 1979 & 1984
Dreyfus & Dreyfus, 1986	Philosophy & artificial intelligence.	Adults, gender not specified but male by inference. US airforce pilots, chess players, musicians. Compared the novice development with the teacher/expert. Mainly graduates?
Benner & Tanner, 1987	US nursing. Phenomenology	Adult. ? all female. 21 nurses studies who had been five years in the clinical speciality and peers determined were 'experts'., mainly interviews and some observation.
Fischbein, 1987	Educational psychologist. maths & science: mainly physics	Mainly children. Gender not specified usually novices/naive.
Rew, 1987 Rew, 1990	US nursing	1987- Nurses who considered they were 'intuitive'. 7-20 years experience. 1990- 25 nurses. Male and female. Structured interviews.
Schraeder & Fischer 1987	US nursing	Adults, mainly female neonatal nurses: experienced for 1-7 years 15 interviewed and asked to give accounts of 'description of experiences, actions, rationales & consequences' when neonatal nurses act on feelings/ assessments that 'infant doesn't look...'
Young, 1987	US nurses. Holism	41 adult female nurses. Used grounded theory. Nurses were observed and / or interviewed in a variety of clinical areas. Studied 75 descriptive incidents.
Holden & Klinger, 1988	US paediatric nursing	4 groups studies (1) nurses; (2) parents; (3) paediatric nurses (4) student nurses. ? all female. Assessed their diagnostic skills in determining the nature of an infant's crying using a microcomputer.
Jenny & Logan, 1992	US critical care nurses	Adults. Presumable female. 16 'expert' nurses weaning patients from ventilators.
McCormack, 1992, 1993.	UK student nurses.	10 students. ? gender. Midpoint of course. Interviews and diary keeping.
Kenny, 1994	UK nurses	11 enrolled nurses with 5 years experience. Interactive interviews.
Greenwood & King, 1995	Australian orthopaedic nurses.	9 pairs of novice and expert nurses. Verbal reports of assessments.

Governing Variables of the Model 1 and Model 2 Person
(adapted from Argyris and Schon, 1974: Figure 1)

MODEL 1 PERSON (table 1 ibid.)	MODEL 2 PERSON (table 2 ibid.)
Defines goals and tries to achieve them	valid information
maximises winning and minimises losing	free and informed choice
minimises generating or expressing negative feelings	has an internal commitment to the choice and constantly re- evaluates the consequences
is rational	bilateral protection of others

Schematic Representation of Schon's Reflection -in -action



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