

L'interprétation que font les infirmières des situations cliniques: compte-rendu d'une étude menée dans un cadre de soins actifs en Norvège

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Cette étude avait pour but de décrire la nature des interprétations cliniques élaborées par les infirmières dans le cadre de leur pratique. Fondée sur un modèle qualitatif et descriptif, elle a été menée en Norvège dans un cadre de soins actifs. On a sélectionné un échantillon de commodité constitué de six infirmières autorisées procurant des soins directs, que l'on a jugées représentatives des infirmières travaillant dans ce contexte. Les données ont été recueillies par observation pendant trois quarts de travail complets et à l'aide d'entrevues en profondeur auprès de chacune des participantes; on a également consulté les dossiers établis par les infirmières sur les patients. On a procédé à une analyse qualitative des données à l'aide d'une méthode permettant d'unir l'analyse des parties et celle du tout. Les conclusions révèlent qu'au fur et à mesure des contacts avec les patients et des soins qu'elles leur donnent, les infirmières composent un tableau fondé sur une façon particulière d'« envisager » chaque situation clinique, que les auteures désignent ici par le concept de « vue d'ensemble des soins infirmiers ». C'est sur la base de cette dernière que les infirmières fondent leur interprétation des cas cliniques. Il sera nécessaire d'entreprendre d'autres recherches pour étudier comment les infirmières jugent de la portée des renseignements à leur disposition dans la formulation de cette interprétation et pour analyser les caractéristiques de cette vue d'ensemble selon différents cadres cliniques.

Mots clés : vue d'ensemble des soins infirmiers, interprétation clinique

Nurses' Construction of Clinical Situations: A Study Conducted in an Acute-Care Setting in Norway

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The purpose of this study was to describe the nature of clinical constructions that nurses make in their practice. The study was based on a qualitative descriptive design in an acute-care setting in Norway with a convenience sample of 6 registered nurses providing direct patient care. These nurses were considered typical staff nurses working in acute-care settings. Data were collected through observation of and in-depth interviews with participants during 3 full shifts for each nurse and also from nursing documents regarding the patients. Qualitative data analyses were carried out using a method that coalesces analyses of the parts with analysis of the whole. The findings revealed that nurses encounter patients and provide direct care by formulating pictures of encountered clinical situations with a specific way of "seeing," which the authors conceptualize as a comprehensive nursing gaze. This nursing gaze was the basis upon which the nurses arrived at clinical constructions. There is a need for further research to investigate how nurses differentiate the significance of information in arriving at clinical constructions, and to investigate aspects of the nursing gaze in various clinical settings.

Keywords: nursing gaze, clinical construction, nursing practice

Nursing practice involves the engagement of nurses in clinical fields as agents of deliberation and action. In such engagement, nurses observe, assess, recognize, form ideas about, take clinical decisions on, and then act on a particular situation. As cultural agents, nurses are partly socialized into ways of confronting clinical situations and assume, through experiences and interactions with other professionals, specific ways of seeing, knowing, telling, and describing in practice, as suggested for other clinical professionals (Atkinson, 1995; Lave & Wenger, 1991).

The present study investigated the nature of nurses' clinical practice in terms of how they form clinical constructions in acute-care settings in Norway. Our aim was to add to the empirical and theoretical knowledge concerning nursing practice. A prerequisite for developing and changing nursing practice is determining what is actually occurring. Much of the nursing literature focuses on what nurses "should do" or on self-reports or extraordinary cases. Little research has been done on routine nursing

care. Our use of participant observation and in-depth interviews allowed us to take a closer look at what the nurses were actually thinking and doing in their practice.

Background

Nursing practice is a form of praxis (human action) aimed at solving the patient's (or client's) health problems and providing "care" or "help" to that person with his or her living. Practice is understood here as the professional work of nurses in a health-care setting. It involves organized or intentional activities coordinated through nurses' deliberations on the client's situation and the clinical field in which both the nurse and the client are located. Deliberation by the nurse involves arriving at assessments and meanings of a clinical encounter, making decisions about the situation, and developing a program of action (Kim, 1994).

Freidson (1970) believes that clinicians' modes of engagement in clinical situations are guided by a clinical mentality. Foucault (1973) suggests the clinical "gaze" as a special way of perceiving the patient. Atkinson (1995) refers to this as the "clinical eye" and as "rhetoric." While such terms as clinical mentality, clinical gaze, and clinical eye are not similarly defined, they all point to an interesting aspect of clinical practice, namely a special, professional way of assessing the clinical situation. Foucault suggests that the institutionalization of sick care involved a specific medical gaze that became the basis for the disciplinary power developed in the late 19th century. Atkinson (1995), in his study with hematologists, concludes that doctors vacillate within several different frames of reference that constitute the culture of medicine in "reading" patients, constructing clinical cases, and engaging in clinical discourse. His view is that "the production and reproduction of clinical knowledge or opinion are grounded in characteristic modes of perception and legitimization" (p. 47). Atkinson further suggests that medical practitioners engage in a complex interplay between "personal, traditional, and scientific" knowledge that interpenetrates clinical discourse (p. 48). He also reports that physicians use several different "voices" in medical discourse to construct cases.

Ellefsen (2004) found the practice of experienced hospital nurses to be framed by normality, health, need, illness trajectory, and action orientation. In that study, nurses used their ideas regarding normality as a comparative framework for judging deviations, and used health as the basis for identifying disease. Patients' needs determined what patients required, the illness trajectory was used to evaluate patients' progress, and actions were specified as expectations in clinical situations.

Given these frames of practice, the next logical step is to focus on what guides nurses' construction of practice. Nurses seem to have particular ways of observing clinical situations. The concept of "knowing the patient" has been advanced as the pivotal focus in nursing assessment and decision-making (Radwin, 1998). A characteristic of the nursing experience is to focus on the patient when constructing the clinical situation.

The present study set out to reveal the character of the lens through which nurses view patients and arrive at definitions about clinical situations. Although the focus of a clinical situation is the patient, the nurse's clinical construction includes the situation as a whole, encompassing not only the patient but other elements. What orients nurses in the clinical situation? What do they focus on, and what are their areas of interest when they come to an understanding about the patient's situation? What are nurses' specific ways of reading, seeing, hearing, telling, and describing clinical encounters and situations? Because nursing entails a great deal of coordination with different nurses, such processes are important in determining how nursing practice is played out, in terms of not only specific, individual processes, but also collective processes involving many players (i.e., other nurses, nursing assistants, other health-care professionals) with different cultural and role orientations. The present study set out to investigate the nature of nurses' clinical practice in terms of how clinical constructions are made and the meanings of such constructions in nursing practice.

The research question was: *What is the nature of nurses' constructions of clinical situations and how are such constructions made?* Our focus was on the first step in the process of deliberation, the initial view of the clinical situation, which shapes ensuing clinical engagements. Deliberation and engagement point to what nurses are thinking and doing in practice. Clinical construction might be understood as how nurses perceive the clinical situation — what they notice, recognize, and describe — the assumption being that what nurses do in practice is guided by clinical constructions, as these are the initial points in the cascade of clinical decisions and actions that occur during the course of a patient's care.

Study Design and Data Analysis

The present study was part of a larger study of the nature of nursing practice — nurses' clinical engagement, nurses' construction of clinical situations, and frames that guide nurses' clinical constructions — for which data were collected in 1999 and 2000. This article reports only the results regarding the nature of nurses' construction of clinical situations. Clinical engagement is understood as the nurse's means of addressing

patients' needs and requests; frames is understood as the philosophy or ideas that guide the nurse's practice.

As we wished to obtain data on first-hand observation in naturally occurring situations, we chose a clinical fieldwork approach (Brink & Wood, 1994). The result is a qualitative descriptive study conducted in an acute-care setting. The clinical fieldwork approach is a qualitative, naturalistic method carried out in a practice setting in which the emphasis is on description, understanding, and/or explanation of ordinary occurrences as experienced by "usual" actors in a clinical field (Schatzman & Strauss, 1973). The qualitative approach allows the researchers to obtain in-depth, detailed data. When describing field research, Schatzman and Strauss stress the need to get close to the participants: "Their actions are best comprehended when observed on the spot — in the natural environment where they live and work" (p. 5). In our investigation, the aim was to determine what nurses actually experience in their practice.

We chose a convenience sample of nurses working in medical and surgical units in a large acute-care hospital in Norway. The inclusion criterion was 2 years' experience in an acute-care unit as a registered nurse, as we wished to include experienced nurses who were used to providing care and were well acquainted with procedures on the unit. Our sample is thought to be representative of the typical staff nurse, whose main responsibility is direct patient care.

The sample consisted of six registered nurses, all female, three from medical units and three from surgical units. Table 1 gives an overview of the participants in terms of age, years of experience as a registered nurse, and years of experience on the unit.

The senior nursing officer of the hospital informed the nursing officer of each unit about the study. These officers in turn invited experienced nurses to participate. Several nurses on each unit met the inclusion criterion, and the researcher approached these nurses and asked them to participate. The final participants were from five different units, one each from four units and two from another unit.

| | Age <i>Mean (Range)</i> | Years of Experience as RN <i>Mean (Range)</i> | Years of Experience on Unit <i>Mean (Range)</i> |
|---------------|-----------------------------------|---|---|
| Total | 34.3 (28–42) | 7.3 (4–13) | 6.1 (4–8) |
| Medical unit | 35.0 | 6.0 | 5.7 |
| Surgical unit | 33.7 | 8.7 | 6.7 |

Setting

The investigation took place in a 250-bed urban university hospital with an affiliated medical school and nursing school.

Three of the participants were from medical units, two from a unit dedicated to lung diseases and one from a unit for gastrointestinal disorders. The lung unit (26 beds) had 20 nurses and 8 nurse's aides working full time. The gastrointestinal unit (24 beds) had 20 nurses and 7 nurse's aides working full time.

Three of the participants were from surgical units, one each from the urological, gastroenterological, and cardiovascular units. The urological unit (24 beds) had 20 nurses and 8 nurse's aides working full time. The gastroenterological unit (24 beds) had 25 nurses and 4 nurse's aides working full time. The cardiovascular unit (25 beds, five of which were dedicated to orthopedics) had 27 nurses and 5 nurse's aides working full time. For reasons of anonymity the quotations are attributed to either medical or surgical nurses only.

Ethical Considerations

The regional ethics board assessed the participants as not at risk and verbally approved the study. The hospital's director of nursing services granted the researchers permission to carry out the investigation. Nurses who met the inclusion criterion were asked to participate on a voluntary basis after the research process and procedures had been described to them. Written informed consent was obtained once they agreed to participate. The participants were informed that they would be "shadowed" by the researcher during three shifts of their usual duties in providing patient care and would be interviewed at the end of each shift. Data for patients receiving care from the participants were recorded using pseudonyms, in order to ensure their confidentiality and privacy.

Data Collection

The data were collected through participant observation; in-depth interviews with the participants; and review of participants' written reports regarding patients, such as discharge planning notes, other notes, and referrals.

We used the participant observation method described by Schatzman and Strauss (1973), whose fieldwork recording approach includes observational, methodological, and theoretical notes — that is, differences in the written text between "pure" observational notes, and notes on methodological and theoretical issues. Nurses' verbal and non-verbal actions and behaviour were noted and recorded, along with full information about the particular context or situation. The participants were

observed not only when they were in direct contact with patients and families but also as they interacted with nursing assistants, other nurses, and other health-care professionals including physicians. The observer was introduced to patients in the unit as a nurse researcher. When participants were in direct contact with patients, as when providing hands-on nursing, the patient was asked if he or she was comfortable with the nurse researcher present. The researcher spent one shift with each participant prior to data collection (participant observation period) in order to become oriented in the work pattern of the participant and to become acquainted with the participant and the unit. The observation period lasted three full 8-hour shifts for each participant. All shifts were day shifts as this was the one in which most patient-oriented activities took place and because not all of the nurses worked all types of shifts.

Data were collected sequentially — that is, the researcher observed and interviewed each participant for three shifts before moving on to the next participant. The in-depth interview was carried out at the end of each participant observation period (that is, after each shift); thus, each participant was interviewed three times (see Figure 1).

Each interview was audiotaped with the participant’s permission. The questions focused on the nurse’s perceptions and descriptions of the patients during that particular shift. The purpose of the questions was to get a picture of how the nurse perceived the clinical situation of each patient: what, in the nurse’s view, was specific about the patient; what the point of interest was; and how the nurse perceived the situation — what specific things she noticed and the meaning of these. The participants were asked what they would write if asked to produce a detailed nursing note on the patient at the end of the shift. Points of interest from the observation were also discussed. Altogether, the data were based on 144 hours of observation and 18 interviews. The field notes and audiotaped interviews were transcribed verbatim. The transcripts and documentation

Figure 1 *Observation and Interview Process for Each Participant*

| Day 1 | Day 2 | Day 3 | Day 4 |
|-----------------------------------|-------------------------|-------------------------|-------------------------|
| Day shift | Day shift | Day shift | Day shift |
| 07:30–16:00 | 07:30–16:00 | 07:30–16:00 | 07:30–16:00 |
| Orienting participant observation | Participant observation | Participant observation | Participant observation |
| | 16:00–17:00/17:30 | 16:00–17:00/17:30 | 16:00–17:00/17:30 |
| | Interview | Interview | Interview |

obtained from the participants' practice constituted the empirical material for the qualitative analysis. Having estimated, based on previous research using similar methods, that data from five or six participants would be sufficient (Dick, 1998; Esposito, 1998), the researcher concluded that saturation had been reached after data had been collected from six participants.

Data Analysis

Data analysis was continuous, beginning with the initial set of participant observations. First, the participant's interaction with each patient was examined in terms of the research question. Then, each participant's practice with all patients throughout the three shifts was examined in relation to the research question, in order to identify patterns and differences. Finally, the data from all six nurses were compared and contrasted to identify patterns and differences across the sample. Two modes of reading were used. The first was based on fragmentation of the text into categories and instances. The second was intended to capture the flow of the narratives and the order, as described by Atkinson (1992). Confirmation and re-questioning, both during observation and during the interviews, served to enhance the accuracy of the notes. At the same time, the data were checked for representativeness of reality by ensuring that no data were omitted during analysis. The investigators checked the research effects on data collection and data interpretation by reflecting on the processes involved and by asking the participants to elaborate. The findings were validated by means of weighing the evidence and by means of contrasting and comparing (Miles & Huberman, 1984). Nurses' notes and patient documentation were not analyzed in depth but used as background material and as a means of clarifying the nurses' clinical constructions.

Results

We will first describe the sources through which the nurses obtained material for their construction, then present and discuss the elements of their construction.

The Importance of Routines

The daily routines of the nurses are outlined in Table 2. The five types of routines that structured each nurse's day on the unit were important vehicles that met different aims and fulfilled different functions, not only for the nurses' practice but also for the unit as a social organization. Each routine featured not only a main aim that was manifestly understood but also aims that were latent and hidden and understood to be supportive of all aspects of nursing. For example, while the main aim of shift reports

Table 2 *Daily Routines*

| Type | Aims | Supporting Aim |
|--------------------|--|--|
| Nursing rounds | General surveillance of patient status, hygiene, cleanliness, well-being | Information gathering and exchange, guidance |
| Meal rounds | Assessing nourishment, maintenance, well-being | Information gathering and exchange |
| Medication rounds | Recovery, maintenance | Information gathering and exchange |
| Shift reports | Information and transmission | Probing, support, reminders |
| Physicians' rounds | Validation of medical care and process, assessment of patient status | Safety, security |

was the transmission of information, these reports also served as a means for the nurses to go into more detail about patients or gain support for a special procedure, or as reminders about things to be done; and while the main aim of meal rounds was to ensure that patients were well nourished, they also played a part in the gathering and exchange of information.

Construction of Clinical Situations

Nurses' clinical constructions are formed and revised through a complex, evolving process of gaining information, adding its meanings to what exists, and formulating and reformulating ideas about patients' clinical situations occurring simultaneously and circularly, rather than simply and linearly. The nurse engages in a back-and-forth movement among the different sources and between the sources and the picture that is evoked. For each "dip" into the sources, the nurse draws new lines on the clinical picture and erases certain features from it. As information comes in from various sources, the nurse re-adjusts her mental image of the patient and his or her situation.

The picture evocation was on the "surface" in the participants' descriptions of clinical situations. The construction of the clinical situation came through *appraisals of patients* by different *sources*, and the signals from these evoked a picture of the patient and his or her situation processed through aspects of the nursing gaze (Table 3). The nursing gaze is a lens through which the nurses viewed, interpreted, and received

Table 3 *Construction of Clinical Situations*

| Construction of Clinical Situations | Picture Evoked |
|--|--|
| Sources of appraisal of patients and clinical situations | Written material: admission papers, test results, reports, nursing plans Admission discourse Daily routines: nurses' rounds, physicians' rounds, meal rounds, medication rounds, shift reports Encounters: hands-on nursing, meetings in patient's room and in corridor Patient's body language Patient's verbal statements |
| Aspects of nursing gaze | Seriousness of disease Patient's illness experience Patient's managing or handling of clinical situation Functioning |

meanings of clinical situations. It is what pre-existed in the nurses' minds even before they encountered specific clinical situations. The nurses held a nursing gaze to be used in processing information about clinical situations and in arriving at clinical constructions (i.e., clinical pictures) about them.

Sources of appraisal. Sources of appraisal were *written material, admission discourse, daily routines, encounters, and patient's body language and verbal statements*. Written material such as admission papers and the admission discourse gave the nurse the first impression regarding the patient. This impression tended to be overwhelmingly medically oriented, based mostly on the admission diagnosis (which was always a medical diagnosis), physical examination, and physiological test results, and only occasionally on psychological or social information. Nursing care information was sometimes available if the patient had been living in a nursing home or had been attended by the district nursing service prior to admission. Nursing notes and reports became part of the daily impression material after the first shift report.

Daily rounds of various sorts and oral and written shift reports were the main sources of nurses' impressions about patients and their clinical situations. These were used to observe, probe, investigate, and amass information about the patients (Table 2).

The sources became explicit in the daily reports. For instance, the nurse would mention that when she gave patient N medication she noticed xyz, or would allude to something she observed when the patient was walking in the corridor or when she was serving dinner to the patient.

In addition, encounters with patients in their rooms or in the corridors and during hands-on nursing were occasions for gaining information through observation. During such encounters the nurse was not just “passing by” the patient, but observing, noticing, and making mental notes about changes in the patient’s condition or the condition itself. Patients’ body language and verbal statements provided the nurses with supplemental information. Body language included physical signs and symptoms. These were observed through cross-points with patients during routines and encounters. Verbal statements were found in the discourse or in the words and phrases used during encounters and cross-points. Information gained from these sources was subjected to interpretation through the nursing gaze.

Aspects of the nursing gaze. Daily routines, encounters with the patient, the patient’s body language and verbal language, and written material were the cumulative and sometimes revisional bases by which the nurse constructed or evoked a picture of the clinical situation. Such constructions or picture evocations are processed through the nursing gaze, which provides nurses with a specific mind-set and focus to draw meaning from clinical encounters. The clinical construction has four essential elements: *seriousness of the disease*, the patient’s *illness experience*, the patient’s *ways of managing* the situation, and the patient’s *functioning* (Table 3). These elements were evident in the nurses’ comments about the patients, the nurses’ descriptions, and what the nurses noticed.

The nurses focused on the seriousness of the disease based not only on the medical diagnosis and test results but also on the patient’s signs and symptoms. Closely connected to this focus was the nurse’s appraisal of the progress of the disease. The participants questioned whether a specific patient was in a normal recovery process or on a declining trajectory and whether the medical treatment was effective in putting the patient on the road to recovery. For example, one participant from a medical unit was concerned about a patient, diagnosed with osteoporosis and possible pyelonephritis or pneumonia, in severe pain: “The physician has not ordered CT of collumna and we know that we get very limited information from X rays [which had been taken]. This woman has been unable to stand for 14 days and it is important for us to know how much we can do when trying to mobilize her.”

The patient’s illness experience of the disease was another element — disease being the medical diagnosis and definition, illness being the

patient's experience of the disease. Regardless of the diagnosis, the nurses took the patient's experience and views into consideration. They wondered about the impact of the disease on the patient and the patient's experience of it. The above nurse, for example, had this to say about the woman with osteoporosis: "This patient is a real, suffering human being, and I do not know how to help her. She has pain the whole time except when she is asleep." During an admission interview with a patient who had possible prostate enlargement and arrhythmia, another nurse observed uncertainty: the patient did not know what was going to take place in the hospital or the exact nature of his ailment.

An additional element in the evoked picture was the patient's handling of the illness experience, the medical treatment, and the disease trajectory. The questions raised by the nurses in this regard had to do with how the patient was facing the reality of the disease and its treatment. During an interview one nurse was asked to describe a young patient with a urostomy: "Positive and...what word should I use?...positive and motivated, that is how I would describe her. She has a go-ahead spirit."

Functioning was the fourth aspect of the clinical construction. The nurses focused on the degree to which their patients needed assistance and support for the activities of daily living with the disease. "Physically she is fit and usually manages her morning toilet herself," said the nurse of the patient with a urostomy. "She has advanced so much that she can do most of the urostomy procedure herself."

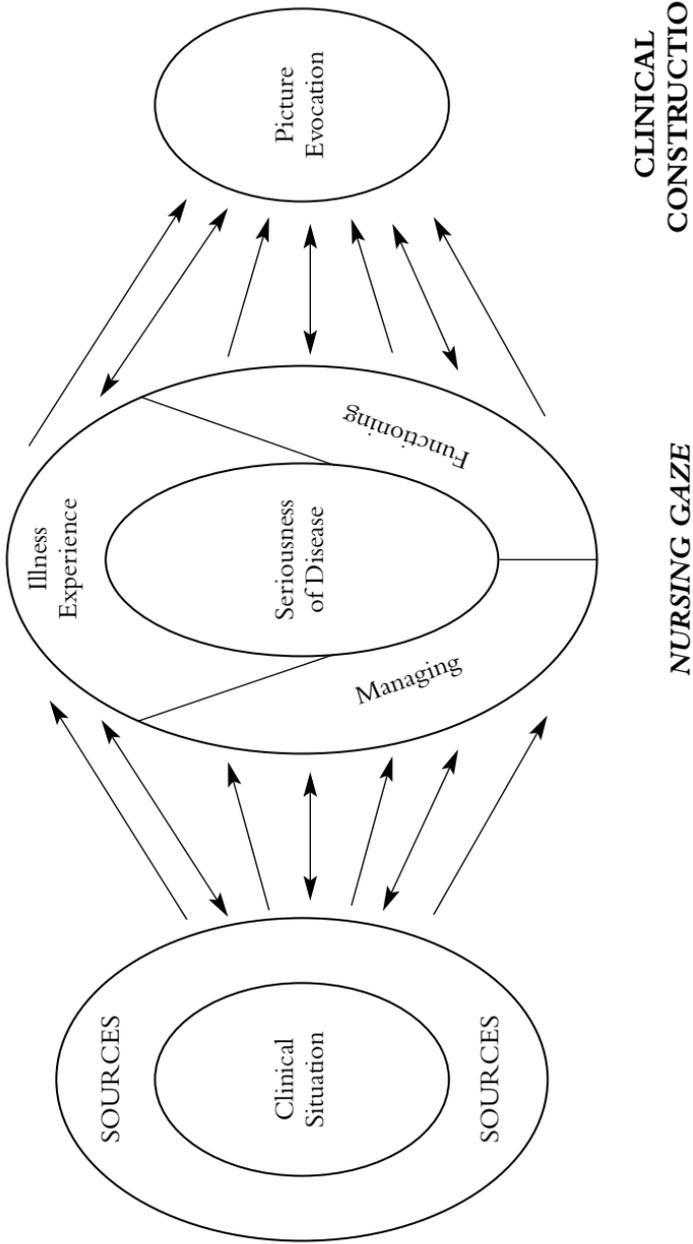
All four elements made up the picture of the patient and the construction of the situation, providing material for clinical engagement and action. In the following examples of picture evocation from the data, two participants describe their patients:

Mr. B...was admitted to hospital because of hematuria and poor general condition [disease]. He has been partly disoriented [illness]. He needs help with his self-care [functioning]. Today he has eaten well and eaten by himself. I think he is better because he is much stronger, partly manages to get out of bed by himself, and is more oriented [managing].

Mr. K is a 60-year-old man with prostate cancer and metastases to bone structures [disease]. He is listless and worn out [illness]. He frequently urinates, has hematuria and diarrhea [disease and illness]. He is mostly bedridden and needs complete hands-on nursing for his self-care [functioning]. He has had four blood transfusions and there is no sign of improvement. He does not like being here. He and his wife hope he can get a little bit better so he can go home for a few days [managing].

Analysis reveals that these two nurses have a comprehensive clinical gaze as manifested in the construction of the clinical situation. Their clin-

Figure 2 Clinical Construction Through a Patient-Focused Comprehensive Nursing Gaze



ical gaze is comprehensive in that it comprises the four elements listed in Table 3. It focuses not only on the patients' medical condition but also on their illness and their responses to the condition, the treatments, and hospitalization. While oriented towards medical treatment, the nurses also attended to specifically nursing aspects of care such as the patients' experiences, situational management, and daily functioning. Patients were "gazed" at with this comprehensive "eye," which caused the nurses to be concerned not only with the patients' recovery from disease but also with their illness and hospitalization. The comprehensive gaze encompasses both short-term and long-term perspectives, according to the disease's development and the patient's experiences and ways of managing. The comprehensive nursing gaze is specific to acute-care situations, as depicted in Figure 2, the disease being its starting point.

Discussion

This study demonstrates the importance of daily routines as sources of information. The findings of Ekman and Segesten (1995) support this conclusion. These researchers found that oral reporting was not enough; to be fully initiated, the nurses in their study had to "know" their patients. They point out that cutting down on routines would reduce nurses' access to information.

The findings of the present study indicate that nurses "see" the patient through the seriousness of the disease, the patient's experience of illness, the patient's handling of the illness and the situation, and the patient's self-care abilities. The seriousness of the patient's condition is based on the medical diagnosis and treatment. Liaschenko and Fisher (1999) identify medical knowledge as the case knowledge necessary to carry out nursing duties. They describe case knowledge as biomedical knowledge of physiopathology, disease processes, pharmacology, and other therapeutic protocols. The seriousness of the condition — that is, whether the patient improves or worsens — as the main priority comes through in nurses' reports.

While the objective side of disease is manifested in the diagnosis, physical examinations, test results, and medical treatment, its subjective side is manifested in the clinical process as played out in hospital and other acute-care settings. Patients' experience of illness and their responses to the clinical condition, as well as the disease itself, are critical aspects of the gaze with which nurses "see" and "read" their patients.

Thus, nurses' constructions of clinical situations suggest a comprehensive gaze. The nursing gaze is not a medical gaze as described by Foucault (1973) but is comprehensive in that it transcends the usual distinction between the medical and care orientations in nursing. It takes

into consideration the patient's personality and perception of illness and treatment (Peerson, 1995). While Mattingly (1989) describes occupational therapists as moving back and forth between two perspectives — biomedical and social — in constructing their work in relation to clients, nursing encompasses several perspectives as it is a profession oriented to supporting people's health. The nursing gaze also takes into consideration the patient's managing and functional level.

Medical diagnosis and treatment are not simply a part of the environment but are the main forces around a patient in an acute-care setting; they make a difference to the patient's stay in hospital. Nursing has been described as "sub-oriented" to biomedicine, with professional narratives presented in such a way that nursing might be constructed as different from medicine (May & Fleming, 1997). A focus on medical diagnoses and treatments is often seen as an obstacle to the practice of nursing as a profession (Ekman & Segesten, 1995).

There may be a certain blindness in the eagerness to describe and verify the uniqueness of nursing practice. The results of the present analysis of nurses' practice support the construction of nursing as different from medicine in that it exceeds the medical orientation. The disease orientation is only a starting point for the nursing gaze within an acute-care practice, as the nursing gaze comprises three other aspects that are critical to the nursing perspective. This goes beyond Reed and Watson's (1994) argument that the medical model can enhance and support nursing care in some settings but has little to offer and may even have a negative effect in other settings.

The present findings indicate that the medical approach is inherent in nursing care and that nursing also focuses on patients as human beings with disease, as human beings experiencing disease, and as independent social beings. The participants in this study were not oriented towards medical diagnoses and treatments alone but used these as part of the basis for a comprehensive nursing gaze.

The nursing gaze may be organized differently in other clinical settings, such as in community health nursing, where health maintenance, health promotion, and chronic health care are the focus.

Limitations

This study has a number of limitations. Because a small convenience sample was used, the results cannot be statistically generalized to other areas of practice. However, the participants were typical nurses working in acute-care hospitals. Participant-distorted behaviour, and the influence of the researcher on the collection, interpretation, and analysis of data, are known biases in the observation and interview methods. However, data

analysis and interpretation were discussed extensively between the two researchers in order to ensure internal validity.

The validity of the data can be supported on several counts. As statistical representativeness was not sought, the sample was selected on the basis of the study's theme and research question. The inclusion criterion secured a typical sample. The participants and the researcher became acquainted before data collection was begun by spending a day together during an orienting participant observation. Also, the researcher observed for a whole shift rather than just part of a shift and therefore was less intrusive. The nurses were used to the presence of observers, such as students and newly appointed personnel. Also, the observation took place during various facets of work, such as patient-nurse interaction, colleague interaction, and report sessions at which the researcher became one of those present. The researcher reflected on possible biases, such as emotions, prejudices, and attitudes, on data collection and analysis. The opportunity to pose questions during observation, and to follow these up during the interview sessions, helped to make the nurses' thoughts and intentions clear to the researcher.

Conclusion

The results of this study show that as nurses encounter patients and provide direct patient care they formulate pictures of clinical situations using a specific way of "seeing." We call this the *nursing gaze*. In acute-care settings the nursing gaze is comprehensive, as it has four interrelated aspects: seriousness of the disease, the illness experience, the patient's managing, and functioning. Although this study is based on data from six nurses, the richness of the data leads us to a theoretical insight for a descriptive model of nursing practice, in which the complex interplay among clinical data and information, nurses' clinical constructions, and engagement in delivering care seems apparent. This theoretical insight provides a basis for debate and further inquiry in order to advance our understanding of nursing practice. It points to further questions regarding the nature of nursing practice such as: How do nurses come to have a nursing gaze of a certain character, and what are the consequences of such a nursing gaze for nurses' work and patient outcomes?

There is a need for further research on how nurses differentiate the significance and importance of the various sources of appraisal (i.e., information) in arriving at clinical constructions. There is also a need for research on aspects of the nursing gaze that differ in various clinical nursing settings such as community health, nursing homes, or primary health care. The nursing gaze and the process of clinical construction are important components of nursing practice and the frontline structure shaping nursing practice.

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