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Résumé

Les efforts de transmission de l'information sur les patients chez les infirmières en soins intensifs

Marie Edwards et Gail Donner

Cette étude descriptive et interprétative avait pour but d'explorer les moyens que prennent les infirmières en soins intensifs pour transmettre de l'information sur leurs patients aux autres membres de l'équipe soignante et en discuter. Trois questions ont été traitées : Quelle est la nature des éléments d'information transmis? De quelle façon communique-t-on ces données? À quelles fins les transmet-on? La collecte des données s'est effectuée dans un hôpital de soins tertiaires, au sein de deux services de soins intensifs, auprès de dix infirmières que l'on a observées, puis interviewées. Pour « tracer le portrait » d'un patient, les infirmières transmettent de l'information sur son état, ses réactions au fil du temps, les interventions qui lui ont été bénéfiques et sa personne. Cet aspect du travail des infirmières est facilité par leur proximité tant avec les clients qu'avec les autres membres de l'équipe, ainsi que par leur participation aux rencontres multidisciplinaires. Les résultats de l'étude comportent des implications pour l'organisation du personnel, l'aménagement des services, la structure des rencontres et l'enseignement infirmier.

Mots clés : soins infirmiers intensifs, information sur les patients, proximité

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The Efforts of Critical Care Nurses to Pass Along Knowledge About Patients

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The purpose of this descriptive, interpretive study was to explore and describe the work of critical care nurses in sharing and discussing their knowledge about patients with other members of the health-care team. Three questions were examined: Which aspects of their understanding of patients do nurses pass along? How is knowledge passed along? To what ends is knowledge passed along? Data collection took place in 2 intensive care units in a tertiary care hospital and involved observation of 10 nurses followed by interviews. Nurses "filled out the picture" for others by passing along knowledge about the patient's status, patient responses over time, interventions that had been beneficial, and the patient as a person. This aspect of nurses' work was facilitated by proximity to both patients and other team members and the inclusion of nurses in multidisciplinary rounds. The results have implications for staffing patterns, the layout of hospital units, the structure of rounds, and nursing education.

Keywords: Critical care nursing, knowing the patient, communication, proximity

It has been suggested that the intensive care unit (ICU) is "a place of witness where every heart rhythm and urine output is monitored, measured, and charted" (Steinmetz, 1999, p. 14). Indeed, the ICU is a place where information from a variety of sources is of interest to a great many people, and nurses spend a significant amount of time collecting, recording, interpreting, and discussing this information. A number of events can happen in a few weeks, days, or hours in the life of a critically ill patient, and if he or she is a patient in an ICU it will most likely be nurses who witness those events as they unfold.

This interpretive study began with our interest in the knowledge that nurses gain, by any number of means, about the patients in their care. More specifically, we were interested in what nurses do with this knowledge. Benner, Tanner, and Chesla (1996) suggest that in order for patients to benefit from what nurses have learned about them through clinical contact, the knowledge must be "preserved and passed along" (p. 197) — that is, shared and discussed with or conveyed to other health-care providers. This study explored the work of critical care nurses in passing along knowledge about patients to other members of the health-care team.

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Literature Review

At the outset of the study, we examined the literature related to knowing the patient and the formal mechanisms used by nurses to communicate with other health-care providers.

Knowing the Patient

Mauksch (1966), in an essay on the organizational context of nursing practice, concludes that in the hospital "the nurse comes and stays while others come and go" (p. 117). Hospital nurses spend the majority of their time in the same physical area as their patients. There are thus unique opportunities for nurses to enter into relationships with and come to know the patients and families in their care. According to Radwin (1996), a nurse's ability to know the patient is influenced by his or her experience, time spent with the patient, and closeness to or intimacy with the patient.

Knowing the patient has been found to be important to nursing practice in studies on expertise in nursing (Benner et al., 1996; Benner, Hooper-Kyriakidis, & Stannard, 1999; Kennedy, 2002, 2004; Peden-McAlpine, 2000; Tanner, Benner, Chesla, & Gordon, 1993), clinical decision-making (Coombs & Ersser, 2004; Hurlock-Chorostecki, 2002; Jenks, 1993; Jenny & Logan, 1992, 1994; Radwin, 1995), nurse-patient relationships (Luker, Austin, Caress, & Hallett, 2000; Lundgren & Segesten, 2002; Peden-McAlpine & Clark, 2002), and ethical concerns in nursing (Liaschenko, 1993). In these studies, knowing the patient involved entering into a relationship with the patient, coming to know something about the patient in the context of his or her illness, and making choices about the patient's care based on this knowledge.

Tanner et al. (1993), in a study of skill acquisition involving 130 critical care nurses in eight hospitals in the United States, noticed a "recurring discourse among nurses about 'knowing the patient' — a reference to how they understood the patient, grasped the meaning of the situation for a patient, or recognized the need for a particular action" (p. 273). This knowing represented an involved understanding, as opposed to a detached, theoretical understanding, of the patient and his or her situation. Tanner et al. identify two categories of knowing: knowing the patient's pattern of responses, and knowing the patient as a person. Both kinds of knowing are "always specific to what can be known in the nurse/patient/family interaction and clinical context" (p. 279).

Liaschenko (1997, 1998) and Liaschenko and Fisher (1999) have found that nurses describe three types of knowledge used in their work: case, patient, and person. Knowledge about the case is biomedical knowledge: the physiology, pathology, and progression of a given disease

and its treatment. Liaschenko (1997) refers to this as "disembodied" knowledge (p. 24), as it is not specific to a particular body or person. Knowledge about the patient extends case knowledge and is specific to a particular individual experiencing a particular illness. To know the patient is to know something of the individual's pattern of responses to his or her illness and the treatments for that illness, the patient's medical and social history, the system and how to move patients through it, and the other health-care providers involved in the patient's care. Knowledge about the person involves knowing "something about what it means for the individual to have a specific history, live a particular life, and engage with the world in which he or she is situated" (Liaschenko & Fisher, p. 38).

Formal Mechanisms for Conveying Knowledge to Other Team Members

There is evidence that nurses spend a significant amount of time supplying information to other health-care providers in hospital settings. Jacques (1993), in an observational study of a primary medical unit in a teaching hospital in the United States, found that approximately once every 6 minutes, or 87 times per day, nurses conveyed information relevant to patient care to other team members (e.g., physicians, clinical nurse specialists, technicians, maintenance workers). In a descriptive study that categorized and quantified the activities of nurses working in an ICU in the United Kingdom, Harrison and Nixon (2002) found that 17.7% of nurses' time was spent observing and assessing patients, 8.06% recording observations, and 9.94% providing information to other team members.

A number of studies have examined the formal mechanisms that nurses use to pass along knowledge about patients to other team members (i.e., change-of-shift report, charting, rounds). It has been found that the main function of the change-of-shift report is to convey physiological data, information on patients' progress, test results, treatment plans, nursing work completed, and nursing work yet to be done (Ames, 1993; Bjornsdottir, 1998; Ekman & Segesten, 1995; Hardey, Payne, & Coleman, 2000; Kerr, 2002; Lally, 1999; Liukkonen, 1993; Manias & Street, 2000; Parker, Gardner, & Wiltshire, 1992; Payne, Hardey, & Coleman, 2000; Strange, 1996). Similarly, it has been found that nurses' entries in patient charts tend to focus on work completed, body parts and functions, treatment responses, and physiological data, including vital signs and laboratory results (Ames; Davis, Billings, & Ryland, 1994; Hale, Thomas, Bond, & Todd, 1997; Heartfield, 1996; Parker & Gardner, 1992; Street, 1992).

Few studies have examined nurses' participation in multidisciplinary rounds (Busby & Gilchrist, 1992; Coombs, 2004; Coombs & Ersser, 2004;

Curley, McEachern, & Speroff, 1998; Hill, 2003; Mallik, 1992; Manias & Street, 2001; Whale, 1993; Zussman, 1992). Researchers have found that nurses have little involvement in rounds (Busby & Gilchrist), their contributions tending to be "reactive" (Whale, p. 160), usually in response to a problem or question introduced by another team member, often a physician (Mallik; Manias & Street, 2001; Whale; Zussman). Coombs and Coombs and Ersser, in a study of the nursing role in clinical decision-making in the ICU, found that while biomedical knowledge was the type of knowledge most frequently used by nurses and physicians during rounds, nurses also presented knowledge related to patients' families, patient comfort, and ethical issues. "A frequent topic of conversation was the frustration experienced by nurses who 'knew the patient' and, on offering this information to doctors, had this ignored" (Coombs & Ersser, p. 250).

The literature provides evidence that knowing a patient can prove beneficial to that patient's care; that nurses pass along to other health-care providers aspects of what they know about a patient, particularly physiological data, test results, nursing work completed, and work yet to be done; and that various mechanisms (e.g., reports, rounds, patient charts) are available to nurses to pass along what they know. There is also evidence that nurses have little involvement in multidisciplinary rounds. Yet to be described are the ways in which nurses think about and approach passing along knowledge, and the ends that nurses pursue in conveying what they know about patients to other health-care providers.

Research Questions

Three research questions were posed: 1. *Which aspects of their knowledge about patients do critical care nurses pass along to other health-care providers involved in the care of those patients?* 2. *How is knowledge about patients passed along to other health-care providers?* 3. *For what purposes is knowledge about patients passed along to other health-care providers?*

The phrase "passing along knowledge," originally used by Benner et al. (1996), was viewed as an active process of conveying to and discussing with other members of the health-care team one's knowledge about the patients in one's care.

Methods

The specific qualitative approach used was interpretive phenomenology, as described by Benner (1994) and Benner et al. (1996). Using interviews and observations of people engaged in everyday activities, one generates and analyzes a text in order to identify its meanings. Through the interpretive process one gains an understanding of the phenomenon of

interest by making visible people's practices, actions, and concerns (Benner).

Paley (2001) draws attention to the problems associated with focusing on "what nurses say they do" rather than on "what nurses do" (p. 190). Benner and her colleagues include observations in their studies, but their work has been criticized because it does not always make clear how observational data have been used or how they add to the texts generated (Padgett, 2000). In the present study, a decision was made to begin with observations of nurses as they interacted with other members of the health-care team (through change-of-shift reports, rounds, and charting) in the clinical setting, so that insight could be gained into this aspect of nurses' practice and so that questions could be asked as nurses went about their work (Meerabeau, 1992). The observations were followed at a later date by individual or small-group interviews. An interview guide was used but the questions evolved both within the interviews and over time. Generally, participants were asked about how they approached the passing along of knowledge and their decisions regarding what information to convey to other team members.

The process of interpretation involved examining the text generated from data collection (i.e., field notes and interview transcripts) for paradigm cases and exemplars. The text was also marked or named, as described by Benner et al. (1996), to identify and organize portions of it relevant to the various lines of inquiry and identify possible themes as the interpretation proceeded. A number of strategies were incorporated into the design to ensure an interpretive account that was coherent, convincing, and applicable (Packer & Addison, 1989). These strategies included: collecting data over a number of months and from different sources (e.g., observations, interviews); exploring and clarifying observations or comments in subsequent meetings with participants; and meeting with two experienced critical care nurses to discuss and validate ideas emerging in the text.

Study Setting and Sample

The study was approved by the appropriate research ethics boards prior to recruitment and data collection. It was carried out in two ICUs in a tertiary care teaching facility in a Canadian city. One of the units was a 10-bed surgical ICU and the other a 6-bed intermediate ICU, although not all beds were open throughout the course of data collection. Ten registered nurses volunteered to take part in the study. Informed consent was obtained prior to proceeding. The mean number of years of nursing experience was 17, with a range of 6 to 28, and the mean number of years of ICU experience was 9, with a range of 1 to 18. Approximately

200 hours were spent observing participants over approximately 38 shifts and a total of 18 interviews were carried out.

Interpretation

One overall theme was identified. The participants described their efforts to first come to know patients and then pass along their knowledge as "filling out the picture":

> *I feel that there is so much information that is coming to me. All of this information is related to the same individual, and all of the information is painting the picture for me, so it is making it fuller and fuller and adds more colour to it — has more colour, is more clear.* (Participant 2)

This notion of the picture was discussed by eight of the ten participants. From their perspective, the picture represented all of the information and knowledge nurses and other team members were able to gather, from any number of sources, about the patient and his or her situation. Important to the development of this picture was the nurses' contact with patients and family members resulting from their sustained presence at or near the bedside. Also important was their access to physicians and other health-care providers throughout much of the day and night. From the observations and interviews, it became apparent that the picture was made up of different types of knowledge, and filling out the picture involved making decisions about who needed to know what, and when.

Types of Knowledge Passed Along

From the viewpoint of the participants, the process of filling out the picture involved conveying information, impressions, and insights related to the patient. The participants believed that nurses are in a key position to fill out the picture, as they remain at the patient's bedside throughout most of their shift. While some structure for interactions with other team members was provided by the systems review format (i.e., central nervous, cardiovascular, respiratory, gastrointestinal, genitourinary, and psychosocial systems), nurses still made judgements, on an ongoing basis, about what others needed to know, wanted to know, or cared about. The types of knowledge that the participants passed along to other team members can be grouped under five headings.

Knowledge about the patient's current status. At some point in every observation, the nurse passed along information, data, or insights related to a patient's status, particularly physiological status, at a particular moment in time, situated in the patient's history and reason for admission to the ICU. This could include assessment data, information about the patient's responses to illness or treatment — both physiological (e.g., vital

signs, laboratory results, test results) and psychosocial — current drug therapies, and the technological supports in use (e.g., ventilator).

Knowledge about the moving picture. The fact that nurses cared for a patient throughout an entire shift or series of shifts enabled them to get a sense of the patient's moment-to-moment responses and how these changed over time. Some of the participants described this as getting a sense of the "moving picture." This picture contrasted with the sometimes static one that other members of the team might see in their brief encounters with patients:

> *[The physicians] can look at them in the bed, and they might be sleeping there, but 99% of the time they are not. They are fighting the ventilator, or just out of control, or in pain.... Because sometimes you can say, "Come and look at my patient — respiratory looks a little bit distressed, their work of breathing." And they'll just kind of look — "Oh, he looks okay." But you wish you could have gotten them there after the distress with the wheezing and the Ventolin.* (Participant 10)

Therefore it was important for the nurse to fill out the picture, to provide other team members with a sense of what the patient looked like at those times when others were not at the bedside — that is, a sense of how the patient was responding to treatments over time.

Knowledge about what works. An important aspect of the picture was knowledge related to interventions, treatments, or strategies that had been tried on the patient and found to work. For example, a nurse might describe to colleagues the best way to approach a dressing with a particular patient or the best way to approach weaning a patient from the ventilator. The idea that something worked usually meant that the approach taken was one that proved effective and practical while causing the patient the least amount of distress.

Knowledge that others care about. From the perspective of the participants, different team members were interested in or cared about different kinds of knowledge. This perception clearly influenced which aspects of their knowledge about patients the nurses passed along in their efforts to fill out the picture. Participants felt that all team members cared about knowledge related to patient problems, especially those problems for which they had a particular role to play in terms of treatment and aspects of the plan of care for which they were directly responsible.

It was the impression of a number of participants that knowledge about problems of a psychosocial nature was not always of interest to other team members, particularly physicians, partly because physicians were not clear about their role in addressing such problems:

> *[Physicians] want to know things they can fix with a medication, or things they can fix with a surgery, or things…they can investigate with a CT scan.* (Participant 8)

> *[Physicians] care about things that they can address, from their perspective.… They may be interested from the psychosocial perspective about — does the family have enough information about the condition and what's going on here, about the plan? And how they are coping. And if there are problems there are you taking care of it?… But they are not going to do anything about it themselves.* (Participant 4)

Knowledge about the patient as a person and as a family member. One aspect of the picture that nurses felt they had more knowledge about than other team members was the patient as a person and as a family member. This was partly because nurses were present at the bedside throughout their shifts and thus could engage in conversations with patients and family members:

> *Like if they [the patients] are really nervous about just being here and all the noises. Or [if they are] scared… And so to tell them [the physicians] that [what the patient fears] is…really important…of course we want all the systems to get better, but I think it is important that you keep in mind each patient as an individual and what they are thinking.* (Participant 10)

Means of Passing Along Knowledge

The participants described filling out the picture in a variety of ways. A large number of interactions between health-care providers in the ICUs involved discussion of physiological data. A common strategy used by nurses to convey this type of knowledge was to present what could be described as bits and pieces of information or ***threads of data*** (e.g., the patient's current vital signs). Participants also described passing along a fuller sense of the patient's story by ***tying the systems together***. This involved placing information, data, and the patient's responses to treatments in context (e.g., providing a sense of the patient's history) and then describing changes in responses as they occurred over time. When tying the systems together, participants would make links between systems — illustrating, for example, how changes in a patient's cardiovascular system had an impact on his or her respiratory system.

A third strategy used by participants to pass along knowledge was ***thinking out loud***. This usually took the form of informal conversations with team members in an effort to make sense of patient information or data, particular concerns about a patient, or feelings or hunches about a patient's illness or care. This strategy might be used when there was confusion or uncertainty about a patient. One participant described it as

"bouncing ideas off each other" in order to problem-solve. When talking to others, nurses threw out ideas to see if they made sense or to see if others could build on them to clarify the situation.

Two other strategies were used by participants to pass along knowledge: ***pointing*** and ***building the case***. Pointing involved drawing to the attention of team members, particularly physicians, specific knowledge about a patient and/or his or her family members and then making a suggestion as to what ought to be done about the issue or concern identified (e.g., seeking a specific order or recommending a particular approach to weaning from the ventilator). Usually the physician or physicians would agree with the nurse's recommendation and the patient's plan of care would be altered accordingly:

> *And nurses become very good at it — quite adept at pointing the physicians in the right direction. Nine times out of ten you'll get what you think the patient needs.* (Participant 8)

> *At rounds I try and convey whatever it is I want the doctors to deal with… If there's some order I want for something, or something I want reassessed or whatever, I make sure that I point that out.* (Participant 7)

Pointing was evident in an exchange between two participants during an interview:

> *The lady [you cared for on day shift] got a CT of her head today, and you know that she doesn't have a cerebral bleed. You got that today.* (Participant 9)

> *Yeah, my lady… I was concerned. Her issue is sepsis, post-op surgery, bowel cancer. She's been weaned, but neurologically — it's my second day with her and I just can't really figure her out. Why doesn't she talk to me? Why is she moaning a bit? Why doesn't she recognize her family? So I reported all this stuff. I said, "Maybe a CT would be good — it would rule things out." She's had a history of coagulopathy. Platelets are 20. So we did that and ruled out a problem.* (Participant 10)

Building the case involved presenting arguments to colleagues advocating for either a particular intervention or treatment for a patient or a particular approach to an intervention or treatment. This strategy differed from pointing in that it was used when there was disagreement about the plan of care and other team members required some convincing that what the nurse was proposing was indeed sound. A nurse might be required to build her or his case over time, and the arguments might not be accepted by others.

Why Knowledge Was Passed Along

Knowledge was passed along for a number of reasons: to ensure patient safety and comfort, to ensure that the wishes of patients were respected, to ensure continuity of care, to justify care decisions, or to shape or influence the plan of care. The ultimate goal in passing along knowledge, as described by the participants, was to see the patient progress to a healthier state or, when that was not possible, to ensure the provision of good palliative care.

Discussion

It was evident that the participants went to considerable lengths to know the patients in their care, make sense of what they knew, and pass along that knowledge to others. While the vast majority of observed interactions between health-care providers involved nurses conveying and discussing knowledge about the patient (Liaschenko & Fisher, 1999), also evident was the passing along of knowledge about the patient *as a person.* Important to this process was the notion of a picture, a notion discussed in two earlier studies. Peden-McAlpine (2000), in a study of expert thinking in nursing, found that nurses constructed "temporal pictures of patients' situations where past and present understanding enabled the projection of appropriate possibilities for future action" (p. 211). Hurlock-Chorostecki (2002), reporting on a study of nurses' decision-making with regard to pain management when weaning patients from the ventilator, uses the phrase "contemplating the big picture," described as "getting to know the patient by stepping back to look at the whole picture" (p. 39). The participants in our study spoke of the importance of filling out the picture by interacting with the patient, family members, and other team members and passing along to other health-care providers a sense of the patient. The purpose of all of this was to promote safe care, ensure continuity of care, promote patient comfort, ensure that the wishes of patients or family members were respected, influence the plan of care, and/or justify care decisions.

Essential to this aspect of nurses' work was proximity (Malone, 2003) to patients, family members, and other health-care providers. Closeness to other team members over time created opportunities for discussion both within and outside of the formal structure of rounds. It was because nurses were physically near other health-care providers that they could think out loud, consult others, test their ideas, point, or build cases. As nurses worked with other team members they developed a sense of what others wanted to know, what they cared about, and how they wanted to receive information. Proximity was essential for the kind of passing along of knowledge described by the participants.

The structure of the multidisciplinary rounds in the study units also proved important for the nurses' sharing of knowledge about patients. The nurses in these settings knew they were required to provide team members with the most up-to-date information on their patients at rounds and to identify current patient problems. As a result, and in contrast with the findings of previous studies (Busby & Gilchrist, 1992; Mallik, 1992; Manias & Street, 2001; Whale, 1993; Zussman, 1992), nurses' participation in rounds tended to be proactive rather than reactive. Participants commonly used direct communication strategies at rounds — for example, building or making a case, previously described by Benner et al. (1996), or pointing, two strategies that involve offering concrete suggestions for addressing patient concerns. This finding differs from that of Manias and Street (2001), who describe nurses engaging in two games (the doctor-nurse game and the game of staging) — both of which involve manipulation and indirect communication — when communicating with physicians in an ICU. The participants in our study indicated that occasions did arise where indirect communication or manipulation could prove necessary in order to get something done, but it appeared that, in these units, nurses' proximity to other team members, the inclusion of nurses in rounds, and the longstanding work relationships between nurses and other team members fostered a more direct style of communication.

Nurses in the Coombs and Ersser (2004) study described frustration at having information that had been conveyed to physicians ignored. This was much less of an issue in our study, perhaps because of the role that nurses assumed during rounds in the study units. This is not to suggest that it did not happen, but because of the frequent interactions between nurses and physicians, both within and outside of the formal structure of rounds, nurses had an opportunity to raise and discuss patient issues at various points throughout the day and night and to suggest or argue for a particular approach to care.

Implications for Practice, Education, and Research

Clearly, the work of critical care nurses in passing along knowledge about patients to other health-care providers was facilitated by four features of the study units: patient assignment, proximity of nurses to other team members, the structure of rounds, and physical layout. The process of filling out the picture was facilitated by assigning nurses to the same patients over time (e.g., two or three shifts in a row). Nurses' proximity to patients and family members over a series of shifts enabled them to know the patients in their care. This proved beneficial for nurses, patients, and families. Nurses' proximity to other team members enabled them to pass along their knowledge. It also gave the participants an opportunity

to hear multiple perspectives (Benner et al., 1999) when seeking to better understand a clinical situation and to think out loud about patients when interacting with trusted colleagues. The structure of rounds, requiring nurses to highlight up-to-date assessment data and patient problems, assured nurses a voice at these important team meetings. The open physical layout of the units and the inclusion of nurses in the bedside rounds were acknowledged as factors that promote nurses' engagement with other health-care providers.

The participants identified a need for education (e.g., within basic nursing education programs) in relation to effective interaction among members of the health-care team. They indicated that prior to coming to the ICU they had limited experience discussing patients at multidisciplinary rounds. Opportunities for students to observe skilled nurses interacting with other members of the health-care team and participating in rounds-like discussions with other members of the team would be a valuable addition to nursing education programs.

Limitations

Limitations of this study include a small sample size, the fact that data were collected in only one facility, and the fact that observation took place when participants were caring for relatively stable patients. More research is needed in this area so that we can better understand this important aspect of nurses' work. It would be useful, for example, to compare the ways in which nurses approach passing along knowledge in different types of units within one setting or in ICUs within different settings (i.e., a multicentred study). Studies with non-nursing members of the health-care team would also be useful, in order to explore what they would like to know about the patients in their care and what they expect from their nursing colleagues when interacting with them in a clinical setting (e.g., at the bedside or at rounds).

Conclusion

The critical care nurses who participated in this study described filling out the picture of the patient's story for other members of the health-care team. This involved sharing information, insights, and impressions about the patient, conveying a sense of the patient's responses over time, and identifying approaches to care that had benefited the patient. The nurses were persistent in their efforts to pass along their knowledge. Their persistence was rooted in a sense of obligation to promote patient well-being. Central to this work was their proximity to both patients and other members of the health-care team. It was also evident that there are clear benefits to ensuring that nurses have a voice in multidisciplinary

rounds. As administrators consider questions regarding staffing patterns, the structure of interdisciplinary team meetings, and the layout of hospital units, and as educators explore ways to improve nursing education, both groups would be wise to attend to the benefits — for both health-care providers and patients — of nurses' proximity to patients, more experienced nurses, and other team members and the inclusion of nurses in rounds.

References

Ames, S. (1993). *Multiple spoken and written channels of communication: An ethnography of a medical unit in a general hospital*. Unpublished doctoral dissertation, State University of New York at Buffalo.

Benner, P. (1994). The tradition and skill of interpretive phenomenology in studying health, illness, and caring practices. In P. Benner (Ed.), *Interpretive phenomenology: Embodiment, caring, and ethics in health and illness* (pp. 92–127). Thousand Oaks, CA: Sage.

Benner, P., Hooper-Kyriakidis, P., & Stannard, D. (1999). *Clinical wisdom and interventions in critical care: A thinking-in-action approach*. Philadelphia: W. B. Saunders.

Benner, P., Tanner, C., & Chesla, C. (1996). *Expertise in nursing practice: Caring, clinical judgment, and ethics.* New York: Springer.

Bjornsdottir, K. (1998). Language, ideology, and nursing practice. *Scholarly Inquiry for Nursing Practice, 12*(4), 347–362.

Busby, A., & Gilchrist, B. (1992). The role of the nurse in the medical ward round. *Journal of Advanced Nursing, 17,* 339–346.

Coombs, M. (2004). *Power and conflict between nurses and doctors*. London: Routledge.

Coombs, M., & Ersser, S. (2004). Medical hegemony in decision-making – a barrier to interdisciplinary working in intensive care? *Journal of Advanced Nursing, 46*(3), 245–252.

Curley, C., McEachern, J., & Speroff, T. (1998). A firm trial of interdisciplinary rounds on the inpatient medical wards: An intervention designed using continuous quality improvement. *Medical Care, 36,* AS4–12.

Davis, B., Billings, J., & Ryland, R. (1994). Evaluation of nursing process documentation. *Journal of Advanced Nursing, 19*(4), 960–968.

Ekman, I., & Segesten, K. (1995). Deputed power of medical control: The hidden message in the ritual of oral shift reports. *Journal of Advanced Nursing, 22,* 1006–1011.

Hale, C., Thomas, L., Bond, S., & Todd, C. (1997). The nursing record as a research tool to identify nursing interventions. *Journal of Clinical Nursing, 6,* 207–214.

Hardey, M., Payne, S., & Coleman, P. (2000). "Scraps": Hidden nursing information and its influence on the delivery of care. *Journal of Advanced Nursing, 32*(1), 208–214.

Harrison, L., & Nixon, G. (2002). Nursing activity in general intensive care. *Journal of Clinical Nursing, 11,* 158–167.

Heartfield, M. (1996). Nursing documentation and nursing practice: A discourse analysis. *Journal of Advanced Nursing, 24,* 98–103.

Hill, K. (2003). The sound of silence – nurses' non-verbal interaction within the ward round. *Nursing in Critical Care, 8*(6), 231–239.

Hurlock-Chorostecki, C. (2002). Management of pain during weaning from mechanical ventilation: The nature of nurse decision-making. *Canadian Journal of Nursing Research, 34*(3), 33–47.

Jacques, R. (1993). Untheorized dimensions of caring work: Caring as a structural practice and caring as a way of seeing. *Nursing Administration Quarterly, 17*(2), 1–10.

Jenks, J. (1993). The pattern of personal knowing in nurse clinical decision making. *Journal of Nursing Education, 32*(9), 399–405.

Jenny, J., & Logan, J. (1992). Knowing the patient: One aspect of clinical knowledge. *Image: Journal of Nursing Scholarship, 24*(4), 254–258.

Jenny, J., & Logan, J. (1994). Promoting ventilator independence: A grounded theory perspective. *Dimensions of Critical Care Nursing, 13*(1), 29–37.

Kennedy, C. (2002). The work of district nurses: First assessment visits. *Journal of Advanced Nursing, 40,* 710–720.

Kennedy, C. (2004). A typology of knowledge for district nursing assessment practice. *Journal of Advanced Nursing, 45*(4), 401–409.

Kerr, M. (2002). A qualitative study of shift handover practice and function from a socio-technical perspective. *Journal of Advanced Nursing, 37*(2), 125–134.

Lally, S. (1999). An investigation into the functions of nurses' communications at the inter-shift handover. *Journal of Nursing Management, 7,* 29–36.

Liaschenko, J. (1993). *Faithful to the good: Morality and philosophy in nursing practice*. Unpublished doctoral dissertation, University of California, San Francisco.

Liaschenko, J. (1997). Knowing the patient? In S. Thorne & V. Hayes (Eds.), *Nursing praxis: Knowledge and action* (pp. 23–38). Thousand Oaks, CA: Sage.

Liaschenko, J. (1998). The shift from closed to the open body – ramifications for nursing testimony. In S. Edwards (Ed.), *Philosophical issues in nursing* (pp. 11–30). London: Macmillan.

Liaschenko, J., & Fisher, A. (1999). Theorizing the knowledge that nurses use in the conduct of their work. *Scholarly Inquiry for Nursing Practice: An International Journal, 13*(1), 29–41.

Liukkonen, A. (1993). The content of nurses' oral shift reports in homes for elderly people. *Journal of Advanced Nursing, 18,* 1095–1100.

Luker, K., Austin, L., Caress, A., & Hallett, C. (2000). The importance of "knowing the patient": Community nurses' constructions of quality in providing palliative care. *Journal of Advanced Nursing, 31*(4), 775–782.

Lundgren, S., & Segesten, K. (2002). Nurses' altered conceptions of work in a ward with all-RN staffing. *Journal of Clinical Nursing, 11,* 197–204.

Mallik, M. (1992). The role of the nurse on the consultant's ward round. *Nursing Times, 88*(5), 49–52.

Malone, R. (2003). Distal nursing. *Social Science and Medicine, 56,* 2317–2326.

Manias, E., & Street, A. (2000). The handover: Uncovering hidden practices of nurses. *Intensive and Critical Care Nursing, 16,* 373–383.

Manias, E., & Street, A. (2001). The interplay of knowledge and decision making between nurses and doctors in critical care. *International Journal of Nursing Studies, 38,* 129–140.

Mauksch, H. (1966). The organizational context of nursing practice. In F. Davis (Ed.), *The nursing profession: Five sociological essays* (pp. 109–137). New York: John Wiley.

Meerabeau, L. (1992). Tacit nursing knowledge: An untapped resource or a methodological headache? *Journal of Advanced Nursing, 17,* 108–112.

Packer, M., & Addison, R. (1989). *Entering the circle: Hermeneutic investigation in psychology.* Albany: State University of New York.

Padgett, S. (2000). Benner and her critics: Promoting scholarly dialogue. *Scholarly Inquiry for Nursing Practice, 14*(3), 249–266.

Paley, J. (2001). An archaeology of caring knowledge. *Journal of Advanced Nursing, 36*(2), 188–198.

Parker, J., & Gardner, G. (1992). The silence and the silencing of nurses' voice: A reading of patient progress notes. *Australian Journal of Advanced Nursing, 9*(2), 3–9.

Parker, J., Gardner, G., & Wiltshire, J. (1992). Handover: The collective narrative of nursing practice. *Australian Journal of Advanced Nursing, 9*(3), 31–37.

Payne, S., Hardey, M., & Coleman, P. (2000). Interactions between nurses during handovers in elderly care. *Journal of Advanced Nursing, 32*(2), 277–285.

Peden-McAlpine, C. (2000). Early recognition of patient problems: A hermeneutic journey into expert thinking in nursing practice. *Scholarly Inquiry for Nursing Practice: An International Journal, 14*(3), 191–222.

Peden-McAlpine, C., & Clark, N. (2002). Early recognition of client status changes. *Dimensions of Critical Care Nursing, 21*(4), 144–151.

Radwin, L. (1995). Knowing the patient: A process model for individualized interventions. *Nursing Research, 44*(6), 364–370.

Radwin, L. (1996). "Knowing the patient": A review of research on an emerging concept. *Journal of Advanced Nursing, 23,* 1142–1146.

Steinmetz, A. (1999). *Wardlife: The apprenticeship of a young writer as a hospital clerk.* Montreal: Véhicule.

Strange, F. (1996). Handover: An ethnographic study of ritual in nursing practice. *Intensive and Critical Care Nursing, 12,* 106–112.

Street, A. (1992). *Inside nursing: A critical ethnography of clinical nursing practice.* New York: State University of New York Press.

Tanner, C., Benner, P., Chesla, C., & Gordon, D. (1993). The phenomenology of knowing the patient. *Image: Journal of Nursing Scholarship, 25*(4), 273–280.

Whale, Z. (1993). The participation of hospital nurses in the multidisciplinary ward round on a cancer-therapy ward. *Journal of Clinical Nursing, 2,* 155–163.

Zussman, R. (1992). *Intensive care: Medical ethics and the medical profession.* Chicago: University of Chicago Press.

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