Expertise in Nursing Practice

Caring, Clinical Judgment, and Ethics

Patricia Benner
Christine A. Tanner
Catherine A. Chesla

SPRINGER PUBLISHING COMPANY

Expertise in Nursing Practice

Patricia Benner, RN, PhD, FAAN, is professor of nursing in the Department of Physiological Nursing at the University of California, San Francisco and an Honorary Fellow in the Royal College of Nursing, United Kingdom. Dr. Benner is the author of *From Novice to Expert: Excellence and Power in Clinical Nursing Practice* which has been translated into 8 languages and provides the background for this research; co-authored with Judith Wrubel *The Primacy of Caring, Stress and Coping in Health and Illness;* is editor of the book *Interpretive Phenomenology: Caring, Ethics and Embodiment in Health and Illness,* and co-edited with Susan Phillips *The Crisis of Care: Affirming and Restoring Caring Practices in the Helping Professions.* She is currently directing a research and development project funded by the Helene Fuld Foundation entitled "Teaching Critical Thinking and Clinical Judgment in Nursing: A Thinking-in-Action Approach" at the University of California, San Francisco, which addresses the pedagogical issues raised in this work.

Christine A. Tanner, RN, PhD, FAAN, is professor of nursing, Community Health Care Systems, School of Nursing, Oregon Health Science University in Portland, Oregon. She has conducted research on clinical judgment in nursing for over two decades, resulting in the publication of numerous journal articles and books. She co-authored with Carnevali, Woods, and Mitchell *Diagnostic Reasoning in Nursing;* and with Lindeman, *Using Nursing Research.* Formerly Director of the School of Nursing Office of Research Development and Utilization, Dr. Tanner has served as consultant on numerous research projects, and her work has challenged contemporary notions of the relationship between research and practice. She has provided leadership in nursing education reform, serving on several task forces and committees for the National League for Nursing, and has consulted with schools of nursing in the U.S., Canada, and abroad. She is currently Editor of the *Journal of Nursing Education.*

Catherine A. Chesla, RN, DNSc, is assistant professor in the Department of Family Health Care Nursing, University of California, San Francisco. She teaches family theory, family intervention and family research methods to graduate nursing students. In her research, she examines family responses over time to the chronic illness of a member, using an interpretive phenomenologic approach. She has published research articles in journals such as *Family Relations, Journal of Community Health Nursing, Journal of Family Nursing,* and *Image; A Journal of Nursing Scholarship.* Currently, she is working with a multi-disciplinary research team to examine family patterns of responses to examine the personal, family, and provider characteristics and processes that influence well-being in persons with non-insulin-dependent diabetes and their families.

Expertise in Nursing Practice

Caring, Clinical Judgment, and Ethics

Patricia Benner, RN, PhD, FAAN
Christine A. Tanner, RN, PhD, FAAN
Catherine A. Chesla, RN, DNSc

with contributions by

Hubert L. Dreyfus, PhD
Stuart E. Dreyfus, PhD
Jane Rubin, PhD

SPRINGER PUBLISHING COMPANY

Springer Publishing Company, Inc.
11 West 42nd Street
New York, NY 10036

Cover design by Tom Yabut
Production Editor: Pam Lankas

06 07 08 / 17 16 15

Library of Congress Cataloging-in-Publication Data

Benner, Patricia
Expertise in nursing practice: caring, clinical judgment and ethics / Patricia Benner, Christine A. Tanner, Catherine A. Chesla.
p. cm.
Includes bibliographical references and index.
ISBN 0-8261-8700-5 (HB)
ISBN 0-8261-8703-X (PB)
1. Nursing—Decision making. 2. Clinical competence. 3. Nursing—Study and teaching. 4. Nursing—Study and teaching (Continuing education). 5. Nursing ethics. I Tanner, Christine A., 1947- II. Chesla, Catherine A. III. Title.
[DNLM: 1. Nursing. 2. Clinical Competence. 3. Ethics, Nursing. WY 16 B469e 1995]
RT73.B365 1995
610.73—dc20
DNLM/DLC
for library of Congress 95-31425
CIP

Printed in the United States of America

CONTENTS

FOREWORD

Benner's earlier book, *From Novice to Expert: Excellence and Power in Clinical Nursing Practice* was received enthusiastically by nurse clinicians who recognized their work in the descriptions of nursing knowledge and skill. The book adapted and enriched the Dreyfus Model of Skill Acquisition for nursing. It was one of the first works to demonstrate the power of using narrative descriptions to capture clinical and ethical judgment. The earlier book challenged some of our most cherished myths, such as: "skill is the mere application of knowledge"; "clinical judgment can be replaced by breaking tasks down into small units and passed off to narrowly trained personnel"; "formal education is sufficient to produce clinical expertise," and more. Others in fields such as social work, physical therapy, and teaching also responded to the work, recognizing similar complexities in their own professions.

However, *From Novice to Expert,* rich as it was, was unable to play out all the many implications of the Dreyfus Model for nursing administration, practice, and education. That left completing the task to the reader. Many of us finished the book thinking, "that means we should do . . . instead of . . ." Some of us enjoy the armchair exercise of searching for implications, of looking for the changes that should be made accordingly. Others prefer to be provided the pathway through the woods or at least a map.

This new book, *Expertise in Nursing Practice,* although not giving all the answers, provides lots of paths and numerous maps, as well as raising many new issues. This work continues to challenge our traditional understanding of what it means to know, to be, and to act skillfully and ethically in nursing practice. Equally important, the book enables the reader to see how we might begin to shape our systems to better accommodate expert caring

work. One of the truths of learning made clear by the work is that clinical learning is a dialogue between principles and practices. To truly grasp a principle, to learn it functionally, requires many practical experiences in which the principle is embedded. Numerous examples of experiential learning and the working out of principles in practice are presented. These multiple examples offer new challenges and open new possibilities for innovation in practice and education.

This new Benner, Tanner, and Chesla book is powerful in its implications. It allows the reader to see the complexity of clinical judgment and caring practices. Like the earlier book, this one uses a research approach that is compelling. Because of its careful documentation, readers will have a hard time ignoring the message. Because the implications are multifold, the book cannot be faulted for only beginning the mammoth task of explicating them.

For me, however, the book had a more personal message and appeal. I realize that all readers will come away with their own unique perspectives, but here are some of the thoughts that were ringing in my head as I put down the book.

It made me think of how the reality of different levels of skill acquisition conflicts with our professional stances, for example, with the notion that a graduate of an accredited school is somehow a finished product, that he or she is ready to perform as a nurse. The book underlines the fallacy of the notion that "a nurse is a nurse is a nurse." True, our nurse administrators have been fighting that image with non-nurse managers for as long as I can remember. Yet, here is the book that can be given to those other managers to explain and validate that perception.

The interweaving of all professionals, especially nurses and physicians, was re-emphasized for me in this book. It was clear that, in many cases, only the presence of one expert level profesional was the life-saving factor. And the expert might just as easily be the nurse or the physician. One expert of either profession might make the critical difference; one nurse who insisted that the physician respond—now and in this way, for example. I thought not only of the expertise required on that nurse's part, but of the bravery, the need to resist the presses of the system to sit down, be quiet, let others decide.

And although the book speaks to the glory of achievements by the expert nurse, one cannot ignore the shadow side. The absence of one expert professional may spell a death or permanent injury for a patient. This is the side we don't want to admit or talk about. When we tell a patient's family, "We did everything we could" that statement may be accurate. But we fail to say, "A more expert team might have been able to do more." To glory in the successes of the experts requires that we recognize the vulner-

abilities of those at lower levels of development, and that we look at the potential impact on their patients.

In earlier eras, head nurses instinctively balanced case assignments on knowledge of the capabilities (developmental levels) of staff nurses. And it was possible to do this because some patients were more critically ill than others. Today, at least in the hospital situation, that is not so easy: every patient is very ill. The only solution seems to be continuous teaming of nurses over the long time required to acquire expertise. Ironically at a time when this model forces us to look at the need for dialogue, and mentoring, and even (yes, I'll say it) apprenticeship, our applied models have carried us in other directions. Primary nursing, for example, is essentially a one-on-one model, and economically driven staffing systems leave little time for the mentoring required. Remember, I'm not telling you about the book here so much as the sort of pondering it sets off in the reader's head. At least that's what it did for me.

Mostly I was left thinking of outcomes, of patients who were saved because there happened to be an expert nurse at hand, of patients who weren't saved because a less-experienced nurse (or physician) failed to pick up on clues in time. It made me think of the messiness of life, of the fact that our notions of scientific control are mostly sops to give us the courage to face a scary situation every day. Life is scary, and thinking that nursing "science" can change all that is scary, ignores life's realities. Still, I could not ignore the fact that accepting the ideas presented here would give us a better handle on the situation and better outcomes, too. Still in my armchair mood, I wondered, could we continue to hide behind our scientific masks after reading this book? This work points to the kind of wisdom, knowledge, and skill required by all clinicians to make our science useful and safe. And it points to a broader understanding of rationality than mere mechanistic calculation. These are just some of the thoughts that spun through my head after finishing the manuscript. And, if we really accepted the implications of this new book, would we be brave enough to act on them?

I would personally like to thank these colleagues for bringing to me the wealth of knowledge and perceptions presented in their book, these clues to the paths we should take. Will nursing follow the right paths? That has always been the question.

BARBARA STEVENS BARNUM, RN, PHD, FAAN

CONTRIBUTORS

Hubert L. Dreyfus, PhD, is professor of philosophy at the University of California, Berkeley. He is internationally known for his writing and teaching on the limits of Artificial Intelligence, and the relationship between everyday social practices, theory, and science. His published books include: *What Computers Still Can't Do* (3rd ed., 1992); *Being-in-the-World: A Commentary on Heidegger's Being and Time, Division I* (1991); *Mind over Machine* (with Stuart Dreyfus) (1988); *Michel Foucault: Beyond Structuralism and Hermeneutics* (with Paul Rabinow, 1982); and numerous articles including "You Can't Get Something for Nothing: Kierkegaard and Heidegger on How Not to Overcome Nihilism" with Jane Rubin, *Inquiry, Vol. 30* (1–2), March, 1987.

Stuart E. Dreyfus, PhD, has researched skill acquisition in order to assess the compatibility of various mathematical modeling and artificial intelligence efforts with uniquely human skills. Besides teaching mathematical modeling in the Industrial Engineering and Operations Research Department at the University of California, Berkeley, he has taught Cognitive Ergonomics, exploring the implications of various theories of skill acquisition for the design of human-computer systems. He has written several mathematical texts as well as co-authoring the book, *Mind Over Machine*, with his brother, Hubert Dreyfus.

Jane Rubin, PhD, has doctoral degrees in Philosophy and Psychology and is a practicing psychotherapist and teacher in San Francisco, California. She has taught courses on Kierkegaard, Michel Foucault, and Charles Taylor at the University of California, Berkeley, and the University of California, San Francisco, School of Nursing. Her teaching has greatly influenced the thinking of this work. She is author of "Narcissism and Nihilism: Kohut and Kierkegaard on the Modern Self" in Douglas Detrick and Susan Detrick (Eds.), *Self Psychology: Comparisons and Contrasts* (1989); and with Hubert Dreyfus wrote "Kierkegaard, Division II, and Later Heidegger" in *Being-in-the-World: A Commentary on Heidegger's Being and Time, Division I.*

ACKNOWLEDGMENTS

This is the first large-scale effort to articulate the nature of clinical and ethical expertise in nursing. This project was truly a community effort. We are especially grateful to Alan Trench and his colleagues at the Helene Fuld Trust for catching our vision for this project and funding it for 4 years. Many doctoral and master's students contributed to the work at both the University of California, San Francisco and the Oregon Health Sciences University.

At the University of California, San Francisco, students and colleagues were integral to the completion of this work. Barbara Habermann, Patricia Hooper, Gina Long, and Susan Thollaug assisted with data collection. Data analysis was also assisted by master's student Karen Reese. Data marking and interpretation engaged many who were at the time doctoral nursing students, including Elena Bosque, Lisa Day, Nancy Doolittle, Barbara Haberman, Patricia Hooper, Margaret Kearney, Annemarie Kesselring, Victoria Leonard, Joan Liaschenko, Ruth Malone, Karen Plager, Lee SmithBattle, Hopkins Stanley, and Daphne Stannard. Daphne Stannard and Ruth Malone helped produce the video that documented some of the central study findings, entitled "From Beginner to Expert", which was produced by the Fuld Institute for Technology. Daphne Stannard deserves special recognition for her consistent contributions in helping the project cohere and stay organized during the latter phases of writing and manuscript preparation. Kathy Horvath and Janet A. Secatore also have our thanks for contributing to long-distance data-collection efforts. We also had able staff assistance from Karen Allen, J. J. Hollingsworth, Julie Richards, Belinda Young and Julie Alden.

Several faculty and graduate students at Oregon Health Sciences University worked with the research team. Sheila Kodadek, Associate Profes-

sor of Family Nursing at Oregon Health Sciences University, and Peggy Wros, then doctoral student and now assistant professor of nursing at Linfield College, and Martha Haylor former doctoral student and now assistant professor of nursing at the University of Victoria School of Nursing, in Victoria, British Columbia were instrumental in the conduct of the study at the Portland site. They assisted in interviews and observations, data entry, verification, coding and overall management, interpretation of data, and preparation of early manuscript drafts. Many other faculty and graduate students participated in data interpretation. Caroline White, professor of nursing, and Margaret Imle, associate professor of nursing, both at OHSU, and Monical Dostal, Linda Budan, Yoko Nakayama, and Dawn Doutrich, all graduate students at the time of the study, were also very helpful in data coding and interpretation. Patricia Archbold, professor of nursing, Lisa Chickadonz, assistant professor of nursing, and Caroline White provided wonderful critiques of earlier drafts of manuscripts.

We are grateful to the hospitals that supported the effort by donating staff time for interviews. And most of all, we are grateful to the 130 nurses who told their clinical stories and the 48 of these who allowed us to observe and interview them while they were working.

The core research team, Patricia Benner, Christine Tanner, and Catherine Chesla to this day enjoy working together. Catherine Chesla did a masterful job directing the first 2 years of the project and then became a full-fledged Coinvestigator. Jane Rubin, Hubert L. Dreyfus, and Stuart E. Dreyfus gave ably and generously of their expertise as consultants. We have chosen to present their chapters as the separately authored works they are, and not to present these consultants as authors of the whole book, in part to relieve them of the responsibility and task of working on the whole manuscript. The book was written collaboratively, with each author signing off on each chapter. We did, however, have primary responsibility for the first drafts of the chapters. Therefore questions should be directed to the author of the first draft. Patricia Benner wrote first drafts for the introduction, Chapters 4, 5, 8, 9, and 13; Christine Tanner wrote first drafts for Chapters 1, 6, 10, and 12; Catherine Chesla wrote first drafts for Chapter 3 and the "Background and Methods" in Appendix A.

Our families were steadfast in their support: Special thanks to Richard, John and Lindsay Benner; to Lisa Chickadonz, Jacob, Katie, and Spencer; and to Jeff, William, and Andreis Vanderbilt.

INTRODUCTION

This book extends the research presented in the book *From Novice to Expert: Excellence and Power in Clinical Nursing Practice,* published by Addison-Wesley in 1984. No one could have predicted the response of practicing nurses all over the world to that account of gaining clinical expertise, and the articulation of the domains of nursing practice. *From Novice to Expert* has been translated into Finnish, German, Japanese, Spanish, French, and Swedish, and a limited number of copies were translated for Russian nurse educators. It has been the source of many conferences and nursing curricula, and the basis for clinical promotion programs in many hospitals in many parts of the world. Nurses commented that *From Novice to Expert* put into words what they had always known about their clinical nursing expertise, but had difficulty articulating.

We believe that this book illuminates the project begun in *From Novice to Expert* with a few changes and many additional nuances. This work provides a much thicker description of the acquisition of clinical expertise and a much more extended examination of the nature of clinical knowledge, clinical inquiry, clinical judgment, and expert ethical comportment. This book is based on a 6-year study of 130 hospital nurses, most of them critical care nurses. In this study we found that examining the nature of the nurse's agency, by which we mean the sense and possibilities for acting in particular clinical situations, gave new insights about how perception and action are both shaped by a practice community. We came to more clearly understand the distinctions between *engagement with a problem or situation* and the requisite nursing *skills of involvement* with patients and families. These existential skills of involvement, knowing how close or distant to be with patients and families in critical times of threat and recovery, are learned over time experientially. Indeed, we will make the claim that the

skill of involvement with patients and families seem to be central in gaining nursing expertise, because promoting the well-being of vulnerable others requires both problem engagement and the existential skills of personal involvement. In this study we came to see the interlinkage of clinical and ethical decision making—how one's notions of good and poor outcomes and visions of excellence shape clinical judgments and actions.

We discovered new aspects of each stage of skill acquisition, but we came to see the competent stage as particularly pivotal in clinical learning because it is at this stage that the learner must begin to recognize patterns and, to become proficient, must allow the situation to guide responses. We came to understand the proficiency stage as a transition into expertise. This study points to the importance of active teaching and learning in the competent stage in order to coach nurses in making the transition from competency to proficiency.

Through this study, the role of sharing narratives, or storytelling, in understanding a practice, demonstrating reasoning in transitions, in communicating intentions, meanings, and concerns, and in creating a community of dialogue and memory has come into sharper focus. Narrative accounts of actual clinical examples reveal everyday clinical and caring knowledge central to the practice of nursing. The concerns, fears, hopes, conversations, and issues of nurses are disclosed and preserved in telling and discussing the stories. A story allows for less linearity, more parentheses or asides, and better captures both forward and retrospective thinking, because the end of the story is known by the storyteller. Thus, a narrative can better capture practical clinical reasoning as it occurs in transition. We have learned that practitioners, through experience within a socially based practice, build narratives and memories of salient clinical situations as they move from novice to skillful practitioner. With experience, concrete situations become coherent and help the practitioner develop a sense of doing better or worse, of recognizing similarities and differences, and of participating in common meanings and practices. Others' practice narratives allow practitioners to recognize reoccurring distinctions and common clinical entities and issues.

The context of nursing practice has changed dramatically in the 11 years since *From Novice to Expert* was published. The caring practices central to nursing were articulated in 1984 in the midst of nursing shortages and in the budding awareness that caring practices were far more than sentiment or attitudes, but were skilled relational and practical know-how. It is these caring practices that render high-tech cures and instantaneous therapies safe. In 1995, in the midst of a very uncertain health care reform, where cost savings are sought primarily in the care provided rather than the cures and diagnostic tests offered, we believe that this work offers a crucial guide-

post for quality care. There is a growing trend to train less educated workers to do many of the tasks nurses have done in order to cut health care costs. In this context, this work calls for an examination of reliability as well as efficiency. Where constant monitoring and astute clinical judgment are required to manage highly unstable patients, fewer tasks can be delegated without losing the nurses' ability to "know the patient" (Tanner, Benner, Chesla, & Gordon, 1993) and recognize early crucial warnings of patient change.

We believe that this work demonstrates what we tend to cover over in the Western tradition: that skilled know-how is a form of knowledge in its own right, and not a mere application of knowledge. Experienced clinicians have mastered a kind of knowledge not available from the classroom. We hope that this work brings out of hiding clinical knowing and clinical inquiry that get eclipsed by our anxiety to teach science and technology. We do not seek to devalue science and technology, only to make room for the disciplined inquiry and ethical comportment that render our science and technology safe in the practice of caring for individual patients and families. We want a larger, legitimate space for teaching practical reasoning in transitions, the hallmark of any clinical practice. We look forward to the new dialogues within and outside the discipline that this work will create.

Like *From Novice to Expert*, this is both a study of skill acquisition and a research-based articulation of the nature of clinical nursing knowledge. We believe that the work will have relevance for other practice disciplines, such as medicine, social work, teaching, occupational therapy, physical therapy, and others. And though all the examples are nursing examples, the progression from principle-based practice, guided by science, technology and ethics, to response-based practice, guided by practical knowledge accumulated through engaged reasoning, will be relevant and recognizable by all practitioners.

DESCRIPTION OF THE STUDY

This book is based upon an interpretive study of nursing practice in critical care units that was conducted between 1988 and 1994. The study was conceived by Patricia Benner and Christine Tanner and proposed to the Helene Fuld Foundation for funding. Coinvestigators who were involved from the proposal phase were Hubert L. Dreyfus and Stuart E. Dreyfus. We here present a brief overview of our approach to the study of nursing practice. A detailed discussion of our concerns and actions in design and conduct of the study can be found in Appendix A.

Four key aims that structured the study were:

1. To delineate the practical knowledge embedded in expert practice;
2. To describe the nature of skill acquisition in critical care nursing practice;
3. To identify institutional impediments and resources for the development of expertise in nursing practice; and
4. To begin to identify educational strategies that encourage the development of expertise.

As in all interpretive work, the project was initially structured, but not constrained, by these guiding aims. In the following pages we illustrate our findings regarding these central questions, and demonstrate as well the central themes and narratives that went beyond the original aim of the inquiry.

The design of the study was influenced by a concern to access practice of nurses in ways that allowed the practice to become visible in all of its aspects. The study design additionally extended what we had learned from previous interpretive study of nursing practice (Benner, 1984a; Benner & Wrubel, 1989) and clinical judgement (Benner & Tanner, 1987; Tanner, 1989, 1993). Additional concerns were to access practice that was carried out in various types of institutions, in different geographic locations, by nurses of varying skill levels practicing with persons with divergent illness processes across the lifespan.

Interpretive phenomenology (see Appendix A for a more detailed explanation of term) was used to access the everyday practice and skill of critical care nurses. The aim of this approach is to explain particular and distinct patterns of meaning and action in the practice of nurses studied, taking into account the context in which they worked, their history, and their particular concerns. Rather than try to characterize a modal or general practice, we attempt to articulate particular and distinct patterns of meaning and action in the nurse-informants. The approach is (a) systematic in its use of tested modes of gathering narrative on practice, (b) disciplined in its focus on the meanings and concerns that can be interpreted from direct text from informants, as opposed to a focus on theoretical abstractions from that text, (c) self-critical and self-corrective in its continual return to the text for arbitrating disputes in interpretation, and (d) produces a consensually validated interpretation that is agreed upon by multiple readers (Benner, 1994b; Packer & Addison, 1989; Van Manen, 1990).

One hundred and thirty nurses practicing in intensive care units and general floor units from eight hospitals, seven of which are located in two far Western and one in the Eastern region of the country, comprised the

group of informants. Nurses were drawn from neonatal, pediatric, and adult intensive care units; those practicing in adult units were distributed evenly across surgical, medical, cardiac, and general intensive care units. Because we sampled for a relatively homogenous group, 98% of the nurses held a minimum of a bachelor's degree. The hospitals from which the informants were drawn included predominantly tertiary care teaching hospitals as well as a community hospital and a Veterans Administration hospital.

Nurses were selected for their expected level of practice (advanced beginner through expert) by supervisors who were asked to consider years of experience, and, for the nurses who were in practice more than 5 years, the quality of their practice. We anticipated that variability of practice would be captured naturalistically in the beginning and intermediate nurses, but with the experienced nurses, we set out to capture variability by asking supervisors or head nurses to name nurses who had been in practice 5 or more years and were considered superb nurses, and nurses who had been in practice the same amount of time but provided safe but less than exemplary care. The final sample was comprised of 25 nurses with less than 1 year of experience; 35 nurses with at least 2 but less than 5 years experience; 44 nurses with 5 or more years of experience and identified as expert, and 26 nurses with 5 or more years of experience and identified as experienced but not expert in their practice. (See Appendix B for detailed description of informants.)

Two central approaches were used to access the everyday experience and skill of nurses caring for patients in critical care: narrative interviews and observation. Small group interviews with four to six nurses who had the same amount of practice experience were conducted repeatedly for three sessions. Nurses were asked to present narratives of recent practice with particular patients and to help assist with obtaining a complete narrative from each informant by actively contributing questions and clarifying uncertainties. A second approach to understanding practice was direct observation of 48 nurses who were observed for three periods of 2–4 hours while they were engaged in direct care of patients in their units. All interviews and any direct discussion during observation periods were audio-recorded and transcribed verbatim to produce a text for interpretation.

Interpretation of text was comprised of initial interpretations of each interview by a subset of the research team prior to the following interview with each group; small group interpretation of portions of text that addressed particular questions; and large group interpretations, in which the full team gathered to examine interpretive accounts that had been worked out on initial questions. The process of interpretation included repeated examination of the text for understanding it as a whole, for understanding

its most salient points, and for understanding the complete, if detailed aspects of the text. Several units of analysis were considered in the ongoing interpretation: individual narrative about each patient, the individual nurse's practice as a whole, the practice of nurses who practiced at the same level, the practice of nurses who practiced at the same institution, and groups of narratives that clustered around a particular theme. Subsets of the research team who were concerned about particular units of study concentrated on the interpretation of that particular text.

We hope that we have put into words once again what nurses and all clinicians know in their practice and that the marginalized caring practices presented here compel the reader to consider the societal worth and knowledge inherent in the caring, diagnostic, and therapeutic work that nurses do. We hope that practitioners from other fields will join us in this conversation so that together we can design better institutions of public caring—in our schools, families, social work, courtrooms—in all places where protection of vulnerability, sponsorship of growth, and the promotion of better citizenship occurs.

Chapter 1

CLINICAL JUDGMENT

The interpretive study of nursing practice provides new insights into how skilled clinicians make judgments in their everyday practice. In this chapter we will show, through interpretation of narrative interviews, that the clinical judgment of expert nurses differs greatly from the usual understanding that has dominated the academic nursing culture for the last 30 years. Specifically, we will show that:

- The clinical judgment of experienced nurses resembles much more the engaged, practical reasoning first described by Aristotle, than the disengaged, scientific, or theoretical reasoning promoted by cognitive theorists and represented in the nursing process.
- Experienced nurses reach an understanding of a person's experience with an illness, and hence their response to it, not through abstract labeling such as nursing diagnoses, but rather through knowing the particular patient, his typical pattern of responses, his story and the way in which illness has constituted his story, and through advanced clinical knowledge, which is gained from experience with many persons in similar situations. This experientially gained clinical knowledge sensitizes the nurse to possible issues and concerns in particular situations.

The vast majority of research on clinical judgment, and on educational approaches to improve it, has focused on that which is deliberative, conscious and analytic; and some would, no doubt, argue that clinical judgment is not judgment at all unless it has these characteristics. In nursing, we have used "clinical decision making," "nursing process," "clinical problem solving," and, more recently, "critical thinking" as interchangeable terms all referring to roughly the same phenomenon. This language both reflects and shapes our

understanding, orienting us toward seeing clinical judgment as rational, and directed only toward resolution of problems and clearly defined ends. To those conversant with the literature, some terms are also theory-laden. For example, in the decision-theory literature, "decision making" is taken to mean the rational selection of alternatives from a set of mutually exclusive possibilities; the selection is based on values associated with each possible outcome, and the probability of each outcome given the possible course of action. The continuing use of this language, and the characteristic focus on conscious analysis, often results in an inappropriately broad generalization: that all expert judgment is deliberative and analytic and if not, it could be improved by making it more analytical.

However, Dewey (1904, 1916/1973), Dreyfus (1979), Dreyfus and Dreyfus (1986) among others have called attention to the notion of "thoughtless mastery of the everyday"; for example, we can get to and from work, walk, have a social conversation responding to another's needs, and ride an elevator, maintaining appropriate social distance, all without conscious deliberation. Similarly much of expert performance in nursing, being attuned to subtle changes in the clinical situation, attending to salient information, and understanding and responding to patients' issues or concerns also often takes place without any conscious deliberation at all. In this chapter, our intent is to open up new possibilities about clinical judgment in the practice of expert nurses by attending to these nonconscious, nonanalytic aspects of judgment.

We use the term "clinical judgment" to refer to the ways in which nurses come to understand the problems, issues, or concerns of clients/patients, to attend to salient information, and to respond in concerned and involved ways; included in our understanding of the term is both the deliberate, conscious decision-making characteristic of competent performance and the holistic discrimination and intuitive response typical of proficient and expert performance (Dreyfus & Dreyfus with Athanasiou, 1986).

We will develop the arguments advanced above by introducing a typical exemplar from a nurse practicing at the expert level, highlighting several aspects of her clinical judgment and describing how these same aspects have either been neglected or misrepresented by technical rationality models of clinical judgment. Then we will examine in more detail the meaning of practical reasoning as it relates to clinical judgment in nursing, and explore alternatives to a diagnostic-treatment model of nursing practice. We do not intend to offer a complete theory or model of clinical judgment, but rather wish to call attention to significant aspects of expert practice. We believe that uncovering the assumptions of the technical rationality model and revealing even a few aspects of clinical judgment will set up new possibilities for our educational practices.

ASPECTS OF CLINICAL JUDGMENT UNCOVERED IN NARRATIVE ACCOUNTS

In this section we will use an exemplar from a nurse practicing at the expert level to explore aspects of clinical judgment. We will illustrate how assumptions and typical research methods of cognitive models have obscured each of these aspects of judgment.

The following account is very typical of nurses practicing at the expert level, both in the nurse's clinical grasp of the situation and in her action as a moral agent; it also captures the several dimensions of family care explicated by Chesla (1990).

Nurse: We had a patient who had been in the OR having a CABG (coronary artery bypass graft). I'd gotten word that he had been hospitalized before, had a very poor heart, multiple MIs, poor ejection fraction. As I was coming to work that evening, I had also gotten word that his family was sitting and waiting in our waiting room. The patient wasn't back from surgery yet, and I heard they were there, so I thought I'll go out and meet them, which I try to do when it works out that way. They were stressed to the max; the minute I walked out they jumped off the chair, they knew I was coming to talk with them. I introduced myself, explained that we really don't hear much until they actually get up to the unit and just talked about what to expect and that they could come in after an hour or so. They proceeded to tell me this whole story about what this poor man had gone through and how it was so rough on him, and so on.

So the patient returned from surgery, and sure enough, was sick as everything, on every drip known to man, ballooned, had had a real hard time coming off bypass, the whole thing. As I listened to the report and I went into the room, I looked at him, and it was clear that it's going to be a miracle if this man leaves this hospital alive. That was the sense I had. So I got settled. I went out and had the family come and just tried to give them a sense of what to expect . . . And we just hit it off or something. They needed—it was like they were just looking for this release valve and I gave it to them. At that point we just kind of clicked.

A few days went by and the patient was really sick, but eventually, amazingly he kind of turned the corner and we were able to start weaning drips. We got him de-ballooned. We got him extubated. And we were all astounded that this man was alive, he was extubated, he was lucid, and he was talking to me. His grandson came in and visited, and his grandson was his pride and joy. The two of them were going at it. He told me how he got his nickname, what he did with his grandson, went to this ballgame, to that ballgame. But it was still obvious, even though he looked better, it was really obvious that he was very, very fragile and any little thing was going to tip him over the edge. And another day or so went by, and it came time to pull his chest tubes and unfortunately he got a pneumothorax and that was all he needed. I knew that

any little thing was just going to be his demise, and sure enough he ended up having to get reintubated, chest tubes put in. It was decided at that point that what he needed was medical management and he was sent back to CCU.

A few days later, his family came up looking for me. H. had gotten to the point where he was in end-stage cardiac disease and there was nothing else they could do and they finally decided to make him a DNR. I said to the family, "Do you mind if I just go in and see him?" At that point he was ventilated and sedated and paralyzed and he had the tropical IVAC forest behind the bed. I had seen him that sick but it bothered me to go down there and see him that sick again. He had gotten better and my last image of him was this man sitting up in bed raving about his grandson.

I went out to the family; they were obviously preparing themselves for his death, and I just felt awful 'cause here I see this man getting better then right back to being as sick as he could possibly be. They were beside themselves. I think they felt guilty about making him DNR and they had this insatiable need to know that they had done everything they could. They felt like, well, maybe there's more.

Int: Were they asking you that?

Nurse: Not in those words, but that was the sense I was getting from what they were saying. Finally, it hit me. I just got this image of him sitting up in bed talking to his grandson and I said, you did do everything. Look how sick he was when he first came into the unit. He got better. We helped him get as better as his heart would let him get. But his heart was too sick. They were kind of able to say, "Yeah, I guess we did." He did get better, but he was just too fragile.

At that point, all of us are sitting in the room, tears are coming down the eyes, and at that point they were able to just kind of loosen up and talk about him. And talk, it was like they were preparing themselves for his death. And you know it just seemed like someone sort of took them off the hook. You don't have to feel guilty anymore. At this point, making him a DNR was the kindest thing you could do for him. I feel like in that situation, even though the outcome for the patient was bad, I was able to make a difference with them, because they were going through a lot. It was kind of hard for me, because it's always stressful when someone dies, and you have to go and tell the family. You know, it's always "What do I say," you know, where do the words come from. For him, I drew on the situation of him, being sick, getting better, look at these milestones he's gone through just in the past few weeks. It's especially hard in those situations where I have to tell the family. I don't mind so much if I know them, but if they don't know me and know what I've been through with their family member, I don't like that. Sometimes I feel like I really know them and that they would appreciate hearing it from someone they know and that someone they know cares and has worked really hard with them and with the patient.

In this situation, the nurse's central concern was her involvement with the family of a dying patient. The nurse seeks out the family, is solicited by their story of the patient's illness and suffering, and recognizes their

preeminent position in the patient's world. The nurse, solicited by the patient and family, "just sort of clicks" with them. She provides perspective for the family through her experience with similar patients, orienting the family to the patient's current status and possible outcomes, while being sensitive to the family's ability to hear and understand her explanations. The nurse's clinical judgments in attending to, and understanding the family's concerns, the ways in which she responded to their concerns, supporting them in their grief, and working through their decisions about no heroic measures were the central themes of the narrative. It should be apparent from this exemplar how little of this practice could be captured by a diagnosis-treatment model. She immediately understood how on edge the family was, and responded to their need for a "release valve." No theory can capture the meaning of this experience for the family; the labels characteristically used in the nursing diagnosis literature simply do not convey sufficient meaning for this nurse to know how to respond to this particular family's concerns.

Also significant in this account are the clinical judgments involved in getting a good clinical grasp, the skill of seeing. The nurse, through having heard about the case from other nurses in the unit, had a prior understanding of the severity of the particular patient's condition and practical knowledge of what would ordinarily be expected of patients in similar circumstances, setting up what would stand out in the particular situation as relevant. She recognized the patient's fragility, saying it was "really obvious that any little thing might tip him over."

What is transparent in the practice is the skill of managing rapidly changing situations—understanding the patient's fragile state, managing the ventilator, chest tubes, drips—these simply do not show up as an issue for the nurse, although clearly she was responsible for this aspect of the patient's care. This nonconscious holistic discrimination of the patient's state and fluid, skillful response, with little evidence of rational calculation, is characteristic of expert clinical judgment. In this situation, at least five interrelated aspects of clinical judgment stand out.

First, the nurse comes to the situation with a fundamental disposition toward what is good and right. It is clear to her that an important part of her practice is noticing and attending to the family's concerns, and to that end, she seeks out the family. Her sense of what is an important end set up what she noticed in the particular situation. What is ordinarily viewed as the main ethical concern in a situation like this—that is, whether continuing life support is in the best interest of the patient—shows up in the narrative, but it is not the central issue for this nurse in this particular situation. Although obviously troubled and saddened by the patient's decline, she recognizes that death is likely imminent and she turns to supporting the family in being with the patient, and in beginning to work through their

guilt and grief. In the technical-rationality model of practice (Schon, 1983, 1987) the work of the practitioner is an instrumental means-ends analysis, with the major decision being which interventions will result in the desired outcomes. The ends, or the "good" in Aristotelian terms, cannot be evaluated through this instrumental reasoning. In nursing, as in medicine, when the goal comes into question, it is a matter of ethics and at least in modern times, ethical and clinical decision making have been viewed as distinct domains in both research and practice (Gortner, 1985; Katefian, 1988).

We argue that even in clinical situations, where the ends are not in question, there is an underlying moral dimension: the fundamental disposition of the nurse toward what is good and right and action toward what the nurse recognizes or believes to be the best good in a particular situation. In the above exemplar, the good that is evident in the nurse's actions in this particular situation is comforting the family. This is not a private, subjectively held "value," nor one that necessarily generalizes across all situations. While the moral dimension of everyday judgment is beginning to receive some attention (Ackerlund & Norberg, 1985; Bishop & Scudder, 1990, 1991; Gadow, 1988; Wros, 1994), it has typically been ignored in the decision-making literature.

Second, the nurse in this situation relies on extensive practical knowledge from working with many, many patients after coronary artery surgery, and with many families of acutely ill persons; and during the course of her care she comes to know H. and his family, both their pattern of responses and who they are as a people. As she describes her actions, recognizing the patient's downhill course, supporting and facilitating the grandson's participation, and responding to the particular concerns of the family, it is evident that no theory could prescribe how she should respond in this particular situation. Rather, it is the tacit knowing (Polanyi, 1958), skilled know-how (Benner, 1983), or knowing in action (Schon, 1983) and knowing the particular patient (Jenks, 1993; Jenny & Logan, 1992; MacLeod, 1993; Tanner, Benner, Chesla, & Gordon, 1993) that sets up the possibility for the nurse to recognize and respond in this particular situation.

In the technical-rationality model of professional practice, the only knowledge that counts is theoretical knowledge. Theory as an abstraction gives the practitioner insight into a broad range of particular, clinical situations. It is presumed that the competent practitioner is able to see a particular situation as an instance of some abstraction; for example, that a particular family situation is an instance of ineffective coping. The theory also prescribes appropriate nursing responses. In this view, then, professional practice is the instrumental application of scientifically derived knowledge and theory to the problems of practice (Schon, 1983, 1987).

Most studies of clinical judgment in both medicine and nursing are founded on the technical-rationality model of professional practice. Most,