ANNALES
UNIVERSITATIS MARIAE CURIE-SKŁODOWSKA
LUBLIN - POLONIA
VOL.LVIII, SUPPL. XIII, 302 SECTIO D 2003

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# *Judging the Moment: a discussion of findings that illuminate hospital nurses' 'hidden' knowledge of how they promote healthy lifestyles*

## INTRODUCTION

Nursing's contributions to promoting healthy lifestyles tends to be concentrated in community practice rather than in hospitals. Consistently over many years hospital nurses have been criticized for their lack of engagement with health promotion (Jones 1993, McBride 1994, Robertson and Hill 1999, Ask et al 2000) and of not having developed skills in, or understanding about health education (Honan et al 1988, Gott and O'Brien 1990, Macleod Clark et al 1992, McBride 1994, Twinn and Lee 1997, Robertson and Hill, 1999). This paper argues that the disquiet surrounding hospital nurses' involvement in health promotion tends to be based on observational studies that rest on a 'masculine' reliance on logical positivism and there is a danger of ignoring those aspects of practice that rely on more 'feminine' knowledge. Findings from a study situated in an interpretive paradigm using strategies of grounded theory are drawn upon to claim that knowledge used by nurses in their health promotion roles may be illuminated and validated through exploration of nurses' 'unspoken' practical knowledge. A sub-category of the study, judging the moment, is used to illustrate how aspects of nursing knowledge can be difficult to articulate and make accessible.

## THE STUDY

This report is based on a study that aimed to explore hospital nurses' perceptions of their health promotion and health education responsibilities. The initial research question was stated as: "How do nurses perceive and manage the health promoting and health educating

aspects of their professional and personal roles in the context of changing practice?" This question demanded a qualitative, interpretive method and a grounded theory approach was selected for the conduct of the study. The data were generated via the use of tape-recorded, loosely structured interviews that used strategies of theoretical sampling between interviews and across populations.

### THE PARTICIPANTS

An eventual sample of fifty volunteers was recruited from various hospital sites in Scotland. All participants were registered nurses, four of whom were men. The nurses who participated reflected a wide variation in terms of age, home responsibilities, length and range of experience, types of initial preparation and academic qualification. They practised in a spectrum of National Health Service and private sector hospital settings from acute adult care to acute rehabilitation care for older people and in community hospitals.

### ETHICAL ISSUES

The study complied with ethical guidelines concerning consent, anonymity, confidentiality and protection from harm. Initial consent to approach nurses was granted by the executive nurses in the various institutions used. The interviews were conducted in the nurses' own time, either as they came or left duty or in their rest periods or took place in the nurses' own homes. Initial contact was made by a general written invitation for nurses to be interviewed and discuss their perceptions of recent changes in practice. Those nurses who indicated they were willing to participate filled in a consent form at the foot of the letter. At the beginning of each interview information regarding the study was given, consent to use the tape recorder was sought and assurances were given regarding the safe keeping of tapes and transcripts, the protection of anonymity and practical confidentiality for individuals and the care settings in which they worked.

### DATA ANALYSIS

Data analysis was conducted according to suggestions offered by Glaser and Strauss (1967), Corbin (1986), Glaser (1992) and Strauss and Corbin (1998) namely: verbatim transcripts of loosely structured interviews, theoretical sampling, constant comparative analysis, coding procedures, data sorting, memo writing and diagramming. The researcher personally transcribed each tape and concept maps of the early interviews were drawn to identify themes within the individual interviews. Open coding was undertaken with the technique of constant comparative analysis serving to differentiate, clarify and label concepts appearing in the data. These concepts were tested as hypotheses through theoretical sampling between interviews, and as categories began to emerge through the aid of memo writing and diagramming. Theoretical sampling to nurses working in community hospitals and in the private sector took place as the study progressed. The categories were developed through the continuation of constant comparative analysis until they seemed to be saturated. The analysis resulted in the generation of a theoretical framework, a sub-category of which, judging the moment, is described in this paper.

Judging the moment concerns the nurses' descriptions of a certain aspect of their communications with patients regarding health issues. Kemm and Close (1995) see effective communication between the client and the professional as fundamental to the health promotion role. The close and continuous engagement with patients enjoyed by hospital nurses in turn increases their potential as health promoters (Latter, 1996). However, the processes

that underlie such interactions can be difficult to define and may include aspects of practice that nurses find hard to articulate. Savage (1995) suggests that these aspects include examples of where nurses state that they base their actions on intuition or 'knowing the patient'. In these situations the reasoning behind decisions for nursing intervention can be difficult to explicate. The present study uncovered 'tacit' hidden knowledge about how nurses judged the moment of when to implement their 'technical' knowledge of health promotion interventions, indicating that rather than ignoring opportunities as suggested by other studies (Syred 1981, Close 1987, Mcleod Clark et al 1992, Jones 1993, Caraher 1994, Robertson and Hill, 1999, Ask et al, 2000), they made decisions regarding of the appropriateness of the timing of health promotion interventions. Nurses in the present study alluded to the difficulty of explaining how they made these decisions when discussing how they judged the moment to discuss health issues with their patients.

FG: So it depends, it depends on what the situation is at the time?

∗Jessica: Just like anything in nursing because I think you get a kind of intuition as to whether or not it's a good time to say something and I think we do that very well but sometimes we don't. It's not a thing you can write down but all nurses do it and it's a good skill to have.

Fenella used the term judge your moment when she was explaining how she would introduce health issues to her patients.

Fenella: You've got to know somebody to know their mood and judge your moment bas cally.

FG: When you say you judge your moment, how do you do that? Let's say you are wanting to say to a student "right, you have to judge your moment" is there any way that you help a student think this is the moment?

Fenella: You can only know by getting to know the person. I mean there's nothing you can definitely put your finger on, I mean every person is an individual so you're looking for the individual things.

Ann was discussing the sort of activities she undertakes that she would label as health promotion:

Ann: A lot of it actually is something I do unconsciously but I don't think it's until you reflect on your experience that you realise what you are actually doing.

Lawler (1991) describes the knowledge that nurses gain through interactions with their patients as interpretive and contextual: the sort of knowledge that comes from practical professional experience. In her work concerning nurses' intimate services to patients, she reported this knowledge as difficult to define, with some aspects yet to be translated into language. In the present study Lydia, a mature and experienced nurse who was articulate in discussing her ideas, seemed to run out of words and engage in deep thinking when asked how she had learned to regulate her interventions with her patients.

Lydia: I think that very unconsciously I think it's like, I might think well why did I do that, why did I say that but it seemed right, you know. I think that a lot of the stuff, a lot of the time if I ask myself why - a lot of the time you do things and you think well "why did I take that line with that patient?" but it's not, something I've though about a lot

FG How do you think we learn to that, because I think we all do that, what is it that helps you over the years to know what seemed right?

Lydia ..... (long pause for thinking) .....I can't say.

Lydia seems to be struggling with bringing to the surface her knowledge, hidden even from herself, of how she knows how to interact with her patients. Other aspect of the nurses'

∗ pseudonyms are used

knowledge, such as the actual information they could pass to patients, or how to teach patients self-care, were easily articulated. However, knowledge regarding their ability to be with their patients sensitively and how they judged the moment of when the patient may wish to engage with the nurse in health promotion activities, defeated their powers of description.

Drawing on Oakshott's notions of 'technical' versus 'practical' knowledge, Eraut (1994) describes how technical knowledge, that is, that which can be codified, appears in texts and syllabi to be taught and learned overtly in the curriculum. Practical knowledge, that which is experience related and used intuitively, however, may be uncodifiable, its description imprecise and omitted from the syllabus, leaving vital aspects of professional practice marginalised.

The marginalisation of the forms of 'unspoken' knowledge that nurses carry may result from more than a simple difficulty of identification and description (Hagell, 1989). Much of the work highlighting these issues is from a feminist perspective, reflecting the occupational segregation of nursing work. Meleis (1997) describes how, despite the profession becoming more attractive to men, nursing remains a predominantly female profession. As such, it continues to carry all the accompanying issues related to the value of women's work, women's contributions and the relationship between nursing and other, predominately male, professions. The most prominent 'male' profession to influence nursing activity is without doubt the medical profession and it can be argued that the nature of medical knowledge is fundamental to power differentials between the two groups.

This can be understood by acknowledging that medical power over nurses was driven by the espousing of the positivist 'true science' method by the emerging medical profession in the middle of the nineteenth century. The other groups providing health care at this time included women healers and midwives whose knowledge lost legitimacy because it was not scientific (Hagell, 1989). Hagell asserts that such groups not only found their activities marginalised and devalued but later, as licences to practise were introduced at the beginning of the twentieth century, also illegal.

It is commonly understood that before Nightingale opened her training school for nurses at St Thomas' Hospital in 1860 and introduced educated women into nursing activities, nurses were predominantly domestic servants employed to clean wards and serve doctors by directly carrying out their instructions. The Nightingale system removed nurses from the direct control of doctors to that of the matron, but subservience to the medical profession persisted. Nightingale herself can be found to assert,

It is the duty of the Medical Officer to give what orders, in regard to the sick, he thinks fit to the nurses. And it is unquestionably the duty of the nurses to obey or see his orders carried out. (Nightingale, 1874:5)

This situation can be partly explained by sex role socialisation as nursing's historical position in health care systems was, and remains, related to women's position in society (Meleis, 1997). A further explanation is the medical profession's use of the 'true' scientific method to define disease as a biological phenomenon and to guard such scientific knowledge within its own domain.

The development of the nursing profession through the Nightingale training schools meant that doctors now had access to an intelligent, trained and skilled person who could be trusted to interpret his directions and aid his diagnosis and prescription by reporting her observations of his patients. Gamarnikow (1991), however, points out that this new ‘intelligent, trained and skilled’ nurse, produced through Nightingale principles, rather than slavishly ‘obeying’ the doctor, interpreted his orders and redefined them as nursing tasks. Nevertheless, the medical profession was keen that the nurse remained an assistant and that the

doctor's scientific knowledge was kept dominant. Gamarnikow (1991:120) goes on to quote a Dr Worcestor who wrote in the Nursing Times in 1905,

In his presence she only has to do what she is told to do: in his absence she must act for him. And as the science of medicine advances it is becoming more and more impossible for the physician to prescribe just what shall be done in every possible emergency. He is obliged to rely more and more on the nurse's common-sense and knowledge of the principles involved.

Here evidence can be found of awareness of the existence of other forms of knowledge, and importantly that the doctor relies upon it. His knowledge, nevertheless, has primacy and without his control the nurse's non-scientific knowledge, like that of the women healers, has no legitimacy and serves to keep her subservient.

Hagell (1989) claims that in an attempt to counter its subjugation to the medical profession, nursing has taken on, or emulated, the medical profession's use of positivist science to further its knowledge base. Recently acknowledgement has begun to be given to the notion that logical-positivism can only partly assist in the explication of nursing work and the generation of nursing knowledge. The nursing profession's use of the positivist paradigm has not been entirely successful in assisting the occupation's quest to be regarded as a true profession and attract equal status and power with other, especially medical, health care professions. Perhaps more importantly, nor has it completely served to make public those aspects of nursing work that are difficult to define and describe. It is these very aspects that some nurse scholars promote as the quintessinal core of that which is uniquely nursing (Parse 1981, Benner 1984, Smith,1992, Benner and Wrubel 1989, Macleod Clark et al,1992, Watson, 1999).

Schon (1991) argues that the theory-practice gap seen in much professional preparation is widened by the academic world's reliance on hard science and scholarship which may not equate with the soft knowledge of artistry: the professional knowing and doing of the practitioner, based on tacit knowledge, embedded in everyday practice. Schon asserts that practitioners may not be able to describe aspects of their competence and he states that he starts from an assumption that competent practitioners know more that they are able to say.

The earlier examples from the present study of how nurses found it difficult or impossible to explain how they judged the moment to initiate discussions with their patients support arguments that aspects of practice are difficult to codify. Findings such as Benner's (1984) are derived through the 'soft' interpretative methods of qualitative research that are required to access the hidden, intuitive and difficult to articulate practice-based knowledge of the competent practitioner. Palmer et al (1994) argue that this knowledge and how it is acquired comprises an important part of learning to be a nurse. It also comprises a form of knowledge that seems to echo that of the women healers and the Nightingale nurses' subordinated knowledge. This knowledge is difficult to observe, difficult to measure but not impossible to translate into aspects of competence to illuminate the reality of practice.

## CONCLUSION

Returning to the findings of the present study, nurses' 'technical knowledge' can be considered as the health promotion intervention they would implement for their patients. However, the higher level skill implicit in this implementation is derived from their 'practical' knowledge in judging the moment when their intervention will be most effective. Such concepts as judging the moment are not readily demonstrated or observed. This challenges a totally positivist approach to the interpretation of how nurses work and studies that have concluded that hospital nurses are missing opportunities for health promotion may be mis-

sing vital aspects of the tacit knowledge that nurses use in deciding when to introduce health promotion messages in the hospital context. The data from this study suggest that expert hospital nurses intuitively respond to signals from their patients and, despite health promotion dogma, make decisions based on what they believe the patient needs at that moment in time, meeting Atkinson's (2000) assertion that confidence in one's self-efficacy may be equated to trusting in your own judgments.

If we accept that the political and social climate of nursing across the world is moving towards a health agenda, we can assume that nurses will increasingly focus on the promotion of healthy lifestyles. To achieve this they will require to incorporate ever more sophisticated interpersonal skills and the "use of self" (Antrobus, 1997:833) into their repertoire to complement their technical abilities. Further research that attempts to consider the intuitive aspects of nursing and that illuminates those aspects of nursing practice that defy positivist description, may prove to be valuable in ensuring the holistic aspects of nursing practice is validated.

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**ABSTRACT**

This paper uses the findings of a grounded theory study that explored the health promotion roles of hospital nurses from their own perspectives. Other work that has investigated hospital nurses suggests they may ignore opportunities for promoting healthy lifestyles among their patients. This study, however, uncovered 'tacit' hidden knowledge about how nurses judged the moment of when to implement their 'technical' knowledge of health promotion interventions, suggesting that rather than ignoring opportunities they made decisions regarding of the appropriateness of the timing of health promotion interventions. An historical perspective is taken to explore the marginalisation of women's intuitive knowledge and a call is made to employ more interpretive paradigms to illuminate the practice knowledge of the skilled, expert nurse.