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# Talking about persons--thinking about patients: An ethnographic study in critical care.

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**Title.**

Talking about persons - Thinking about patients: An ethnographic study in critical care

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**Contributions.**

Study design: CM; MG; MC.

Data collection CM.

Data analysis CM with significant contributions to data interpretation by MG and MC.

Manuscript preparation CM with critical revisions by MG and MC.

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## **Title**

Talking about persons - Thinking about patients: An ethnographic study in critical care

## **Abstract**

### **Background**

Nursing involves caring for the 'whole person' and it is considered inappropriate for nurses to think or talk about patients in objectifying or dehumanising ways. Objectifying discourses can dominate within the arena of critical care, and critical care nurses can experience moral distress as they struggle to think about patients as persons. No previous study has examined the role played by 'impersonal' talk in the delivery of nursing care. This paper reports a study which examined the relationship between nursing practice and the way(s) in which critical care nurses think and talk about patients.

### **Objectives**

The study objectives were to (1) identify and characterise the ways in which critical care nurses think and talk about patients; and (2) describe patterns of nursing practice associated with these different ways of thinking.

### **Study design**

An ethnographic study was undertaken within one critical care unit in the United Kingdom. Data were collected over 8 months through 92 hours of participant observation and 13 interviews. Seven critical care nurses participated in the study. Data analysis adopted the perspective of linguistic ethnography.

### **Findings**

Analysis of these data led to the identification of seven Discourses, each of which was characterised by a particular way of *talking* about patients, a particular way of *thinking* about patients, and a particular *pattern of practice*. Four of these seven Discourses were of particular significance because participants characterised it as 'impersonal' to think and talk about patients as 'routine work', as a 'body', as '(un)stable' or as a 'medical case'. Although participants frequently offered apologies or excuses for doing so, these 'impersonal' ways of thinking and talking were associated with practice that was essential to delivering safe effective care.

### **Conclusions**

Critical care practice requires nurses to think and talk about patients in many different ways, yet nurses are socialised to an ideal that they should always think and talk about patients as whole persons. This means that nurses can struggle to articulate and reflect upon aspects of their practice which require them to think and talk about patients in impersonal ways. This may be an important source of distress to critical care nurses and emotional exhaustion and burnout can arise from such dissonance between ideals and the reality of practice. Nursing leaders, scholars and policy makers need to recognise and legitimise the fact that nurses must think about patients in many ways, some of which may be considered *impersonal*.

### **What is known about this topic**

- Nurses aspire to care for the whole person
- It is considered inappropriate for nurses to think or talk about patients in ways that are 'objectifying' or 'dehumanising'
- Critical care nurses can experience moral distress because they fail to think and talk about patients as whole persons.

### **What this study adds**

- Safe and effective care requires nurses to think and talk about patients in a variety of ways, including as 'routine work', as 'body', as '(un)stable' or as 'medical case'.
- Critical care nurses themselves can characterise these ways of thinking and talking as impersonal and hence professionally inappropriate.
- Nurses find it difficult to describe, reflect upon or celebrate these 'impersonal' aspects of their practice.
- Nursing scholars, educationalists and policy makers must recognise and legitimise the fact that there are times where it is appropriate for nurses to think and talk about patients in apparently impersonal ways.

## Introduction

There is international consensus from nursing leadership and scholarship that nursing has a characteristic focus upon caring for the whole person (e.g. Bartz 2010; World Health Organisation 2010; Scott et al 2014). Ways of thinking or talking which fail to acknowledge the patients as a whole person are considered professionally inappropriate, and are characterised as being 'reductionist' or 'objectifying' forms of discourse. This paper presents findings from an ethnographic study which challenges this consensus by highlighting the important role played by impersonal talk in critical care nursing practice.

## Whole person care

The nursing literature, educational texts and professional rhetoric consistently highlight that nursing involves caring for the 'whole person' (Watson 1998; McCormack & Titchen 2001; Royal College of Nursing; McCance et al. 2011; Scott et al, 2014). Nursing has historically defined itself through constructing a difference between nursing and medicine (May & Fleming 1997) and it has been considered particularly inappropriate for nurses to adopt biomedical models which have been described as 'reductionist' and 'dehumanising' (Christensen & Hewitt-Taylor 2006) or "a barrier to compassion" (Kings Fund 2009). Similarly, technology is suggested to have an 'objectifying' and 'dehumanising' impact on the way in which nurses perceive patients (Locsin 1995; Barnard and Sandelowski 2001; O'Keefe-McCarthy 2009). Dehumanising, reductionist or objectifying ways of thinking or talking about patients are therefore widely problematized, and have been characterised as coping strategies (Benner et al. 1999) or responses to anxiety (Menzies-Lyth 1959). Language which is variously described as 'objectifying', 'dehumanising' or 'reductionist' will be referred to as *impersonal* talk throughout this paper, and the rationale for this terminology is presented during the discussion of the findings.

This paper considers the role of impersonal talk in critical care nursing where issues relating to 'reductionist' biomedical models or 'objectifying' technology are of particular relevance. Critical care nursing involves the care of patients who have "manifest or potential disturbances of vital organ functions" (World Federation of Critical Care Nurses 2007: p.1), and critical care nurses work within a curatively focussed and highly technological environment. Impersonal talk is common in this environment, and critical care nurses have described how they struggle against "forgetting there is a person" (Villanueva 1999: p. 221), and report frustration or moral distress arising from the extent to which they fail to care for the 'whole person' (Beeby 2000; Cronqvist et al. 2001; Cronqvist et al. 2004; Cronqvist et al. 2006; Lawrence 2011; McAndrew et al. 2011).

These arguments suggests that impersonal talk is problematic, undesirable, and incompatible with a focus upon the person, and presume a relationship between the ways in which nurses think about, talk about and behave towards patients. 'Objectifying' language is problematic because *talking* about a patient in this way carries an implication that the nurse may *think about or treat the patient as* an 'object'. At a time when there is increasing concern with the values of healthcare staff (Francis 2013) the use of objectifying or dehumanising language may be taken to reveal inappropriate values or attitudes. The relationship between language and behaviour or values is often implied within criticisms of impersonal talk, but is rarely examined. No previous research has been undertaken to

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examine the relationships between the ways in which nurses think about or talk about patients, and the nature or quality of nursing care delivered. In the absence of such evidence, it is not known whether nurses' use of impersonal talk in one context reveals values or attitudes which will negatively impact on the way that they deliver nursing care in other contexts.

## **Discourse**

In this study the relationship between the ways in which nurses think, talk and practice was understood through an analysis of the nature of discourse. Modern theorists view discourse as "a general mode of meaningful symbolic behaviour" (Blommaert 2005: p.2) rather than holding a restricted view of discourse as relating only to the spoken or written word. This means that discourse can be understood as the totality of what people *do* as well as what they *say*. Discourse is also intimately associated with concepts of identity (Lemke 1995; Blommaert 2005). To use a particular form of discourse is to ascribe a patient an identity as (and so to think of them as) a particular kind of being. For example, to use an 'objectifying' discourse is to construct the patient an identity as - hence think about the patient as - an 'object'.

Foucault (1969, 1973) notes that the ways in which people use language tends develop into relatively stable patterns known as discursive formations or Discourses. Foucault (1969) further argues that there is a unity to a Discourse which means that its' elements may not be separated. A Discourse is therefore a pattern which links ways of talking about, thinking about and behaving towards patients. To talk about a patient as an 'object' is to think about them as an object; to treat the patient as an object will always be associated with thinking and talking about that object.

Within any social setting it may be expected that many distinct Discourses will circulate, and the recognition that nurses may talk and think about patients in many different ways highlights the importance of considering context. Whilst it may be wrong for a nurse to talk to a patient in a way that makes that person feel no more than a medical case, it is not clear that this means a nurse should not talk to colleagues about the biomedical aspects of that persons' care. There is a need to understand the relationship between nursing practice and the ways in which nurses think and talk about patients in different situations and contexts.

## **Aims**

This paper reports a study which aimed to examine the relationship between nursing practice and the way(s) in which critical care nurses think and talk about patients. The objectives of the study were to:

1. Identify and characterise the different ways in which critical care nurses think and talk about patients.
2. Describe patterns within nurses' practice that are associated with these different ways of thinking and talking.

## Methods

An ethnographic study was undertaken within one critical care unit in the United Kingdom (UK) over a period of 8 months during 2006 and 2007. Data were collected through participant observation and interview. Analysis was informed by the principles and perspective of linguistic ethnography which highlights the need to pay close attention to the details of situated language use (Rampton et al. 2004; Creese 2008).

## Sample

The study site was a 10 bedded critical care unit within a 400 bedded District General Hospital in the UK. Prior literature (e.g. Benner, 1984) indicated that expert nurses may think and/or talk about patients differently to novices, and so participants were recruited as either 'experienced' nurses (more than two years' experience on the unit and having completed a recognised formal programme of critical care education) or 'inexperienced' (less than 6 months experience of critical care at commencement of the study). Four 'experienced' and three 'inexperienced' participants took part in the study thereby providing an opportunity to elicit any differences that may be attributable to degree of expertise.

Two initial participants were volunteers who responded to written invitations circulated on the unit with five further participants recruited during field work. The study aims were explained to participants as seeking to characterise what it was to 'think like an intensive care nurse' and it was emphasised that the research team held no expectations that there were 'preferred' ways in which nurses should think and talk about patients.

Participant ages ranged from their early twenties to late forties. Six participants were female and one was male, broadly reflecting the gender balance of nurses on the unit. All participants are referred to as female throughout this paper in order to maintain anonymity. The three 'inexperienced' nurses comprised two UK graduates (one newly qualified; one who with two years' experience), and one nurse who had trained abroad and who had 10 years post registration experience (two years in the UK). The four 'experienced' nurses comprised one graduate nurse, two nurses who had undertaken registered nurse training, and one nurse who had trained as an enrolled nurse before taking a registered nurse conversion course some years earlier. The 'experienced' participants had between 3 and 27 years of experience in critical care. This sample therefore was heterogeneous with respect to age, prior nursing background and degree of expertise in the speciality.

## Data collection

Data were collected by participant observation and interview. Observation of nurses' practice was undertaken by CM (a registered nurse) working in a participatory role so as to contribute to care delivery whilst not having primary responsibility for patient care. One participant was observed on only one occasion before she left employment on the unit. Remaining participants were observed on three or four occasions for periods lasting between 3 and 6 hours. Overall, 92 hours of observation were undertaken over 23 periods. The focus of observation was on participants' verbal or physical interactions with, or about, patients anywhere within the unit environment. Field notes were initially recorded in an A5 booklet

and these notes were used as the basis for writing an expanded account within 24 hours of completing each period of observation.

Thirteen interviews were conducted, each lasting 45 to 70 minutes. One interview was held with the nurse who left the study, and other participants were interviewed on two occasions. For each participant the first interview was held immediately after the first time they were observed, and the second interview was held at a mutually convenient time soon after the final observation period. All interviews began with 'broad survey' questions inviting participants to comment upon any issues which they felt significant to the study aims. The first interviews then 'talked through' events of the preceding shift, whilst in second interviews participants read and commented upon field note entries describing previously observed episodes. Interviews were semi-structured using a schedule of questions / prompts which ensured that for each episode of care participants were invited to discuss: how they felt they had been thinking about patients; their goals and motivations; their relationship with or attitude to the patient; and the degree to which they considered these episodes typical of their practice and that of others.

To facilitate analysis, interviews were audio-recorded and then transcribed utilizing the conventions of Jeffersonian transcription (Wetherell et al. 2001). In the interests of clarity, findings are presented here without such notation, and with redaction of minor repetitions or indications of hesitancy which characterise normal speech.

A research journal was maintained throughout the study in order to document key decisions and early analytical insights so as to facilitate a reflexive analysis of these data.

### **Ethical considerations**

Access to the study site was negotiated through the lead nurse and through discussion with nursing and medical staff. Nurse participants gave written consent, and verbal consent was sought from patients, or (where this was not possible) verbal assent from their next of kin. In order to ensure patient safety principles were agreed in advance of commencing fieldwork as to how 'sub-optimal practice', 'embedded poor practice' or 'professional misconduct or incompetence' would be distinguished and managed in the field. All participant and patient related data captured within the field notes were anonymised. Ethical approval for the study was given by the then Southampton and South West Hampshire Research Ethics Committee B.

### **Data analysis**

Data analysis began with the analytical insights that occurred in the field, and with a reading and re-reading of the data in order to ensure immersion in the data. Although ethnographic analysis is "iterative and often cyclical" (Fetterman 1998, p.112), analysis of these data included the stages identified by Brewer (2000) of data management; coding, developing qualitative descriptions; establishing patterns; developing a classification system of 'open codes'; and examining negative cases.

Data management was achieved through content coding of field notes by the type of activity which was being described. All coding was undertaken manually and recorded using

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software from Microsoft Office applications. Qualitative descriptors were developed for each interaction described, where possible utilising the language of participants themselves and facilitated by identifying areas of similarity or contrast between the descriptions of superficially comparable activity. The emergence of patterns within these qualitative descriptions informed the selection of data extracts for further detailed analysis as outlined below.

Analysis of interview data recognised that in research interviews people may express views and understandings which differ from those which underlie behaviour in other contexts (Hammersley & Atkinson, 1995), and may be expected to actively manage their projected self (Biber & Finegan 1989; Blommaert 2005; Englebretson 2007). Interview data were therefore treated as ‘talk about practice’ rather than as revealing what participants were ‘really thinking’, but nonetheless helped to reveal the Discourses which participants utilised whilst talking about practice.

In order to identify and characterise discreet Discourses (representing different ways of thinking and talking), a proforma was developed from the work of Foucault (1969) and Lemke (1995) in order to identify the key elements of a Discourse (Figure 1).

<b>Figure 1: Characteristics or elements of a Discourse</b>	
<b>1. The topic, entity or process constructed by the Discourse</b>	
<b>2. Identity or roles which the Discourse makes available</b>	The identities available to both nurse and patient. A way of thinking about a patient was considered the identity which a Discourse ascribed to the patient
<b>3. Function of the Discourse</b>	The ‘purpose’ of the discourse which gives cohesion between other elements
<b>4. Ideological functioning and relations to other Discourses</b>	
<b>5. Context or Activities typically involving the discursive practices constituting the Discourse</b>	The patterns of practice associated with the Discourse
<b>6. Specific linguistic features of the Discourse</b>	e.g. lexical choices which typify the Discourse

Drawing upon a range of linguistic analytical approaches, an initial 45 data extracts from the field notes were examined alongside related excerpts from the interview data. Features of discourse which were typically “co-located” (Fairclough 2003) were identified and clustered under the headings in the above proforma until distinct discourses could be characterised. No new Discourses were identified after the first 30 extracts had been examined demonstrating that data saturation was reached. A re-reading of the entirety of the data facilitated further characterisation of these Discourses and a search for negative cases.

## Findings

### Overview

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Two contrasting sets of findings emerged from these data. The first of these was the identification of seven discreet Discourses. These represented seven different patterns of practice which were associated with distinctive ways of thinking and talking about patients. The seven ways in which participants thought about, talked about and treated patients were as:

1. routine work
2. (un)stable
3. a medical case
4. a body
5. a set of needs
6. a social being
7. a valued individual

All participants demonstrated each of these patterns of practice at least once during each period of observation, but analysis of putative negative cases showed that participants were only able to think about patients in one way at any moment in time. Nursing practice therefore required nurses to move between these different ways of thinking and talking about patients from moment to moment. 'Experienced' and 'inexperienced' participants all thought and talked about patients in each of these ways and so experienced critical care nurses did not think about patients in ways which were unique. The key difference between the 'experienced' and 'inexperienced' groups lay in how they *moved between* these ways of thinking. More experienced practitioners moved between different ways of thinking with rapidity, ease and fluidity, whilst less experienced nurses became 'stuck' in ways of thinking and talking about patients which were not always clearly appropriate to the moment.

The second set of findings relates to the ways in which participants characterised these Discourses. Descriptions of nurses thinking or talking about patients as routine work; as (un)stable; as a medical case; or as 'body' were often interpreted as criticism. This was largely because these ways of thinking were *impersonal* (in the sense that they did not clearly recognise the patient as a person), and participants found it difficult to reconcile their identity as nurses with the fact that they were required to think and talk about patients in impersonal ways. Findings relating to these four ways of thinking and talking about patients are now presented.

### **Thinking about the patient as routine work**

Extracts within the field note data demonstrated that at times nurses focussed only upon the work which needed to be done. This focus on the 'work' represented a task orientated way of thinking, talking and behaving and which mean that nurses failed to acknowledge even the physical body of the patient while engaged in this 'work'.

*She changes the infusion over with no comment to the patient. As she works she places the old empty syringe on top of Mrs Yates and it rolls down the bed to rest against Mrs Yates's hand. ... Mrs Yates is not acknowledged to be anything other than a slightly uneven working surface*

Field notes: Nurse 2

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Although this may appear problematic, the field notes record no evidence that Mrs Yate herself was aware of this transient episode. An understanding of context is crucial to evaluating this care given that there were many occasions before and after the above brief incident when Nurse 2 interacted meaningfully with Mrs Yates. Moving between different ways of thinking and talking about patients was a key feature of all of these data.

Nonetheless this was a pattern of practice in which communication with patients was either absent or restricted to simple and restricted information giving. Several participants recognised this and acknowledged that on occasion they could neglect to talk to patients, or fall back unthinkingly on 'stock' phrases to communicate:

*"I think a lot of the times we say things that patients are not gonna understand - like I'm just gonna suction you. Well that doesn't actually make any sense"*

Nurse 7: Second Interview

Although the failure to talk to patients can be problematic, it is also clear that a valuable purpose was served by nurses thinking about patients as 'routine work' at appropriate times. Thinking and talking in terms of 'routine work' was also associated with managing and structuring time. Nurses spoke frequently of getting or staying 'organised', and the hourly need to document observations provided the fixed points around which other routine elements of work were fitted. The way in which nurses would structure their 'work' around the hourly need to undertake observations is clearly demonstrated in the following:

*Nurse 5 looks up from the nurse's station towards the group of doctors who are on the ward round ...*

*"So – the 5 o'clock obs, do the ward round and do some eye and mouth care"*

Field notes: Nurse 5 (recorded at 16:50)

Thinking in terms of the 'routine' work which they needed to do was therefore a key means by which nurses would manage time. Other aspects of the way that 'routine' work was undertaken are illustrated by the following.

*...at the end of treatment, I see that Nurse 5 is almost absent-mindedly tidying the monitoring cables – not only ensuring that Mrs Williams is not lying on any cables in a way that could cause discomfort, but also ensuring that the cables fall neatly away from the monitor itself and remain untangled*

Field Notes: Nurse 5

The description of this behaviour as 'absent-minded' is illustrative of the finding across all of these data that critical care nurses would habitually maintain tidiness, control and order within the physical environment for which they were responsible. Nurses would almost unthinkingly tidy working surfaces, straighten bedsheets or untangle intravenous lines, giving rise to a recognisable pattern which participants would jokingly refer to as form of obsessive compulsive behaviour.

### **Thinking about patients' as (un)stable**

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This was a way of thinking and talking in which nurses would construct patients as a series of abstract and disconnected physiological systems known through the medium of technology. Patients were talked about as being either stable or unstable depending upon whether or not specified 'targets' or 'parameters' (such as oxygen saturation, central venous pressure or mean arterial pressure) were achieved and maintained. Nurses would talk about patients in precise and quantifiable terms, and would construct patients as being unpredictable and prone to 'go off' or 'become compromised'.

This was a way of thinking about patients which meant that nurses responded to changes in patients' condition only when clearly stated parameters were breached, without apparent consideration of their wider clinical significance. The extract below illustrates this by describing an experienced critical care nurse who is responding to the absolute value of a parameter:

*Mr Young's oxygen saturations drop to 83%. Nurse 5 comments to me that 'they' want his 'sats' to be above 85% and moves to the cubicle doorway. She watches intently through the doorway as the sats rise to read 84% and then 85%. Once Mr Young's monitor shows that his oxygen saturations are 85%, Nurse 5 brusquely turns away from the doorway and continues her conversation with me. It is clear that so long as they remain above this level she sees no immediate need to intervene.*

Field Notes: Nurse 5

This episode was of interest given that the nurses' actions were a response to physiological changes which she herself later acknowledged to be of little or no clinical significance. Although nurses were *able* (in other contexts) to judge whether changes in physiological parameters were significant, this episode illustrates that they did not always practice in a way which demonstrated this understanding. This may be understood by recognising that critical care practice often requires nurses to respond in circumstances where prolonged deliberation would be inappropriate. The following example demonstrates this as well as showing how a focus on maintaining physiological "targets" could demand intense concentration:

*Nurse 4 is in the process of changing over the noradrenaline infusion by 'piggy-backing' the two infusions, and is very closely attentive to the cardiac monitor as she weans down the original infusion ... she watches the monitor and responds every few seconds to changes in blood pressure by making alterations in the rate of the infusion.*

Field Notes: Nurse 4

Although technology has an 'objectifying' influence in this episode this is not clearly inappropriate. The nurse responds to no aspect of the patient apart from their vital signs, but this is for a short period of time and there is no suggestion that this was associated with a negative experience for the patient. Conversely, noradrenaline is a powerful vasoconstricting drug with a short half-life, and ensuring a continuous rate of infusion whilst the two syringes are changed is essential to patient safety. The ability of nurses to think and talk about patients as '(un)stable' is therefore vital to effective patient surveillance and to the

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ability of nurses to intervene and control patients' physiology in ways which ensure patient safety.

### **Thinking about patients as a 'medical case'.**

In contrast to thinking about patients as (un)stable, participants would at other times draw upon a Discourse of the 'medical case'. This was a way of thinking and talking in which the primary focus was upon the *significance* (rather than the absolute value) of physiological changes in the patient condition. Rather than considering each discreet 'parameter' in isolation, this Discourse constructed a complex system in which patterns of ordered and disordered physiology could be recognised. The following extract shows how a nurse could be aware of a 'target' blood pressure without this dominating the way that she is thinking and talking at this time.

*"They'd write that on the chart just to give us an idea. And I do need to get back to the doctors about the fact that, you know, the MAP {Mean Arterial Pressure} is less than sixty-five, but the urine output is such and such."*

First Interview: Nurse 1

This is a Discourse which minimises the authority of 'targets' (by suggesting such figures are arbitrary and exist "just to give us an idea"), and instead allows the nurse to express a judgement about the significance of the blood pressure with reference to the patient having an acceptable urine output. Understanding the significance of such changes meant that the 'medical case' played an essential role in enabling participants to appreciate how the patient's illness was changing over time or moving towards resolution. When thinking and talking about patients in this way nurses frequently referred to patients' progress to indicate a perceived 'direction of travel' (e.g. "he's sorting himself out" or "I think he's on track").

Recognising and communicating these patterns in disordered physiology was central to thinking and talking about patients as a 'medical case'. Although these patterns were often complex, a shared understanding was often used as the basis for communication between experienced nurses. In the example below Nurse 7 uses a simple nod towards a ventilator to communicate a pattern that the researcher was clearly expected to recognise as Transfusion Related Acute Lung Injury (TRALI)

*[She communicates] using a shared set of understandings / experiences to highlight patterns and concerns. At one point for instance she tells me that he has had a massive transfusion and that now his chest... Her voice trails off but she nods to the ventilator to suggest that the transfusion may be one reason why he needs the ventilatory support that he does.*

(Field Notes: Nurse 7)

Similarly, a pattern of disordered physiology was alluded to by the participant who described a patient to me in the following terms:

*"She was the hip yesterday"*

(Field notes: Nurse 5)

Referring to a patient a 'the hip' could be construed as reductionist and objectifying, but again the context of this comment is important given that there were few instances within these data when nurses used such phrases within earshot of patients themselves. The ability to think about patients as a 'medical case' enabled nurses to understand the treatments they delivered and to perceive the trajectory of patients' illness, and talking about patients in such ways played a valuable role in allowing for swift heuristic communication of complex patterns of disordered physiology between nurses.

### **Thinking about patients as a Body**

A primary focus on the body of the patient was not a prominent feature of these data overall. Other than when delivering intimate personal care (which only took short periods of time each day), nurses tended to pay specific attention to patients' bodies only briefly and as a site to be examined. Frequently this involved 'prodding or 'poking' such as when examining an area of apparent injury such as cellulitis.

The examples below suggest that even this 'objectifying' is not always clearly inappropriate. The first extract describes the practice of an inexperienced critical care nurse dealing with a patient who is unresponsive:

*[Nurse 2] gently shakes Mrs Yates's arm and calls her first name quietly. She is hesitant as she pauses again before leaning over to rub Mrs Yates in the centre of the chest with her hand.... I have the impression that this manoeuvre was intended to be a sternal rub, although the manoeuvre is conducted so hesitantly and gently that I am not at all sure that it would serve its purpose as a 'painful stimulus'.*

Field notes: Nurse 2

Setting aside the debate over how and when 'painful stimuli' should be performed, it is clear that this was an ineffective attempt at such an assessment. A clear contrast can be seen with the practice of a more experienced nurse who had a concern that a patient was not responding.

*[Nurse 4] approaches Mr Thompson once more and calls down to him loudly, almost shouting, to ask him to open his eyes. There is no response and she immediately performs a vigorous sternal rub with no observable hesitation. ...I can see a clear shift in her pattern of behaviour.*

Field notes: Nurse 4

These extracts differ primarily in the hesitancy of the two participants. The more experienced nurse was able to perform an effective assessment without hesitation as her concern for the patients' condition mounted. This was evidenced by an observable 'shift' in her behaviour as she moved between two different ways of thinking about the patients. In this context it may be argued that the *failure* of the less experienced nurse to think about patients as 'body' was one reason for an apparently ineffective assessment.

### **Talking about persons**

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A second related set of findings emerged from the interview data. Descriptions within field notes made clear that nurses thought and talked about patients in many different ways, yet a striking feature of the interview data was that a lot of these descriptions of practice were interpreted as criticism. When talking *about* their practice, participants expressed the view that it was inappropriate for nurses to think and talk about patients in impersonal ways.

A concern to present themselves as caring for *persons* was common to all participants in the interviews, and where this was in question they frequently offered a defence, excuse or apology. In a typical extract, Nurse 6 commented that a particular episode from these data was “quite bad” and reflected that “I think it does get kind of impersonal at times”. In another example, another participant emphasised that any “depersonalisation” was “very subconscious” whilst she assisted a surgeon in the physical exploration of a patients’ facial wound:

*“I think probably with those things you probably have depersonalised. You’ve taken the person away from that I think - very subconsciously”*

Second Interview: Nurse 5

Acknowledging that critical care practice could require nurses to think about patients as ‘(un)stable’, a further participant stated that:

*“You are unfortunately focusing more on their observations. I mean you are obviously caring for them as a person but in quite a different way.”*

First Interview: Nurse 7

Given that the monitoring of patients is a primary function of critical care, it is remarkable that a critical care nurse considers it “unfortunate” that at times she has to focus on a patients’ observations. One reason why critical care nurses apologised for these aspects of their practice can be seen in comments such as the following:

*“I don’t know if this is a really un-nursey thing to say ((laughs)) but I think the most important thing is making sure the patient’s safe.”*

Second Interview: Nurse 2

*“Privacy and dignity is one of the nursing.... things that nurses are supposed to do. You know - the role I suppose ((laughs)) But at that time it wasn’t exactly the most important thing to keep the patient covered, it was to make sure that they maintained their airway and they were breathing”.*

Second Interview: Nurse 6

Participants consistently characterised it as professionally inappropriate (or ‘un-nursey’) to think and talk about patients in impersonal ways. Specifically this meant that they apologised or justified themselves for thinking or talking about patients as ‘routine work’; as ‘(un)stable’; as a ‘body’ or as a ‘medical case’. These critical care nurses thus problematised essential elements of their work such as ensuring safety, monitoring critically unwell patients or prioritising a threatened airway. Participants could not reconcile their

identity as nurses with everything that they did in practice because being a nurse was considered dependent upon thinking about patients as a whole person.

## Discussion

These findings resonate with previous studies which describe facets of critical care nursing practice. The 'routine' thinking identified in this study reflects how Almerud et al (2008) found critical care nurses to actively manage time, and the habitual tidying behaviours described by Manias & Street (2000) and Philpin (2007). Although a result of 'routine' thinking, these behaviours play a role in keeping the environment tidy, managing time, and ensuring the correct functioning of equipment - all of which are essential to minimising risk in critical care (DH 2005). Monitoring and supporting patients with failing body systems is the primary purpose of critical care units (WFCCN 2007) and the ability to think about patients as '(un)stable' thus underpins the "ongoing vigilant assessment" described by Chaboyer & Creamer (1999: p. 66) as central to the critical care nurses' role. The ability to think about patients as a 'medical case' enables critical care nurses to perceive and understand the trajectory of a patient's illness and represents the "intellectual work" (Chaboyer & Creamer 1999: p.66) that is necessary in order to understand the complex supportive treatments which nurses initiate and deliver.

Safe critical care practice therefore requires critical care nurses to adopt patterns of practice which can be characterised as impersonal, and this study draws on an understanding of discourse which means that the ways in which nurses think about, talk about and behave towards patients cannot be separated. Because critical care nurses must treat patients as '(un)stable' then they must (at times) think about talk about patients as such. Patient safety demands that nurses undertake 'routine work' and so it follows that that nurses must (on occasion) think and talk about patients in these terms.

It is well recognised that nurses utilise different forms of knowledge (Carper 1978; Liaschenko & Fisher 1999), and Gobbi (1998, 2005) has previously shown how this requires nurses to work as 'bricoleurs' who draw upon a range of Discourses. This study shows that as nurses move between these Discourses they must also think and talk about patients in very different ways. There can be no one 'right' way in which nurses think and talk about patients because nursing practice requires that nurses move between different ways of thinking about patients as appropriate to the moment.

Whilst nurses are expected to have a focus on the patient as whole person (Watson 1998; McCormack & Titchen 2001; RCN 2004; McCance et al. 2011; Scott et al, 2014), these findings demonstrate that nurses cannot think about patients in such terms at any one moment in time. Whilst nurses may consider it *undesirable* to think about patients as 'routine'; 'as body', as 'medical case' or as '(un)stable', an interpretation of these findings though the work of Polanyi makes clear that nurses aspire to an ideal of 'whole person' nursing care which is literally *unachievable*. In "The Tacit Dimension" Polanyi (1966) argues that the whole person is a concept which cannot be articulated in discourse: different Discourses allow us to understand people as different kinds of beings whilst the 'whole' must be tacitly understood. This interpretation is supported by these data where a search for

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negative cases within descriptions of nursing practice could find no instance where a nurse was demonstrably thinking about a patient as such a 'whole person'. It not possible for nurses to think and talk about patients as whole persons, but rather the delivery of nursing care requires nurses to think about the patient as discreet aspects of this 'whole' from moment to moment.

Nurses move between different ways of thinking, each of which represents different aspects of the 'whole person', and in this study more experienced nurses moved between these ways of thinking with the greatest fluidity. Although a full exposition is outside the scope of this paper these findings may be interpreted through an understanding of the 'clinical wisdom' described by Benner et al (1999). Benner derives 'clinical wisdom' from the Aristotelian concept of *phronesis* which incorporates the notion of correct perception (Aristotle 1984). The 'clinical wisdom' which characterises expert practice can thus be conceptualised as incorporating the faculty to perceive and think about patients in ways that are appropriate to the moment.

One implication of these findings is that no one way of thinking or talking about patients may be considered inherently wrong. Nurses move between many different ways of thinking and talking about patients, and these may only be judged to be appropriate or inappropriate to a specific context. This conclusion calls for a re-appraisal of those critiques which reject 'objectifying', 'dehumanising' or 'reductionist' forms of discourse because these criticisms must be limited in scope. It can only properly be argued that it is reductionist to think about the patient *solely* or *inappropriately* in biomedical terms, 'dehumanising' to think about the patient *solely* or *inappropriately* in terms of technology, and antithetical to evidence based practice to *solely* or *inappropriately* focus upon 'routine' work.

Safe and effective critical care practice therefore requires nurses to think and talk about patients in many different ways, some of which can be characterised as impersonal. This recognition is important because these interview data show that critical care nurses can themselves consider it inappropriate to think or talk in these ways. Participants found it difficult to articulate and reflect upon important elements of their practice without offering a defence, apology or excuse, and this finding must be situated within a wider context in which critical care nurses are known to experience moral distress when they fail to think about patients as 'persons' (Beeby 2000; Cronqvist et al. 2001; Cronqvist et al. 2004; Cronqvist et al. 2006; Lawrence 2011; McAndrew et al. 2011). These findings reveal that nurses may aspire to an ideal of 'whole person' care that is literally unachievable, and therefore that there continues to be:

"an artificial 'theory / practice' gap in nursing: in which codified ideas about what nursing ought to be; and what nursing actually involves are subject to a considerable disparity between aspiration and achievement" (May & Fleming, 1997: p.1097).

This disparity is significant given that dissonance between the ideals and the reality of nursing practice is a key cause of emotional exhaustion and burnout (Bakker et al. 2005; Maben et al. 2007; Sabo 2011).

Working to close this 'theory / practice gap' presents a significant challenge because of the many ways in which the need for whole person care is reinforced to nurses throughout their careers. Student nurses are exposed to theories and models of whole person care in order to ensure that registrants deliver care which is "person-centred" (NMC 2010) and as members of the healthcare workforce nurses are expected to respond to people with "humanity" (DH 2009). It will therefore be necessary to re-appraise elements of nursing scholarship, nurse education and healthcare policy so as to recognise and legitimise the fact that that nurses need to think and talk about patients many different ways. In particular, nursing scholars and educationalists must reappraise implicit or explicit claims that it is wrong or professionally inappropriate for nurses to adopt biomedical and other impersonal forms of discourse.

This conclusion is particularly salient at a time when there is an increased emphasis on the values of healthcare practitioners and the need to strengthen compassionate cultures in healthcare (Schantz 2007; Francis 2013). Whilst there is a relationship between the ways in which nurses think talk and act, these findings show this relationship to be complex and highly dependent upon context. Nurses move fluidly and rapidly between many different ways of thinking and talking about patients, and these data provide no evidence to support the view that thinking and talking in impersonal ways (such as referring to a patient as "the hip yesterday") demonstrates values or attitudes that negatively impact on care delivery in other contexts.

In general, participants in this study were highly sensitive to context. Whilst they would often (for example) talk *about* patients as 'medical cases' or as 'routine work', these were not ways of talking which they used in their interaction *with* patients. Judgements about nurses' values and attitudes cannot therefore readily be drawn from how they think and talk, and should instead be based upon how nurses' behaviour impacts upon the outcomes and experience of the people they care for.

## Conclusions

This study was conducted with seven participants in one critical care unit in the UK and other nurses must make their own judgements regarding the extent to which the details of these findings are of relevance to their own areas of practice. The wider transferability of this study rests upon a methodological grounding which conceptualises Discourse as patterns in the totality of what nurses do, say and think.

This study has shown that nurses can think and talk about patients as 'routine work'; as '(un)stable'; as a 'medical case' or as 'a body', and these 'impersonal' Discourses represent patterns of behaviour that are essential to the delivery of safe and effective nursing care. Nonetheless nursing scholars reject these Discourses as 'objectifying' or 'reductionist', and participants in this study characterised them as professionally inappropriate or not 'nursey'. These findings reveal a dissonance between nurse's ideals and the realities of nursing practice which may contribute to nurses' emotional or moral distress; this has implications for critical care nursing practice, education and research.

Practitioners and educators need to recognise that critical care nurses move between different ways of thinking, and so may need guidance, opportunities for reflection and role modelling to help them develop the clinical wisdom necessary to perceive patients in ways which are appropriate to the moment. Educationalists must avoid promoting unexamined professional ideologies which may serve to promote moral distress in nurses, and make explicit that there are many legitimate ways in which nurses do and must think about patients.

Talking or thinking about patients in any one way does not necessarily reveal attitudes or values that influence care in other contexts, and nursing scholarship must recognise that it can be unhelpful to characterise forms of talk as simply 'objectifying' or 'dehumanising'. At a time when there is an increasing focus on the need to sustain compassion in care, the research community must ensure that nursing care is evaluated on the basis of measures which reflect patient outcome and experience rather than professional ideals. This will be facilitated by research which examines the relationship between patient outcomes or experiences and the ways in which nurses think and talk about their practice.

Overall, there is a need to recognise and validate the fact that nurses must think and talk about patients in many different ways. Nursing scholars, educationalists and policy makers must articulate a vision of 'whole person care' clearly, and in ways which avoid constructing dissonance between nurses' ideals and the ways in which they do and must think and talk about patients.

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