# An Interpretive Study of Everyday Practices and Clinical Judgments by Experienced Psychiatric Nurses

By

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# ABSTRACT

TITLE: An Interpretive Study of Everyday Practices and Clinical Judgments by Experienced Psychiatric Nurses

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The overall goal of this interpretive study was to explore the clinical world of experienced Japanese psychiatric nurses. Specific aims were to: (a) describe everyday practices of experienced psychiatric nurses who work at mental hospitals in Japan, (b) explore the characteristics of clinical judgments which are embedded in their everyday practices, and (c) understand the meaning of *experienced* in the expression experienced psychiatric nurses. Data in this study were written documents, that is, texts. The texts were composed of (a) transcripts of dialogic interviews in which participants were storytellers and the researcher was the listener, and (b) the researcher's observation notes. Participants were 23 psychiatric nurses and licensed assistant nurses, 18 females and 5 males, who were selected from three mental hospitals located in metropolitan Tokyo, Japan. The dialogic interviews lasted approximately one hour, during which the participants tried to describe their memorable experiences from everyday practice. The interpretations of the texts were developed by means of the hermeneutic circle which is the constant task of

understanding. Themes, issues and exemplars in the texts were tentatively categorized from three perspectives: care, development of expertise and history.

With regard to the process of interpretation, the findings that emerged were as follows:

1. Four levels of expertise were found in the work performance patterns of experienced psychiatric nurses in everyday practices: the routine work performer's practices, the practices of an experienced nurse as a good neighbor, the practices of a veteran nurse with marked individuality and the advanced experienced nurse's practices. Quality differences were also found to exist among the four patterns of work performance.

2. The central concerns and issues which were revealed by the interpretation relate to conscious, deliberative judgment in everyday practices. In particular, the clinical judgments in the stories of patients' suicides raised two issues: the nurses' concerns and involvement in the patient-nurse relationship as well as temporality in clinical judgments. The issue of conflicts between group consensus and the judgments of individual nurses was also revealed. Most episodes which brought conflict in the nurse himself/ herself or the nursing team were judgments regarding activities of daily living that are very private aspects of human existence.

3. Memorable experiences were found to make a transformation in nurses' values, beliefs and world views. In particular, the transition to advanced nurses was

reflected by not only professional experience but also the experiences in the nurses' own lives.

The findings in this study will be useful for Japanese psychiatric nurses making role transitions from institutional care to community care. And the issues surrounding clinical judgments will contribute toward work performance changes, which will enable psychiatric nurses to develop their expertise.

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# CHAPTER I

# INTRODUCTION

## Statement of the Problem

Nurses have been devoted to the development of theoretical knowledge and skills about cognitive processes in order to make accurate judgments/decisions and to solve problems related to patient care (Field, 1987; Tanner, 1987, 1989). Increasingly, nurses have been required to make judgments/decisions in complex clinical situations based on very little or ambiguous data (Rew, 1988; Young, 1987). It is not possible to standardize the processes involved in the decisions and actions that lead to safe and effective care in highly complex situations (del Bueno, 1990).

On the other hand, we have often observed that experienced nurses provide the appropriate care after only a few minutes of patient contact. Why is it that experienced nurses can make judgments/decisions and take actions immediately? Nursing researchers point out that expert nurses make clinical judgments/decisions through their intuition based on their previous experiences in clinical practice (Benner, 1984; Benner & Tanner, 1987; Polge, 1995; Rew, 1988, 1991; Schraeder & Fischer, 1987; Young, 1987). The clinical judgments of expert nurses differ from those of inexperienced nurses. Expert nurses grasp situations and know the particular patient through clinical knowledge gained from experience with many people in

similar situations (Tanner, 1996). This experience, Benner (1982) states, does not refer to a mere passing of time, but the experience rooted in systematic study and actual clinical practice that is the crucial element in the development of clinical knowledge.

Clinical experiences contribute to producing clinical knowledge and to developing nurse expertise. The more experience nurses have in direct patient care, the more likely they are to make appropriate judgments and provide effective care. However, the relationship between clinical experience and the development of nurse expertise is not clear (Garb, 1989; Henry, 1991). Despite having a great deal of experience, some nurses never develop their expertise; in other words, experienced nurses are not necessarily expert nurses. For example, in institutions such as mental hospitals, nurses develop a subculture that strongly influences their practice (Goffman, 1961; Morrison, 1990). Much of the everyday practice of these nurses is shaped by group norms which eventually become routine and stereotyped rather than individualized by patient needs and each nurse's unique competencies. Even when nurses have a great deal of experience, the routine and stereotyped everyday practice does not necessarily contribute to their expertise to provide effective care, because it lacks reflection.

Clinical experience is a necessary condition for becoming an expert nurse, but it alone is not sufficient. Here arises the question of how nurses have accumulated their experience as clinical knowledge/wisdom and developed their expertise.

Expert skills/knowledge based on experience is characterized as *practical knowledge* or knowledge in clinical practice. Experts immediately grasp situations using intuition and practical knowledge. The skills of expert nurses stand out in their clinical judgments which are embedded in their everyday practice. Dreyfus and Dreyfus (1986) stress that "when things are proceeding normally, experts don't solve problems and don't make decisions; they do what normally works" (pp. 30-31). Nevertheless, when expert nurses perform actions based on what normally works, the nurses must have encountered a variety of possibilities in order for them to provide effective care in the patient situation and respond to the situation consciously or unconsciously to make a choice of actions for effective practice. Dreyfus and Dreyfus (1986) explain that because experienced-based holistic discrimination produces deep situational understanding, the expert can determine what is deemed important in a situation. The differences between expert nurses and non-expert nurses show up in their everyday practices in both deliberate, conscious clinical judgments and unconscious, non-analytic clinical judgments (Tanner, 1996).

Previous studies reported differences of clinical expertise in developmental stages from novice to expert, when comparing experienced nurses with inexperienced nurses (Benner, 1984; Benner, Tanner & Chesla, 1992, 1996; Corcoran, 1986a, 1986b), and in the expert ability of experienced nurses to make a difference to the patient (Astrom, Norberg, Hallberg, & Janssin, 1993; Tanner, Benner, Chesla & Gordon, 1993). However, there are few studies concerned with the differences in

clinical expertise among nurses with the same amount of experience (Polge, 1995; Rubin, 1996). Studies focusing on clinical expertise and competencies of experienced psychiatric nurses, in particular, are few (McElroy, 1990). In Japan, there has been no study of the clinical expertise of experienced psychiatric nurses. Developing a description of the everyday practices of experienced psychiatric nurses would be a contribution in itself. It is also possible that a description of the clinical worlds of these nurses would uncover ways in which the transition to expert nurse occurs. Furthermore, the study might reveal contributors and barriers in Japanese psychiatric hospital settings that promote or hinder the development of expertise through clinical practice.

## Purpose of This Study

The overall goal of the study was to explore the clinical world of experienced Japanese psychiatric nurses. The specific aims of this study were to: (a) describe everyday practices of experienced psychiatric nurses who work at mental hospitals in Japan, (b) explore the characteristics of clinical judgments which are embedded in the everyday practices of these nurses, and (c) understand the meaning of *experienced* in the expression experienced psychiatric nurses. This study was set in Japan because the researcher is a Japanese psychiatric nurse.

Based on Benner and Tanner's research (Benner, 1984; Benner & Tanner, 1987; Benner et al., 1992, 1996; Tanner et al., 1993), the researcher assumed the difference between expert nurses and non-expert nurses would be rooted in patterns

of everyday practices and clinical judgments embedded in their everyday practices. However, the concept of an expert nurse was not clear in Japanese clinical nursing. Japanese people recognize experienced nurses as veteran nurses, but the terms expert nurse (as described in American literature) and veteran nurse were not necessarily equivalent. The concept of an expert nurses as it is revealed in Japanese psychiatric nursing practice was also eventually also examined in this study.

## Sociocultural Background

In this study, the researcher focused on the everyday practice of experienced psychiatric nurses who work in mental hospitals in Japan. The researcher chose to explore the clinical world of experienced Japanese psychiatric nurses because the nurses are key to designing and providing care that supports: (a) the tradition of institutional care, and (b) a more professional role for nurses in changing mental health care systems.

### Tradition of Institutional Care

Historically, mentally ill patients in Japan were taken care of by their families. The Japanese people firmly believed that patient care was the family's responsibility and that patients led happier lives living with their family. However, many patients stayed in miserable environments, referred to as private confinement, in close proximity to the family dwelling but in a separate structure. The enactment of the Mental Hygiene Law in 1950 abolished the private confinement of mentally ill

patients and empowered the government to stimulate profit-making enterprises out of private mental hospitals. Mental hospital care was started in Japan at that time.

An amendment was made to the 1950 Mental Hygiene law in 1965 as the direct result of an accident to the then American Ambassador, Dr. Reishauer. Dr. Reishauer was hurt by a patient with schizophrenia, and the incident highlighted the lack of community mental health care services in Japan. The amendment established new systems including: (a) local mental health centers, and (b) community mental health services within existing public health centers. Although these mental health systems materialized, the amendment was more successful in spurring the development of institutional care in mental hospitals than community mental health care systems over the next 20 years.

The mental health movement has been strongly influenced by social change that began to accelerate modernization in the 1960s. Modern technological production, in particular, had a tremendous impact on every facet of social life, and the "world of work" occupied a dominant position in Japanese social life. However, despite the westernizing of social structure after World War II, Japanese culture maintained that the family should share in the responsibility of patient care. For mentally ill people who were unable to work and live independently, there was no alternative to hospitalization. Institutional care was needed to provide relief for the families. Consequently, mentally ill persons took the patient role in mental hospitals.

Under the amendment of the Mental Hygiene Law in 1965, public health nurses, social workers and other community mental health professionals sent persons in the community with mental health problems to mental hospitals. At that time, mental health professionals believed that it was good for patients to get psychiatric treatment. However, private mental hospitals were built during this period of economic growth, and many unlicensed aides were employed to provide nursing care. During the 10-year-period from 1960 to 1970, the number of psychiatric beds expanded to approximately 143,000 beds (see Appendix A). Most of the mental hospitals were merely asylums without professional psychiatric treatment and care programs. It was during this period that the participants in this study were hired as psychiatric nursing staff.

In the 1970s, hospital conditions were totally different from those in an ideal therapeutic community, and the traditional treatment for patients in mental hospitals was criticized. What occurred inside mental hospitals was revealed through scandals which documented patient maltreatment. Open-door systems soon evolved in mental hospitals, and physical conditions improved. However, hospitalized patients did not obtain liberation, and even today the number of mental hospital beds continues to increase (see Appendix A).

The community mental health movement of Japan in the 1980s focused on expanding community-based facilities (e.g., day treatment centers, social clubs, workshops, half-way houses and group homes) for mentally ill persons, while at the

same time maintaining the traditional mental hospital settings. In Japan, there has been no deinstitutionalization movement such as has been evident in the United States and the European countries. There are still many long-stay patients as well as nurses who provide custodial care in traditional mental hospitals.

Institutionalization has not only been a problem among inpatients but for nursing staff in mental hospitals as well. Psychiatric nurses who had spent substantial amounts of time with patients in the hospital were confronted by the reality that they were falling behind in the community mental health movement. In the last 10 years, Japanese psychiatric nurses, especially those who have worked in mental hospitals for a long time, have had to make a transition from institutional care to community care.

The Mental Hygiene Law was replaced by an amendment to the Mental Health Law in 1998 and then that amendment was modified in 1993. These changes were aimed at the protection of human rights for the mentally ill, the promotion of their social rehabilitation and the development of the community mental health care system. In addition, the focus of psychiatric and mental health service was shifted from hospital-based care to community-based service.

Role for Nurses in Changing Mental Health Care Systems

The 30-year history of mental hospital care produced many institutionalized patients. Both nurses and patients in the psychiatric wards lost hope that the patients would ever go back to their families or the community, so the ward became their home. Nursing staff tried to maintain a peaceful and quiet atmosphere in the ward by

providing consistent day-to-day care. The transition from institutional- to community-based care, mandated by the Mental Health Law, revealed that the methods used to care for long-stay patients prior to its enactment were inadequate for patients who were to be relocated to the community. Psychiatric nurses and other mental health professionals had not sufficiently recognized the necessity for providing those patients with social skills that would enable them to develop self-care abilities.

The current movement to community mental health services has resulted in many changes in mental hospitals. As the patients obtain freedom and autonomy in everyday life in mental hospitals, the nurses' everyday practices, which the participants in this study described, have gradually changed. Therefore, it is important to uncover clinical competencies in psychiatric care developed by experienced nurses who have made efforts to provide care in silence for so long. It is also important to explicate how experienced psychiatric nurses have confronted and overcome the barriers and difficulties brought about by the many changes.

Japan is currently going through another major change, reforming the health care systems to accommodate the needs of their aging population. The Mental Health Law was amended again in 1995 to reflect the 1993 Basic Law for the Disabled and the Community Health Care Law established in 1994. In particular, as the new Basic Law for the Disabled provided for those with mental disabilities, the Mental Health Law needed to incorporate welfare measures. Mental health services are gradually

beginning to focus on social welfare rather than medical care. Consequently, psychiatric nurses will perform collaborative work with various professionals including social workers and clinical psychologists in mental health service. Psychiatric nurses will need to be able to identify their competencies and professional roles in the reformed mental health care systems. As part of the remarkable transition to community mental health care, this study will serve Japanese psychiatric nurses in their efforts to transition from traditional institutional care.

# CHAPTER II

# REVIEW OF LITERATURE

The review of literature was directed toward identifying what is known about clinical expertise, especially development of knowledge through everyday practice, clinical judgment and their relationship to experience. Additionally, there is evidence that the development of nurses' expertise is strongly related to clinical settings where nurses provide patient care. Therefore, organizational and cultural aspects are included in the discussion of clinical expertise and clinical experience.

## Clinical Knowledge

### Knowledge Development and Practice

Nursing scholars have discussed the relationship between theory, research and practice since scientific nursing was emphasized in late 1950s and early 1960s. The fundamental feature of nursing is practice. Nursing knowledge and theory are developed through scientific research, and nursing practice is improved by the scientific knowledge and theory based on the research (Lindeman, 1990). Lindeman (1990) describes the traditional view of research in nursing practice as follows:

> (a) the primary responsibility for developing knowledge belongs to the nurse-scientist, (b) neither the staff nurse nor the patient is an active participant in developing new knowledge, (c) the staff nurse applies knowledge in the real

> world, (d) decisions about how new knowledge will be used are not a part of the research process. (p. 166)

The traditional view holds that nurse clinicians are different from nurse scientists, with clinicians applying knowledge acquired by scientists. This distinction between nurse clinicians and nurse researchers and between scientific knowledge and experiential knowledge has contributed greatly to the gap between knowledge and practice. In this view, the most (if not all) legitimate knowledge is that discovered or verified through scientific methods. Experience-based knowledge is viewed as value-laden, prone to bias and not reliable until tested empirically (Benner, 1982; Lindeman, 1989). Most scientific researchers and theorists through the 1980s accepted this conventional view of the relationship between science and practice and largely ignored the competencies and expertise of nurses who provide patient care using knowledge.

However, a few outstanding nursing scholars focused on the components of practice. Wiedenbach proposed a situation-producing theory together with philosophers Dickoff and James (1968a, 1968b). Benner (1984) applied to nursing a model of skill acquisition developed by Hubert Dreyfus, a Heideggerian philosopher, and Stuart Dreyfus, a mathematician (1986).

Wiedenbach, who published her work, Clinical Nursing: A Helping Art, in 1964, contributed to knowledge development based on practice in the 1960s. Wiedenbach claims knowledge, judgment, and skills as three aspects to the practice

of clinical nursing, that is, knowledge encompasses everything that has been comprehended, judgement involves the ability of the nurses to make sound decisions, and skills represents the nurse's ability to achieve the appropriate outcome (Fitzpatrick & Whall, 1989, p. 91). Moreover, she claims that identification, administration, and validation are three components of practice directly related to the patient's care. Wiedenbach developed her model to cultivate the nurse's ability to provide effective care, and it was used as such in the 1970s and 1980s in Japan (Toguchi, 1980).

Wiedenbach emphasized that nurses should perform everyday practice consciously as professional nurses. She asserted that "theory is born in practice, is refined in research, and must and can return to practice" (Dickoff, James & Wiedenbach, 1968, p. 415).

Benner published her work, From Novice to Expert, in 1984. She attempted to explicate the characteristics of clinical knowledge embedded in nursing practice through her research project. Benner identified 31 competencies of skilled nursing practice that emerged from analysis in her research and classified them into seven domains: (a) the helping role, (b) the teaching-coaching function, (c) the diagnostic-monitoring function, (d) effective administration of rapidly changing situations, (e) administrating and monitoring therapeutic intervention and regimens, (f) monitoring and ensuring the quality of health care practice, and (g) organizational and work-role competencies.

One of Benner's (1984) main contributions was to highlight the significance of practical knowledge in nursing expertise and the relationship between theoretical knowledge and practical knowledge describing it this way:

> Knowledge development in an applied discipline consists of extending practical knowledge (know-how) by means of theory-based scientific investigations and the charting of the existent 'know-how' developed through clinical experience in the practice of that discipline. (p. 3)

Benner pointed out that theory is derived from practice and then practice is altered or extended by theory (Marriner-Tomey, 1989).

Both Wiedenbach and Benner described the nature of nursing practice in terms of complementary philosophies. In the 1960s, Wiedenbach attempted to develop epistemological knowledge in nursing practice, while in the 1980s, Benner attempted to describe practical knowledge as embedded in nursing practice. In a discussion about the movement during the 20-year period from Wiedenbach to Benner, Lindeman (1990) notes that the following new view of research arose:

> (a) the research subject is given an active role in the research process, (b) knowing 'how' is viewed as equally important to knowing 'that', (c) the scientist and practitioner are partners in research, and (d) research takes place in clinical research settings. (p. 166)

The body of knowledge has served as the rationale for nursing practice. However, the nurses, who were devoted to the development of scientific knowledge in nursing,

were aware that various forms of knowing contribute to the development of knowledge for a practice discipline (Carper, 1978; Chinn & Kramer, 1991; Moch, 1990). Chinn and Kramer (1991) note: "Nurses' patterns of knowing provide ways for sharing insights and understanding that can be used in practice" (p. 11).

Knowledge as Embedded in Practice

According to Schön (1983), professionals have become aware of the limits of technological rationality. Problems in practice are characterized by complexity, uncertainty, instability, uniqueness, and value-conflict, and not all characteristics are suitable to the model of technical rationality based on the positivist epistemology. From the positivist perspective, professional practice is a process of problem solving through instrumental application of scientific knowledge. In the real world of practice, however, problems do not always surface for the clinician to resolve. Moreover, in everyday practice, clinicians make judgments for which they cannot state adequate criteria, and they display skills for which they cannot state the rules and procedures (Schön, 1983).

Professional knowledge does not always match the changing character of the practice situations. A gap exists between professional knowledge and the demands of real-world practice in that basic and applied sciences are convergent, whereas practice is divergent (Schön, 1983). The gap is identified as a significant difference between ways of knowing: knowing that and knowing how, theoretical knowledge and

practical knowledge and scientific knowledge and knowing-in-action (Benner, 1983, Polanyi, 1974; Schön, 1983).

Knowing-how and practical knowledge are skills of knowers. The skillful knowing and doing are enabled through the personal participation of the knower in all acts. Polanyi referred to these kinds of knowledge as personal knowledge. Personal knowledge, therefore, is concerned with the knowing, encountering and actualizing of the concrete, individual self (Carper, 1978). For nurses in particular, knowing is a pattern of knowledge gained through interpersonal relationship, and to gain the personal knowledge in nursing care, it is essential that the relationship be established (Jenks, 1993).

## Clinical Judgement

### Issues Concerning Clinical Judgment

Gordon (1988) summarizes the common understanding of clinical judgment as "cognitive, mental, or intellectual reasoning, that involves combining data through inference, logic, probability statistics, or decision rules, based on a series of conscious steps" (p. 267). Clinical judgment is, therefore, primarily intellectual, cognitive, analytic.

In nursing, the term *clinical judgment* includes nursing process, nursing diagnosis, clinical decision making, diagnostic reasoning and information processing. According to Tanner (1987), the distinction among these terms is found in the theoretical perspectives: the rationalist perspective and the phenomenological

perspective. For example, the term clinical decision making implies a rational application of formalized and/or scientific knowledge as the means for making the decision. On the other hand, the term clinical judgement is characterized by arational approaches based on tacit knowledge including intuition and experience in addition to rational/analytic approaches.

Tanner (1987, 1989) defines clinical judgment as the use of knowledge in making one or more of several kinds of decisions: (a) observations to be made in a patient situation, (b) the evaluation of the cues observed and/or recognition of patterns and meanings, and (c) actions to be taken (or not taken) with or on behalf of the patient. Insofar as this definition which is based on Kelly and Hammon's (1964; Kelly, 1966) work, Tanner considers clinical judgment as a process that includes nurses' actions.

Brykczynski (1989) stresses that clinical judgment is the essence of practical wisdom. Therefore, expert nurses' practices are shown in their clinical judgment. Brykczynski (1989) describes the characteristics of clinical judgment as follows:

> Clinical wisdom is the kind of global integration of a body of knowledge that develops when theoretical concepts and practical know-how are refined through experience in actual situations. Clinical judgment is the essence of practical wisdom. It is the least specifiable, yet most crucial, aspect of clinical knowledge. (p. 76)

There is an assumption that clinical judgments by expert nurses who hold knowledge embedded in clinical practice differ from those who make clinical judgments with the decision-theory perspective and the information-processing perspective (Tanner, 1989). Expert nurses often make judgments/decisions using their perceptual abilities characterized as a gut feeling, a sense of uneasiness or a feeling that things are not quite right. They also use intuitive grasp or intuitive perception based upon prior experience and understanding (grasping) the clinical situation as a whole (Benner, 1984; Schraeder & Fischer, 1987).

Merleau-Ponty (1962) clearly makes a distinction between judgment and perception:

> I cannot put perception into the same category as the syntheses represented by the judgments, acts or predictions. . . . Perception is not a science of the world, it is not even an act, a deliberate taking up of a position; it is the background from which all acts stand out, and is presupposed by them. (p. x)

For Merleau-Ponty, perception gives a sense "to see" on the hither side of judgment and the far side of the quality or impression. That is, perception is the world of actual experience which is prior to the object world. Therefore, to perceive is to grasp the sharpness of an object in the background, and this ability as clinical judgment is the expert nurses' *intuitive grasp* (Benner, 1984).

When nurses make clinical judgments, they not only act on practical knowledge and experience, but also use theoretical knowledge. Tanner (1989) and Brykczynski (1989) stress that both types of knowledge are required in complex clinical situations.

Clinical Judgment with Rationale

Nursing diagnosis as a problem-solving process refers to strategies utilized to make a judgment in clinical settings. Nursing diagnosis is a labeling skill of clinical judgment/decision making and recognition of the health problems that are focused on in nursing. The term diagnosis is used as a category name for a health problem and a process of identifying health problems (Gordon, 1987). Gordon notes that the following points were emphasized in the description of diagnosis as a process of judgment:

1. The diagnostic process includes the collection, interpretation, and clustering of information. Then a name is given to the health problem.

2. Diagnosis as a process and diagnosis as a category can be separated for purpose of discussion, but they are inseparable when used in practice. (p. 28)

Nursing diagnosis is a cognitive process and a highly standardized diagnostic judgment skill directed at interventions. The thinking process and the knowledge used in nursing diagnosis are clarified. However, it is unclear in actual complex situations how nurses are able to make judgments and provide effective care based on nursing diagnosis or problem-solving skills.

Nursing diagnosis and problem solving in nursing process developed in the '70s are central concerns. On the other hand, they have been criticized by clinicians because

of limitations in actual clinical practice, because nurses are involved performers in clinical situations. A nurse's emotional or subjective responses to situations influence his or her judgments, and the nurse's judgments are influenced by social context factors (Field, 1987). Wilkinson (1987/88) reports that nurses who feel a strong sense of responsibility for their own actions seem to be unable to cope with moral distress in making ethical judgments/decisions regarding patient care. Similarly, in an actual situation nurses are required to make a subjective qualitative judgment/decision. Arguments have arisen as to whether highly standardized and decontextual nursing diagnosis/problem-solving skills are useful in highly complex clinical nursing situations. McGuire (1985) claims that different types of problems require different kinds of strategies.

Refuting the notion that nursing diagnosis is decontextual, Gordon (1994) proposes a model of clinical judgment which integrated diagnostic-therapeutic and ethical reasoning. Gordon argues that most ethical concerns arise in the context of nursing assessment, diagnosis, caregiving, and evaluation. She also asserts that all clinical situations have diagnostic-therapeutic and ethical dimensions and that the ethical dimensions are an integral part of each nursing process component.

Addressing another concern, Shamansky and Yanni (1983) point out that nursing diagnosis may preclude the intuitive elements of decision making which are embedded in expert practice. Consequently, the relationship between the amount of clinical experience and the extent of one's problem-solving ability is inconsistent. A

gap exists between being an expert experienced nurse and being an expert problem solver or an expert diagnostician. In their study about expert nurses knowing the patient, Tanner and her associates (Tanner et al., 1993), stress that "The practical discourse on knowing a patient and its significance to clinical judgment simply cannot show up when practice is viewed through the lens of the rational models" (p. 279).

Intuition and Intuitive Judgment

Tanner (1989) uses the term *intuition* to describe judgment without rationale. Moreover, Benner and Tanner (1987) state, "Intuitive judgment is what distinguishes expert human judgment from the decisions or computations that might be made by a beginner or by a machine" (p. 23).

How is intuition defined when used in the context of nurses in a clinical setting? Intuition may be a sixth sense that involves perceptions outside the traditional channels of hearing, sight, smell, taste, and touch. Issack (1978) states that terms such as hunch, guess and feel are synonymous with intuition when they are used in a context which alludes to arriving at knowledge without conscious awareness of rational thinking. Intuition also is defined as a personal ability to grasp the deeper meaning and significance of problems without the use of linear analysis (Bruner, 1960). Hence, intuitive behaviors may reflect skills at integrating and synthesizing diverse and complex information (Cosier & Aplin, 1982).

Benner and Tanner (1987) interviewed 21 expert nurses who had at least 5 years of experience in a single clinical area. They considered the examples of nurses'

intuitive judgments using six key aspects of intuitive judgment introduced by Dreyfus and Dreyfus (1986): pattern recognition, similarity recognition, commonsense understanding, skilled know-how, sense of salience, and deliberative rationality. Benner and Tanner stressed that the experts' intuitive judgments are recurring, skilled capacities based on education and experiential learning. The problem with formal logic is that it ignores the human expertise that can involve itself in ambiguous, open, unstructured situations. Finally, Benner and Tanner concluded that intuitive knowledge and analytic reasoning are not in an either/or opposition; they can work together.

In her conceptual analysis, Rew (1986, 1988) defined intuition in terms of knowledge that was received in an immediate way, was perceived as a whole, and was not arrived at through a conscious linear, analytic process. Rew (1988) interviewed 11 registered nurses and asked (a) how they experienced intuition in clinical practice, and (b) what they did immediately after an intuitive experience occurs. In response to the first question, the majority of nurses described their intuitive experiences in both global and specific feelings. Several nurses described their experiences of intuition as knowing rather than feeling. Analysis of the responses to the second question resulted in the formation of three categories of responses: affective, cognitive, and behavioral. Affective, cognitive, and behavioral consequences of intuition are reflected in decisions and actions. As a result, Rew (1988) indicates, "Findings provide evidence that nurses recognize intuition as a component of clinical practice in making decisions and taking action" (p.153).

Based on her earlier research, Rew (1991) interviewed 16 nurses who worked with child or adolescent psychiatric-mental health patients. She reported that in situations that are frequently ambiguous and of crisis proportions, such as psychiatric-mental health care of children, nurses who are sensitive to nonverbal cues and willing to act on their hunches can make a difference in the care planned and provide effective care.

Young (1987) believes that nursing process is a multidimensional activity that may include intuitive data and decisions that are grounded in subjectivity. In her research using the grounded theory approach, Young asked 41 female registered nurses to describe their past intuitive experiences. From the results Young was able to conclude that in the process of intuition, there were isolated cues, images, feelings, and recollections of past and present experiences that became integrated with the current situation. The outcome of an intuitive experience is a consequence in the form of knowing or doing, that is, the data indicate that intuition functions during nursing judgments as both a process and a product.

Polge (1995) conducted a quantitative study using instruments and examined the relationship between self-reported level of nursing proficiency and the use of intuition to make clinical judgments in critical care nurses. The study showed that as the level of nursing proficiency increased from advanced beginner to expert, there was a significant increase in the use of intuition to make clinical judgments.

As Benner and Tanner (1987), Rew (1988, 1991), Young (1987) and Polge (1995) all suggest, intuition in nurses is related to their previous experiences in clinical practice. The more experience nurses have, the more they use intuitive judgments, because the expert's ability has been developed through clinical experience. Experience provides the critical source material from nurse-patient interactions and judgments that become the framework of clinical intuition (Young, 1987).

Moreover, Young (1987) suggests the following elements of the personal dimension which refer to conditions and attributes that facilitate intuition: (a) direct patient contact, (b) self-receptivity, (c) experience, (d) energy, and (e) self-confidence. The personal dimension is significant when considering individual differences among experienced nurses.

Clinical Judgment in Psychiatric Care

Most of the research on clinical judgment and on intuition has been conducted in critical care settings. In contrast with critical care settings, psychiatric nurses are more often required to make judgments in fuzzy and ambiguous patient situations. Regan-Kubinski (1991) conducted a qualitative study of clinical judgment based on the model of nursing process in psychiatric care. Fifteen American psychiatric nurses in this study were interviewed, and the in-depth interview data were analyzed using comparative content analysis. The findings of this study suggest that their nursing judgment rests primarily upon present patient behavior, embedded in a context of past psychiatric history, previous functioning, and psychiatric diagnosis. Furthermore, these

findings suggest that nursing judgment has an action-oriented rather than a labeling function.

Liukkonen (1993) performed content analysis on nursing care plans in psychogeriatric wards in a mental hospital in Finland. In the study, Liukkonen found that the nursing plans focused on the patient's physical needs more than psychic and social needs in a problem-solving approach. Despite the psychogeriatric patients' need for comprehensive care, nurses made an assessment only on the patient's physical aspects.

Research on clinical judgment/decision-making in psychiatric and mental health care has also focused on ethical/moral aspects. In a study of 177 psychiatric nurses in the Unites States, three case vignettes depicting restrictive situations were used (Garritson, 1988). Three possible interventions, each representing a different moral principle, were presented in each vignette. The subjects were to select one intervention for each vignette. Garritson found that nurses selected interventions supporting the beneficence principle more than those representing autonomy and distributive justice. In a study conducted in Sweden by Lützén and Nordin (1993a, 1993b), benevolence as a central moral concept of nurse decision making in psychiatric settings derived from a grounded theory approach. The subjects were 14 experienced psychiatric nurses. In this study, benevolence was defined as the wish to do good compared to beneficence which is the practice of doing good.

The decisions of psychiatric nurses in psychiatric hospital settings are strongly influenced by patients' limitations and social expectations. Psychiatric nurses experience conflicts between patient autonomy and control in the ward. The nursing judgment/decision focused on patient autonomy will be more difficult to make than that focused on patient beneficence.

Toguchi, a psychiatric nurse specialist and prominent leader in the area of nursing in Japan, and her associates (including the researcher in this study) have explored the clinical judgments and everyday practices of psychiatric nurses since 1980. This group held seminars for psychiatric nurses and discussed the relationship between clinical judgment and nursing action in everyday practices from 1980 to 1984 (Nakayama, 1984; Toguchi, 1980; 1981; 1982; 1983). In these seminars, interpretation of a case study through group discussion was used as a study method. This methodology focused on the process of caring in terms of "KATARAI" (in Japanese), that is, telling stories, searching the hidden meanings of the stories and, through discussions among a case presenter and group participants, uncovering the nurse's judgment which was the basis for his/her taking a particular action in a clinical situation. The issues of conflicts between individual judgment and group consensus in nursing teams, and disconnection between making judgment and providing care were disclosed using "KATARAI." It was discovered that in psychiatric hospital settings, even experienced nurses did not make their own judgments; rather, they worked on the rules and group norms in the nursing team. Therefore, the nurse's action in a clinical

setting was considered a reflection of a choice made from multiple possibilities in the situation.

These studies of clinical judgment in psychiatric care suggest that nursing action is more significant than cognitive judgment itself, and psychiatric nurses more often use criteria which enable them to evaluate moral judgments easily.

## Clinical Expertise

### Differences Between Novices and Experts

Observing the expanding influence of computers on society, Hubert Dreyfus (Dreyfus, 1979, 1984; Dreyfus & Dreyfus, 1986) chose to examine the notion of the superiority of artificial intelligence over human capabilities. He tried to understand human capacities and skills and determine what goes into becoming a human expert. Based upon the study of chess players and airline pilots, Dreyfus developed a model of skill acquisition with his brother, Stuart Dreyfus (Dreyfus & Dreyfus, 1986). In their study, the Dreyfus brothers identified five stages of skill acquisition and development: novice, advanced beginner, competent, proficient and expert.

Benner (1984) applied the Dreyfus model of skill acquisition to her work, conducting research using interviews and participant observations in six hospitals. The subjects were 42 (21 pairs of) newly graduated nurses and 51 experienced nurses.

Benner and her associates pointed out that the difference between levels reflects changes in four general aspects of skilled performance: (a) movement from a reliance on abstract principles and rules to the use of past, concrete experience; (b) shift from

reliance on analytic, rule-based thinking to intuition; (c) change in the learner's perception of the demand situation; and (d) passage from detached observer to involved performer (Benner, 1984; Benner et al., 1992).

Corcoran (1986a, 1986b) conducted a study of task complexity in hospice nursing using information processing. The subjects were six expert nurses in leadership positions and five novice staff nurses. The planning task was to develop a drug administration plan with a goal of controlling pain. The presented cases had severe chronic pain, and the subjects were required to make a decision in complex situations. Based on the findings, Corcoran (1986a) identified several factors as nursing expertise. First, knowledge of sources, types, and treatments of pain are important in the development of nursing plans to control pain. Expertise requires domain-specific knowledge and decision-making skills. Second, in the more complex cases, nurses generated more alternative actions. Third, the strong relationship between expertise and quality of plans are explained by the variability in nursing experience.

Hobus, Schmidt, Boshuizen, and Patel (1987) conducted research with 18 experienced doctors, 12 final-year medical students, and 5 doctors who had graduated less than 1 month prior to the research experiment as its subjects. The purpose of the research was to look for the reasons why the differences between experts and novices arise. As a result, they were able to determine that experienced doctors make extensive use of contextual information. The medical education provides the students with the anatomic and pathophysiological knowledge needed to understand the patient's

symptoms. However, in a critical phase of the diagnostic process, doctors are needed to understand the context of a patient.

Comparing the clinical judgment process in experienced nurses with student nurses, Itano (1989) found out that experienced nurses collected more cues than student nurses. As Pyles and Stern (1983) noted, that past experience lets nurses take in cues and analyze them so rapidly that their conclusions appear to be instantaneous. Astrom et al. (1993) also found that the involvement of experienced and skilled nurses had a positive effect on the patient. These studies indicate that clinicians develop their expertise through clinical experience.

However, in a review of studies on training, experience, and clinical judgment in the mental health field, Garb (1989) concludes that the study reports do not support the notion that experience is positively related to professional competence. For example, in a personality assessment study, experienced clinicians were no more accurate than less experienced clinicians, and presumed expertise was not related to the validity of judgments (Garb, 1989). Why was the value of experience not supported in the mental health field? Garb points out that clinicians have trouble learning from their experience because feedback is unavailable or biased for some tasks, and the judgment strategies of clinicians are not always adequate. Garb's research further indicated that clinical experience is not a sufficient condition to make accurate judgment. In order to become expert clinicians, they needed to be able to learn from experience.

Rubin (1996), a participant in Benner's research group, conducted a non-expert/experienced nurses' study. Participants in this study included 25 nurses who had worked in ICUs for at least 5 years and were identified by nursing supervisors as being experienced. Rubin found that the practice some experienced nurses described was safe but not expert. They never came to experience their patients as individuals because their contacts were limited to the patient's medical needs; therefore, the nurses had little memory of their patient contacts. Consequently, despite years of experience, they do not accumulate their clinical experience in patient care. In other words, these nurses have no developmental trajectory of skill acquisition to expert.

Clinical Competencies and Domains of Practice

Benner (1984) identified seven domains of nursing practice as competencies: (a) the helping role, (b) the teaching–coaching function, (c) the diagnostic and patient monitoring function, (d) effective management of rapidly changing situations, (e) administering and monitoring therapeutic interventions and regimens, (f) monitoring and ensuring the quality of health care practices, and (g) organizational and work role competencies. In this research, Benner showed that "nursing is a practice with its own competencies derived from the practice of nursing itself" (Bishop & Scudder, 1990, p. 65). The practice requires developing from the novice stage to that of expert.

Fenton (1985) identified competencies and skills of clinical nurse specialists using Benner's domains of nursing practice. Fenton conducted interviews and participant observations of 30 master's-prepared nurses who worked as clinical nurse

specialists at a large health sciences center. As a consequence of this study, Fenton added "consulting role of the nurse" as a new domain of clinical nurse specialists, and stressed three domains—organizational and work-role competencies, monitoring and ensuring the quality of health care practice, and the consulting role—as important competencies of clinical nurse specialists.

Brykczynski (1989) added a new domain and the competencies in her research based on Benner's 1984 study. The subjects in the research were 22 experienced nurse practitioners practicing in hospital-based ambulatory care settings. Brykczynski labeled the new domain as "management of patient health/illness status in ambulatory care settings," interpreting this domain as more typical of nurse practitioner practice. Using Benner's domains of nursing practice, McElroy (1990) also tried to uncover clinical knowledge in expert psychiatric nursing practice. Once again, clinical knowledge, consistent with competencies in Benner's domains, was found in the paradigm cases of expert psychiatric nurses.

Influence of Work Setting on Individual Nurses' Expertise

Nurses work with other nursing staff and health care professionals. Shanley (1988) reports that for charge nurses, the relationship with nursing staff members is the most important criteria in the evaluation of whether a nurse is a good or a poor mental health nurse. Corcoran, Narayan and Moreland (1988) claim that peer dialogue is useful for the continuing development of experienced nurses.

In order for a nursing/treatment team on the ward to be successful, group consensus and a sharing of ideas and values is often required. The quality circle, a Japanese management style, is a strategy used to develop the nurse's expertise in terms of sharing ideas and improving the quality of product and service toward patient care. It is best described as a small group of employees that meets regularly to identify, analyze, resolve, and prevent problems associated with their area of work (Smith, Mangelsdorf, Piland & Garner, 1989). The contributions of quality circles to nursing management include: (a) participating in organizational decision making, (b) improving the quality of patient care, (c) increasing nurse job satisfaction, (d) improving recruitment and retention of nurses, (e) reducing costs of nursing care, and (f) maximizing nurses productivity (Wine & Baird, 1983; Smith, et al., 1989).

The underlying strategy of this management style is a group-oriented working style. In Japan, nurses are expected to perform their role as a nursing team in hospital settings. The quality circles significantly contribute to support the function of the nursing team as a task performance group and to create morals and norms in the team. However, while a group becomes cohesive, group decision making tends to "average out" individual differences in opinions among group members (McGrath, 1984). The group cohesiveness influences clinical decision making/judgment of the individual nurse. That is, although the nursing team allows nurses to be a part of the decision-making process, it often does not accept the minority opinion. The pressure to conform isolates nurses who have different opinions or judgments from those of the

team. As a result, the creativity of individual nurses decreases, and the nursing staff become task-oriented. This form of work style in a psychiatric ward does not function as well in a crisis situation.

Goren and Ottaway (1985) address the problem of organizational chronicity. They found that as a result of avoiding the risk of failure, collusion develops in a team, and the team does not want to change. Consequently, the organization produces a culture of chronicity which is characterized by staff prediction of negative outcome and passive acceptance.

Furthermore, work based on formal models that is highly routinized hinders nurses from developing expertise. Gordon (1988, 1984) points out that formal models which require group consensus and standardized behavior result in monotonous social interaction. The formal models do not allow for tact, understanding, and the nuances of interpretation in situations.

Morrison (1990) describes the problem of task-oriented nursing staff in psychiatric settings as a tradition of toughness. The primary purpose of this study was to explore the relationship of organizational factors and violence. Morrison conducted the study using participant observation and in-depth interviews of patients and nursing staff members in the psychiatric units of an urban, a general, and a public hospital in the United States. The data, produced by interviews and participant observations, were analyzed using grounded theory. The 'tradition of toughness' was the key concept that emerged from the data. This concept was composed of three

components: value, norm and role. That is, control of patient behavior was emphasized, resulting in unit norms and staff roles in psychiatric care. The study results suggested that, "When control and safety are highly valued, then procedures and standardized behaviors result that seem to promote violence" (p. 36).

This tradition in psychiatric units was maintained by enforcers, staff members with high status, the staff member's feeling of belonging to the group, and the organizational need to manage violent patients. Morrison (1990) comments that the contribution of the formal system to toughness is unclear, but reports that the informal organizational system has a strong influence on promoting and maintaining the tradition of toughness. The tradition in mental hospitals takes over through informal mechanisms for training and socializing new staff members.

## Summary

As the result of observing an ever-widening gap between professional knowledge and real-world practice, nursing theorists and researchers have tried to develop nursing knowledge for a practice discipline and to identify the nursing knowledge embedded in practice. Based on Benner's (1984) work, which applied the Dreyfus model of skill acquisition, nursing researchers have tried to uncover clinical knowledge and clinical competencies of expert nurses. In the studies addressing clinical judgment, the differences between experts and non-experts in the area of clinical expertise were explored, and clinical judgment based on intuition and experience was identified as an expert nurse's ability used by expert nurses. However,

most of these studies on clinical knowledge and clinical judgment focused on highly complex care settings such as critical nursing care. There are few studies addressing clinical judgments and everyday nursing practices in psychiatric mental health care settings.

Furthermore, the review of literature strongly adhered to the view that expert nurses develop their expertise through clinical experience. Although clinical experience was found to be a necessary condition, it was not sufficient to promote the development of an expert nurse. The relationship between clinical expertise and clinical experience is, however, unclear. Rubin's (1996) study of experienced nurses who were likely non-expert experienced nurses found only one study which focused on clinical knowledge, and clinical and ethical judgment. Rubin's study suggested that for experienced nurses who lacked knowledge of qualitative distinctions and memorable experiences with patients, the years of experience did nothing to advance their skills to the expert level.

In psychiatric and mental health care, most of the studies on everyday nursing practice and clinical judgment, including moral decision making, were focused on patient violence and nursing staff dilemmas. A few studies uncovered the clinical world in psychiatric hospital settings in the United States and Japan. Consequently, this interpretive study of everyday practices and clinical judgment by experienced psychiatric nurses will address the clinical world in Japanese psychiatric hospital settings. It will identify not only the content of psychiatric nurses' experiences but

also examine the meaning of the word experienced in the expression experienced psychiatric nurses.

# CHAPTER III

# METHODS

## Research Design

The study design for this research was based on the philosophic underpinnings and methods broadly referred to as *hermeneutics*. Hermeneutics is the theory and practice of interpretation of texts, but it is neither firmly united behind a single theory nor a rigorous philosophical method. That is, hermeneutics is a philosophical movement or a family of critical concerns rather than a body of doctrine (Shapiro & Sica, 1984; Wachterhauser, 1986). Gadamer (1984) defines hermeneutics as the way to an entirely different notion of knowledge and truth that is revealed and realized through understanding. Gadamer also described it as interpretive study. In this study, the term hermeneutics refers to a method for interpretation of the written documents.

Data in this interpretive study were written documents, that is, texts. The texts were composed of (a) transcripts of clinical episodes and stories that participants described, (b) transcripts of the researcher and participants' dialogue, and (c) the researcher's observation notes.

The narrative texts of (a) and (b) were produced by dialogic interviews in which participants were storytellers and the researcher was the listener. The oral episodes and stories that participants told in the interview were dynamically

developed by respondents and different from written case reports and case histories (Polkinghorne, 1988). Van Manen (1990) explains about the dialogic structure of questioning-answering:

> Every time a view is expressed one can see the interpretation as an answer to a question that the object, the topic or notion, of the conversation asks of the persons who share the conversational relation. (p. 98)

Van Manen defines the dialogic interview as hermeneutic interview.

A nurse's practice experiences are personal. Although they cannot share the experience itself with another person, fellow nurses can begin to understand the meanings and realities in the clinical situations which nurses describe. The interpretation in this study does not aim at re-experiencing another nurse's experience. Rather, it aims at using narrative texts of everyday practices to grasp the hidden meanings of practice that were verbalized by nurses. The interpretation of narrative texts made it possible to reveal the nurses' concerns, clinical knowledge/wisdom in everyday practices and clinical judgments.

## Sample

### Settings and Participants

The participants in this study were 23 psychiatric nurses and licensed assistant nurses, 18 females and 5 males, who were selected from three mental hospitals located in metropolitan Tokyo, Japan (Appendix B). Nineteen participants were nurses, and four participants were licensed assistant nurses. Although most of the

nurses participating in this study were assistant head nurses and head nurses, each nurse provided direct patient care. The following criteria were used to select the participants: (a) more than 20 years experience on a nursing staff with direct patient care, and (b) more than 10 years of psychiatric nursing experience. Selection of participants was done in two phases to ensure a cross section of educational background and level of nursing license (nurse or assistant nurse).

First phase. The largest group of participants in this study was selected from the staff of a 700-bed private mental hospital. This private hospital is characteristic of traditional, asylum-like mental hospitals. Its history spans more than 60 years. There are many institutionalized patients living in this hospital, and the largest body of professional personnel are middle-aged nursing staff. A list of 60 experienced nurses and licensed assistant nurses was presented to the researcher by a nursing director in this mental hospital. The researcher sent each person on the list a personal letter requesting their participation in this study. Thirteen nurses and 4 licensed assistant nurses participated in this study. Two more nurses participated and attended the interview, but after it was discovered that they did not meet the criteria, their interview data were not used. Eight of the nurses and licensed assistant nurses who responded refused to participate, and four did not meet the schedule for an interview. Twenty-nine of the listed nurses and licensed assistant nurses did not respond. Age, educational background and the level of nursing license were not used as criteria to select participants. However, during the process of interviewing the participants and

interpreting their narrative texts, their ages and educational backgrounds were discovered to have influenced their nursing experience. Eight of the participants were approximately 60 years old, and 5 of the participants graduated from a 2-year nursing program for assistant nurses.

Second phase. Following the first phase, the researcher decided to arrange for a second sampling to recruit nurses who were in their 40s and/or had graduated from a regular 3-year nursing program to become nurses. (See information about the Japanese nursing education system in Appendix C). The participants of the second phase were selected from a 750-bed, asylum-type private mental hospital built approximately 30 years ago, and from a national hospital which holds 200 psychiatric beds and has a history for providing long-term psychiatric care. The procedures and criteria of selection were the same as for the first phase sample. The participants selected during the second phase were 2 nurses from the private mental hospital and 4 nurses from the national hospital. The participants were recruited personally by two nurses who were members of the seminar for psychiatric nurses in Japan (see Chapter II) and knew the researcher in this study as a result of that seminar. The researcher got permission from the nursing directors of each of the two hospitals before the participants of the second phase took part in the study,

## Life Courses of Participants

Participants' life courses as nurses were varied. Generally, however, the participants were divided into four groups by age, educational background, and social and economic situation when they began working as nursing staff.

The Japanese nursing education system is extremely complex, in part because the nursing education system has been strongly influenced by the Japanese social-economic situation. Consequently there are 13 possible pathways to become a nurse, a public health nurse and/or a midwife (see Appendix C). Also, there are two levels of nursing licenses: nurse and assistant nurse. The basic nursing education for nurses is a 3-year program in nursing open to high school graduates. The assistant nurse program is open to junior high school graduates and above. Licensed assistant nurses can later enter a 2-year nursing program to became nurses. The following described the life courses of the participants.

### Traditional Japanese Women: Stopped Work to Care for Family

The first group of typical nurses is comprised of approximately 60-year-old females who grew up during World War II. When they were adolescents, they experienced the end of the war, during which time values and belief systems changed remarkably. Some of these nurses were educated as military nurses and were active at the end of the war. Some of them entered their initial nursing programs just after the war ended.

Nurses in this first group were brought up in a traditional Japanese family and learned to obey their fathers and husbands. They quit their careers while taking care of their children, but they liked to work and came back when they were in their late 30s and 40s. Motives that influenced their return to work were death of a spouse, divorce or children becoming independent. They started nursing in the general hospitals and then transferred to work in the mental hospitals. After 30 years of age, these nurses had difficulty getting nursing staff positions in general hospitals because of age discrimination. That is, the general hospitals recruited young nurses. Mental hospitals, which had severe nursing staff shortages, hired nurses without age limitations. As a result, middle-aged nurses went to work at the mental hospitals. These nurses who experienced the end of World War II were trained to be hard workers, and they were strong-minded. They were survivors who overcame various barriers.

Opportunity Came to Work in Mental Hospital

The second group was comprised of nurses and licensed assistant nurses who were educated in mental hospitals. This group included all the male nurses in this study and only one female nurse, all in their 40s or 50s. They graduated from high school and started working as nursing aides at the mental hospitals. The mental hospitals were historically isolated from the community as asylums, and it was traditionally common that non-professionals worked at mental hospitals as nursing aides until they were trained as licensed nurses. Some nurses earned their nursing

license as they worked, and consequently their only work experience has been at mental hospitals.

Half of this second group of nurses remain licensed assistant nurses. Some tried to get the nurse license, but gave up for various reasons. In the 1960s, the nurses in this group organized a labor union with nursing aides at mental hospitals and worked to improve their work environment. One of the participants in this study was a labor union leader for 21 years.

The reasons the participants in this group became psychiatric nurses varied. Initially, they thought their work at the mental hospital would be time limited and short, yet all the participants interviewed had more than 20 years experience as psychiatric nursing staff. One participant said, "I think that I like patients as I continue working with patients at the mental hospital." For others, time just passed. Yet another said that she was motivated to become a psychiatric nurse because of patient care. She learned how to care from psychiatric patients and thus developed her expertise.

Private mental hospitals in Japan were built during the economic growth in the 1960s. At that time mental hospital administrators wanted men on their staff for their physical strength as well as for additional manpower. Participants in this second group include male nurses recruited at that time.

Although the second group and the third group come from the same generation, their motivation to become nurses differs greatly. The second group's

nurses were required by administrators to enter assistant nurse programs in order to continue working at the mental hospitals. In contrast, the nurses in the third group chose assistant nurse programs because they truly wanted to become nurses.

Married But Working as Nurse

The third group of participants were females in their 40s and followed a different professional pathway from licensed assistant nurses to nurses. During the 1960s, the difference between the assistant nurse programs and nurse programs was not well differentiated. Most participants believed that an assistant nurse's license was sufficient, so they continued to work as licensed assistant nurses at the hospitals. However, the nursing field was in the process of change from the late 1960s to 1970s, and some licensed assistant nurses went back to 2- or 3-year nurses programs to become nurses.

The social context for this group born after World War II differ from that of the first group. These women never planned to stop working when they married and had children. They were brought up during the era of economic development in Japan when women workers found acceptance in Japanese society and had the support of their husbands to work. As part of the new health care movement in Japan, these women were required to get a nurse license.

Most of the nurses in the third group in this study have become advanced nurses and work as leaders at the mental hospitals. They have been promoted from assistant nurse, to nurse, to assistant head nurse and to head nurse. Whenever they

confronted difficulties in their lives, they overcame the difficulties as transformative experiences and developed their expertise as nurses. Nurses in the third group tend to be hard workers and strong-minded, similar to those in the first group.

Chose Psychiatric Nursing

The fourth group of nurses in this study are in their 40s and 50s and are graduates from nursing schools affiliated with the national hospitals. When they were young, few nurses worked at the mental hospitals immediately after graduating from 3-year nursing programs. Nursing school teachers usually advised students to work at general hospitals when they were beginners, so the nurses who chose to work at mental hospitals were truly interested in psychiatric care. For example, one nurse who became a psychiatric nurse immediately after graduating from a national nursing school, was very interested in the human mind, so she chose psychiatric nursing. She started working on an open-door unit in a national mental hospital. Another nurse also chose psychiatric nursing directly out of nursing school because she lived with a mentally ill family member when she was a child. That family experience influenced her decision to become a psychiatric nurse.

The participants in the fourth group continued working as staff nurses for 20 years because they would have had to move to the another national hospital had they been promoted to a head nurse/supervisor position. The nurses who pursued that course moved to higher positions in nursing: from staff nurse, to head nurse/nursing supervisor and to nursing administrator. The only higher position-directed career

course is the path of administration. One nurse in the fourth group who became an advanced nurse felt limited by keeping her staff nurse position, recently accepted a promotion and became an assistant head nurse. Nurses in this group chose psychiatric nursing, but found it very difficult to continue working in psychiatric care because of the Japanese nursing career development system.

## Data collection

### Interview Procedure

The researcher interviewed all participants who agreed to participate in this study. Experienced clinical nurses, who are doers, tried to express their everyday practices through speaking. Therefore, the goal in the interviews was primarily to help participants tell stories, including histories and episodes, frankly and freely, in their own language and from their clinical experience (see Appendix D).

The researcher focused on responses to the following:

1. Please describe your clinical experience briefly since you graduated from nursing school or you started working as a nursing staff member.

2. Please describe your practice today. How are you working with patients?

3. When you look over your experience as a clinical nurse, are there any episodes or stories that stand out in your mind? Please tell the episodes or the stories which still strongly remain in your mind.

4. By what have you been supported to being a nurse? Please tell the episodes or the stories in everyday practices which still remain in your mind.

Relating to the attitude of the interviewer, Mergendoller (1989) notes that the interviewer asks occasionally for clarification and probes when memories seem emotionally salient to the tellers. In these interviews, the interviewer responded naturally to the participant's episodes and stories, in other words, participated/conducted dialogic interviews.

The interviews lasted approximately 1 hour. However, the interviews continued until the participant completed telling their stories or talking about their experiences. The interviews were conducted in a small room in the participant's hospital, depending upon the participant's choice. All interviews were taped and transcribed in the teller's native language, Japanese. Japanese transcripts of 16 participant's interviews were translated into English to aid the researcher's advising team.

Observation Notes

The researcher in this study did not conduct the participant observations as field research. Ricoeur (1991) points out:

> When the text takes the place of speech, the interlocutors are present not only to one another but also to the situation, the surroundings, and the circumstantial milieu of discourse. (p. 118)

Therefore, the researcher and the participant shared the reality in the interview situation. The audiotape captured the verbatim reality. The researcher's own responses to the situation during the interview were recorded as observation notes.

Before or after the individual interviews, the researcher visited the wards where participants worked for 15-60 minutes to gain a sense of the surroundings and the milieu to their stories. The researcher observed and perceived everyday patient activities, nurse-patient interactions and atmosphere such as tenseness, noise, smell, and friendliness in the ward and recorded them in observation notes.

## Interpretation of Texts

### Methodological Foundation

The texts consist of the transcripts of individual interviews and the researcher's observation notes. Interpretation of texts was developed by means of the hermeneutic circle based on Heidegger's (1927/1962) hermeneutics. In this study, the hermeneutic circle was used in the following dimensions:

The hermeneutic circle is a method of interpretation between the parts and the whole. This method involves building an interpretation of whole texts out of its constituent parts. The part (each story or episode) has meanings, but the meanings are understood in the context of the whole texts. The whole texts can only be understood in terms of its parts, and the parts only acquire their proper meaning within the context of the whole texts (Brown, Tappan, Gilligan, Miller & Argyris, 1989).

The hermeneutic circle is the constant task of understanding. According to Heidegger (1972/1962), in the circle is hidden a positive possibility of most primordial kind of knowing. On the other hand, the interpretation of the texts reflected on the researcher's own preunderstanding of psychiatric care. In particular, the researcher in this study is a Japanese psychiatric nurse with 25 years of experience and knows well the background contexts of psychiatric care in Japan. Even though it was impossible to divest completely of preunderstandings, it is important to become as clear as possible about the way the fore-structure of the researcher's understanding influenced the interpretation (Packer & Addison, 1989).

In this study, as Packer and Addison (1989) delineate, understanding the participants' everyday practices by immersing the researcher in their world, reflecting on the researcher's own preunderstanding of their experiences, and placing the researcher's interpretations within a large background context are central elements of an interpretive approach.

Procedure

Reading texts. First, the primary reader (the researcher in this study) read the whole texts of each participant written in Japanese, and focused on each episode, story, and situation. Second, the reader identified the following:

1. What was the situation? What happened there?
2. What were the participant's concerns?
3. What themes and issues recurred in the situation?

The product of the readings were themes and issues in each episode, story and situation. Brown's research group (Brown, et al., 1989), which has conducted research using an interpretive method, suggested multiple readings because each reading approaches the texts from a different standpoint. In the present study, the reader used multiple readings from standpoints of care (everyday practices and participant's central concerns), the development of expertise (clinical judgments and learning from clinical experience), and history (the process of accumulated clinical experiences and the reflections of personal life history).

Interpreting texts. Themes, issues and exemplars in participants' stories were tentatively categorized from standpoints of care, the development of expertise and history. These were interpreted in each participant's social context, and the thematic relationships in and between the text of each participant were explored by the primary reader. Next, two Japanese readers and two participants in this study who are psychiatric nurses collaborated to develop the interpretation of texts. The Japanese readers explored the meaning of memorable experiences in the participant's social background and everyday practices in Japanese culture, and uncovered the clinical world of experienced psychiatric nurses. Finally, the researcher translated the texts to English and wrote and re-wrote the interpretations until the American readers (the researcher's advisors) concurred that the interpretations were understandable, consistent with the texts, and coherent.

## Methodological Rigor

As described in the methods section, interpretations in this study include the validation procedure in terms of the hermeneutic circle. Packer and Addison (1989) point out that the components of validation are related to the manner of inquiry:

> A manner of inquiry is guided by a sense of the complexity of the relationship between researcher and research participant. So an interpretation is oriented by the researcher's effort to come into the hermeneutic circle in an appropriate manner (p. 277-278).

In addition, Packer and Addison (1989) suggest four approaches to evaluation of interpretive accounts, all of which were components of this interpretation. The first approach to evaluation is examining the relationship between the interpretation in texts and external evidence. That is, the researcher will be required to seek information that lays outside the texts. The second approach to evaluation is the participant's interpretation. The third approach is to seek consensus among researchers/readers of the texts. This evaluation will be done by discussion among researchers/readers in the same project and consultation with colleagues not involved in the project. The fourth and final approach to evaluation is to examine the relationship between an interpretive account and future event.

In this study, the dialogic interviews themselves included the validation procedure. The dissertation committee members were employed as readers of texts for establishing rigor/trustworthiness of interpretations. Moreover, for the validation

procedure of interpretations, two Japanese psychiatric nurses who studied in graduate nursing programs were employed as readers. The multiple interpretations of texts by insiders (the researcher and the participants) and outsiders (the dissertation committee members who are English speakers and the Japanese psychiatric nurses) were used to uncover the biases and prejudices of each reader's understanding.

Mishler (1986) recommends the researcher keep returning to the original recordings and devise explicit transcripts. The interviews in this study were conducted in Japanese, and Japanese texts were produced based on the interview data which were then transcribed. Then the Japanese texts were translated into English. Biases of translations and cultural differences were unavoidable. Therefore, whenever differences in interpretation between the Japanese readers and the American readers were evident, the researcher returned to the original recordings, Japanese transcripts and English-translated texts and determined whether these differences were a result of interpretations from different points of views or from cultural differences among the readers.

Additionally, the researcher's observation notes from interviewing and visiting the psychiatric wards where participants worked served to enhance accurate interpretations. The researcher's perceptions in the clinical settings were useful to determine the interpretations of the narrative texts. The interpretations were informed by the stance of Gadamer (1989) that the sensitivity to the text's alterity involves

neither neutrality with respect to content nor the extinction of one's self, rather it is important to be aware of one's own bias.

## Protection of Human Subjects

The consent to participate in the study was individually informed and voluntary after approval by the Oregon Health Sciences University Human Subjects Review Committee (see Appendix E). The research was conducted systematically through the organizations for which the participants worked, although it was understood that because Japanese culture often demands conformity it might be difficult for participants to refuse to participate or withdraw from the research project. In Japan, informed consent applies to the organization/group to which participants belong rather than the individual. Therefore, the researcher sent letters to the presidents and nursing directors in the private mental hospitals and acquired permission to interview experienced nurses. Subsequently, the researcher sent a letter to the nursing director of a national hospital requesting permission to interview experienced nurses. The researcher, however, did not report to the presidents and nursing directors whose nurses agreed to participate in this study.

Once permission from the administrator was gained and the list obtained, the researcher sent a letter directly to potential participants asking them to take part in this study. The researcher was careful to consider the protection of the subjects' autonomy in informed consent.

This study provided a good opportunity for participants to review their clinical experience, to express their thoughts and feelings regarding their everyday practices, and to reveal their personal beliefs, values and abilities. Sometimes it broached the participants' privacy. The researcher did not push participants share experiences they did not want to disclose. However, some participants shared stories that they had never before revealed to others. Some participants, in describing their career experiences, included experiences from their personal lives.

For the protection of participants' privacy, audiotapes, transcripts, computer disks and texts were kept in locked cabinets. In order to make the transcripts and do the interpretations, the texts were shared with research assistants, the dissertation committee members and two Japanese readers. To protect privacy and confidentiality, the participants' names were substituted with a random coded initial, making it impossible to identify specific individuals or hospitals from the narrative texts in this study.

## Limitations

In this study, the researcher used dialogic interview as a method of data collection. Although this method provided ample data, group interview might also have been appropriate. In Japan a method of interpretive case study group discussion known as "KATARAI" (telling stories to each other in Japanese) would also be useful for Japanese advanced psychiatric nurses who have many memorable clinical experiences. Using the "KATARAI" method of telling stories and responding freely,

the discussion itself is interpretive. Therefore, if "KATARAI" were used as a method of data collection, the narrative texts would be richer, and a deeper understanding might be gained because participants in the group who have different experiences would make different interpretations. "KATARAI" focuses on revealing the hidden meaning of the deliberative clinical situation and the process of more creative care. Thus, the different aspects of psychiatric nursing practices would be uncovered by group discussion.

Although "KATARAI" was expected to be used in this study, it was not actually used. The participants preferred to use dialogic interview with the researcher rather than group discussions. The clinical nursing experiences they described were undetached from the participant's personal lives. In order for the participants to describe their clinical experiences in terms of feelings, thoughts, values and beliefs, they had to be able to reveal themselves. Hence, the participants described and interpreted their everyday practices and memorable experiences in psychiatric care within the safety of the relationship between the participant and the researcher. Consequently, narrative texts were limited to plain and slightly narrow descriptions. Perhaps after reviewing their lives as psychiatric nurses through the dialogic interview, and thereby having discovered the boundary between their professional and personal lives, it would be possible to conduct a group discussion as a second step.

Furthermore, this research has a limitation of sampling. Continuing to interview the participants with different backgrounds in different types of psychiatric hospitals would be important for future research.

# CHAPTER IV

## PATTERNS OF EVERYDAY PRACTICES

As Heidegger (1962) and Dreyfus and Dreyfus (1986) have observed, much of human activity can be characterized as thoughtless mastery of the everyday; that is, most of our day-to-day activities are carried out with no conscious thought and transpire with few memorable events. Moreover, it is usually very difficult to describe or explain everyday activities in response to questions such as "When and how did you wear your jacket?" "How many times did you breath this morning?" "How do you learn to walk?" Experienced nurses carry out much of their practice without conscious deliberation as long as events occur or unfold as expected. When there is a breakdown, or the situation is unexpected or out of the ordinary, then it claims the nurse's attention, deliberation and thoughtful response. These situations will stand out as salient or memorable episodes, while most ordinary practice and everyday occurrences go unnoticed or are quick to disappear from memory. Therefore, everyday practices cannot be described in the absence of outstanding or unusual episodes.

Twenty-three experienced psychiatric nurses agreed to participate in this study. When the researcher actually contacted some of the experienced psychiatric nurses and requested their participation in this study, one nurse refused, saying:

I don't have any particular episodes in everyday practices which I can describe. I try to forget daily practices within the day. I mean, I have forgotten patients

> care at the same time as I have finished my shift-work. It is a burden to have patients care remain in my mind.

Although gaining an understanding about the clinical world of the nurses who refused to participate in this study would have been advantageous, it was clearly not possible.

Participants were asked to describe their current day's practice in the interviews (see Appendix D). Not all of the examples reflected the participants' current practices. Some of them represented practice experiences the nurses recalled as salient past practices. As time has passed, their past practices have become linked with present practices. Hence, the examples from their past experiences were used to describe the characteristics of their current work performance.

The ways the nurses described their work and the central concern of their narrative accounts revealed four rather distinct patterns of everyday practices. The term *concern* is used to describe the recurring aspects of practice which mattered most to the nurse informant. Concerns determine how a person approaches any given situation, what is seen, what is unseen, and how a person acts (Benner et al., 1996).

The four patterns of everyday practice which emerged from this interpretation were: (a) the practices of routine work performers, (b) the practices of experienced nurses as good neighbors, (c) the practices of veteran nurses with marked individuality, and (d) the practices of advanced experienced nurses.

The first pattern of everyday practice was based on daily routine work as a member of the nursing team. An experienced nurse illustrated his everyday practice

based on the patient's daily schedule. Another experienced nurse described her main work as the management of the patients' charts. For example, her routine was ordering the records of patients' physical examinations and checking patients' health problems in the records. The everyday practices of these nurses were characterized as being based on routine work rather than on patient-nurse interactions, so that the pattern of practices was named the practice of routine work performers.

The second pattern of everyday practices was based on patient-nurse interactions. Some experienced nurses talked about their everyday life with patients in the mental hospital. For example, their everyday practices were illustrated as playing games with patients, having a chat with patients and taking care of plants and flowers with patients. These nurses described developing wisdom in everyday life that came about as a result of working with patients. However, there were few salient episodes in which the nurses were required to make clinical judgments. The pattern of these everyday practices was named the practices of experienced nurses as good neighbors.

The third pattern of everyday practices was named the practice of veteran nurses with marked individuality. These nurses tended to talk about unusual individualized care which strongly reflected their personalities. Japanese staff nurses who work on the wards are required to function as a nursing team. However, the veteran nurses with marked individuality were devoted to patient care in spite of the range of routine work, common sense practices as a nurse, and group consensus within the nursing team.

Consequently, they were able to recall many outstanding episodes and stories of individualized patient care which included ethical/moral issues in everyday practice.

The fourth pattern of everyday practices was identified as characteristic of advanced experienced nurses. They were critical of their routine work in the psychiatric ward and tried to introduce innovation into their job. They shared their stories of clinical judgments and innovations within the nursing team. These advanced experienced nurses developed their expertise and made transition to expert through patient care.

The experienced nurses' work performance characteristics in everyday practices were not only influenced by the nurses' educational backgrounds and past nursing experiences, but also by relationships with doctors, relationships among the nursing team, and their positions in the ward. In this chapter, everyday practices will be described in the form of episodes and stories related to the nurses' interactions with patients, nursing staff, and doctors. Specific performance characteristics of each pattern are also identified.

## Practice of Routine Work Performers

Experienced nurses who are routine work performers are skilled nurses. They perform their routine work completely and quickly. They have medical knowledge and provide adequate physical care. As soon as they accept a doctors' orders, they take actions based on the orders. They prefer to work with doctors and often become doctors' assistants.

Care Plan as Daily Routine Work

The routine work performers make a care plan for patients, but they conduct the plan amidst their daily routine work. The following is an example of a nurse who has worked with chronically mentally ill patients for many years.

"We Make It a Rule"

> Nurse A: In spite of the open-door unit, there are many patients who lie on the bed all day long. They don't take exercise, leading to a circulation deficit, overweight, or weak legs. That is why I suggested taking a walk once a day unless patients have special reason that they can't. We make it a rule to make 3 rounds in our hospital yard. At first, there was a criticism that it was strange if people from outside of the hospital saw the scene that patients and nurses were wandering around in the hospital. But we continued it, and now patients have stronger legs than us.

The nurse observed the patients' situations on his ward and conducted the exercise program. He observed the condition of his patients and believed exercise might be good for them. As the program was repeated without perceiving patients' responses to the situation or patients' needs, it became a rule for both nurses and patients in their everyday practices. As the nurse described, the nurses took the patients out as part of their daily routine work. The patients walked for exercise at the same time and in the same way; therefore, the practice became ritualistic.

Task Oriented Performance

The practices of routine work performers are based upon the nurse's point of view and task orientation. Some experienced nurses raised questions about the performance of routine work performers. Nurse B, who works at a closed-door unit where there are long-stay patients with severe mental illness, expressed frustration at having to perform daily routine work. She illustrates her everyday practices as follows:

"As If Washing Potatoes"

Nurse B: More than half of the patients in my unit need help when they take a bath. Many patients need to be led to the bathroom, too. And many patients depend on nurses even though they can move their hand when they shampoo. I wish I could let patients do whatever they can for themselves, but we don't have enough time. We can't use all day just for bathing.

Interviewer: Is it much faster?

Nurse B: Yes, it is. I think if I let the patients take enough time and do these things for themselves, they may be able to learn how to do such things little by little, but we have too much work to do to let them.

Interviewer: How many patients do you usually have in a certain bathing time? Here are approximately seventy patients, but some patients can take care of themselves if only you tell them the bathing time, can't they?

Nurse B: Yes, half of them can. Even such patients need cuing to keep themselves clean. Before, we didn't watch such patients closely, but one patient

> died in the bathroom. The patient could wash herself, and there were only 20 minutes that no one else was with her in the bathroom. When next patient came in the bathroom, she was floating in the bathtub. The bathtub of this unit was rather deep. We discussed reconstruction of the bathroom, but there were some problems. So now we have nurses watch patients during the bathing time. For nurses, there is an advantage that we can find the patients who can't wash themselves very well and teach them. But from the patients' point of view, it may be uncomfortable that they are watched and told to do this, to do that. It's difficult to find the way which is good for both sides. It takes about one and a half hours to bathe such patients who need help.

Nurse B has approximately 25 years of experience on a nursing staff at mental hospitals. She started working as a nursing aide at a mental hospital after graduating from high school. She worked as an licensed assistant nurse for a while and got the nurse's license three years ago. Her education included a new curriculum which advocates care different from the old-fashioned care commonly found in mental hospitals. She indicated that the way patients are bathed is like washing potatoes, and she feels it is inhumane. On the other hand, she understands why this method is used, that is, there are many institutionalized patients and nurses have a great deal of routine work to do in a short time span. Consequently, although she dislikes that patients are treated like potatoes when bathing, she cannot entirely deny the appropriateness of the

practices of the routine work performer. The practices of routine work performers are strongly connected with the characteristics of the psychiatric ward.

For example, despite having nursing aides available to help patients take baths, the experienced routine work performers continued to participate in traditional care, such as patients' bathing, because experienced nurses find clinical wisdom in their routine work. Nurse B said:

> We can check the patients' whole body. For example, we found patients who were bitten by ticks, so we tried to get rid of the ticks. Another time we found a patient who had an internal bleed from a fall. One nurse found that a patient's breast was hard as a stone. The patient could wash herself, so the nurse found it by chance while she watched the bathing patients. We took the patient to the university hospital, and she had many tests. The doctor thought that it might be a cancer, but every time she saw the doctor, the tumor became smaller little by little. She's still here. It's a great advantage to have nurses watch the patients bathing so that we can check patients' conditions.

The practices of routine work performers are important to maintain a baseline of everyday practice in the psychiatric ward. In particular, as experienced routine work performers provide continuously standardized care, their performance makes the ward administration easy, and consequently patients' everyday lives remain safe and stable. Nursing administrators and doctors often endorse routine work performers as good nurses.

## Practice of Experienced Nurse as a Good Neighbor

Experienced nurses as good neighbors take care of their patients as if they were family members. They are very kind and comfortable to be around. The experienced nurses and patients spend a good deal of time together doing everyday activities. The nurses avoid overinvolvement in patient problems and keep some distance so as not to confront social reality. Hence, the ward has become the patient's home and as a result, these nurses produce dependency in patient care and institutionalization. The following are illustrations of the everyday practices of licensed assistant nurses:

> Nurse C: Patients were very friendly. I liked gardening with them. If I work hard, the patients worked earnestly, too. That encouraged me to continue to work there.
>
> Nurse D: I usually talk to the patients about their hobbies, families, or hometown. Even a patient who didn't open up until that time would start talking to me. For example, the patient who is playing mahjongg there, he needed for a long time to calm down. He trusts me very much, calling me "Dad." Once I told him that my daughter was born in the same place as his birthplace. He lost his own father 5 or 6 years ago from cancer. So he started calling me "Dad," and I think it's good for him.

Practical Wisdom in Everyday Life

Experienced nurses as good neighbors seldom perform based on the patients' care plans or therapeutic goals. Rather they have a sort of philosophy based on their experience such as:

> Nurse C: Some people may ask, "What is the best in psychiatric care?" I think it is important that both the patients and the staff are happy. When there are two or more people, it is not good if one is happy but others are not. . . . So I think it is good if the patients and staff are equal. I don't think it is good when the staff behave as if they were teachers and the patients take the part of students.
>
> Nurse D: I always talk to a patient, "You are now a patient, and I am now wearing a staff uniform. But we are basically the same human beings. I also have a lot of weak points." Then the patient would open up. While working in a hospital where there were many patients who were in crisis situations, I learned communication naturally little by little.

For experienced nurses as good neighbors, there are fewer boundaries between patients and nurses. They view the patients as fellow human beings and see them as equals. Their philosophy is not theoretical, but practical. Experienced nurses as good neighbors prefer to learn through working with patients and produce practical wisdom for everyday life. They acknowledged that their patients taught them many things. A licensed assistant nurse talked about how he communicated with a patient in the protection room:

> If the patient is crouching and you are standing, you will look down on him. So we both crouched and kept the same eye level and talked. If you talk from the higher place, the patient would feel that you are haughty when he is looking up to you from his lower eye level, even if you don't mean it.

Using Common Sense

Experienced nurses as good neighbors also use common sense to understand the patient's situation. Their concrete advice based on common sense in everyday life is useful for long-stay patients who are going back to the community.

> They listened to me when I gave advice. The other day I talked to a patient who worked outside of the hospital. I taught her what she should do when she couldn't get to work on time. I said to her, "You have to call your boss first. Your boss will be worried about you, and as if you are in a hurry, you might forget to check the kitchen and the stove might be still on." She listened to me very calmly and I found that her eyes were full of tears. She said that she was happy to listen to me, because she felt as if she were being given advice by her mother.

The experienced Nurse T, who was a mother and a wife, introduced her life experience into the long-stay patients' care. In the interview, she talked about them using phrases like "her younger sister's care" rather than "a mental patient's care." Nurse T's focus was on helping the patient with social disability to be able to maintain their everyday life. She had a great deal of common sense gained from her life experience which

enabled her to effectively assist her patients with their everyday needs. Such common sense, which experienced nurses use, is effective in promoting self-care abilities in their patients.

Practice of Veteran Nurse with Marked Individuality

Veteran nurses with marked individuality are skilled nurses. They often prefer to take care of difficult patients and in doing so provide effective care. In this way they differ from the other staff nurses who usually acknowledge the superiority of the veteran nurses in the team. The abilities of veteran nurses with marked individuality are strongly associated with their senses. For example, they seem to grasp who is a good nurse and who is their favorite patient by intuitive sense. They understand intuitively the characteristics of patients and the members of the nursing staffs with whom they work.

Effective But Unusual Care

The veteran nurse with marked individuality often seems to behave like a lone wolf. She/he dislikes standardized and ordinary care. Therefore, she/he takes risks, breaks rules and may violate ethical guidelines. The following story was told by the veteran Nurse E.

"Nurse Slapped My Cheek"

The patient was a 28-year-old married woman. She killed her child and tried to commit suicide by jumping off a building. She injured her back, but she got the runaround from hospitals and didn't get adequate treatment. For example, she

used a catheter herself without disinfecting it. I was surprised because I have never seen such a patient. She refused everything and everybody. Only her mother took care of her. After she was admitted, she continued using a catheter herself. Young nurses tried to help her, but she refused nursing care. One day I asked the young nurses, "Why don't you take care of her. You are educated nurses." They said that they didn't want to argue with the patient and also they were afraid to be in bad graces with her. I said to the young nurses, "You shouldn't say that. Here is a hospital. It is wrong to make the patient use a catheter without disinfecting it. As long as I am here, I will take care of her." Then I went to see her and tried to use a catheter with my hand. She got angry and put on fearful airs. I said strongly, "If you don't want to get nurses' care, you should be discharged." I reported to the doctor in charge and the assistant head nurse that I slapped her on her cheek because she didn't take advice from others. After that I did care for her catheter.

She came to nurse station and said, "Ms. E slapped my cheek." The assistant head nurse asked her, "Why were you slapped by the nurse?" I was lucky because the assistant head nurse gave me freedom and I continued to care for the patient. Then the patient took medicine and six months later, she became better and was discharged. When her discharge was scheduled, she said to me, "Ms. E, you took great care of me, thank you. The doctor and nurses' efforts

brought me discharge." I have never heard from a psychiatric patient such words of thanks.

This story stood out in her 35 years of nursing experience and still rouses feelings of guilt. She said, "After this episode, I never slapped a patient's cheek. I was aware of my strong personality and ashamed that I didn't control my emotional feeling."

Nurse E had many outstanding episodes in her nursing experience. For example, by developing a patient-nurse relationship, she helped a difficult long-stay patient who was a troublemaker in the ward to rehabilitate and be discharged. These practices were effective only because of her personality. Even though we found that there were excellent nursing skills in her practice, she was not able to share those nursing skills with the other nurses. The veteran nurse who was trained as a "doer" like Nurse E seldom expresses his/her emotional feelings and ideas. The practices of veteran nurses with marked individuality are comprised of personal, practical knowledge.

Challenging the Nurse Who Provides Ordinary Care

The following episode also comes from an advanced nurse with marked individuality. Nurse F is presently an advanced experienced nurse, but this episode reflects the characteristics of veteran nurses with marked individuality. That is, she grasped a patient situation and developed the patient's social ability, orchestrating the relationship between the patient and her primary nurse. Nurse F worked with the patient without telling the primary nurse, so that the primary nurse did not know what was happening behind her back.

"Nurse-Patient Game"

She was a long-stay patient with a chronic mental illness. When I went shopping with some patients to a convenience store in the hospital, she always joined with us and bought some candies and snacks. But she was stopped from having candies and snacks by her primary nurse because she didn't eat regular meals. The primary nurse thought that if she ate candies and snacks before regular meals, she wouldn't eat her meal. So only if she ate regular meals could she have candies and snacks. When the primary nurse found that the patient had candies and snacks, the nurse took them away and put them into the patient's locker. The primary nurse muttered, "Who gave the patient money?" I think that the primary nurse knew who gave her money, but she didn't ask me. I don't understand the reason why the primary nurse controlled the patient's shopping and eating because the patient had no physical problems and went out freely. I sometimes asked the primary nurse the reason why the patient needs continual controlling, but the primary nurse said nothing.

When the patient stopped going shopping, her social skills were getting lower. I suggested that she goes shopping and gave the strategies to keep her candies and snacks without negotiating with the primary nurse. But the patient always failed and her snacks and candies were taken away. When I worked evening-shift, the patient came to see me and got some candies and snacks. It is a repetitive cycle of a "rat game" among patients and nurses.

Nurse F often neglected the harmony of the nursing team. Occasionally she unconsciously/consciously provoked a patient into a response. Although the provocation disrupted the harmony of the nursing team, Nurse F was able to use the patient's response to increase his/her understanding of the patient's situation/character. This way of learning about the patient is a characteristic of veteran nurses with marked individuality.

It seems that the abilities of the veteran nurse with marked individuality developed only when the work environment is not totally structured and standardized. As nurses are educated in scientific/rational ways of thinking, we may meet fewer nurses with marked individuality such as the veteran nurses in these interviews.

## Practice of Advanced Experienced Nurse

Advanced experienced nurses are likely to be experts. Their everyday practices are fluid and consistent, so they look as if they are performing without making judgments; however, whenever someone asks them about their judgments, they are usually able to explain them. That is, they make judgments and take responsibility for them in their everyday practice.

### Clinical Judgment Embedded in Everyday Practices

Nurse G is a licensed assistant nurse with 29 years of nursing experience. She graduated from an assistant nurse's program which is affiliated with a national mental hospital in southern Japan. She said:

When I was in my early twenties, I worried that I didn't have enough life experience because when patients told me the various troubles in their work and interpersonal relationships, I couldn't give them good advice. Now I can talk to them not only based on my experience but give advice from a wide/multifaceted perspective.

The nursing team members who work with the licensed assistant Nurse G agree that she is an advanced nurse with an excellent practice. The following is an example of a practice demonstrating clinical judgment embedded in her everyday practice which flows with stability.

Nurse G: I focus on not aspects of their illness, but their everyday life. When I share everyday life with patients without intent, they open their mind naturally. When I became aware that a patient might have some problems, I wait until the problems appear. The patient usually comes to see me and explains his/her state, and the problem is uncovered. I understand what is troubling the patient. If I approach the patient too soon, the patient will be pushed into the problem and may close his/her mind. While I look after the patient usually after a short time, the patient's problem gradually emerges, and I can grasp the patient's situation without a special approach.

Interviewer: Even though you noticed that something was different, you don't take an action soon, do you?

> Nurse G: Of course there are cases when we have to make a judgment immediately. But this unit differs from an acute unit. Most of the patients are long-stay patients with chronicity. We don't need to say something before the patients brings up their issue. If we looked about the patient, we can find intuitively some differences in his ordinary everyday life.

In this situation, waiting until the patient brings up his/her problem is an example of the advanced experienced nurse's judgment in the practice. The nurse trusts the patient's ability/strength to manage his or her trouble, and waits to sees what the patient wants to do. Of course, the nurse's judgment to wait is based on her expert ability to know the patient and grasp the patient's situation. The advanced experienced nurse's practice includes reading and responding to nuances in particular situations.

Seeing Patients' Potential

Advanced experienced nurses also practice from the patient viewpoint and provide individual care for patients. Nurse J, an advanced experienced nurse, told a story that illustrates the differences between the rule-governed nurses and herself. She criticized the nurses who provide custodial care as follows:

"Remodeling Routine Work"

> Even if you make a protest against the way nurses do things, they would say, "That's the rule here. You are wrong." The fact is that the nurses dominate the patients. There are so many rules and if a patient doesn't keep the rule, a nurse scolds the patient. The nurses are rough in speech when they scold the patients,

like "Don't do that!", "What's this!?", "You know that, don't you?" in strong tones. They don't seem to care about a trust relationship between nurses and patients. Because of such attitudes of nurses, the patients get used to being scolded, and they are rough in speech when they answer the nurses. It's disgusting. . . . Not necessarily consciously, but I try not to scold the patients or shut them into a frame of rules. For example, there is a rule here that taking a walk starts at one o'clock. But if a patient really wants to go out earlier, I may unlock the door 5 minutes earlier. But I can't do such a thing all the time, because I may come into conflict with some staff for that. When I helped bathing, one of the nursing aides said, "You are always gentle." I wondered why she said so, and noticed that I don't talk too much when I take care of the patients in the bathroom. I would talk to a patient, like "I'm going to shampoo your hair. Next, your arms. Let's wash your body. Can you wash your groin for yourself?" But other than these, I wouldn't chat. If I help the patient quietly who always takes one hour or one hour and half to take a bath quarreling with the nurses, she would finish bathing very smoothly. I think in some cases the patients can act properly without being nagged so much.

The advanced experienced nurse grasps the whole situation and gives patients freedom to care for themselves. She looks at the patients' abilities and relies upon her judgments, responding situation by situation.

This advanced experienced nurse, Nurse J, is a staff nurse in a closed-door unit for chronic patients. But she had experience working as a head nurse and as a nursing supervisor in a psychiatric ward for 14 years. She knew how staff nurses can take responsibility in their practices and how to comport herself within staff nurses' competencies. Her way of thinking and courses of action were oriented toward problem-solving. She seemed to make good use of her energy and gave priority to doing well. Hence, she is calm, flexible and has energy for patients.

It is important for advanced experienced nurses to recognize the patient's potential and his/her own abilities and limitations. That is, advanced experienced nurses come to trust patients through nursing experiences with patients. Through their experience, they also know that even though positive outcomes are possible through immediate intervention, they can time an intervention more appropriately. The advanced experienced nurse grasps and accepts patients' abilities and limitations, and they can delay intervention until the patient is more able to respond.

An Impromptu Act

Experienced psychiatric nurses have the experience to deal with very psychotic patients in dangerous emergency situations. The advanced experienced nurse is usually able to function in a dangerous situation as if it were his/her ordinary everyday practice, and take care of difficult patients using their sense and feelings rather than theoretical knowledge. At the same time, their intuitive actions are based in clinical wisdom which

they have gained through experience. An advanced experienced nurse, Nurse F, described the following episode involving a psychotic patient's care:

"I Don't Know Why I Did It"

I worked the night-shift at an acute psychiatric ward with psychiatric emergency unit in the general hospital. The patient was a young girl. When her family took her to the psychiatric emergency unit at midnight, she was very psychotic. She hurt herself. For example, she pulled her hair out. As she didn't control herself, she was admitted from the emergency unit to a secure room in the acute psychiatric ward. Despite a lot of tranquilizers, she didn't calm down. Her psychotic state continued. At that time, I thought that her anxiety was increasing, but we couldn't give her any more medicine.

As I was the nurse in charge of the secure room, I told the other night-shift nurses that I would take care of her until other patients came to the secure rooms. I brought a mattress into her room and lay with her because so long as I stayed with her, she became calm and lay for a while. Early in the morning, the patient called me, "Wake up, Nurse! Wake up! Why are you sleeping here?" The patient had awakened and had returned to reality. On the other hand, I had fallen asleep unawares and was awakened by the patient. What happened, she had recovered dramatically.

In the interview, Nurse F said, "I don't know why I did it, but to stay with the patient was the only choice for me in this situation." This is an impromptu act without

deliberate thinking. In Japanese this is called "TOSSA NO KOUDOU." It is also an action taken by the expert nurse based on intuitive judgment.

Even though staying with the patient was the only choice, it was a potentially dangerous one because the patient was a psychotic person who had just come into the emergency unit. However, Nurse F grasped the patient's condition immediately. In addition, she knew that the patient was small, thin and very medicated. So she judged that it would be fairly safe to stay with the patient. Before Nurse F became a psychiatric nurse, she worked as an oncology nurse for 8 years. She had excellent physical nursing skills. She observed not only the patient's mental state but also the patient's physical state carefully. She knew how tranquilizers would affect the patient's state, and she provided comfort and safety by staying with the patient in this situation. ~~However,~~ Nurse F indicated that this episode was unusual, one which could be experienced unexpectedly.

Another experienced nurse, Nurse K, also described an outstanding episode in which she acted in an emergency situation.

> The accident happened when a nurse and I were walking the passage to go out for dinner at the evening shift. The patient was eating something at the passage and said, "Oh-Oh-Oh" to us. We looked at him "What?" and found him choking with the food. As he was rather thin and short, I grabbed his feet and hung him upside down, and hit him on the back and got the food out. We managed to help him.

Nurse K grasped the situation and assessed intuitively the patient's size and her own ability. Her judgment was embedded in her action.

Benner et al. (1996) described intuitive links between seeing the salient issues in the situation and ways of responding to them as expert practices. The intuitive judgments of the nurses in the previous episodes illustrated expert practice which was linked naturally between observing the patient's condition and taking action. The experienced nurses' exceptional practices created clinical wisdom within a situation and brought effective care to patients.

## Qualitative Distinctions of Work Performances

The characteristics which illustrated the four patterns are phases of experienced psychiatric nurses' practices. Some nurses made a transition from routine work performers to advanced experienced nurses, some made a transition from good neighbors to advanced nurses, and some stayed in the position of routine work performers or good neighbors.

What are the qualitative differences among the four patterns of practices? Advanced experienced nurses more or less have experiences as routine work performers, good neighbors and veteran nurses. How do advanced experienced nurses' practices differ from the other experienced nurses?

### Experienced Routine Work Performers Versus Advanced Experienced Nurses

Advanced experienced nurses and veteran nurses with marked individuality in this study also had a component of routine work performer. In particular, most

advanced experienced nurses recognized that they were also advanced routine work performers. Advanced experienced nurses performed the routine tasks quickly and produced free time to spend with patients. Nobody in the nursing team complained; as a matter of fact, the nursing staff respected them because when the routine work of the other nurses was upset, advanced experienced nurses helped them immediately.

Advanced experienced nurses are advanced routine work performers, but experienced routine work performers are not advanced nurses. As long as routine work performers provide practices based on rules and care standards within the group consensus in the nursing team, they never became expert nurses even though they had vast clinical experience. Gordon (1984) pointed out that standards of care and similar models guide nurses' behaviors; however, these only provide orders and guides to typical situations and general assurance of safe activity. Therefore, the practice of routine work performer based on the rules and care standards does not assure quality care.

Advanced experienced nurses use standards of care in the ward and with the patients' care plans, but they also usually go beyond their routine application and judge whether it is effective to apply the rules in individual patient's situations. For advanced nurses, the rules and care standards are only standards, not ways to provide individualized care.

Experienced Nurses as Good Neighbors Versus Advanced Experienced Nurses

Most psychiatric nurses become aware that their practices have a component of the good neighbor's practice. However, when advanced experienced nurses provide care like that of a good neighbors' practice, their practices tend to cultivate aspects of the patient's healthy thoughts and behaviors and support his/her self-actualization. Benner (1983) defines such a practice as a caring practice. According to Benner, "the caring practice is helping patients maximize their ability to continue with meaningful life activities despite their limitations" (p. 211). Consequently, the caring practice differs from the good neighbor's practices.

Good neighbors, who are kind people who live closely with patients, seldom consider the patients' care plans or therapeutic goals and do not make professional judgments. Unless experienced nurses as good neighbors consider themselves mental health professionals who are required to make judgments directed toward attainment of therapeutic goals, they will not become advanced nurses.

Veteran Nurses With Marked Individuality Versus Advanced Experienced Nurses

Veteran nurses with marked individuality hold a cluster of memorable cases in their memories and often provide effective care to difficult patients. For this reason the practices of veteran nurses are at the level of proficient or expert as described by Benner (1984; 1996). Veteran nurses break rules and neglect the harmony of the nursing team in order to exercise their own judgment in individual patient situations. They do not express their inner feelings, concerns, thoughts or judgments to other

nurses because they act on their intuition. Therefore, veteran nurses with marked individuality cause misunderstandings and sometimes are viewed as troublemakers on the nursing team.

Japanese advanced nurses who are referred to as veteran nurses have gained expert skills of leadership and interpersonal relationships with patients and their families, nursing staffs, doctors and other health professionals. Advanced experienced nurses in this study showed the expert skills of leadership and interpersonal relationships in their efforts to bring innovation to their nursing team. These expert skills are part of the critical care expert practice which Benner et al. (1996) described as the skills of involvement and working with and through others. On this point, advanced experienced nurses in this study are equivalent to expert nurses who were defined by Benner (Benner, 1984; Benner et al., 1996) in the United States.

## Summary

The episodes and stories verbalized by the experienced nurses explicated different characteristics of nursing practice. Although the practices of routine work performers are inflexible and stem from the nurses' point of view, these practices are important to maintain a baseline of everyday practices in the ward. Experienced nurses as good neighbors are very kind and take care of patients as if they were family. The practices of experienced nurses as good neighbors are based on common sense and understanding the situation through the patient's eyes. However, experienced nurses as good neighbors seldom act on the patients' care plans or therapeutic goals.

Consequently, they promote patient dependency. Veteran nurses with marked individuality take risks and provide effective care for difficult psychiatric patients. They are sometimes viewed as troublemakers because they break rules and neglect the harmony of the nursing team. Advanced experienced nurses usually grasp the whole situation, innovate the everyday practice in their ward and give patients freedom. Their practice is based on a patient-nurse trust relationship, and they know the patient's potential and their own abilities and limitations.

The Japanese refer to experienced nurses as veteran nurses. Not all experienced psychiatric nurses in this study were expert nurses, but advanced experienced nurses were equivalent to expert nurses in Benner's studies (1984, 1996).

# CHAPTER V

# CENTRAL CONCERNS AND ISSUES IN CLINICAL JUDGMENTS

As experienced nurses manage every situation through flexible judgment, their practice flows smoothly, as if nothing unusual happens. In this situation, the experienced nurses' clinical judgments are completely embedded in their everyday practice. However, in the clinical world of psychiatric care, unexpected, complex or troublesome situations occasionally arise which challenge the nurses' abilities to make effective judgments.

In this study, three major areas emerged in which nurses found it difficult to make judgments, or in retrospect, questioned the appropriateness of the judgments because of untoward consequences. These were: judgments related to patient suicides, values still deeply held by group consensus among the nursing team, resolving moral conflicts related to competing, and promoting innovation in traditional hospital care. In this chapter, which is focused on conscious, deliberative judgments in everyday practices, situations where nurses are required to make judgments and the nurses' judgments which come into question, will be described and discussed.

## Clinical Judgment and Patient Suicides:

## Relationship and Temporality

Most participants described trust relationships with patients as aspects of outstanding episodes and stories in their experiences. Their caring was geared toward developing the patient's health and ordinary life in the community. However, in addition to stories of recovery, the psychiatric nurses described suicides of patients. These episodes and stories demonstrate two central concerns in everyday practices: clinical judgment in the patient-nurse relationship in psychiatric care and the way in which temporality influences evaluation of the judgment.

### Clinical Judgment in Patient-Nurse Relationship

The first story comes from Nurse H who has 24 years of nursing experience in a mental hospital. He was a nursing aide for 9 years and a licensed assistant nurse for 8 years. He became a nurse about 7 years ago, and now is an assistant head nurse in a closed-door unit.

At the beginning of the interview, he said, "I have a lot of good stories with patients, but I don't know what and how I can say. . . ." "Uh . . . I don't recall a story which I can tell . . . ." For a while, he talked to the interviewer about his experience with nursing students, and then suddenly he shared the following story about a patient.

#### "Our Relationship Was Too Close"

Nurse H: I have recalled a sad episode which I recently experienced. The patient came from the same hometown as me. That evening, he came to see me and told

me about his past in a friendly manner. He had spent his life as a "YAKUZA" (gangster) in our hometown and had killed a person. After two or three days of talking about his past to me, he committed suicide igniting himself.

Interviewer: He burned himself to death? Did it happen on your ward?

Nurse H: No, it wasn't on the ward. He went for a walk and bought oil at the gasoline station close to our hospital. Then he poured oil upon himself and tried to make a fire with his lighter. At first, his lighter didn't work, so he went to a family market and got a new one. Finally, he succeeded in igniting himself and died. Therefore, I thought that it was bad to make him tell about his past life experiences. Recalling this incident must have deepened his guilty feeling, and because of this, he committed suicide.

Interviewer: How did you come to know about his accident?

Nurse H: On that day, I was in a meeting in the hospital conference room. The nursing director entered the room and said that there was likely an incident of self-burning in the hospital area. I felt something intuitively and hoped it was not him.

Interviewer: Intuitively?

Nurse H: My intuition came out. And I called the nursing staff in my ward unit, "Is he there?" They said, "He has gone out." I said, "Please look for him soon." I went out to look for him. We also called patients on the intercom asking them

to return to the ward. Everybody came back to the ward except him. So, I went to see the person who burned himself, but I couldn't identify him. The person was dark burned. It seemed that the person was him, but my feelings of denial were strong, so I couldn't recognize that the dead man was him.

Interviewer: I understand your feeling.

Nurse H: I didn't want to confirm his death in my mind. I was in strong denial and didn't believe that the person who burned himself was our patient. I recalled that he wore black sandals, but my memory was ambiguous. After that, his family went to the police office and identified the body. I worry about this incident very much because I think that he was motivated to commit suicide because of recalling his guilty feelings.

Interviewer: The patient came to talk to you, didn't he?

Nurse H: Yes, he did. But when I consider that situation now, I should have turned to the conversation and changed the subject. I knew that he felt very guilty for his past. I should have told my feeling to the doctor in charge and suggested "It is better for him to stop going out because he is depressed and in crisis." When I felt that something was wrong, I should have stopped him from going out. Despite the fact I felt that something was different after talking with him, I didn't take an action. If I had taken an action, I might have been able to keep him from committing suicide. But I failed to protect him. That is the heaviest burden for me. I was depressed for a while.

The nurse and the patient were from the same hometown on a small island in southern Japan. The island is a great distance from Tokyo. The patient may have opened up to the nurse after discovering the nurse was a hometown buddy. When the nurse heard the patient's sad stories, he sympathized with the patient. The nurse said, "Our relationship was too close."

Peplau (1969) insisted that professional closeness differs from the relationship with friends and neighbors and stated, "it requires the nurse to observe not only the patient, but her own participation in the nurse-patient situation" (p. 346). Interpersonal intimacy, which is the outstanding characteristic of a chum relationship, may cloud the nurse's judgment in the nurse-patient relationship. In her study of expert psychiatric nursing practice, McElroy (1990) points out that the nurse's concern that she not be over-involved with the patient, that she maintain a distance that would be therapeutic for the patient, was shared by other participants.

The nurse's judgment in patient-nurse relationships depends on the nurse's concern, whereas the nurse's care in patient-nurse relationships is often frozen by social norms/expectations. Nurse H was concerned about the patient's situation, but he did not share his concern with the doctor or the other nursing staff. He used his own judgment. Why did Nurse H not voice his concern to the others? He said:

> Our ward's environment has been changing rapidly since the Mental Health Law was enforced. Patients get a lot of freedom and take responsibility themselves. Most patients go out freely despite our ward being a closed-door

unit. Patient's rights in the mental hospital required health professionals to change.

Nurse H had a conflict between his responsibility as a psychiatric nurse and his trust in the patient's ability. Had the patient not been a psychiatric patient in the mental hospital, most people would say that he/she chose to commit suicide. Traditionally, psychiatric nurses have been burdened with social expectations to prevent patient suicides. Hence, psychiatric nurses watched and controlled patients in the closed-door units. Even contemporarily, suicidality is a major consideration in deciding whether to hospitalize a patient, and making judgments as to whether patients intend to commit suicide is still an important judgment task for psychiatric nurses (Regan-Kubinski, 1995). Therefore, the suicide of an inpatient is obviously viewed as a failure of a nurse's judgment. In the new movement of mental health care which emphasized human-rights and patient autonomy, Nurse H took this approach with patients in everyday practice. He gave patients freedom and helped them to develop their social skills. Consequently, his patient committed suicide, and he failed in the exercise of his judgment as a psychiatric nurse.

This makes the argument or dilemma of dichotomy: One is to make a judgment as a professional nurse to support patient autonomy. Another is to consider the range of responses to the patient including an understanding of the nurse's personal caring as a factor in responding to his patient. Nurse H's conflict was influenced by his personal

regard for his "hometown buddy," his professional concern for the patient's guilt and his ethical concern for the patient's autonomy.

Clinical Judgment and Temporality

If nothing happens, no one questions a nurse's clinical judgment, but when something unexpected happens as in Nurse H's story about the patient who committed suicide, the nurse's judgment is immediately questioned. In such instances, clinical judgment is not context free, rather it is very situational. Even though a nurse may have made an adequate judgment at the time, their reality changes because of a patient's suicide. They may feel that the judgment was wrong. When the reality changed with the passage of time, the nurse negatively reviewed the situation concerning this patient although he/she perceived it positively before the patient's suicide.

This research produced yet another story about a patient's suicide, as recounted by a veteran nurse with marked individuality:

"What is Wrong"

A doctor asked me to take care of a patient. The patient who came from Korea didn't speak Japanese well. When he was admitted to the psychiatric unit, he was depressed and withdrawn. He wouldn't talk and just lay on his bed all day. He was likely unadaptable to the hospital life. So I became his primary nurse.

I tried to communicate with him and knew that he wanted to smoke. At first I proposed that we go to buy a pack of cigarettes together. The next day we bought the cigarettes at an automatic vending machine in the hospital. After that,

> we went shopping together several times, and during that time we would communicate with each other. He was getting more open with me. One day, when I was reporting from day-shift to evening-shift, he glanced at me and was going past the nurses station. I said to him, "Where are you going?" The patient said, "I am going to buy cigarettes." I stopped my report and came to see him. I said "Wait! I am reporting now. Could you wait until I finish shift-report?" He responded, "I can go alone, because you taught me how to buy cigarettes." He looked so good. I and the other nurses in the nurses station sent him off with smiles. At that time, I did not doubt that he would come back soon. But he never came back to the hospital. He committed suicide.

This is a story which still remained in the veteran nurse's mind. The nurse regretted that she did not stop him from going out. The veteran nurse says that at that time she did not consider suicide as a possibility for this patient. Looking back she is still unable to discover why the patient committed suicide.

This raises the issue of temporality and clinical judgment. Clinical judgment is the nurse's judgment only here and now and in the particular situation. In spite of the passage of time, the nurses were looking for a causal relationship between their judgment of the patient's condition and the patient's suicide. Although the nurse's judgment regarding the likelihood that the patient would commit suicide was not an issue at the time, it became an issue once the patient committed suicide. The nurse reviewed the relationship with her patient and evaluated her clinical judgment at that

moment, then time passed, the patient's feelings may well have changed with time. The patient is in temporal, and the nurse is also in temporal (Benner, 1985; Leonard, 1989), that is, the patient and the nurse are existing in different time span.

As shown in Figure 1, both the patient and the nurse exist within a global historical-communal temporal flow. According to Heidegger (1927/1962), each person projects their future possibilities, retrieves their past memories/skills, and unifies them in the present. The historicity of the patient who exists in the historical-communal world flow might be related to his suicide. When the nurses made their clinical judgments, they had to decide what was better for the patients on the basis of their clinical experience and intuition in the situation. However, when the nurses learned that their patients had committed suicide, they needed to evaluate their judgments based on this subsequent knowledge. A nurse's care/concern when a judgment is made in a situation and their care/concern when they review that judgment after learning of a patient's suicide is significantly affected by the passage of time.

Heyd and Bloch (1991), who are psychiatrists, describe that suicide is not only a functional problem to which therapeutic techniques are applied but also an existential one. A patient's suicide is a complex and difficult problem in psychiatric care. On the occasions of the suicide stories in this study, the relationship of temporality and clinical judgment was an important issue.

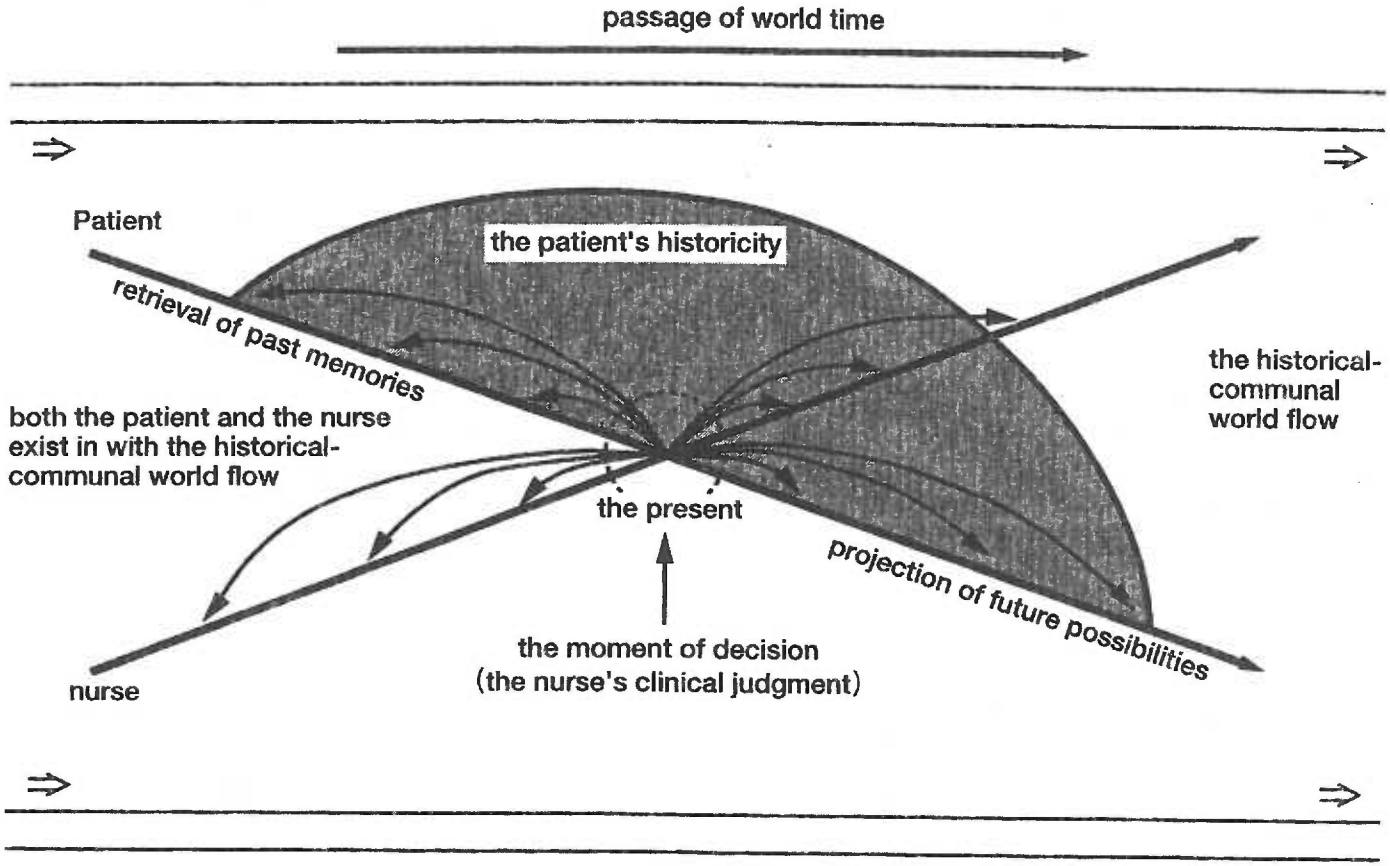


Figure 1. Clinical judgment and temporality.

Note: Richard Askay, Professor, Department of Philosophy, University of Portland, contributed to the development of this figure.

## Clinical Judgment and Group Consensus

The outstanding episodes of most participants described focus on patient-nurse relationships. Direct care in the patient-nurse relationship seems to be the most interesting and most rewarding work for Japanese psychiatric nurses. Because approaches to nursing care for ward policy and individual patient nursing care plans in the mental hospitals are group-determined, the patient-nurse relationship offers nurses the opportunity to develop expertise and assist in the patient's recovery.

The exemplars that follow show ways in which clinical judgment embedded in practice is evident in the competency of the individual nurse. Conflicts between the individual nurse's clinical judgments and group consensus raise questions from multiple perspectives, especially with regard to implementing change in mental hospital nursing practice.

### The More Nurses Provide Individualized Care, the More Nurses Have Conflicts

Each mental hospital is a microcosm. There are rules, group norms and customs peculiar to each mental hospital. Traditionally, psychiatric wards had been controlled by these norms and customs and have provided safety for patients, staff and society. In particular, psychiatric nurses were protected from dangerous situations by the group-oriented approach. In the group-oriented nursing team, the responsibilities for patient care in a ward rests with the team. As a group they agree to a care plan and the rules of daily living in the ward. It is expected then that all members of the team will conform

to these plans. It is believed that this conformity to the group consensus in the plan is essential for continuity and consistency in patient care.

However mentally ill patients' needs are very complicated, varied and individual. They change and may require a different approach than what was agreed upon by the team. When nurses make judgments to deviate from usual practice in order to provide effective care, the judgment sometimes causes the nurse/patient to break the rules of the ward. The following is an episode described by an experienced nurse who had approximately 10 years of nursing experience in a general hospital and 11 years of psychiatric nursing experience.

"Conformity Pressure in the Nursing Team"

> We had a patient who wanted to be discharged and see his family. His family promised to visit him at the day time, but they didn't show up. So he wanted to call and talk to his family. At that time we couldn't let the patients use the phone without the permission of the doctor who was in charge. I was working the evening-shift when the patient came and asked, "Could you call my family?" again and again. So I asked the nursing supervisor on duty if I could make a phone call for him. I thought, "He might get irritated and get injured by breaking glasses. Then it would be much better if he could calm down only through talking to his family and making sure when they can come next." I told my judgment to the supervisor on duty and she agreed, so I let him talk to his family on the phone.

> The next day other nurses talked about that behind my back, "How come she could decide such a thing on her own discretion?" and they complained to the supervisor of our ward. But I thought it would be better for the patient, and the supervisor on duty agreed. The patient said that he was getting upset and felt like breaking glass, but he knew he wouldn't do such things if only he could call and talk to family. The nurse who worked the night-shift told me that he calmed down after the call. I think such a small thing can keep patients from becoming psychotic. Later I reported what I did to the doctor in charge of him, and the doctor said it was Okay. So I thought I didn't do wrong, but I felt uneasy.
>
> Even now, there are many situations that I should make my own judgment. For example, a patient came to me at midnight to say that he felt restless and that a cigarette would calm him down. It didn't fit the rules of our ward, but only giving him one cigarette really calmed him and helped him sleep well. I think nurses should make judgments depending on each patient's condition even if doesn't necessarily fit the rule which the nursing team decided. . . .

This is typical of episodes in mental hospitals. No one expressed their concerns directly to the nurse, but rather complained behind her back. The nurse had a reputation among the members of the nursing team for delivering adequate care to the patients. However, as shown in this case, even though she sought and received advice from the nursing supervisor on duty, she broke the rules and neglected the group consensus. As

a result of this incident, the nurse has felt pressure to conform, to work within the group consensus. The conflict in staff members not only shows up in Japanese clinical situations but was pointed out in a psychiatric hospital setting in the United States (Forchuk, 1991).

To work as a nursing team on the ward often requires group consensus and a sharing of ideas and values. Even though a nurse may make a judgment regarding a patient's situation, she does not take action based on the judgment. Rather she provides care based on the rules and consensus in the nursing team.

Nursing Care Plan and Individual Nurse's Clinical Judgment

Nurse M talked about the relationship of nurses' individual judgments and the nursing care plan. She noticed the lack of individuality in nurses' approaches. Therefore, when she became a head nurse, she created a policy to manage the nursing team and foster individual nurses' expertise.

> When I became a head nurse, I watched for each nurse's characteristics on the team. One nurse did one thing very well, while another nurse couldn't so well, but she did other work quickly. . . . I tried to make a team in which each nursing staff member with different characteristic could develop their abilities efficiently.

The nursing care plan is sometimes obstructive to developing an individual nurse's ability. When the nurse makes a judgment which differs from the nursing care plan, some nurses would say that you can't have your own

judgment because it is confusing and loses the consistency of the care plan. Yet when a patient's state or situation changes rapidly, the nursing care plan may not fit the situation any more. That is, the nursing care plan may not always be best for the patient. We need a basic nursing care plan in order to identify each patient's treatment goal and to know what the patient needs and what is effective care for the patient. The patient-nurse relationship in psychiatric care is constantly developing and changing. Nurses don't block their freedom by themselves.

The following is an episode which Nurse M experienced in her psychiatric ward:

"Whose Rule Is This?"

A patient with schizophrenia was brought in by a rich family. He was unstable and spent money wastefully. He didn't control himself. His family gave up trying to manage his behavior. So he entered the psychiatric unit to learn to manage his everyday life within a framework. The nursing team made his care plan. One aspect of his care plan was to decrease his smoking. He was a heavy smoker who smoked 40 cigarettes a day. The nurses wanted him to decrease to 10 cigarettes a day. Of course, it was too hard for him to decrease so remarkably. He always made trouble with the nursing staff because of smoking.

One day, when I entered the nurse's station, the nurses were arguing with him. He wanted an additional 10 cigarettes. I asked the nurses the reason why they chose to limit to 10 cigarettes a day. The nurses didn't answer clearly, so I

gave him another 10 cigarettes. The patient smiled gleefully and returned to his room. I knew I broke the rule which the nursing team made as his care plan. I had a staff meeting soon and discussed his care plan. There was no reason why his smoking must be controlled by the nurses. His problem was not smoking, but wasting money.

We had a meeting with the patient and his family and decided on a limit for spending money. His family gave him 8000 yen (approximately 80 US dollars) every week and the patient managed the money himself. After that, he sometimes wasted the money buying too many cokes, but he didn't argue with the nurses because of his smoking. He became calm.

The staff nurses in this nursing team were aware that the patient's problem was complex and not only a smoking problem. Nevertheless, most inpatients in this unit were limited to 10 cigarettes per day, so the inclusion of this 10-cigarettes-per-day rule in the patient's care plan was based on common sense. However, the nurses were not concerned about the patient as a whole. Instead they were focused on keeping the rule in force and not allowing a nurse's individual judgment of the patient's situation to supercede it. The staff nurses became completely rule-governed. Nurse M made the focus of the nursing staff's concern change to the care of the whole patient regardless of whether it resulted in the breaking of a rule.

Gordon (1984) points out the dangers of excessive reliance on formal models such as standards of care, procedure manuals and nursing care plans. Two points are

similar to the problems which experienced nurses described in this study: (a) demand for excessive conformity when the same standard for all people is used, and (b) confusion between following rules and the need for judgment. When nurses who repeatedly perform everyday practices depend on the nursing care plans and standards without exercising individual judgment, nursing care of the team averages out, and the nurses gradually neglect patients' responses for nursing care outside the boundaries set by the standards. The nurses' clinical judgments are influenced by pressure to conform, and the nurses' concerns focus on keeping the rules and group consensus in the nursing team.

The issue of individual nurse's clinical judgments and group consensus in the nursing team can be explained by the linear model of clinical judgment (Figure 2). It is a problem of how the clinical judgment of an individual nurse does not link with her/his nursing action, because group norm or role expectation in the ward where the nurse works strongly influences his/her action. That is, even though the nurse made a judgment regarding the patient's situation, she/he did not take an action based on the judgment, but rather provided care based on the rules/norms developed by group consensus in the nursing team. Nurse K and Nurse M pointed out this problem in their exemplars. They argued that nurses' expertise cannot develop unless the nurses provide care based on their own judgments.

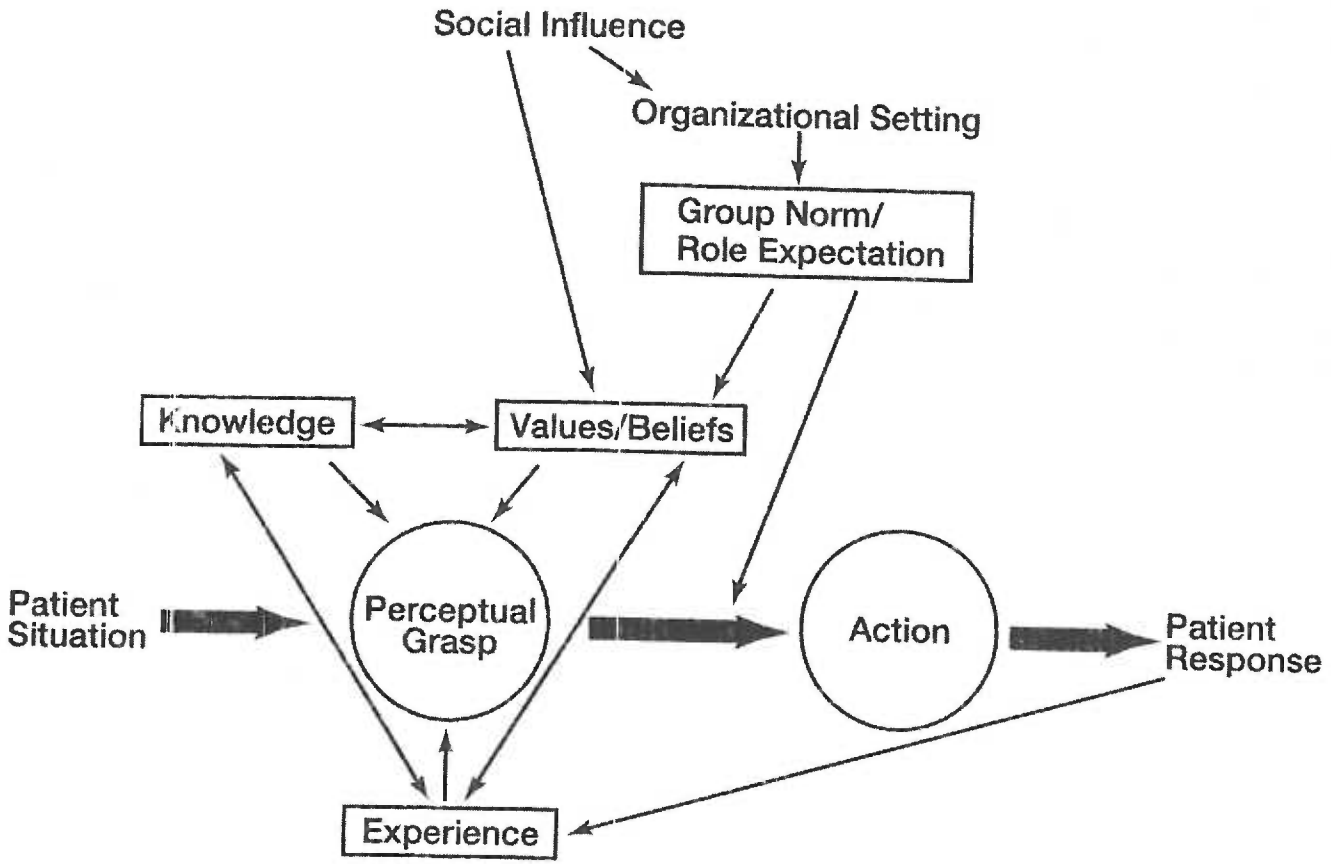


Figure 2. Clinical judgment and group consensus

## Moral Issues in Everyday Practices

The narrative texts by experienced psychiatric nurses uncovered some moral issues which were embedded in everyday practices. The most frequently occurring moral issue was the conflict between protection of patient autonomy and maintaining control on a ward. Fisher (1995) identifies balancing support for patient autonomy with the need to maintain unit control as one of the ethical problems encountered in psychiatric nursing practice with the dangerous mentally ill. Even in the long-term care setting, immediately perceiving potential for patient violence or suicidality is an important judgment task of psychiatric nurses. Nurses who do not have enough skills to exercise their personal judgment, use control of patients and staff members in the ward to prevent incidents they are not skilled to deal with. As illustrated in the suicide story of Nurse H, balancing the protection of each patient's autonomy with performing responsibly as a psychiatric nurse is not easy, rather it is a dilemma facing psychiatric nurses.

As the previous story illustrates, a secondary issue is the conflict on the nursing team between individualized care and conformity pressure. Most episodes in this study which brought about the conflicts in the nurse herself/himself or the nursing team were related to small issues regarding a patient's daily living such as their eating, smoking or bathing. The therapeutic environment in mental hospitals has been gradually changed in the last 10 years by measures of the Mental Health Law in Japan. Yet, why are these small aspects of the patient's daily life still important enough to be issues in psychiatric

long-term care? How is it that they are important enough to interfere with reforming psychiatric long-term care? Why are the concerns of psychiatric nurses still focused on the patient's activities of daily living? In reality, the issues are not limited to the nurses' responses to eating, smoking and bathing issues; rather, they cover the whole clinical world in everyday practices.

As the findings in this study suggest, when patients' activities of daily living were controlled by the rules of the ward, conflicts come out between rule-governed nurses and the nurses who tried to provide individualized care from the patient's point of view. Whenever the basic elements of patients' practices in everyday life were controlled, the more likely it was that private inhuman treatments for patients resulted. Advanced experienced nurses who provided care from the patients' viewpoints could not participate in the practices that resulted in inhuman treatment.

Analogously, Rader (1994) talked about the bathing of nursing home residents with dementia. She criticized the standardized care of bathing on routine assigned days. Standardized care disturbed the activities of daily living which the residents had already established in their lives. For the residents, everyday practice such as bathing, represented their most private concerns. Rader emphasized the need for individualized care in nursing homes.

Implementing flexible individualized care is a complex problem in Japanese mental hospitals due in part to cultural norms about group consensus. In addition, the different educational career paths of male and female nurses may create tensions arising

from different initial orientations. In particular, male licensed assistant nurses often began work in mental hospitals as nursing aides, hired in the 1970s and early 1980s to control patients and to protect the staff. In contrast, females were oriented to more humanistic values based on physical care in general hospitals. The tradition which puts high value on control and safety in mental hospital settings still produces conflict in nursing teams, as is illustrated by the following example described by the experienced psychiatric nurse, Nurse K, who was trained initially in general hospitals:

> Today I had a disagreement between the rules of the unit and each patient's need. It happened at lunch time. There was a male assistant nurse in charge of passing medicines today. He tried to give medicines before lunch to one patient who always takes a long time to eat, so that he could finish duty and leave. He could have asked another nurse to do it, but he thought it was his responsibility. When the patient didn't want to take the medications before lunch, then the male licensed assistant nurse scolded the patient violently. I said "You don't have to scold him. He will take the medicines for himself after the lunch." There were other two nurses and they also said, "Yeah, he will." Then the male licensed assistant nurse burst into a rage and shouted, "It's always male nursing staff who should take responsibilities, more duties, and more so and so. Only men!"

There was a moral conflict between the male licensed assistant nurse who kept rules and control in the ward and the female nurses who tried to provide flexible, individualized care. The more the female nurses in this situation provided

individualized care to patients, the more the male licensed assistant nurse tried to maintain control in the ward. The conflict among nurses sometimes carries over to patient care, perhaps creating confusion for patients because of inconsistency on the part of the nursing team.

The ethical/moral issues of mental health and psychiatric care are focused on the human rights of inpatients such as beneficence, autonomy, confidentiality and so on. However, Forchuk (1991) suggests that the inpatient ethical/moral problems generally involve staff conflict. As shown in the findings, Japanese ethical/moral problems are founded in conflicts among nursing team members in everyday practices.

## Promoting Innovation in Traditional Institutional Care

It has been approximately 30 years since the number of mental hospital beds last expanded. Despite Mental Health Law amendments in 1988, 1993 and 1995, many long-stay patients have not been discharged from the mental hospitals. Unless nursing care changes, the institutionalization of patients will continue. The advanced experienced nurses described how strategies to introduce innovations conflict with traditional group norms in the psychiatric ward. Overcoming organizational chronicity is an important issue for advanced experienced nurses and nursing leaders in the mental hospitals.

### Strategies to Obtain Group Consensus for New Norms

Nurse F, who worked at a national hospital, considered strategies to increase innovation on the nursing team. She is an advanced experienced nurse who has more

than 15 years of psychiatric nursing care experience, but she moved to the national hospital approximately 4 years ago. Consequently, Nurse F was not a veteran of the ward.

"NE-MAWASHI"

Nurse F: We made a lot of changes in our ward during one and a half years. It was very old-fashioned; for example, the service counter and front door of nurse station were closed, and patients could not enter the nurse station without nurses' permission. Moreover, the weekly schedule was rigid, that is, Tuesday was shopping day and Thursday was the day for going out with nursing staff, etc. We made a big change and gave patients freedom.

Interviewer: Did anybody protest the changes? Do you have any strategies for change?

Nurse F: I think that some nurses were against the radical changes, but nobody complained to me directly. So it was done without asking questions. . . . For instance, in the past, nurses returned hot water service bottles to nurse's station every night at 9 p.m. Now hot water service bottles are in the dining room 24 hours a day.

Interviewer: You try to do something after grasping situation. How do you get sense of all right?

Nurse F: It is power balance. The timing is important to ask the nursing staff the question. Consensus was made within the nursing team gradually, and it took

one year to make the changes. There are many well educated nurses in the national mental hospital. The nurses in my ward are well trained. When something was decided at a nursing staff meeting, all staff members would accept the decision. On the other hand, if something was refused at the meeting, the rules returned to the old rules. For example, nurses made a lot of efforts to get consensus for an open-system service counter. But when one patient came over the service counter, the counter was closed immediately. When some nurses tried to open the counter again, the timing was difficult. They proposed the open-system service counter at the staff meeting, but some nurses presented evidence of how dangerous the open-system service counter had been. They did not reach consensus. In that situation, I thought that it was not good to push for a conclusion. So I avoided making a decision.

Interviewer: You are saying that if we do not get consensus in the team, we should avoid an immediate conclusion, aren't you?

Nurse F: Yes. We are changing circumstances gradually, and we have to wait until the population of those in agreement is larger than the population of those who disagree within nursing staff. I often talk informally to other nurses when we are working night-shift together.

Generally, Japanese group-oriented nurses prefer decisions made by the majority to decisions made individually. Nurse F referred to it as the "power balance" within the nursing team and used this characteristics of Japanese nurses as a strategy to make

changes. Nurse F knew that even though nurses agreed to the changes personally, they would change their opinions immediately if they knew the majority of the group disagreed with the changes. Nurse F laid the groundwork for achieving her objective. She waited until most nursing staff accepted the change in the rule, and she talked informally to the other nurses. She used the Japanese strategy called "NE- AWASHI" (dig around the root of a tree before transplanting) which is used to obtain group consensus.

Overcome Institutionalization

In the following narrative, Nurse S used a different strategy, drawing upon the power of his position as a head nurse, and succeeded in introducing an innovation to custodial and static care in the mental hospital. As Nurse S gained respect and confidence from staff nurses during his 20 years as a nurse at that hospital, he led the nursing team and shared the innovation process.

"Knowing Patients and Making Change"

Nurse S: I moved into a closed-door unit as a head nurse. There were 6 patients in the locked protection rooms in the unit. When I met patients in the protection room, I felt there was something wrong. I knew a few patients because they stayed at the ward where I had worked before. In particular, I found a young patient who looked unfit there. He was 16 years old. He was very anxious and tightly wound. I asked nursing staff why he stayed in such a protection room. The reason was that he was abused by other patients in his ward. The nursing

staff called him by his pet (child) name and put him in protection room without questioning the harmful influence of doing so; and additionally, he was like a mascot among nurses. I thought that it was wrong. I made six patients' care plans soon and organized an intensive care team. I became the leader and chose two primary nurses for the protection rooms. We tried to open the doors of the protection room and shortly could take patients to a cafe in order to have breakfast once a week.

Interviewer: Did you go to a cafe outside of the hospital with the patients who stayed in protection rooms? It would be so difficult because if they went out easily, it would be unnecessary for them to stay in locked protection rooms, wouldn't it?

Nurse S: Of course it was very difficult. At first, I communicated with patients intensively for a couple of months. I got a big response and thought my first inspiration was correct. I knew that they would keep their common sense. I believed that they would absolutely recover. Then I took them to a cafe in the hospital. Their manner was not disturbing at the cafe. So I thought that if they had opportunities to go out, their realities of everyday life might come back more easily. I made a decision to take them to a cafe outside of the hospital. The sixteen-year-old patient looked so happy in the cafe, and he was looking forward to going to the cafe every time with a smile.

> Also, I disliked the nursing staff calling the young patient by his pet name. I changed his pet name for a new one. I called him "a young man" with respect. When I tried to call him "a young man," he respond with a bright face. After that we called him "a young man." He was getting better and got out of the locked protection room shortly. He returned to a general room. He could talk to the other patients and expressed his will and feeling, particularly, he learned to say "No!" He stood up to abuse in his room. He recovered dramatically. Finally, despite his parents' divorce, he was discharged and got a job. I still thought that what I did was striking.

The expert practice of Nurse S overcame institutionalization. Psychiatric patients in locked protection rooms were usually treated as hopelessly impaired patients. The plan of Nurse S was in opposition to the common sense of other professionals in the hospital. The practice of taking patients in the protection rooms to eat breakfast at a cafe was extremely innovative. It followed that if the patients who were considered to be the most hopelessly impaired had potential for improving, most patients in the ward could potentially improve. It resulted in elimination of the principle of "safety first" in the ward which nurses had held, and also delineated the problem of organizational chronicity.

After he told this story, Nurse S said strongly, "This is a paradigm professional episode. The practice in this episode was based on my feeling that something was wrong, and it made a big difference in my nursing practices."

Nurse S took a big risk. However, reviewing the process of caring for the patients in locked protection rooms, he observed the patients' states very carefully and provided the care programs in accordance with the patients' pace. Even though the care plans were based on his intuition, when asked, he could describe concepts and actions quite specifically.

## Summary

The clinical judgments in the suicide stories raised two issues: (a) nurses' concern in the nurse-patient relationships, and (b) the temporality of clinical judgments. Clinical judgment is influenced by closeness in the nurse-patient relationship. When the nurse has a close relationship with a patient, the nurse experiences the dilemma of a dichotomy between the nurse's personal caring and the professional role.

Furthermore, the exercise of clinical judgment in a situation brings with it the issue of "here and now." However, the evaluations that result from a nurse's exercise of clinical judgment are usually based on the outcome of the patient care. There is a time lapse between making a judgment and evaluating the outcome. For example, in the case of the patient suicides, the nurses negatively reviewed the situations concerning their patient, although they had perceived it positively before the suicides. When reality changed with the passage of time, the interpretation of the nurses' clinical judgments in these situations changed. The patients and the nurses are in temporal. The temporality in clinical judgment is an important issue relating to evaluation of a judgment.

Additionally, the issue of conflicts between group consensus and individual nurse's judgment emerged. When group consensus and the nursing care plan create pressure on nurses to conform, each nurse becomes rule-governed and provides uniform care for all patients without exercising their own judgment. This issue is whether group consensus obstructs the development of the individual nurse's judgment.

Furthermore, everyday practices which are provided by nurses are strongly associated with the privacy of the patient. Therefore, the uniform everyday practices based on rules in the ward subjected the patients to inhuman treatment and raised a moral conflict among the nursing team.

The last issue in everyday practices is how advanced experienced nurses innovated the group norms/consensus in nursing teams. Efforts to initiate an innovation necessitated a focus on the power balance of the nursing team. Therefore, "NE-MAWASHI" was found to be an effective strategy in the Japanese culture to obtain the group consensus for an innovation. An alternative strategy was the use of a person's power afforded to them by their position, as well as strong leadership, as was the case for the head nurse (an expert nurse) who was able to overcome the organizational chronicity in the team.

# CHAPTER VI

# EXPERIENCES THAT SHAPE PATTERNS OF EVERYDAY PRACTICES

The interpretation of the narrative texts revealed two types of memorable experiences that shape patterns of everyday practice. The first involved an initial experience in nursing which became central to the development of the psychiatric nurse's moral and philosophy. The second involved memorable experiences which caused a significant change in the nurse's everyday practice and transition to an advanced nurse.

Most participants in this study had one or more particular patient care experiences by which they were surprised or impressed. For example, some routine work performers talked about how they helped long-stay patients to return to their community. These experiences brought a sense of fulfillment to the routine work performers and were memorable and outstanding experiences. However, even though these were memorable experiences, the experiences did not initiate a change in their everyday practices, because the nurses worked with patients from the nurses's viewpoint. In other words, there was no evidence of a shift in perspective or new understandings as a result of the experience.

However, some nurses described memorable experiences which made a difference in their practice. The following episodes and stories illustrate what those nurses learned from experience and how the experience opened their eyes and resulted in changes in their nursing practices.

## Initial Nursing/Caring Experiences

For some participants, their initial experience in psychiatric care strongly influenced their developing values, beliefs and practice as psychiatric nurses. The nurses who finished their nursing education in the 1950s did not learn psychiatric nursing. They mainly trained as skilled nurses who worked at the general hospitals. In Japan, there were few mental hospitals until the middle 1960s, and they were seen as distinctly different. The community was strongly prejudiced against mental patients. Even mental health workers were stigmatized in society. Nurses with general hospital nursing experience had opportunities to work at mental hospitals because a substantial number of mental hospital beds opened in the 1970s and the mental hospital administrators hired middle-aged nurses. For the nurses who worked at general hospitals, mental hospitals were an unknown clinical world.

### Memorable Experiences: An Encounter

Nurse N, who is 63 years old now, will soon retire. She started working again in the 1970s when her husband died at 43 years of age. She worked in an emergency room in a general hospital until she was 51 years old. For a while, she stopped working, but

because of the nursing shortage she went back to work at a mental hospital. Nurse N talked about her initial experience at the mental hospital.

"I Sympathized With a Patient in the Situation"

On that day, I had to take a patient to angiography room with a male nursing aide. When we nearly reached the room, the patient stopped and didn't move at all. It was as if he was attached by a magnet with hundreds of volts. The male nursing aide said, "Don't worry, Don't be afraid. If you can't move, I will carry you on my back." The male nursing aide tried to make him move, but he didn't. When I saw the scene, I thought how delicate the patient is. I knew that psychiatric patients had a lot of hidden emotional aspects which we didn't know. I had doubted whether they are human or spacemen and thought about it all night. However, the patients were the despair of their families and were persecuted by society. If health professionals didn't care for the psychiatric patients, who would care for them? As I sympathized with the patient's miserable situation, I was in tears. I said, "Are you all right? I would like to work with you. Please tell me your feelings." The patient smiled and nodded, "Thank you, I have never met such a nurse who spoke kindly to me." When I watched his smile, I promised myself that I would work with psychiatric patients as long as I am a nurse.

The patient said, "I am sorry, nurse. I can't get the angiography today. I made a decision to refuse it today. I want to keep my decision, but I will get it tomorrow because I don't want to make you cry anymore."

The significance of this episode for Nurse N was that it reminded her of why she became a psychiatric nurse. Nurse N worked for 12 years at two mental hospitals. At one time she wanted to quit working at the mental hospital, because there were no distinctions in the roles between licensed nurses and non-licensed nursing aides. The veteran male nursing aides used their influence and acted like bosses. Because she was a newcomer to the ward, everyday she cleaned up the living and dining rooms, stairs and bathrooms along with patients. She didn't like her job. She looked for a general hospital that would hire her, but could not find a position because of age discrimination. When she became depressed, she thought about what the episode with the patient at the angiography room meant for her. That episode pulled her back to her starting point in psychiatric care. She said to herself, "I promised the patient to work together." After that, when she confronted difficulties in her family life and her professional life, she always remembered her initial psychiatric episode.

This episode was an encounter when the nurse viewed a psychiatric patient as a person. It was also her first experience as an involved performer who shared feelings with a psychiatric patient. Over the years when she experienced difficulties and felt deadlocked in interpersonal relationships on the nursing team, she was able to compare her situation with that patient's situation. She said that even though she worked in

miserable settings and her self-esteem as a nurse decreased, her situation was better than that patient's situation. That episode in which she made a connection with the patient encouraged her to continue working at the mental hospital. Finally, Nurse N said, "If I retire, I would like to constantly be a good neighbor who is very understanding for mental patients in community."

Another participant was Nurse T who graduated from the first regular program for nurses after World War II. She married and stopped working for 15 years. However, she came back to work when her children grew older and then continued working for approximately 24 years. Nurse T faithfully kept the traditional spirit which she gained in her basic nursing education: "Nurses should always be gentle and kind to patients" and "Nurses should never make trouble for the nursing team."

The following is the first episode which she described in the interview.

"Her Gentle Human Nature Came Back"

I've been working here just as a physical laborer (blue collar worker); I always tried to get along with the patients and that was all. I didn't step out from my daily routine.

There is one episode that I was deeply impressed with. It was not long after I started working here. I was a little over 40. The patient was in her twentieth year, and was married and 8 or 9 months pregnant. She used violence and came here accompanied by a policeman. I was so surprised, because she was in the protection room and tore the Futon (cotton-quilted bed clothes) into

> pieces all over the night, both the bed spread quilt and the mattress. She made a huge cotton mountain in the protection room in one night, screaming in an angry voice. I could do nothing but just look at her. I was so surprised. Then we took her to a university hospital to deliver her baby, although it was rather premature birth. After she settled down physically, her gentle human nature came back to her gradually. She was discharged in about half a year, and has helped her family business. I guess she needed medicine for a while, but now she is perfectly normal. It's a surprise for me.

When Nurse T began to work at the mental hospital, there were many non-professional workers. She could not accept their work performance in patient care because of their inadequate manner and morals as nurses. Moreover she could not relate to the psychiatric patients who were likely there for the remainder of their lives. She once tried to quit working at the mental hospital because the mental hospital setting totally contradicted her belief as a nurse. However, the episode with the young woman who made the mess in the protection room changed her focus. She was sincerely concerned for the psychiatric patients, and eventually working with patients became a great pleasure.

Nurse N and Nurse T were very kind and gentle nurses and treated the patients like family. Nurse T described herself as a physical laborer. Skilled nurses were trained to perform nothing but routine work. However, episodes in which the trained skilled nurses made connections with patients changed the nurses' values and beliefs. They

learned to understand the patients as people through the experience. Nurse N and Nurse T developed human relationships with patients and naturally became good neighbors of these patients.

Psychiatric Care Learned From Patients

Nurse R, who has 20 years of psychiatric nursing experience, said that she learned psychiatric care from the patients. She was one of the nurses who chose psychiatric nursing directly after nursing school. The following initial experience provided her motto.

"Patients Were My Teachers"

> When I started working on the ward as a psychiatric nurse, I met a patient who was teen-age with auditory hallucination. I was her primary nurse. At first, we communicated with each other closely. But she gradually said to me that someone spoke against me behind my back. I knew that it was auditory hallucinations, but I didn't know how to respond to her. I didn't exactly understand the patient's feelings about the auditory hallucination. The patient complained to me, "You don't understand my feelings because you don't get mentally ill." It was true. If I wanted to understand the patient, must I become mentally ill? I was confused. Finally, I reached a conclusion: I can accept the patient's pain, but I am not the patient. The mental illness is hers, not mine. I told her, "I understand your anxiety and your pain, but I can't experience mental illness which you have experienced." She said, "You must dislike me." I said,

"No, but I am stressed because I don't know enough to communicate with you."

At this moment, I wanted to be honest. I thought that when I talked to patients, I should never tell a lie. This experience become my motto in psychiatric care.

Over the years that Nurse R has worked with patients, the patients have taught her many things: psychiatric symptoms, the point of view of the patient, and human freedom related to patients' rights. At first, she didn't know psychiatric symptoms, and she was struggling with patients. She said, "I was getting anxious with the patients together." But patients taught her; for example, they showed her what is manic, what is psychotic and what is anxiety.

At that time, she was a young nurse, and each experience was new. However, when she became an experienced nurse, she could accept many things and made an accurate estimate of the situation. She said, "To become an experienced nurse may lose the impact of experience."

Nurse R illustrates how practical knowledge was produced when the knowledge she acquired at nursing school was combined with what she perceived or observed in actual situations. She called this practical knowledge, experience. However, she said when she became an experienced nurse, she did not have an outstanding experience. Nurse R stated that interactions with patients were not distinguishable because she was able to predict possibilities. Therefore, there were no surprises in her advanced practice; thus, the practice flowed without distinguishable episodes. Nurse R's story

was one comprised of nothing but practical knowledge embedded in her advanced practice.

## Experience Which Made a Transition to Advanced Nurse

Early in their careers, the nurses performed daily routine work and doctors' orders completely. They were tough nurses and good doctors' assistants. However, for some, experiences made a big change in their practice. They came to make their own judgments in care situations and to provide individualized patient care. These nurses made a transition to advanced nurses as a result of the memorable experiences.

### Paradigm Shift: A Transition to Expert Nurse

The following is a story about a head nurse who was recognized as an expert nurse by a colleague. Nurse S worked for 25 years on a psychiatric nursing staff. His decision to become a nurse was not very strong. He said, "I didn't have a good relationship with my father, so I wanted to be apart from my parent. Therefore, I chose to work at a mental hospital in Tokyo." When he entered the psychiatric world, he did not know what his work in the mental hospital would be, but the initial episode influenced him to become a psychiatric nurse.

#### "The First Caring Experience"

> On the first day I started working at a mental hospital, the nursing director told us, "Today it snowed. You should make the patients warm." There was not sufficient heating in the ward 27 years ago. At that time, I went around the

> rooms in the wards and stuffed the door and window crevices with newspapers. When I finished stuffing the last room at eleven o'clock at night, an older woman gave me an orange and said to me "Thank you." It made a strong impression on me. This was my first caring experience in a psychiatric unit.

His first experience seemed to strongly impress him, and for a while he believed that his job was to bring enjoyment and happiness to the patients. He enjoyed his job very much. Then Nurse S said:

> One day, when I rounded the patient rooms, I found that a young patient stayed in his bed. It's a beautiful day. I really wanted him to go outside with us. When I tried to pull him out of his bed, he hit me. But I wasn't angry with him. Rather I thought, "What a poor young man."

Unlike the first episode of the old woman who gave him the orange in gratitude for his care, the second episode depicted a young patient responding negatively to his care. Nurse S said that despite being hit by the young patient, he did not become angry at the young patient because he believed that he was there to help, to protect vulnerable people. Nurse S said that both episodes were not professional nursing practice but rather non-professional practices as a kind neighbor.

While he worked in the mental hospital as a nursing aide during the daytime, he went to a 2-year assistant nurse's program at night. And then while he continued working at the mental hospital as a licensed assistant nurse, he went to a nurse's program for licensed assistant nurses at night for 3 years. He became a nurse when he

was 23 years old. The following memorable experience had a major impact on him. Nurse S explained:

"Shameful Experience"

When I became a licensed nurse, I worked in an acute unit in the mental hospital. Occasionally hospitalized patients went back home without their physician's permission; that is, patients escaped from the mental hospital. I visited their home as soon as possible. I always persuaded patients into going back to the hospital.

One day, I went to see a patient who escaped from the psychiatric ward. When the ward staff telephoned his wife, she asked his primary physician to take her husband back to the hospital because he refused to return to the hospital. In his mental state, he obviously needed treatment. His physician and the nursing staff discussed and decided to take him back. The physician asked me to visit his home with another male nurse. I didn't know him very well, but I had confidence in myself because many times I had succeeded in taking patients back to the hospital without trouble. I thought somehow it would come out all right if I met him.

We went to see him after our day shift work, because that day was busy. When we arrived at his home at 8 p.m., he and his wife sat in their couch quietly in the living room with their two sons. He was relaxed and it looked like a happy family.

I talked to him and asked him to go back to the hospital, but he strongly refused. While I continued trying to talk him into complying, he was getting more and more agitated. I made a decision that we should use force to take him back before he became psychotic. We held his arms on both side. Just then my eyes contacted his elder son's eyes. His children kept silence while we were holding their father. It was awful for his children. It was a very, very sad scene. During the 2-hour drive back to the hospital, I and the other male nurse were miserable. This affair left an indelible memory in my history as a psychiatric nurse. I had never thought that psychiatric care was such fearful work and never forgot his elder son's eyes.

After that, I made a big change in my practice. Even though I visited patient homes to take them back to hospital, if the patient looked good, I would not persuade the patient by force. I asked him and his family to return the patient to the hospital the next day. Once when I did not come back to the hospital with the patient, his primary physician complained to me a lot: "If the patient raises a social problem, how can we take our responsibility?" But my judgment was usually correct because nobody raised any social problems. Moreover, when I visited the patient's home, I was careful about my timing and thought about the situation involved in the visit.

In the third episode, Nurse S was able to articulate his conscious understanding of what is most important in psychiatric care. Prior to his movement towards advanced nursing,

he had not fully recognized these crucial components of practice. After he had the third episode which was truly his most memorable experience, "carefully timing" and "grasping situation" became key concepts in his practice. Then Nurse S always kept the patient's point of view at the forefront and provided individualized care.

The narratives of Nurse S showed how he had developed his value and beliefs as a nurse through patient care and how memorable experiences worked on transitions to expert nurse. Benner (1984) indicated that "proficient and expert nurses develop clusters of paradigm cases" (p. 8). Similar clusters of paradigm cases were confirmed in the process as Nurse S became an advanced experienced nurse. These memorable experiences are also very similar to what Benner et al. (1996) describe as sustaining narratives and narratives of learning.

## Reflections of Life Events

The life experiences of some participants showed how experienced nurses overcame barriers and continued to develop their expertise. Nurse Y and Nurse Z were hard workers and pursued life courses typical of nurses at the time of Japanese economical growth in the 1970s. The following stories tell how their life events are reflected in their everyday nursing practice.

### "Broken Belief, Work Hard and Try Hard'"

Nurse Y is an advanced nurse with 22 years of experience in psychiatric care. After she finished junior high school, she entered an assistant nurse's program in a national hospital. She worked and studied there for 4 years and became a licensed

assistant nurse. Then she entered a nurse's program for assistant nurses, but quit the program after getting married. She talked about her life after marriage as follows:

> I moved into Tokyo and started working at the mental hospital as a licensed assistant nurse. I had two kids. Ten years ago, I made a decision to enter a nursing school. I was working full-time at the hospital and studying at a nurse's program for 3 years. In the early morning, I woke up and prepared breakfast, lunch and dinner for my family, and took younger son to nursery school and then I went to my school. After school, I worked evening-shift. I came back home at midnight. Next day, I worked day-shift. I repeated such a schedule for 3 years. Everybody said, "You are an incredibly hard worker."

She became a licensed nurse and works as a head nurse. She said that she noticed a lot of things during her study at the nurse's program. She said, "I was highly controlling and dominating in patients' everyday lives. When I remember my practice, I am ashamed of having done such things and doubt whether such things can be consider nursing." And then she talked of her childhood.

> My father died when I was very young. He got malaria on the battle field, came home, and died of cardiac valvulitis. It was hard for my parents to have me in such circumstances. My father died when I was 2 years old. I didn't start walking until I was nearly 2 years old. So I was laid in a hammock in the house, and my mother tied it with a rope which someone pulled by the foot to swing me while she was working in the field; my father couldn't even swing me

> because he got tired too soon. My mother had 5 children, and in addition to that, the oldest son got intercostal pleurisy. My mother had really a hard time. I received a message from my mother saying "Work hard and try hard." So I don't mind working hard. Instead, I demand the same effort of other people unconsciously. I didn't notice that my children felt alone when I went to school for a month without even one day off. I had the same experience in childhood. I was always given a message: "Try hard and you will overcome a difficulty." I credit my mother that I am competent from trying hard. But on the other hand, because of my competence, I have a tendency to demand the same effort of other staff at work. It's hard to change myself, and I am worried by my inflexibility. How I can say . . . the truth is, I guess, that I'd like to learn more from work.

For Nurse Y, working hard was normal in her life. She believed that the harder you work, the more you produce. She had no doubt that working hard was the best way. Therefore, when her son was an adolescent, opposed her and used violence against her, she did not understand what was wrong. At that time, her son was in trouble with his school teacher, but he could not express his feelings to his teacher. Instead he complained to his mother that she had not paid attention to his feelings and that she did not love him. She was very upset and worried because she was aware that her son rejected the beliefs she stood for. Her son continued to disregard her authority over him and refused her care.

While her son grew up and became independent, Nurse Y understood that each person establishes their own life. She became aware that "work hard and try hard" is her belief which she established in her life. Subsequently she became more flexible in order to provide individualized care for her patients. The experience with her son changed her world view. In the interview, although the interviewer asked her the question about her past nursing experience, she never talked about her past nursing care during which she dominated the patients.

"World View Changed by Failure"

Nurse Z has approximately 7 years experience as a licensed assistant nurse at a general hospital and approximately 20 years nursing experience at a mental hospital. When she was 40 years old, she entered a 3-year nursing program for assistant nurses. The following is her story:

> I worked as a nurse on the night-shift, did chores at home as a housewife, and went to school as a student. I weighed much more before, but now I lost so much weight because such a life was too hard to continue. When I was a senior, the nursing practice as a student was very hard for me; I had to write many reports until one or two o'clock in the morning. Such a life gave me diabetes, so I decided to be a nursing student during the daytime and a patient at night. As a 40-year-old student, I was an embarrassment to my colleagues at the hospital and my family. If I dropped out of nursing school, I would lose the reason why I

worked so hard. I stayed in the hospital for 20 days and was under insulin treatment, and finally I got all the credits I needed to finish nursing school.

But when I took the national board examination for the first time, I became hypoglycemia and failed to get the nurse's license. I studied for one more year by myself and passed the board examination. I thought, "I'm so blessed about everything; nice faculty, nice husband and kids . . . that's why I'm tried by God over this. In addition, I came to understand patients' feelings more than before because of being hospitalized myself." I was very ashamed by my failure on the national board examination. During the year when I was studying by myself, many people said various things, like "You'll be okay. You could raise kids and go to school at the same time. You'll do it." Such an encouragement was a big pressure on me, and I felt depressed. I thought I was being helped by God, and because of that I grew as a human being. I came to sympathize with the patients' feelings and could find what you call psychiatric nursing.

The most important thing in nursing is that you always grow as a human being. For example, you need great patience to talk to the patients. Such patience will make you grow, and it will make your nursing better. You should always keep yourself mentally stable. You should stay in your best condition when you have contacts with the patients. If you feel irritated when you leave home, the patients will also feel irritated. So you should make a good family; if

you are irritated in your own family, the patients will feel it. If your family is full of laughter and you are like a sun in such a family, you can also make a comfortable atmosphere at work. And if you are stable, there is a possibility that you can calm down a patient who is very nervous and agitated. I learned such things from the experience of staying in the hospital as a patient.

I have such a personality that I say whatever I think is right and do things quickly. As I worked in the operation room before, I have a tendency to do things fast. Many co-workers told me that I did things quickly. But it's not always a good thing for co-workers. Young nurses are okay, but older nurses who are retiring and nurses who had some chronic illness, such nurses don't prefer working with me.

When I failed in the national board examination, my husband said, "Oh, congratulations!" I felt so vexed that I shed tears at the age of 44; how come I have to be told such a thing after going to school for 3 years in the hardest situation and failed! Then my husband said, "If you passed the examination this time, you would become snooty. You had better be put down once, so that you can understand other people's feelings; because of this setback, you didn't become such a person who believes everything in this world moves for you. So, congratulations!" Even now, I can't forget it. His word made me study so hard for a year; I thought I shouldn't waste the experience. I still can't forget how I felt at that time.

After she became a nurse, her practice completely changed. She always provides care from the patient's point of view. When she faced a difficulty and made a judgment/decision, she remembered the experience when she was a patient. She talked about an episode which brought a conflict between nurses and a psychiatrist.

Nurse Z: One example that I experienced recently happened when we had a nursing student. A patient whom the nursing student took charge asked her, "Can I buy ice cream or coke once a day? It's too warm." The student asked nurse in charge if it was okay or not. Nurse made a judgment that it was okay, but the doctor in charge said "No." He said, "The patient doesn't eat enough at mealtime because of hallucinations. If she eats sweets such as ice cream and cream puff, she wouldn't eat meal. So I wouldn't let her buy such sweets. It is not a good time for her now." But the nursing staff said, "It's too warm to forbid cold drinks." The student was in trouble and didn't know what to do. But the nursing staff made the decision not only from the reason that it was warm, but also from the data in the everyday nursing record that how much the patient ate at every meal.

Interviewer: You mean that the patient had a problem that she didn't eat enough food at meal time, but it had no relation with ice cream. Even if the patient didn't eat ice cream, she eats meal when she wants and does not eat when she doesn't want to eat.

> Nurse Z: Right. We sometimes have such a difference in decision making between doctors and nurses. When I should make my own decision in such a case, I always remember the experience of being hospitalized as a patient. When I stayed in the hospital for 20 days, I found that a nurse's behaviors influence a patient's feelings very much. For example, what the nurse said, how the nurse behaves, how the nurse closed door. While I meet such the nurse's behaviors, I thought that I don't want to be such a nurse. Since then I always think, "How do feel if I were the patient." If I were she, I would want ice cream in such very warm weather. Even if doctor says no, the patient would eat. It's the best decision; many people have various ideas. But you need to stop and think from the patient's point of view. I would have ice cream if it's so warm. It wouldn't make very serious difference even if you give her ice cream once or you don't. It's my personal decision.

In Japanese psychiatric settings when a doctor gives an order to the nurses, the nurses usually obey, even though they may have a different opinion or judgment regarding patient care. But in this episode, the nurse did not obey the doctor's order because she focused on the patient-nursing student relationship. Nurse Z reviewed the nursing record of the patient and made a decision. She was certain of her decision from the patient's point of view, which Nurse Z learned from her own experience as a patient.

It is inconceivable for routine work performers to disobey a doctor's order. However, Nurse Z was making a transition to an advanced experienced nurse through

positively making her own judgment within her area of responsibility. This episode is an example of a nurse's responsible subversion, pointed out in a study by Hutchinson (1990). According to Hutchinson, responsible subversion is defined as rule-bending behaviors among nurses for the sake of their patients. Therefore, these nurses make their nursing judgments and take action responsibly by consciously planning what is best for the patient. Hutchinson describes the following examples: A minor subversion is that of permitting visitors during no-visitors hours; a major subversion is that of giving a medication without a physician's order. These nurses are subversive in that their behavior violates rules made by the hospital, nursing administrators or physicians.

## Learning From Experience

The narratives of participants provide illustrations of the clinical world in psychiatric nurses for approximately 25 years. Mental health policy and psychiatric care were strongly influenced by Japanese social customs. In particular, when the participants in this study began to work at the mental hospitals, non-professional nursing care was provided. The initial experience of psychiatric care in which nurses learned from patients made the nurses change their values and beliefs as nurses, that is, they became transformative experiences. The nurses became involved performers in patient situations and respectfully worked with patients.

Furthermore, the nurses who worked at mental hospitals after graduating from nursing schools did not set boundaries between themselves and their patients. The initial experiences the younger nurses had with the patients and/or the patients' families

opened the nurses' eyes, and they became aware of their responsibilities through experiences in psychiatric care. Benner et al. (1996) describes experience as follows:

> Experience occurs when one encounters a practical situation in such a way that one's understanding of the situation is altered. Experience is gained when one actively learns to recognize to do and be better and worse in practical situations and to see and feel salient ethical distinctions. (p. 233)

Similarly, the findings of this study show that experienced psychiatric nurses gained their values, beliefs and ethical components—to respect the patient as a person—through experience. These psychiatric nurses learned to provide care from the patient's point of view by experiencing involvement in situations. This knowledge, wisdom and belief gained through experiences is personal, that is, practical knowledge (Benner, 1984; Tanner, 1996).

For the nurse, the knowledge and beliefs gained through experience produce self-confidence in the area of making clinical judgments, or a sense of "DAIJOBU" (in Japanese). In English it refers to a sense that "all is right" and a feeling of security. As shown in the episodes of Nurse S and Nurse Z, the experienced nurses who hold the patient's point of view through their memorable experience make their own judgments even if it means ignoring doctor's orders. These self-confident experienced psychiatric nurses would be able to make a responsible subversion.

On the other hand, the nurses' life experiences showed how experienced nurses overcame barriers and continued to develop their expertise even though they were

influenced by the social situation. The nurses who became licensed assistant nurses during the era of economical growth in Japan were educated as routine work performers. They studied in nursing programs for assistant nurses to become nurses while they worked full time at a hospital and took care of their families. They were incredibly hard workers. However, they experienced failure as a result of their efforts. The experiences in their lives made them transition from routine work performers to advanced nurses.

Life events influenced their practices in significant ways. As Heifner (1993) points out, nurses have been taught not to disclose personal information about themselves, but rather to focus interactions on patients. Japanese nurses also have been trained to maintain distance in nurse-patient relationships. For nurses, the patients were subjects who needed nursing care. As long as the nurses saw the patients as nursing subjects, transformative experiences were not produced. Life events forced the nurses to be involved in certain situations, and they became a case in crisis. The experience as a party to the situation changed the world view of each of these nurses.

The pattern of everyday practices is not only connected with their nursing education and clinical experience, but also their personal life histories. Nursing experiences are connected to their life experience. Therefore, work performance of experienced psychiatric nurses shows a form of existence.

## Summary

Initial experiences in psychiatric care for experienced nurses—those who provide care from the patients' point of view—consisted of an encounter where each nurse met a psychiatric patient as a person. The nurses were involved in the patient situations and knew the patient. The nurses developed an ethical component through the patient-nurse interactions/relationships. These experiences sharpened the pattern of work performance, in particular, the practice of experienced nurses as good neighbors and the advanced experienced nurses' practice.

Furthermore, the practical knowledge learned from patient-nurse interactions and gained through involvement in patient situations increased the nurses' self-confidence in making clinical judgment. The self-confidence of experienced nurses enable them to bend the rules for the patient's sake in the mental hospitals which have a tradition of controlling the patient's group.

In the process of becoming advanced nurses, some nurses who were routine work performers experienced a transformation in their beliefs and values through a memorable personal life experience. This life experience enabled them to make a transition to advanced experienced nurses.

# CHAPTER VII

# SUMMARY, IMPLICATIONS RECOMMENDATIONS AND CONCLUSIONS

## Summary

The overall goal of this interpretive study was to explore the clinical world of Japanese experienced psychiatric nurses. Specific aims were: (a) to describe everyday practices of experienced psychiatric nurses who work at mental hospitals in Japan, (b) to explore the characteristics of clinical judgments which are embedded in their everyday practices, and (c) to understand the meaning of experienced in the term experienced psychiatric nurses. The setting for this study was in Japan, because the researcher is a Japanese psychiatric nurse.

It was explicit in the review of literature that expert nurses develop their expertise through clinical experience. However, there were few studies concerned with the differences between clinical expertise among nurses with the same amount of experience, and few studies which examined clinical judgments and everyday nursing practices in psychiatric care. Uncovering the everyday practices and clinical judgments of experienced psychiatric nurses is fundamental to identifying their clinical competencies to provide effective care.

This study design was based on the philosophic underpinnings and methods broadly referred to as hermeneutics. Data in this study were written documents, that is, texts. The texts were composed of (a) transcripts of dialogic interviews in which the participant were story-tellers and the researcher was the listener, and (b) the researcher's observation notes.

Participants were 23 psychiatric nurses and licensed assistant nurses, 18 females and 5 males, who were selected from three mental hospitals located in metropolitan Tokyo, Japan. The participants tried to describe their memorable experience (episodes and stories) in everyday practices during dialogic interviews that lasted approximately 1 hour. The interpretations of texts were developed by means of the hermeneutic circle—the constant task of understanding—and themes, issues and exemplars in the texts were tentatively categorized from the standpoints of care, development of expertise and history.

The ways nurses described their work and the central concerns of their narrative texts revealed the following issues and findings: Patterns of everyday practices, central concerns and issues in clinical judgment, memorable experiences that shaped patterns of everyday practices.

Four patterns of everyday practices which emerged from this interpretation were: the routine work performers' practices, the practices of experienced nurses as good neighbors, the practices of veteran nurses with marked individuality and the advanced experienced nurses' practices. Quality differences were also found among the

four patterns of work performance. That is, the practices of advanced experienced nurses differed from the other patterns of work performance in that they showed an ability to: (a) read and respond to the nuances in the patient situation, (b) perceive the patients' potential and know the nurse's own abilities and limitations, and (c) deviate from group decisions when the situation required it.

The central concerns and issues which were revealed by the interpretation related to conscious, deliberative judgment in everyday practices. The clinical judgments in the stories of patient suicides, in particular, raised two issues: the nurse's concern and involvement in the patient-nurse relationship, and the temporality in the clinical judgment. That is, clinical judgment was found to be influenced by closeness in the nurse-patient relationship and by circumstances distinctly associated with the period in which the judgment is made. Additionally, the evaluation of the nurse's clinical judgment was usually based on the outcome of the patient's care.

The issue of conflicts between group consensus and judgment of individual nurses also emerged. When group consensus and the standard care plan created pressure to conform in the nursing team, nursing staff became rule-governed and provided uniform care for patients without drawing upon the individual nurse's judgment. Everyday practices provided by nurses were found to be strongly connected with the private aspects of inpatient. Therefore, the uniform everyday practices based on rules in the ward resulted in inhuman treatment for patients and produced a moral conflict among the nursing team. In these situations, Japanese advanced experienced

nurses tried to innovate the group norms/consensus in the nursing team using "NEMAWASHI," or position power, and overcame the organizational chronicity in the team.

Memorable experiences were influential in transforming nurses' values, beliefs and world views. An experienced nurse's initial experience in psychiatric care, in the form of an encounter in which they met a psychiatric patient as a person, resulted in the nurse providing care from the patient's point of view. In the process of becoming advanced nurses, some nurses experienced a transformation in their beliefs and values through private life experiences. These private-life experiences enabled them to make a transition from routine work performers to advanced experienced nurses. The life events made the nurses personally involved, and they became a case in crisis. The experience as a party to the situation made the nurse's world view change. The personal experiences of nurses were found to strongly reflect on their everyday practices, and the work performance of experienced psychiatric nurses showed a form of human existence.

## Implications

### Implication for Japanese Psychiatric Care

Japanese psychiatric care has been provided in the form of long-term care in hospital settings. Despite the movement toward deinstitutionalization in Western countries, many chronically mentally ill patients remain in mental hospitals in Japan. Unlike the United States, however, Japanese mental health services based on

institutional care has not produced the problems associated with the homeless mentally ill. Nevertheless, as Harding (1991) points out, Japanese psychiatric care is experiencing an increase in ethical problems in the macro-environment of mental health services.

In a 1968 report to the Japanese government, Clark, a British psychiatrist, proposed the development of a community mental health system in Japan that would allow many long-stay patients to receive treatment in the community, thus permitting them to be discharged from mental hospitals. Although this system was theoretically developed, as described in Chapter I the number of psychiatric beds in mental hospitals increased dramatically in the 1970s, and government policy mandated reinstitutionalization of patients who had stopped treatment in the community. There were no patient human rights or treatment choices.

The Japanese psychiatric care situation in the changing social context of the past was reflected in the episodes described by experienced psychiatric nurses in this study. Therefore, the patterns found in the work performances of experienced psychiatric nurses revealed the quality of nursing care that has been provided in mental hospitals in Japan. The characteristic pattern of work performance in Japanese mental hospitals was symbolized by everyday practices as good neighbors. The practices of experienced nurses as good neighbors was the main approach based on the nurse-patient relationship in Japanese mental hospital settings. For experienced nurses as good neighbors, practicing was being with the patients in the mental hospital. They

performed everyday practices in a way that met the needs of patients and provided them with a comfortable atmosphere in which to live. In addition, nurses tried to overcome their prejudices about psychiatric patients in terms of blurring the distinctions between normal and abnormal as well as professional and nonprofessional ambiguous. It was a way to coexist with the psychiatric patients in the mental hospitals. Eventually, the coexistence produced institutionalization of both patients and nurses.

In 1987, an amendment to the Mental Health Law divided Japanese mental health services into two systems: acute treatment care in hospital settings and long-term care based in the community. The further medicine advanced, the more nurses were required to act on practice with treatment goals in acute medical care in their ward. As Regan-Kubinski (1995) describes, in acute care settings the judgment tasks of psychiatric nurses focus on current patient functioning and behavior relating to mental status and psychiatric symptoms. For example, the practices of experienced psychiatric nurses as good neighbors are not sufficient in acute psychiatric care. Rather, it is important for the experienced psychiatric nurses to challenge whether their practices, which were developed in long-term hospital care settings, can apply to community mental health care. In particular, psychiatric nurses are required to make judgments independently and provide individualized care in community mental health care. Unlike the psychiatric ward, there is no conformity pressure or group consensus. Rather, psychiatric nurses need to develop the ability to exercise clinical judgment physically,

psychologically and socially, and to establish a system for consulting with each other in community mental health care.

The four work performance patterns uncovered in this study suggest a clear vision for the everyday practices of Japanese psychiatric nurses. These work performance findings will be helpful to Japanese psychiatric nurses in their efforts to understand the characteristics of everyday practices in mental hospital settings. These findings will also benefit Japanese nurses who must make role transitions from institutional care to community care.

Implication for Clinical Judgment

Japanese nurses have viewed clinical judgment as a cognitive judgment in nursing process similar to the problem-solving process and nursing diagnosis. These judgments in clinical setting are objective and visible, and can be evaluated by others. However, the findings in this study indicate that clinical judgment and everyday practice are undetachable, that is, clinical judgment related to patient care is embedded in everyday practice. The relationship of clinical judgment with everyday practice in nursing care can be compared to the relationship between lines and spots. The lines are everyday practice as non-deliberate actions, and the spots are clinical judgments as deliberate actions in clinical situations. In the other situations, clinical judgment is defined as a nurse's response to the situation such as knowing the patient (Tanner, et al., 1993).

In this study, clinical judgment is not the process of thinking but rather practicing. For Japanese nurses, practicing (i.e., providing care to patients) is the most important aspect of their job, because even though a nurse's thoughts and judgments are good, they are meaningless if the nurse does not provide care based on their judgment (Toguchi, 1980, 1981, 1982, 1983). Part of this issue was described in relationship to group consensus and individual clinical judgment (See Chapter V). In particular, practicing in nursing care includes moral and ethical aspects.

Dogen, a 12th century Japanese Zen Buddhist wrote that awareness of each moment in everyday practice is indispensable to the way of mindfulness. According to Dogen's Zen Buddhism, self-cultivation and self-salvation are only attained through awareness in everyday practice (Abe, 1985; Akizuki, 1990). Although Dogen's Zen Buddhism is not a central concern for Japanese today, his spirit is embedded in Japanese culture. Cultivation of the mind through practicing is the essence of all traditional learning in Japan. Similarly, practicing is still the spiritual foundation for nurses in this study.

The computer era and introduction of computer systems into Japanese hospitals has made a great deal of data and information available. Computers have given nurses easy access to personal information, care plans and nursing diagnoses for individual patients. With its many benefits, the computer is still not capable of practicing. Practicing is a human act in a social context.

The problem addressed in this study is how rationale standardized data and diagnosis can be used in actual Japanese hospital settings to provide individualized care. This study found that advanced experienced psychiatric nurses saved time by performing routine work quickly and spent the time saved providing individualized care. Computer systems and standardized care plans help if nurses use them to effectively perform routine work in the ward.

## Recommendations

The following will be needed for future research:

1. Everyday practices of experienced Japanese psychiatric nurses are tacit. The experienced nurses seldom systematically describe their everyday practices. They believe that wisdom for practicing is learned "by the follies of others" and learned "from the backs of seniors." This was the old-fashioned way of learning for the Japanese experienced nurses. Future research about everyday practices of experienced psychiatric nurses will need to use different research methodologies. Some experienced psychiatric nurses refused to participate in the dialogic interview of everyday practices in this study. It is theorized that these nurses were likely non-expert experienced psychiatric nurses who were unwilling to describe their everyday practices because they felt uncomfortable at the prospect of having their everyday practices evaluated by the researcher. Limited contribution by non-expert experienced psychiatric nurses was one limitation of this study. Long-term observation of the participants in the wards where they work may be necessary to acquire this information. If the researcher is able

to establish the trust relationship with non-expert experienced psychiatric nurses, they will likely open up and express their feelings and beliefs about psychiatric care through everyday practices.

2. It would be important to explore the abilities of veteran nurses with marked individuality. Current higher education based on theoretical knowledge will not produce such a nurse. A comparison between characteristics of veteran nurses with marked individuality—those who gain exceptional clinical wisdom through experience—with nurses who gain scientific knowledge, would permit exploration of these abilities. This research would reveal the background meanings of nursing education in history.

3. Cultural differences with regard to ethical and moral considerations of psychiatric care would also be recommended as a topic for future research. The ethical problems associated with staff conflicts in psychiatric hospital settings were identified in the literature review and narrative texts in this study. Therefore, a discussion of ethical and moral issues in psychiatric care contrasted internationally and between disciplines would be beneficial. In particular, study is needed on cultural differences in respecting individual patient's right and autonomy in decisions about daily living. It is expected that there will be less control of patient decision making and more individualized care during short hospitalizations. Research related to ethical and moral considerations would contribute to the development ethical guidelines for psychiatric care in hospital settings and community settings.

4. The relationship between the development of nurses' expertise and nursing administration systems in Japanese hospitals would be another important issue to address. Transition to an expert psychiatric nurse is connected with the nurse's career development. Very few episodes involving administration style emerged in this study. The nursing administration system which contributes to the pattern of work performance will need to be addressed in a future research.

5. The result of this study indicate that a nurse's life experiences reflect on their everyday practice. There were differences among generations and between gender in a nurse's motivation to become a nurse, in the role of the nursing team and in their life course as a nurse. A study of the relationship between the pattern of work performance and a nurse's life history would be useful in considering a strategy for role transition to advanced nurse.

6. In this study, dialogic one-on-one interviews were used as a research method. Use of group discussion as a way to change viewpoints about what is good practice would be an important contribution to future research, because the narrative in the group discussion will enable nurses to learn from the experience of others. Using narrative to encourage one to be reflective is useful to reveal the psychiatric nurses' clinical world and to cultivate their clinical competencies in nursing practices.

## Conclusions

1. Four levels of expertise among psychiatric experienced nurses were found in the patterns of their work performance in everyday practices: practices of routine

work performers, practices of experienced nurses as good neighbors, practices of veteran nurses with marked individuality and practices of advanced experienced nurses.

2. The issue of clinical judgments was revealed in the closeness of the nurse-patient relationship, time differences between making a judgment and evaluating the judgment, conflict between group consensus and the individual nurse's judgment, and the moral components in patients' activities of daily living (the very private aspects of human existence such as eating, smoking and bathing).

3. The work performance patterns of experienced psychiatric nurses were strongly connected with each nurse's life course. In particular, the transition to advanced nurse was reflected not only by professional experience but also by the personal experiences in a nurse's life.

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# APPENDIX A

## TREND OF PSYCHIATRIC BED AVAILABILITY IN JAPAN

TREND OF PSYCHIATRIC BED
AVAILABILITY IN JAPAN

| Year | Number of beds | |
|---|---|---|
| | Total | Per 10,000 persons |
| 1951 | 21,899 | 2.5 |
| 1961 | 99,332 | --- |
| 1965 | 164,027 | 16.5 |
| 1970 | 242,022 | --- |
| 1975 | 275,468 | 24.5 |
| 1980 | 304,469 | --- |
| 1985 | 333,570 | 27.5 |
| 1988 | 351,469 | --- |
| 1990 | 358,251 | 29.0 |
| 1993 | 362,962 | --- |
| 1995 | 362,180 | 28.8 |

# APPENDIX B

# PARTICIPANTS

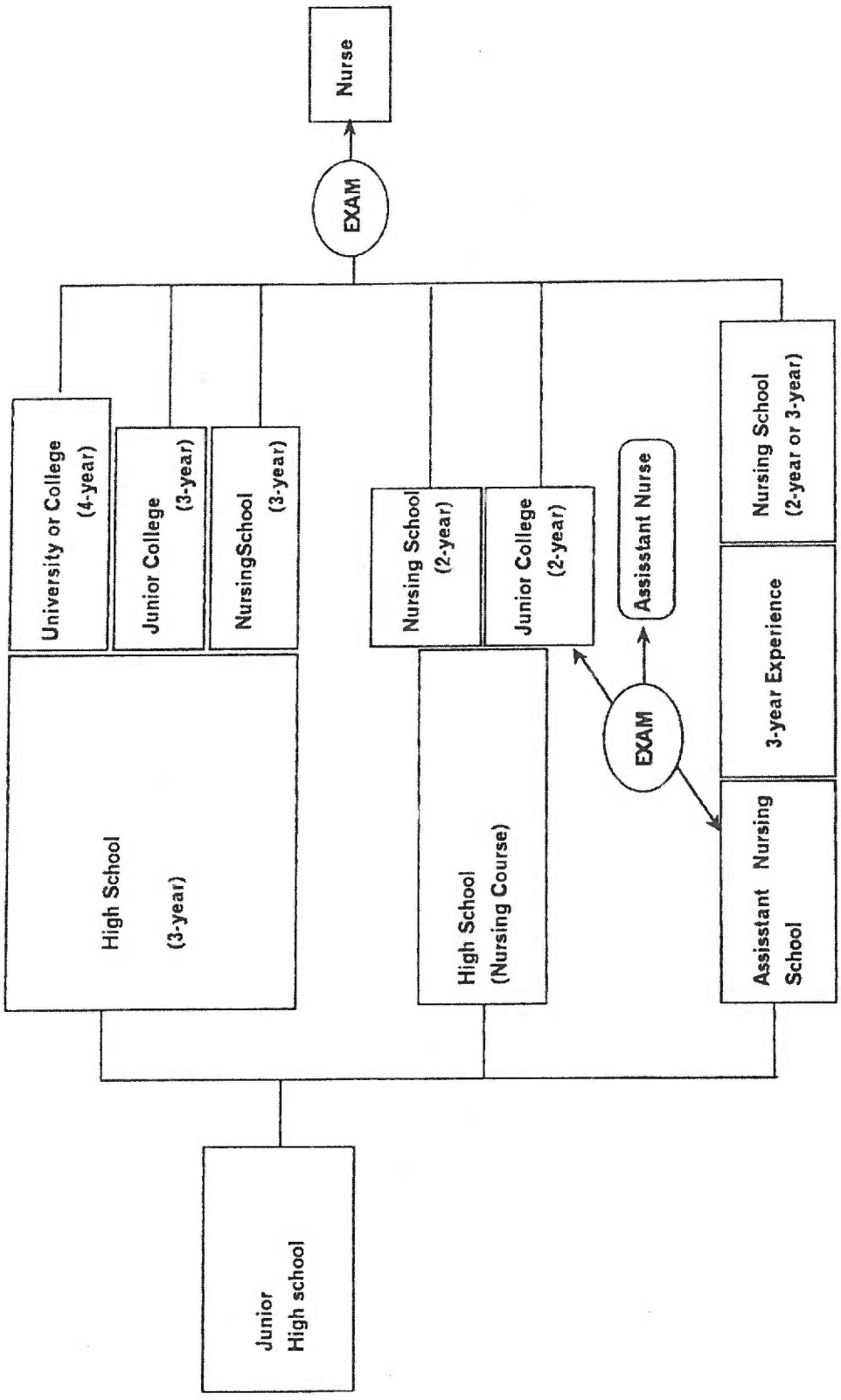
# APPENDIX B

## PARTICIPANTS

| | | Sex | Nurse | Assistant Nurse |
|---|---|---|---|---|
| 1st phase | Hospital #1 | Female | 12 | 1 |
| | 17 | Male | 1 | 3 |
| 2nd phase | Hospital #2 | Female | 1 | 0 |
| | 2 | Male | 1 | 0 |
| | Hospital #3 | Female | 4 | 0 |
| | 4 | | | |
| Total | 23 | | 19 | 4 |

# APPENDIX C

## JAPANESE NURSES' EDUCATION SYSTEM




Japanese Nurses' Education System

# APPENDIX D

## GUIDELINES FOR INDIVIDUAL INTERVIEW

## OF EXPERIENCED PSYCHIATRIC NURSES

# GUIDELINES FOR INDIVIDUAL INTERVIEW

# OF EXPERIENCED PSYCHIATRIC NURSES

1. Please describe your clinical experience briefly since you graduated from nursing school or you started working as a nursing staff member.

   (a) Do you choose psychiatric nursing yourself?

   (b) Why do you choose to become a psychiatric nurse?

2. Please describe your today's practice?

   (a) Is it a typical day? If it was not, please describe a typical day's practice.

   (b) How are you working with patients?

3. When you look over your history as a clinical nurse, is there any episode or story that stands out in your mind?

   (a) Would you tell me the episodes in past patients' care which still strongly remain in your mind?

      -- Why do you recall them?

      -- How were you involved in the situation?

   (b) Would you tell me an example of a nursing situation (patient care) that you still think about?

      -- unsolved problems

      -- a case that remained a guilty feeling

   (c) Would you tell me an example of a nursing situation in your experiences that you are proud of?

      -- unexpected successful case

4. Would you tell me what is the most important clinical experience that contributes to develop your expertise as a nurse?

   (a) Would you tell me what you have learned from your clinical experience or patients' care?

   (b) Would you tell me what it is that you were taught by patients?

Is there anything else important about your history and experience as a nurse you would like to tell?

5. Why do you continue working as a psychiatric nurse (at psychiatric unit)? By what have you been supported to being a nurse?

   (a) Would you tell me what is your belief (the most important) when you work with patients or you provide patients care?

# APPENDIX E

# CONSENT FORM

APPENDIX E

OREGON HEALTH SCIENCE UNIVERSITY
Consent Form

TITLE

An interpretive study of everyday practices and clinical judgments by experienced psychiatric nurses.

PRINCIPAL INVESTIGATOR AND RESEARCH GROUP

The principal investigator is Yoko Nakayama, R.N., M.A., from Japan. She is a Ph.D. candidate of Oregon health Sciences University School of Nursing. She offers to answer any questions that might arise. Her telephone numbers are (503) 452-2478 (Portland, Oregon, USA), 03-3543-6391 (St. Luke's College of Nursing, Tokyo, Japan) and 0429-62-5384 (c/o Takashino, Iruma-shi, Japan).

This study is a doctorate dissertation under the supervision of Dr. Christine Tanner, Dr. Barbara Limandri, Dr. Caroline White (Oregon Health Sciences University) and Dr. Richard Askay (University of Portland). In addition to these supervisors as the research group members, the research associates, including translators and consultants, will participate in this research because the study is conducted between Japan and the United States.

PURPOSE

The purposes of this study are: (1) to explore and describe everyday practices of psychiatric experienced nurses who work at mental hospitals in Japan, particularly, (2) to explicate the characteristics of clinical judgments which are embedded in their everyday practices, and (3) to understand the meaning of 'experienced" of experienced psychiatric nurses.

PROCEDURES

If I agree to participate in this study, my participation will include:

1. Individual interview. The interview will focus on my background as a nurse, and everyday practice, episodes and stories in clinical experiences. The first interview will last approximately 2-3 hours, and subsequent interviews will be

conducted until I have completed talking about my stories. The interviews will be in the hospital (e.g., interview room or small conference room), depending on my choice. The interviews will be taped and transcribed in Japanese. My Japanese transcripts may be translated into English.

2. Group discussion and the follow-up discussion. After the individual interview, if I am asked to participate in group discussions, I will do so. Also, if I am asked to become a case presenter in the group discussion, I will write briefly the patient care situations I currently confronted or experienced with hesitation, puzzlement, deadlock or stumble, and talk about the story.

The group members will be 6-8 nurses, and the group discussion will focus on clinical judgments in deliberative clinical situations. The group discussion will be held at the hospital conference room and last approximately 2-4 hours. The group discussions will be taped and transcribed in Japanese. The follow-up discussion will be conducted based on the transcript of the first group discussion. The Japanese transcripts of group discussions may be translated into English.

3. Observation. After individual interview, the researcher will visit the ward where I work to grasp the circumstance as backgrounds of my stories.

CONFIDENTIALITY, RISK AND DISCOMFORTS

All interviews/group discussions will be tape recorded and transcribed. The only risk of the study to me is the potential loss of some privacy. My confidentiality will be maintained as much as possible. The researcher will keep my name separate from the recorded interview and transcripts. My name will be coded by number and kept in a locked file so that my confidentiality will be protected. Any information that could be traced to individual patients will be deleted from the transcripts.

I understand that I may refuse to participate or withdraw from this study at any time without affecting the relationship with my hospital.

BENEFITS

I will use this study as an opportunity to review my clinical experience. I also will be able to learn or share the clinical knowledge in psychiatric care with colleagues through participating in this study.

COSTS

Although I may spend my private time for interviews/group discussions, there will be no cost. When the interviews/group discussions take place outside of the hospital, the researcher will pay the cost of transportation.

I have read the foregoing and agree to participate in this study. In addition, I agree to the conditions listed on the following page regarding use of excerpts from interviews with me.

My agreement is indicated by my initials by the ONE condition which applies.

_____ Transcripts of interviews/group discussions may be reviewed only by research group members and used in Nakayama's dissertation which will be written in English.

_____ Transcripts of interviews/group discussions may be reviewed by research group members. In addition, they may be used in publications or presentations on the condition that my anonymity be maintained.

_____ Transcripts of interviews/group discussions may be reviewed by research group members. In addition, they may be used in publications or presentations on the condition that they will be attributed to me. Before they are used, I will have the opportunity to review the manuscript and reconsider my decision.

_____ Transcripts of interviews/group discussions may be reviewed by research group members. In addition, they may be used in publications or presentations on the condition that they will be attributed to me.

_____

Participant Signature Date

_____

Investigator Signature Date