

Aspects of Registered Psychiatric Nurses' Talk about their Clinical Judgement & Decision-Making

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In loving memory of my sister Connie, who taught me to read.

In heartfelt appreciation and gratitude for the support and guidance of my supervisors,
Professor P. Anne Scott, Deputy President, Dublin City University & Dr. Padraig
MacNeela, NUI Galway.

Soli Deo Gloria

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Abstract

Researchers have been investigating the clinical judgement and decision-making of nurses for several decades now. However, prior to the research described in this thesis, Registered Psychiatric Nurses (RPNs) working in the Irish Republic had not been the subject of a comprehensive study looking specifically at their clinical judgement and decision-making. As this is the first study conducted in this area, it takes an exploratory descriptive approach.

With a comprehensive review of the literature and pilot study (n=7) as its basis, a novel mixed methods study was designed. Simulated cases presented in an audio-visual format were used to collect *in-vivo* and retrospective data in the form of narratives from participants (n=40) across the Irish Republic. The sample comprises RPNs across all levels of experience working in several sites, representing the full range of Irish mental health services. The data were analysed using comparative keyword analysis and conversation analysis informed discursive analysis.

Quantitative and qualitative analysis reveals participants' judgement and decision-making to be routinised and habitual, hinging on reference to typicality grounded mainly in psychiatric diagnoses. The role of participants can be seen to represent the paternalism of the social order of which it is part. Participants express confidence and certainty in their judgement and decision-making, even where paraverbal and other discursive evidence points towards situations characterised by uncertainty.

The study's findings are of particular interest given the direction envisaged for the profession of psychiatric nursing by leading academics, health service providers and professional and statutory bodies. The findings of this study suggest that if psychiatric nursing in the Irish Republic is to proceed towards more person-centred, autonomous practice with a stronger therapeutic focus, dramatic restructuring of psychiatric nurses' roles will be required. In conclusion, the thesis discusses this situation with reference to the challenges made evident by the study, along with the viable options available to address them.

Chapter One - Introduction

1.1 Introduction

This study explores the clinical judgement and decision-making of registered psychiatric nurses (RPNs) working in the Irish Republic. It is part of an interdisciplinary, collaborative, Health Research Board funded “Integrated Programme of Research to Maximise the Effectiveness of Clinical Nursing Resources” - the first study to consider nurses’ clinical judgement and decision-making in the Irish Republic. This programme of research is foundational, with no body of judgement and decision-making research from an Irish context to build on.

As part of a foundational programme of research, this study is exploratory and descriptive. Exploratory descriptive studies are often used to investigate areas about which little is known in a specific context. They have proved useful in nursing, psychiatric nursing and mental health generally (Koopowitz et al 2003, Newton et al 2007, Gleeson & Higgins 2009).

The exploratory nature of this study lies in two main features. As with exploratory studies generally (Pridemore 2006), it is the first study of its kind in the Irish Republic. Given this, it does not seek to test any hypotheses (Nunkoosing 2005, Tachibana 2005). Instead it seeks to give a general overview of psychiatric nurses’ clinical judgement and decision-making in an Irish context in order to serve the development of policy, practice and education in psychiatric nursing, as well as informing future research studies.

1.1.1 Stylistic Issues

Researchers often write in the first person (Porter 2000), as I have done throughout this thesis. This is in order to lend as much reflexivity (Porter 2000) as possible to my description of the study. Reflexivity is that process whereby the researcher acknowledges and considers the pros and cons of any personal stake holding, subjective opinions and/or values with regard to the research and its subject matter. Writing reflexively has positive implications for trustworthiness and credibility of research findings (Hall & Callery 2001), and this aspect is discussed in relation to the study design and methodology in Chapter Three.

Throughout the thesis I refer to “psychiatric nursing”. I am aware of the various opinions on what terms should be used to refer to nurses working in the field of mental health. As this debate is not the focus of this study I have deferred to the term used by the statutory body that governs nursing in the Irish republic, An Bord Altranais.

Various terms are used to refer to people who avail of the services of psychiatrists, nurses and other mental health professionals. Where people are resident in hospitals I do not differentiate them from the general populace resident in hospitals, and simply refer to them as “patients”. Where people are availing of community based services I have avoided terms such as “client”, “consumer” etc., that differentiate individuals from the general populace (Barker 2004), simply referring to “people”. Where syntax demands it I use the phrase “service-user”. This is out of grammatical and syntactical necessity, and is not intended as an ideologically loaded term.

1.2 Clinical Background & Context

The background and context for this study is essentially that of the work of psychiatric nurses within the adult mental health services in the Irish republic. In their “Vision for Change” mental health policy document, the Department of Health and Children (DoHC 2006) deals in some detail with the work of psychiatric nurses, who make up the majority of mental health services staff. The latest figures available show that there are 9,796 registered psychiatric nurses working in the Irish Republic (An Bord Altranais 2008a), about 10% of whom are located in community-based services (DoHC 2006).

The policy describes the roles that are envisioned as being undertaken by psychiatric nurses as part of proposed changes in service provision. This involves the psychiatric nursing role becoming more specialised. This scope for specialist practice is not seen as applying only to the nursing role, but also to the roles of other team members.

The Mental Health Commission (2005) is keen to have the voices of service-users heard with regard to the improvement of the quality of mental health services. One of the issues that arose in their consultation with key stakeholders around care provision was the need for nurses to be more integrated members of the mental health team. The Mental Health Commission (2005) has reported that mental health service providers see a need to have mental health care integrated more closely with primary care, with greater psychiatric nursing involvement with the primary care team. They cite the example of making psychiatric nurse consultations available as a matter of course in GP surgeries and accident and emergency departments.

As part of the broader profession of nursing, psychiatric nursing in Ireland has also been influenced by wider changes that affect all branches of nursing. The general thrust of these changes has been to increase the autonomy and responsibility of the nursing role. The most significant area of change has been that of nurse prescribing, (An Bord Altranais 2008b).

Rooted in the custodial asylum system of addressing mental health problems, Irish psychiatric nursing has undergone many changes over recent decades (Nolan & Sheridan 2001). What has been described above is the direction that the profession should now take, as proposed by two of the major stakeholders and powers in Irish healthcare provision (Mental Health Commission 2005, DoHC 2006). I have taken this into account for this study, with the intention of providing evidence that will be useful in charting the future direction that the profession needs to take in order to best serve the public.

1.3 Theoretical Background & Context

In this Chapter I set out the broad conceptual background to human judgement and decision-making. In Chapter Two I examine the clinical application of these ideas as discussed in nursing research and academic writing. Together, these chapters are intended to provide the reader with a comprehensive introduction to the main concepts and issues being explored in this study.

To those coming to the topic for the first time, the terminology used in the judgement and decision-making literature can be confusing. Buckingham & Adams (2000a, 2000b) see this situation as stemming from the proliferation in the nursing literature of theories on clinical judgement and decision-making. Indeed Dowding & Thompson (2003) have commented that the complex nature of judgement and decision-making is bound to be reflected in an equally, if not more complicated theoretical background.

Like the medical literature, the nursing literature on judgement and decision-making has drawn for the most part from psychology. However, this should not be to the exclusion of other perspectives and disciplinary approaches to the topic. Therefore, in this study I have used a more sociologically oriented perspective to understand nurses' judgement and decision-making in context.

To this end, this chapter gives a broad account of coverage of the topic of human judgement and decision-making in the philosophical and social sciences literature as well as in the psychological and nursing literature. These disciplines have seen the discussion of various approaches and concepts relating to human judgement and decision-making, and I have aimed to capture this here. My intention is not to be exhaustive or comprehensive, but to consider each area within the context of its relevance to nursing.

A caveat for any reader of "judgment" and "decision-making" literature is that these two terms are ascribed varied meanings throughout the literature. This applies not only

within disciplines as well as across them, but within publications. For the sake of clarity, in this thesis I do not use a plethora of terms. Instead I limit myself where possible to the use of the terms “judgement” and “decision-making” with specific reference to two distinct phenomena. In order to understand what is meant by these terms, it is necessary to fully discuss what they have come to represent across different disciplines.

1.3.1 Human Judgement & Decision-Making

It is difficult to frame singular definitions that cover the application of concepts in human judgement and decision-making across the social sciences (Packard 1962). Psychology is primarily concerned with the cognitive processes of judgement and decision-making. This involves consideration of the rationality and/or accuracy of judgements and/or decisions in order to assess if they are “sound” or “good” (Connolly et al 2000, p2).

A prerequisite for this is the recognition and explanation of what constitutes being ‘good’ or ‘sound’ with regard to judgement and decision-making in the area being studied. This is often beyond the scope of any one discipline, and therefore psychology, philosophy sociology, organisational and business studies are very much relevant to nursing judgement and decision-making. With psychology’s focus on cognitive aspects of human judgement and decision-making, the social sciences more generally provide the necessary examination of the contexts in which humans make judgements and decisions.

This broad perspective is helpful in accounting for influences external to the cognitive faculties of the judge or decision-maker. Philosophy in particular can add to the discussion on what constitutes “good” or “sound” judgement, as well as serving to pull all strands together in a meaningful way. The contexts that need to be considered in this regard range from wider society down to immediate work group and environment.

This is particularly important in nursing, where clinical practice involves a more intimate degree of social contact than many of the other disciplines that feature prominently in judgement and decision-making research (e.g., agricultural science, meteorology, or air traffic control). Yet philosophical or sociological perspectives tend not to be incorporated into the design or discussion of nursing research on clinical judgement and decision-making. With this in mind, I consider the contribution of psychology to the study of human judgement and decision-making, before discussing approaches from across the social sciences generally.

1.3.1.1 Human Judgement & Decision-Making in Psychology

The psychological literature around judgement and decision-making has been dominated by discussion around the benefits of analytic versus intuitive judgement since the early 1950s. Meehl (1954) favoured analytic over intuitive judgement and decision-making, and Holt (1958) was one of his first critics in this regard. Holt (1958) argued that judgement, because of its very nature, must be to a large degree intuitive.

Although Meehl's work over the years did not deny this, his contributions did move the study of judgement and decision-making towards a more analytic focus (Kleinmuntz 2000). This focus tends towards examining the accuracy of judgements and decisions rather than focusing on rationality *per se* (Gigerenzer & Hoffrage 1995, Grove & Lloyd 2006). In differentiating between accuracy and rationality, Hammond (2000b) explains that accuracy implies actual empirical precision with regard to the outcome of a judgement or decision. This may or may not be achieved in the case of a rational process of making a decision or judgement. Even though the process of arriving at a certain judgement or decision may be perfectly rational, this is no guarantee of its accuracy.

Advances in computer science from the 1960s on influenced shift away from the dominance of Freudian and behaviourist perspectives towards a focus on human information processing (Connolly et al 2000). Technology enabled the use of mathematics in research in a way that had not previously been possible. Psychological research of judgement and decision-making began to draw heavily on statistical analysis and mathematics – with a new emphasis on experimental study, judgement analysis and decision analysis (Connolly et al 2000).

Decision analysis involves a four-step process that requires the decision-maker to first identify the inherent relationships between the probabilities, available options and prospective outcomes of a situation (Narayan et al 2003). This involves *a priori* decomposition of the process (Raiffa 1970), using a top-down expectation for how the decision should be made. In contrast, judgement analysis involves a 'bottom-up', *a posteriori* decomposition of the judgement process.

In judgement analysis, an *a priori* analysis of the judgement process is possible using a gold standard for the outcome of the judgement. For both judgement and decision analysis, it is necessary to be able to reduce a "sound" or "good" judgement to mathematical terms (Connolly et al 2000, p3). Whilst the two approaches themselves do not offer a way to determine what is meant by "good" or "sound" in the first instance,

they are highly effective at examining judgements and decisions once ‘soundness’ or ‘goodness’ has been attributed numerical value.

Informal decision analysis is a more qualitative approach to decision analysis that offers a way to determine what constitutes a ‘good’ or ‘sound’ judgement or decision. Although it does not involve arithmetic to the same extent, it is based on the same concepts as formal decision analysis insofar as it quantifies outcomes, options, and probabilities. Informal decision analysis is used where the purpose of decision analysis requires less rigour from a statistical perspective, e.g., for patient decision aids (Owens et al 1987, Blank et al 2006).

With informal decision analysis, the aim is to ascertain a patient’s *preferred* treatment as opposed to the *best* treatment in terms of likelihood of positive outcome (Deadman et al 2001). Informal decision analysis is more qualitative as it serves more qualitative ends, such as increasing patient responsibility and building the clinician-patient relationship through shared decision-making. For this reason, informal decision analysis is more suited to clinical practice, whilst formal decision and judgement analysis approaches are more useful for research purposes.

The empirical focus of formal decision analysis and judgement analysis has been seen as particularly useful in researching the role of human intuition in judgement and decision-making. Kahneman (2003a, p697) defines intuition as “thoughts and preferences that come to mind quickly and without much reflection”. Since the early 1970s the focus of psychological research has shifted from the usefulness of intuition (Hadamard 1945) towards examining the tendency for error in intuition (Tversky & Kahneman 1974, Kahneman & Tversky 1982).

Several theoretical concepts, such as stereotyping (Wittenbrink et al 1998, Wegener et al 2006), heuristics (Tversky & Kahneman 1973) and pattern recognition (Deutsch et al 1994, Rosenfeld & Weschler 2000) have been developed as a result of research and conceptual work around the role of intuition in human judgement and decision-making. Heuristics is the term used to describe the cognitive process by which individuals use probability-like judgements to arrive at a subjective likelihood estimate on which subsequent judgements are based (Tversky & Kahneman 1974, Goldstein & Gigerenzer 2002). The use of heuristics has been shown to reduce task complexity, simplifying the judgement process. This occurs by replacing intricate analytic processes involving the assessment of probability and prediction of values with simple heuristic rules - although not without widening the scope for error (Tversky & Kahneman 2000).

Pattern recognition is defined by El-Deredy (1997, p99) as “the ability to identify and interpret meaningful regularities in noisy or complex environments”. This involves four distinct cognitive processes: acquiring information, recognising salient features, detecting similarities between patterns, and subsequent evaluation of the situation (Rosenfeld & Weschler 2000). This process is not deliberate and analytic, but rapid and intuitive.

Social psychology has seen the study of stereotyping grow considerably over the last two decades (Wegener et al 2006). Gaertner & McLoughlin (1983, p23) describe a stereotype as “in part, a collection of associations that link the target group to a set of descriptive characteristics”. Research has focused either on stereotyping as automatic or stereotyping as a controlled behaviour (Wegener et al 2006) - with the greater focus on the automatic nature of stereotyping (Perdue & Gurtman 1990, Fazio et al 1995, Banaji & Hardin 1996, Dovidio et al 1997).

Subjective expected utility theory (SEU) has proved useful in examining the rationality of judgements and decisions. This approach accounts for the beliefs and values of a rational person making a decision, calculating different possible outcomes and identifying the optimal choice for the individual in the given situation (Shaban 2005a). SEU is one of a range of theories based on the expectancy values element of Bayesian theory (Edwards 1954, Gigerenzer & Hoffrage 1995).

Savage (1954) developed SEU from the expected utility theory of von Neumann & Morgenstern (1947). Expected utility theory aims to give a mathematical explanation of a person’s decisions based on their rational use of a rule-based approach to maximise the expected utility, or benefit, from a decision. In doing this it uses a probability-weighted average to account for what might be ‘expected’. SEU differs from this in that instead of basing maximum expected utility on probability-weighted averages it uses the person’s own subjective expected utility.

From the 1960s onwards, psychologists studying human judgement and decision making became interested in developing descriptive theoretical explanations and models of human information processing (Neisser 1967, Newell & Simon 1972). The study of human information processing considers the roles played by our limited or ‘bounded’ rationality, short-term memory and an infinite long-term memory store. Information processing theory has been one of the most influential approaches to studying and explaining how nurses make clinical judgements and decisions (Thompson & Dowding 2009c).

Consideration of the hypothetico-deductive process is another popular, similar approach that has proved useful in this regard. Studying this process involves gaining insight into how individuals selectively generate several hypotheses in relation to a specific task or situation (induction) (Elstein et al 1978). Having thought about various potential outcomes, the individual then rules out one or more of these hypotheses (deduction) (Cacioppo & Tassinary 1990).

Whilst these approaches are considered mainly with the cognitive processing involved in judgement and decision-making, some researchers have sought to account for the attention paid by individuals to the ecological aspects of judgement tasks. This involves identifying relevant ecological factors and trying to account for their complexity and variability. This is achieved by representing them numerically for the purposes of statistical and algebraic modelling (Brunswik 1952).

The most popular approach in this regard is that of social judgement theory (Hammond et al 1975). It involves the application of models such as the lens model to judgement tasks in order to account for the role played by social factors (Hammond et al 1975, Hammond 1978, Cooksey 1996). Social judgement theory has been successfully applied to nursing (Dowding 2002) and medicine (Wigton 1996).

One of the most useful developments of social judgement theory has been Hammond's (1988, 1996a) non-traditional cognitive continuum theory (Connolly & Beach 2000). This has proved particularly useful in modelling and exploring the relationship between intuitive and analytic approaches in judgement and decision-making (Offredy et al 2008, Beckstead 2009). In doing this, cognitive continuum theory places the cognitive processes of analytic and intuitive judgement at either end of a spectrum, each seen as more suited to certain situations than to others.

Cognitive continuum theory also places types of judgement tasks along a continuum of six categories, ranging from well-structured to ill-defined tasks (Hammond 1978). Well-structured tasks stand in contrast to ill-defined tasks in terms of the amount and relevance of information available and complexity of the task at hand. Also considered are the potential for accuracy and pressure due to time constraints inherent in a task (Hamm 1988). In this way, cognitive continuum theory seeks to account for both the ecological and cognitive elements involved in the process.

At the analytic end of the continuum Hammond uses scientific experimentation as an example of the type of task in which analytic thinking predominates, whereas at the other end of the continuum quasi-rational intuition is dominant (Hammond 1978). The more intuitive processes described in the cognitive continuum might lend towards

acceptable outcomes for certain non-complex task types. Their use, however, leads to less favourable outcomes for those tasks which require what Coler (2003) has referred to as a more predictive, or analytic, approach.

As might be expected, approaches in psychology to human judgement and decision-making are concerned mainly with the cognitive processes involved. However, there is also a concern for the ecological elements, e.g., task features, time pressure, and so on. These, along with aspects of cognitive processing, can be represented numerically for the purposes of quantitative research and modelling.

As demonstrated in this section, the theories, models and frameworks produced by this type of enquiry form the basis for exploring the cognitive and immediate ecological factors involved in human judgement and decision-making. To account for the more qualitative aspects of human judgement and decision-making, such as what is 'good' or 'sound', changing individual preferences, and wider social influences, it helps to look beyond what psychology has to offer. Of particular help in this regard are the contributions of philosophers, sociologists and other social scientists and commentators.

1.3.1.2 Human Judgement and Decision Making: Beyond Psychology

In its focus on individual judgement and decision-making, psychology differs from approaches that are concerned with the wider social context. For the most part these involve consideration of the societal and organisational contexts in which people make judgements and decisions. These raise issues such as role, semiosis and the sharing of objectives.

The nature of inquiry into these aspects of judgement and decision-making differs from that of psychology in that psychologists are interested primarily in the individual. Social scientists considering the wider interactional context of judgement and decision-making are interested in individuals as part of work groups, institutions and society as a whole. Their research differs from psychology in that this wider social context is its main focus.

Consideration of shared objectives is a key element in social theories that look at decision-making from the perspective of the group or organisation as opposed to the individual (Bourgeois 1980). The degree to which objectives are shared by a work group is vital to the fulfilment of a decision task, and will itself hinge on the degree to which the group has shared understanding of both the means and the ends (Simon 1957). This shared understanding is often enshrined in a clearly stated, mutually accepted, and socially valorised form, e.g., an organisational strategy.

Given this, any consideration of judgement and decision-making from a wider social perspective must first deal with how meaning is made (semiosis). This involves looking at individuals' understanding of roles and routine social practices in relation to judgement and decision-making. This reveals the complexities, in both theoretical and practical terms, of the wider social aspects of human judgement and decision-making.

For example, researchers seeking to understand judgement and decision-making processes may find that participants are simply following a pattern of behaviour without consciously choosing a course of action. Theoretical concepts explaining such situations are vital to understanding instances of human judgement and decision-making, particularly where individuals simply cannot explain why they decided to take a particular course of action. There is overlap here with the psychological concept of intuition, and awareness is needed at this point that social and psychological theories often consider the same phenomena from different viewpoints.

From sociological perspective, oft-repeated activities that become patterned over time so that they are carried out without any apparent deliberation in judgement or decision-making are explained by the concept of habituation (Berger & Luckmann 1967). The application of this concept can be useful in considering routinised practices, especially where there is difficulty in explaining the apparent opacity as regards any intelligible process. What a psychologist sees as a lack of conscious decision-making predicated on cue-based judgement, a sociologist may view as habitual, routinised behaviour.

Despite seeming, on these grounds, to characterise low-skilled work, habituation is essential to highly specialised work (Berger & Luckmann 1967). The routinisation of certain activities permits attentiveness to more highly skilled tasks that are more demanding. Habituation is, therefore, one of the necessary prerequisites for the emergence of specialised roles (Berger & Luckmann 1967).

Understanding the development of roles and related judgement and decision-making requires an awareness of the meaningfulness associated with these roles and the work that they involve. Meaning is a fundamental concept in sociology, and has been seen by structuralists and symbolic interactionists as forming the very basis for society (Rochberg-Halton 1982). This is borne out in the extent to which meanings are formed (semiosis) and shared within and between groups. This has significant bearing on the discussion of judgement and decision-making in the sociological literature.

Peirce (1895/1998) offered the classic definition of semiosis as a triadic process involving an object, a sign representing that object, and an interpretant who finds meaning in that sign. The relevance of this concept for judgement and decision-making

is apparent in its relationship to the interpretation of cues as signs. Such interpretation is considered in empirical terms in social psychology approaches such as the lens model (Brunswik 1952, Cooksey 1996).

Whilst such approaches consider individuals' interpretation of cues from a quantitative perspective, semiosis also takes into account the qualitative interpretation of cues. Making sense of how individuals find and share meaning is what the study of semiosis is primarily concerned with. Modern definitions of semiosis may vary, but almost invariably draw on Peirce (1895/1998), particularly in terms of the need for an interpretant in the process (Sebeok 2001).

Vital to understanding the place of semiosis in the analysis of judgement and decision-making is Peirce's (1895/1998) contention that an object cannot be studied in isolation from its being mediated to the interpretant by means of a signal. This is because the mediation of the object cannot be studied in isolation either (Glassman & Kang 2007). Therefore, it is important not to artificially separate the mediatory function from the sign, let alone the overall process of semiosis.

Although all three elements of the triad of semiosis must be given due consideration, the object does remain the least accessible element of the triad (Glassman & Kang 2007). A major implication of this is the need to account for the social situation of judgment and decision-making, as well as accounting for the effect of the intrusion of the researcher into its naturalistic setting. This needs to be addressed in terms of study methodology, reflexivity and the need to account for the role of the researcher.

This in itself must be addressed within the wider context of semiosis as human activity (Glassman & Kang 2007). This principle applies both to the semiosis being engaged in by the participant and the semiosis being engaged in by the researcher studying that participant's activity. The importance of not focusing solely on the mediation of a sign when studying semiosis is of particular relevance to the study of the semiosis that occurs when individuals attempt to arrive at a judgement or decision as a group (Glassman & Kang 2007).

This is because the meaning attributed to the sign may have neither correspondence between, nor stability for, all the interpretants involved. This sharing of meaning has been given much consideration in the sociological and related literature around group judgement and decision-making. In doing this, the social sciences literature uses a diversity of terms.

These include 'shared meaning', 'shared understanding' and 'shared beliefs'. Insofar as they have common meaning, these terms are used interchangeably in this study as they

have been in the literature. This concept of shared meaning draws to some extent of Habermas's description of shared comprehension as an important part of the consensus that exists within and between lifeworlds (Habermas 1992/1996). More specifically, shared meaning is seen as the starting point for communicative action. The degree to which people in any given social context have shared meanings will depend on their belief systems and also on prevailing knowledge structures (Shakespeare 1998, Repert et al 2002).

In terms of applicability to judgement and decision-making, the wider social science literature views shared meaning as part of the culture of organisations (Smircich 1983, Kunda 1992). With Habermas (1992/1996), the business/management research literature on organisational decision-making views shared meaning/understanding in the context of consensus (Bazzoli et al 1998, Boster et al 1983, Phillips & Bana e Costa 2007). Whereas some commentators equate shared understanding with consensus (Wooldridge & Floyd 1989, Bowman & Ambrosini 1997), others see it as only one component of this complex social phenomenon (Noble 1999).

In the healthcare literature around organisational decision-making, the concept of shared understanding appears in relation to consensus as well as in terms of the shared understanding of roles (Cott 1998) and decisions regarding resource allocation (Heritage et al 2001). It is also an important element in the exploration of shared decision-making between health professionals and those who avail of their services. This is especially true in the context of patient-centred communication (Epstein et al 2005, Johansson et al 2005, Wirtz et al 2006, Halpern 2007).

Individuals tend not to share their own conceptualisations of phenomena and processes ad-lib, but in a specific social context in which they are engaged with others in an activity (Shakespeare 1998, Lam 2004). It is within this context that the hegemony proposed by Gramsci (1971) can be seen to operate (Brandist 1996). Where the social actors involved in an activity share social homogeneity they are likely to develop a broadly homogenous view of their situation (Midthassel 2006).

However, where this social homogeneity is not a feature of the group, discrete views may develop that hinder smooth operation of the work group (Vallaster 2005). Given this social context, communication between individuals involved in such activity is seen not only as vital to the development of shared understanding (White 2002), but also of accommodating diversity that might otherwise fuel antagonism (Vielhaber Hermon 1996, Vallaster 2005). Where the area of the activity is characterised by ambiguity, this

communication needs not only to be frequent, but structured (Jacobs & Heracleous 2006).

As with habitualisation and intuition, and semiosis and the interpretation of cues, the conceptualisation of shared understanding in sociological literature has a distinct parallel in the psychological literature. The building of consensus has direct relation to Hammond's (1988, 1996a) inclusion of peer-aided judgement in his cognitive continuum. Also, the structuring of communication and other elements of judgement and decision-making to avoid ambiguity and dissension finds a parallel in Hammond's consideration of system-aided judgement as part of the cognitive continuum.

The aims of this study involve the social context of nurses' judgement and decision-making as well as the cognitive processes involved. An approach is needed, therefore, that brings together the wider social perspectives on human judgement and decision-making with a psychology of judgement and decision-making that also considers its social aspects. This is in distinction to the more traditional laboratory-based approaches of cognitive psychology research which are concerned with the cognitive processes of the individual in isolation, to the exclusion of the influence of other individuals on participants.

The work of Mead (1934) is essential to understanding the philosophical basis for the role of language in the formation of shared meaning in terms of social homogeneity and heterogeneity. Mead (1934) saw language as the basis for the management of difference between self and others within and without one's social group. Mead's work is seminal in terms of the pragmatist school of thought that formed the basis for the symbolic interactionist approach to sociology (Rochberg-Halton 1982), and so his work is also essential to understanding the role played by shared meaning in social action.

Because they draw on modes of cultural expression, individual narratives speak not only of an individual's subjective reality (Berger & Luckmann 1967). Narratives also represent the social group and culture from which they are speaking. This again links back to Gramsci's (1971) concept of hegemony, as certain discourses tend to be dominant (Mogensen 1997).

Ethnographic methodologies examine narratives to explore shared cultural understandings and their influence on social action (Bruner 1986a). This is both in terms of how the shared cultural understandings evident in narrative influence social action and the role played by social action in constructing shared understanding (Bruner 1986b). This is seen as a dialectical interaction between experience and narrative.

Wider sociological theory has not focused solely on the transmission of shared beliefs within groups, but on broader issues such as the extent to which beliefs are shared across groups (Hollis 1982). These beliefs are shared not just because they have been transmitted between groups, but because of their basis in a human rationality that transcends social groups. These shared beliefs are seen as underpinning transcultural “rules of coherent judgement” (Hollis 1982, p74).

From a psychological perspective, this is explained in terms of epistemic rationality underpinning instrumental rationality – or beliefs underpinning actions (Thomson & Dowding 2009c). Whilst psychology considers how the individual relates the abstract and theoretical to the practical, from a sociological perspective the same phenomenon is considered from a group, institutional or societal perspective. The consideration of influence of preferences and values (Thompson & Dowding 2009c) is instrumental to both these perspectives.

This concept is an important addition from sociological theory, which I believe can complement the dominant perspective of social psychologists in judgement and decision-making in business and organisational research. It lends to this area the consideration that judgement/decision rules that are shared within a work group may not be peculiar to that work group. Instead they may stem from a wider set of societal norms and values that influence judgement and decision-making and other cognitive activity.

As discussed above, the application of a mix of social psychology and sociological theory in business organisation research has shown the role played by shared meaning in organisational decision-making. However, sociological research has found that collective action does not necessarily rely on such explicitly shared understanding (Bender 2003). In light of interpretive sociological theory, it is apparent that in the absence of explicitly shared meaning, individuals assume that meanings are shared with their peers.

This explains how social action can occur without being contingent on explicit expression of shared meaning. Shared understanding, therefore, is not seen as an end in itself, but is a function of the cohesiveness of work groups (Fine 2006). The implication of this for the researcher is to realise that an objective analysis of individuals’ shared understandings based on empirical data is not always possible, and is perhaps not what the researcher should pursue in any case (Midthassel 2006).

Instead, acknowledgement of the limited extent to which shared understanding can be accessed should be acknowledged and reflected in what the researcher seeks and claims

to study. For this reason research in this area can often focus on very specific elements of narrative and semiosis, for example, shared metaphors (Jacobs & Heracleous 2006). In my discussion of the psychological background of judgement and decision-making research I considered the extent to which psychology can help determine what constitutes a ‘good’ or ‘sound’ judgement or decision. Here, the same issue arises again, with the attribution of a judgement or decision as ‘good’ or ‘bad’ being linked to the outcome and consequences for the wider social group. This is not to the exclusion of the rationality of the individual judgement or decision-making process, but rather accounts for some of the external forces influencing it (Packard 1962).

What is ‘good’ or ‘bad’ will inevitably differ across various contexts. This is because such attribution will depend on the value systems of the individual and the group within which they are working. To further consider this issue it is necessary to turn to the philosophical literature around judgement and decision-making.

1.3.1.3 Philosophy & Human Judgement and Decision Making

Consideration of the philosophical literature around human judgement and decision-making is necessary to inform this study on issues such as the normative basis for judgement and decision-making, particularly in terms of its rationality. Philosophers exploring human knowledge see the exploration of judgement as fundamental to their enquiries, as it is viewed as one of the oldest and most basic elements of rational thought in humans (Polanyi 1962). For this reason, the philosophical literature on judgement and decision making is broad in its scope, addressing topics that range from technical application to consideration of moral judgements.

However, this study is concerned with the clinical application of judgement and decision-making theory, and my review of the philosophical literature will reflect this focus. I will consider such issues as the person-centredness of these processes and associated issues of moral agency. Ultimately this involves addressing the issue of what makes someone a ‘good’ judge or decision-maker.

Philosophical writing on human judgement can be traced back as far as Aristotle (Thomson 1953), and key figures in the development of modern philosophy, such as Kant, dealt with human judgement as a cornerstone of the cognitive faculties (Korner 1955). A discussion of this literature is essential not only because it constitutes the oldest body of academic discourse around human judgement and decision-making, but also because it addresses issues that underpin the different perspectives from which psychological and social science research and commentary approach the topic.

Aristotle's development of the thought of Plato to frame the concepts of *techne*, or technical skill, and *phronesis*, or practical knowledge (Dunne 1993) is fundamental to the philosophical treatment of judgment and decision-making, especially in terms of the types of knowledge and reasoning used. Dunne (1993, p10) has described the traditional understanding of the concept of phronesis as a form of practical knowledge that is "nontechnical but not, however, nonrational". The idea of *techne* is strongly linked to craft or making, being the technical ability to make or craft something.

As well as these two ideas, philosophers examining human judgement and decision-making have drawn on Aristotle's concepts of the *spoudias* ("the person of sound disposition and outlook" (Dunne 1993, p36)) and *phronimos* ("the man of practical wisdom" (Rhodes 1991, p322)). According to Dunne (1993, p10), it is not just because they are seminal that these concepts remain relevant, but because they have "since hardly been surpassed" as organising principles. This can be seen in the application of these principles throughout the philosophical literature around work roles, often without attributing them to Aristotle or naming them "*techne*", "*phronesis*", "*phronimos*" or "*spoudias*".

For the most part, this literature has centred on holistic theories regarding education (Lakes 2000). Of particular relevance for my study is its application to vocational education (of, e.g., nurses or teachers). Vocational education involves the engagement of individuals who seek to develop themselves in preparation for assuming a vocational role in order to serve the public good.

The motivation to become a certain type of person in order to serve the public good is no longer seen as intrinsic to the success of those who engage in vocational education (Dunne 1993). This stands in contrast to the original idea of vocational education as shaping the *spoudias* or *phronimas*. The judgement of such a professional was seen to be characterised more by a striving for qualitative goodness within a principles-based framework, than quantitative achievement *per se*.

Free of such values, research can identify the characteristics of the murderer whose judgement and decision-making is sound insofar as the practice of murder without detection is concerned. However, in the Aristotelian-based vocational paradigm a murderer could never be considered a good judge of anything, as his homicide is not a desirable end however skilled the means (Rhodes 1991). This is not to say that the place of values in the Aristotelian paradigm preclude its forming the basis for consideration of the process of making accurate judgements and decisions.

Indeed, it was from an Aristotelian standpoint that Newman (1870/1985) viewed capacity for judgement as a personal quality of the experienced expert, to the extent that he saw expert personal judgement as superior to technical judgements derived from scientific method. In arriving at both moral and intellectual judgements, Newman (1870/1985) took a dichotomous view, proposing that thinking based on practical experience was to be preferred to logical reasoning. This preference for personal intuitive reasoning over rule-based deduction was not novel, having been characteristic of the earlier work around the nature of judgement by philosophers such as Ramus and De Tracy (Flower & Murphey 1977).

The tendency towards the intuitive in judgement is very much Aristotelian, although it could be viewed as being at odds with modern rationalism (Dunne 1993) and stands contrary to evidence-based paradigms such as cognitive continuum theory (Hammond 1988, 1996a, Standing 2008, Beckstead 2009, Braude 2009). Nevertheless, philosophers writing in early modernity on judgement worked from the common foundation of the Aristotelian concept of intuitive judgement. Reid's development, in the late 18th century, of this standpoint did not so much describe human judgement as intuitive as attribute the capacity to judge to human intuition (Flower & Murphey 1977).

In developing his constructional theory of perception, Reid characterised human perception as essentially judgemental in nature, leaving no room for talk of feelings or sensations that cannot be accounted for in terms of cognitive structures. He saw this cognitive perception as being instantaneous, innate and not inferential (Flower & Murphey 1977). Writing in the mid-19th century, Bowen concurred with Reid's model of intuition as judgement, but differed from Reid insofar as he did not draw a great deal of distinction between conceptualisation and judgement (Bowen 1864/2007).

Whereas Reid saw concepts, or conceptions, as categories that were derived from judgement, Bowen suggested that one could equally view judgements as elements of concepts or concepts as elements of judgement (Flower & Murphey 1977). This lack of distinction made Bowen's epistemology problematic, insofar as he suggested that concepts were arbitrary mental products that were only verifiable by way of discernment in the form of intuitive judgement – itself an arbitrary process (Flower & Murphey 1977). However, Aristotle's view of intuition was not that it should replace deductive reasoning with arbitrary judgement, but that it was a necessary supplement to the deductive process (Dunne 1993).

The intuitive nature of critical judgement implied by *phronesis* is also discussed by Collingwood (1938). He viewed critical judgement as a tacit part of the artist's work,

rather than as detached evaluation in line with certain external standards. Like Aristotle's *phronimos* or *spoudias*, Collingwood (1938) posits that the judge must possess an inherent ability to engage in this process.

The judgement process is conceptualised by Collingwood (1938) as an integral to artistic endeavour, rather than the subject of afterthought. This can be related to the idea of the *phronimos* or *spoudaios* pursuing their vocation as opposed to merely engaging in technical work. The philosophical writings of Arendt (1958), who makes clear distinctions between labour, making and action also point towards a kind of vocational intuitiveness. Arendt's (1958) use of the term 'action' is akin to Aristotle's *phronesis*.

Gadamer (1960/1975) adopted the Aristotelian notion of judgement as virtuous in nature and essential to *phronesis*. In this paradigm, judgement does not occur in isolation, but is communicated to others in a beneficial way. In teleological terms, Gadamer (1960/1975) has found this value-based conceptualisation to offer a truer representation of human judgement than that offered by modern positivism.

What appears to underpin this stance is the Aristotelian concept of value-based judgement (*gnomē*) combined with scepticism about the objectivity claimed by positivism. This scepticism relates in particular to positivism's purported ability to distinguish objective thought from subjective thinker. As Dunne (1993, p289) puts it, "theoretical reason, as a ruler of action, first founders on the rock of character".

The teleological also underpinned the thinking of Kant (1790/1978) around judgement. Kant's (1790/1978, p18) definition of judgment as "the faculty of thinking the particular as being contained in the universal" influenced later philosophers such as Smith (Flower & Murphey 1977). Analytic judgements, according to Kant, serve to clarify meaning, whereas synthetic judgments are inferential (Kant 1787/2003).

As a rationalist, Kant (1790/1978) proposed that judgement constituted personal analysis or synthesis. This stood in contrast to the propositional nature of judgement posited by empiricist philosophers such as Hume (Korner 1955), Ramus (Graves 1912) and Agricola (Howell 1961). Kant's conceptualisation of judgement views it very much in the personal context, and so is more akin to a psychological approach than the empiricists' impersonal propositional logic of judgement (Flew 1979). However, the fact that Kant proposed judgement as personal analysis or synthesis from a rationalist perspective as opposed to that of empiricism means that in terms of method the empiricist view is closer to the perspective of modern psychology.

Whereas philosophy was once the main source of academic writing on the nature of human judgement and decision-making, the development of the field of psychology

over the last two centuries has provided a basis for the study of human judgement that is more grounded in scientific method. This shift from a Kantian rationalist to an empiricist consideration of human judgement and decision-making, however, does not negate the contribution of philosophy. There are epistemological, ontological and moral issues around the study of human judgement that cannot be dealt with by appealing solely to empiricist research.

Although such research is the standard approach to ascertaining the accuracy and efficacy of judgements and decisions, a more qualitative approach is better suited to the question of whether judgements and decisions are 'good' or 'sound'. This is because the inquiry may also need to ask what is 'good' or 'sound' in the specific context of a nurse's practice. In light of this, nurses' judgements and decisions are best explored initially using a mix of quantitative and qualitative methods that can accommodate the concept of the nurse as a *phronimos* or *spoudaios*, as opposed to merely a research subject engaging in technical work. With this in mind, I will now move on to consider the aims and objectives of this study.

I set out the aim and objectives of the study at this point, rather than at the end of Chapter Two, due to the exploratory nature of the study. The preceding overview of the general literature has given a preliminary overview that provides sufficient information to determine the aims and objectives of the study. Because of the exploratory and descriptive nature of the study these aims and objectives are relatively broad. For this reason that the literature reviewed in Chapter Two will help address and refine the study's aims and objectives, as opposed to actually generating them.

1.4 Study Aim & Objectives

The literature considered in this chapter points towards the importance of studying the cognitive processes involved in the clinical judgement and decision-making of nurses in their social context. To this end, I have set out to explore the social and cognitive aspects of the clinical judgement and decision-making of Registered Psychiatric Nurses (RPNs) working in the Irish Republic. I achieved this by conducting an exploratory descriptive study, which is described in detail in the ensuing chapters.

This study has employed a mixed methods analysis of RPNs' retrospective and *in-vivo* accounts of their judgement and decision making with reference to simulated cases and cases drawn from clinical practice. The relationship between participants' cognitive processes and the social settings in which they work is complex. An approach involving

both quantitative and qualitative methods of data analysis aims to address this complexity.

I discuss this matter further in Chapter Three of this thesis. In concluding this chapter, and by way of introduction to the study, I present the study's overall aims:

- To explore the judgement and decision-making of RPNs working in the Irish Republic, in terms of both the cognitive processes involved and their social context.
- To consider and apply the findings to psychiatric nursing practice and education, as well as to policy issues and future research in this area. This applies primarily to the Irish context from which the data were generated and, where valid, to psychiatric nursing generally.

To this end the study comprises the following objectives:

1. To give a comprehensive account of clinical judgement and decision-making in nursing, in particular as it applies to psychiatric nursing
2. To understand how and why RPNs make clinical judgements and decisions
3. To gain as much insight as possible on the cognitive processes and social context of the clinical judgement and decision-making of RPNs.
4. Having fulfilled the aims and objectives above, to make applications to psychiatric nursing in the Irish republic, with particular reference to its future development.

Chapter Two – Literature Review

2.1 Introduction

The purpose of this review is to provide a survey of the literature on clinical judgement and decision-making in psychiatric nursing. This is in order to inform the fulfilment of the research aims and objectives introduced in Chapter One. The objectives that this chapter sets out to meet in order to fulfil this purpose are:

1. To provide a critical synthesis, around prevalent themes, of the research findings found in the literature on clinical judgement and decision-making in psychiatric nursing and nursing generally.
2. To provide an overview of conceptual work on clinical judgement and decision-making as related to psychiatric nursing and nursing generally.
3. To identify common themes and disparate findings.

In reviewing the nursing research literature I set out to ensure inclusion of as much of the available relevant literature as possible. In 2004, systematic searching of the literature was begin using several databases of academic publications. This ensured that articles from non-nursing and non-healthcare sources were included in the search, as would both research and conceptual papers.

The search terms used were “nurse” OR “nursing” AND “decision” OR “judgement” OR “judgment”. These were derived from those used by Dowding & Thompson (2003) in their review of the literature. Although as with Dowding & Thompson (2003), the search was limited to the English language, it was not limited to papers reporting research findings and/or methodology. This was because the review seeks to incorporate conceptual as well as research publications.

Also, whilst the focus of the review by Dowding & Thompson (2003) looked at the quality of nursing judgement and decision-making in practice, this review has a broader remit, seeking to give a comprehensive overview of clinical judgement and decision-making as it applies to psychiatric nursing. A great deal of overlap was found between the results of these database searches. On “SWETSwise”, the database’s automatic search of 17,401,914 articles yielded 225 relevant articles. A search of the SpringerLink research database resulted in “no articles which satisfy the search criteria”, whilst searches of the PsycInfo and PsycArticles databases yielded 778 and 14 relevant articles respectively.

The PubMed database yielded 15,451 articles, very few of which were relevant. Those that were relevant had already been found using the SWETSwise, SpringerLink, PsycInfo and PsycArticles databases. Indeed there was considerable overlap between all of the database search results.

After consulting senior researchers in the field, it was decided to also employ snowball sampling (Robson 1995) based on updated literature searches for the remaining duration of the study. This was because it was advised that many papers relevant to judgement and decision-making have titles and/or keywords that might not easily be found using a few key terms. Hallstrom & Elander (2005) have also employed this strategy in their review on decision-making in paediatric care.

Certain articles were not the primary focus of the literature review on the grounds that it is concerned mainly with the clinical practice of registered psychiatric nurses. These fell into one or more of the following categories:

- Articles primarily about the decision making of undergraduate student nurses, nurse educators and/or clinical supervisors.
- Articles about non-clinical decision-making (e.g., decision to quit job, human resource management decision making etc.)
- Articles where decision making was not the main topic of research or discussion, but mentioned as marginal to the main topic or focus of research
- Articles that described studies testing the efficacy of generic decision-support tools which did not focus on the clinical judgements and decisions of nurses *per se*
- Articles that were neither research nor conceptual pieces, e.g., editorials, book reviews etc.

Publications that did not meet the above criteria are occasionally mentioned in this chapter, but do not make up the bulk of its content. This has been done insofar as they assist by providing necessary background, clarification or elaboration on the topics covered in the primary literature reviewed. Many research papers focus on a particular type of nursing, but with the purpose of examining topics that apply to nursing generally. An example of this is the paper by Corcoran-Perry et al (1999) on line of reasoning. Although Corcoran-Perry et al (1999) have looked at this phenomenon in the context of coronary care nurses, its findings have implications for nurses generally that cannot be ignored in a review such as this.

It is also the case that many authors discuss clinical judgement and decision-making in nursing generally. The matters covered by generic papers referred to in this review have as much relevance for psychiatric nursing as they do for general nursing. Indeed, the dearth of specific literature on psychiatric nurses' clinical judgement and decision-making is such that other authors writing on the topic have had to go to the general literature for background (e.g., Cook et al 2001). By way of example, in Crook's (2001) focused review of the literature on the topic of expert psychiatric nurses' decision-making only four out of 31 papers used are on psychiatric nursing.

2.2 Background

As with other disciplines, many researchers investigating clinical judgement and decision-making in nursing tend not to distinguish between judgement and decision. An example of this is Bucknall (2003, p312), who writes, "For the purposes of this article, judgement and decision-making are synonymous". In contrast to this broad use of the terms, some writers use them more specifically.

For example, Thompson (1999, p1222) uses the term "decision-making" to refer to "decisions taken by nurses relating directly to issues of nursing diagnosis or intervention in clinical settings". This, Thompson states (1999, p1222), "represents the operational face of nursing". Like Shaban (2005a), he views the term "Clinical decision making" as encapsulating "clinical judgement ... clinical inference ... clinical reasoning ... and diagnostic reasoning" (Thompson 1999, p1222).

Dowding & Thompson (2003) outline the importance of differentiating between a judgement and a decision, recognising that each represents a distinct cognitive process. In their 2002 textbook Thompson & Dowding (2002) paraphrase Dowie (1993) to define a judgement as "the assessment of alternatives" (Thompson & Dowding 2002, p15) and a decision as "a choice between two alternatives" (Thompson & Dowding 2002, p14). However, Dowie's (1993) original definition, which leaves out the word 'two' to simply describe decision-making as a choice between alternatives is perhaps more salient with regard to the realities of clinical nursing practice.

Concepts and definitions forged in the medical and psychological literature have informed academic and research literature in nursing from the outset (Kelly 1964, Hammond et al 1967, Grier 1976). Dewey's writings from the 1930s onwards and Elstein's work in the 1970s on medical decision-making had a strong influence on the conceptualisation of

clinical judgement in nursing (Coler 2003). However, use of knowledge from other disciplines is not limited to knowledge from the professions represented in multidisciplinary healthcare.

For example, in taking into account how different types of judgement are used in clinical practice, Coler (2003) has drawn on the philosophy of Immanuel Kant and Mark L. Johnson. In doing this Coler (2003) has equated Kant's 'reflective judgement' with clinical or observational judgement, and his 'determinate judgement' with predictive or actuarial judgement. Predictive judgement and observational judgement are both addressed within the Judgement Axis of the ICNP (ICN 2002).

Coler (2003, p16) argues that the combination in practice of the more clinically-grounded observational type of judgement with what she describes as the more "actuarial" form of predictive judgement has been facilitated and made more visible in practice through the use of information technology and the standardised approach to nursing terminology. Coler (2003) goes on to describe predictive judgement as quantitative in nature, and observational judgement as relying more so on the clinician's intuition. This illustrates, as did my consideration of psychological, social and philosophical theory in Chapter One, how the approach to nursing judgement as intuitive/analytic is not unique to nursing but is grounded in wider thinking around human judgement and decision-making.

The perceived intuitive/analytic dichotomy is also apparent in Rashotte & Carnavale's (2004) conceptualisation of both perspectives as well as in work by others such as Lamond & Thompson (2000), Taylor (2003), Salanter et al (2003) and Thompson et al (2004). Indeed, debate around the dichotomous model of analytic versus intuitive judgement has permeated the nursing literature over the last couple of decades (Benner & Wrubel 1982, Carnevali & Thomas 1993, Ubel & Loewenstein 1997). As such it constitutes the overarching theme in clinical judgement and decision-making (Rashotte & Carnavale 2004).

2.3 Intuition, Analytic Thinking & Cognitive Continuum Theory

There is no universally accepted definition of intuition in the nursing literature (Thompson & Dowding 2002, Shaban 2005a). Much of the nursing literature around intuition tends to be ambiguous (Lamond & Thompson 2000). This ambiguity lies in the lack of clarity as to whether reference is being made to intuition as a form of knowledge (Rew & Barron 1987) or intuition as a way of using knowledge (Ritter 2003). By way of clarity for the reader,

reference to intuition in this study is to what Kahneman (2003a, p697) describes as “thoughts and preferences that come to mind quickly and without much reflection”.

There has been a tendency toward a dichotomous approach in terms of the usefulness of intuition and analytic thinking in judgement and decision-making (Taylor 2003, Nyatanga & de Vocht 2008). Thompson (1999) suggests that this is indicative of a wider tension in the nursing literature between intuitive humanism and systematic positivism.

In Chapter One I noted the roots of this tension in the writing of philosophers on judgement and decision-making over the last couple of centuries. Here, and throughout this work, I will seek to apply their ideas to understanding intuition in nursing. At this point it is important to note that those grounded in systematic positivism place greater emphasis on the features of the task involved, whereas those coming from the perspective of intuitive humanism tend to view the individual making the judgement or decision as being at the heart of the matter (Thompson 1999).

Taking a critical standpoint on these two viewpoints, authors such as Easen & Wilcockson (1996) have questioned the validity of taking a dichotomous perspective. As with any dichotomy concerning the application of theory to practice, resolution of the underpinning philosophical issues can be pursued in a non-dualistic manner (Dunne 1993). Authors such as Bunge (1983) and Gould (1996) have offered such a dialectical synthesis in their epistemological models of the humanistic use of positivist knowledge.

This approach is evident in the description by Rashotte & Carnavale (2004, p169) of a clinician’s development of proficiency in judgement and decision-making as a “sequential learning process” that involves reflective practice, transformative learning and experiential learning. It is also evident in the popularity in the nursing literature of reflective practice (Taylor 2003). Schon’s (1987) work on reflective practice has been seen as especially relevant in helping nurses account for intuitive elements of clinical judgement and decision-making (Carr 2004).

However, due to the opacity of intuition, nurses find it difficult to reflectively articulate its use (Nyatanga & de Vocht 2008). For this reason, Taylor (2003) has questioned the contribution of reflective practice to improving decision-making in clinical practice. There is similar concern from a research perspective about the extent to which intuitive clinical judgements can be analysed (Thompson & Dowding 2002).

Research on intuitive judgement in nursing tends towards techniques that are limited by hindsight bias, such as critical incident analysis (Lamond & Thompson 2000). This

provides particular difficulties for the promotion of evidence-based practice (Lamond & Thompson 2000, Taylor 2003, Paley 2006). These points need to be addressed in any study of nursing judgement and decision-making, and I intend to do this more fully in Chapter Three, where I discuss the methodology of this study.

Notwithstanding prescriptive philosophical or values-based perspectives on intuition, researchers have described its centrality in nurses' clinical judgement and decision-making (Andersson et al 2006), particularly in psychiatry (Welsh & Lyons 2001). Taking into account the tension between descriptions of intuition as a concrete and valid phenomenon and evidence of its opacity (Harbison 2001), I will now consider how researchers have approached intuition in nursing.

2.3.1 Nursing Research on Intuition & Analytic Thinking in Clinical Judgement & Decision-Making

The idea of combined application of intuitive and analytic approaches in nursing (Smith 1988, Grobe et al 1991, Easen & Wicockson 1996, Ritter 2003) is not novel and reflects a similar view in the psychological literature (Nisbett et al 1983). Benner (1984, Benner et al 1992) has drawn on the work of Dreyfus (1972) in an attempt to accommodate both perspectives –ultimately valuing intuition as central to expertise (Benner & Wrubel 1982, Benner et al 1996, Benner et al 1999).

This perspective is shared by others such as Gerrity (1987), Rew & Barron (1987), Schraeder & Fischer (1987), Young (1987) and Kosowski & Roberts (2003). However, intuition is not a reliable basis for the most accurate judgements and effective decisions (Kleinmuntz 2000). Buckingham & Adams (2000a) attribute the relatively low professional status of nursing to its association with intuitive judgement and decision-making.

2.3.1.1 Pattern Recognition

Since the publication of the seminal work of Tversky & Kahneman (1971), psychological concepts have provided the basis for the exploration of nurses' reliance on intuition. Benner & Tanner (1987) and Ritter (2003), for example, described the use of pattern recognition in nurses' clinical judgement and decision-making. The psychological concept of pattern recognition is to be differentiated from the term as it is used in the wider nursing research and philosophy literature. In nursing research and philosophical writing, pattern recognition is an “emancipatory process” that relates to “the process of expanding consciousness” (Newman 1994). Although both uses of the term describe pattern identification, in the

wider nursing literature it occurs in the context of Newman's (1997) writings on nursing and health - which is distinct from its meaning in cognitive psychology.

In line with Hammond's (1988, 1996a) view of intuitive judgement, researchers in nursing have described pattern recognition as appropriate for non-complex cases where patterns can easily be recognized by the clinician (Offredy 1998) and where a quick decision is required (Easen & Wilcockson 1996). However, Cioffi & Markham (1997) and Cioffi (2000) have found that nurses use pattern recognition for complex judgement tasks, in particular where there is increased uncertainty. Pattern recognition has been described by Benner & Tanner (1987) as working alongside skilled know-how as a distinct element of expert intuitive clinical judgement and decision-making.

The ability to rapidly recognise a typical scenario or type of person (Patel & Groen 1986) is a key feature of expertise, especially where there is time pressure and increased uncertainty (Klein 1998). According to Benner (1984), nurses begin to develop their ability to use pattern recognition in their first six months of practice as registered nurses, combining domain-specific knowledge from their pre-registration education with experiential knowledge that they are beginning to consolidate as novice practitioners (Benner 1984). Perhaps influenced by the seminal work of Benner (1984), some nursing researchers use the concept of pattern recognition as fully representative of nursing intuition (Ilfie et al 2006, Ruth-Sahd & Tisdell 2007). In accounting for and explaining nurses' use of intuition, nursing researchers sometimes combine this concept with heuristics, in particular the recognition heuristic (Simmons et al 2003).

2.3.1.2 Heuristics

The concept of heuristics has been useful in accounting for how nurses use intuition to respond to uncertainty (Gilovich & Griffin 2002). Research on heuristics stems from attempts to understand more about both the rationality and accuracy of judgements and decisions (Hammond 2000b). The use of heuristic strategies by nurses tends to be considered in terms of task interreaction (Ciofi 2002). This involves the study of judgement and decision-making where there is significant uncertainty (Orasanu & Connolly 1993).

Anchoring is a heuristic strategy involving 'anchoring' on an initial estimate which is adjusted as relevant data become available (Tversky & Kahneman 1974). Individuals tend not to move too far away from their initial 'anchored' position, increasing the scope for error. Ciofi (2001) has described how nurses form anchor points based on experience and knowledge, making adjustments based on subsequent knowledge and learning.

The representativeness heuristic (Kahneman & Tversky 1973, 1996, Tversky & Kahneman 1974), describes how individuals make predictive judgements based on the extent to which they can see the outcome represented in the raw data under consideration. Much of the research work demonstrating its use is based on algebraic or statistical reasoning (Cahan & Snapiri 2008). This poses difficulties to its application to a qualitatively-based consideration of the complexities of the social situatedness of judgement and decision-making in nursing.

The recognition heuristic is an alternative perspective on the cognitive processes which the representative heuristic attempts to explain (Goldstein & Gigerenzer 2002). It represents an attempt to broaden the scope of study to account for ecological validity by using multiple values as opposed to single value prediction rules. Much of the research on the recognition heuristic has also been limited to algebraic and statistical modelling based on quantitative data (Cahan & Snapiri 2008). Where qualitative data has been collected on in nursing and midwifery studies looking at use of the representative or recognition heuristic, analysis has been in terms of base rates, statistics and percentages with a view to measuring accuracy (Cioffi & Markham 1997, Cytryn et al 2009).

Using the availability heuristic a person bases their assessment of the probability, frequency or causation of an event on the degree to which occurrences of such an event are readily available in their memory (Ciofi 2001). With no regard for statistical probability, they assume that because they remember it to have been so, that it is so (Thompson 2002). As with representativeness, experience - in particular range of experience - is an important factor in its use.

Also important is the recency of the events and their saliency and vividness (Ciofi 2002). A nurse working in an accident and emergency department is more likely to use the availability heuristic in a case of myocardial infarction than is a nurse working in a mother and baby clinic, as s/he will have seen more myocardial infarctions, more recently and can therefore recall these with more vividness and saliency. Buckingham & Adams (2000b) view both the representativeness and availability heuristics as describing, to a degree, the process of classification which they see as central to judgement and decision-making and proffer their own unifying framework as offering a clearer representation of the process.

Although she does not refer to the literature around heuristics, Delaney (2006) describes how nurses working in psychiatric inpatient units for children and adolescents draw on prior knowledge in interpreting cues. She uses staff interpretation of a child's behaviour to

show how the nurse interprets this behaviour. Interpretation, she argues, will depend on what the nurse has already witnessed in such cases in terms of antecedents to and consequences of the behaviour. She also describes how the nurse draws on their knowledge of how children's cognition, emotions and behaviour interact in interpreting cues in such scenarios (Delaney 2006).

2.3.1.3 Stereotyping

Nursing researchers often refer to the representativeness or recognition heuristic in explaining nurses' matching of cues from presenting cases to similar cases they have previously encountered (Cioffi & Markham 1997). Sterotyping is one of several explanations of this aspect of cognitive functioning (Wittenbrink et al 1998). Most studies of stereotyping in nursing focus on undergraduate nurse education and tend to view stereotyping as socially and morally undesirable, rather than as a value-free cognitive function that facilitates the development of expertise (Page & Thorn 2004, Dearing & Steadman 2008, Grady et al 2008).

Where commentators focus on nursing practice or wider mental health care, a predominantly social rather than cognitive perspective is taken (Burr & Chapman 1998, Foster & Oneyekwu 2003, Ladwig et al 2006). Without much critical discussion on stereotyping as a basic and universal aspect of human cognitive functioning, its negative social implications form the basis for research and comment (Clarke 1998, Evans 2002). This is in contrast to the psychological literature discussed in Section 1.3.1, where a more detached and objective outlook by researchers has permitted investigation into the presence of stereotyping and how it works.

Unlike most researchers in the nursing literature, Rogers & Kashima (1998) have taken a critical look at stereotyping in mental health care. Although they do see stereotyping as undesirable, they engage in a critical discussion of the cognitive processes involved. Given the ability of individuals to actively resist stereotyping, Rogers & Kashima (1998) see a need for raised awareness of its negative aspects.

2.3.1.4 Intuition, Analytic Thinking & Cognitive Continuum Theory

Many nursing commentators view intuition as practical knowledge that is "nontechnical but not, however, nonrational" (Dunne 1993, p10). From a psychological perspective it is clear that intuition is inherently "nonrational". To consider the implications of this for nursing, I now consider how intuition works alongside more rational approaches to clinical judgement and decision-making. I will draw in particular on cognitive continuum theory (Hammond

1988, 1996a), as well as the nursing literature on analytic thinking in judgement and decision-making.

Many commentators in the nursing literature, including Thompson (1999), Harbison (2001), Lauri & Salantera (2002), Thompson et al (2004), Cader et al (2005), Offredy et al (2008) and Beckstead (2009) have looked to cognitive continuum theory to explain the combination of analytic and intuitive approaches in nursing. Standing (2008) has adapted cognitive continuum theory for nursing by including reflective practice, patient-aided judgement, research and its critical appraisal, the use of tacit-explicit knowledge along a continuum and the use of ethical codes of practice. She sees the application of these strategies by nurses as fitting within an adapted nine-point format of the cognitive continuum for use in education and practice. It remains for its theoretical structure to be tested by research.

As adaptive practitioners, nurses combine intuition, peer-aided judgement and system aided-judgement depending on task type (Beckstead 2009). Of particular importance in this regard are the level of ambiguity and the complexity of the task structure (Hamm 1988). Cognitive continuum theory views structural task complexity in terms of the amount of information required and the number of 'steps' involved in the process of reaching a decision. Task ambiguity considers factors such as familiarity, observable outcomes and availability of cognitive organizing principles such as clinical practice guidelines (Rycroft-Malone 2002). The presentation of a task contributes to complexity in terms of time frame for completion and the amenability of the task to 'decomposition' – that is, its being broken down into component parts.

As intuitive judgement, widens the scope for error and makes for less transparent judgement and decision-making, Lamond & Thompson (2000) favour leaning towards the more analytic approaches of peer-aided and system-aided judgement. Narayan & Corcoran-Perry (1997), Luker et al (1998), Harbison (2001), Lauri & Salantera (2002) and Beckstead (2009) concur. In the context of cognitive continuum theory, intuition is characterised by speed, opacity, focus on 'at hand' data, lack of apparent rationality and propensity for error involved in such judgements and decisions. Hammond (1978) placed medical decision-making towards this end of the cognitive continuum, specifically describing it as quasi-rational. Hamm (1988) has also described medical decision making as fitting into the quasi-rational category, seeing it as representing peer-aided judgement.

Nursing researchers (Offredy et al 2008) see nurses operating in this category also. Whilst this may be seen as acceptable in situations where it represents the optimal approach, Lamond & Thompson (2000) contend that greater focus on analytic judgement processes in nursing would serve the dual purpose of promoting more incisive research into the clinical judgement and decision-making of nurses whilst at the same time promoting evidence-based practice. Thompson et al (2004, p70) explicitly equate intuitive decision-making with non-evidence based reasoning and rational decision-making with a less intuitive approach, thereby concluding that a non-intuitive approach lends towards “better decision performance”.

Furthermore, Dowding & Thompson (2002) see the more analytic end of the cognitive continuum as representing the direction in which not only nurses, but also healthcare professionals in general, should lean. However, some see this as a dichotomous outlook, characteristic of the tendency to herald positivist knowledge as a panacea, whilst failing to satisfactorily tackle the very real issues of uncertainty and ambiguity that face nurses in everyday practice (Braude 2009, Taylor 2003). A non-dichotomous approach that strives to address the analytic-intuitive dualism as a construct of human reasoning, rather than an over-arching reality, is seen as truer to the philosophical underpinnings of judgement and decision-making theory.

A resolution of this dichotomy, therefore, is perhaps better achieved through strategies drawing on a broader philosophical basis, such as dialectical synthesis, than by approaches that seek to unilaterally promote one aspect of the dichotomy over the other. However, it is also important to be cognisant of the need for a truly dialectical resolution of this dichotomy, and not a mere reversal of ostensible superiority of the one epistemological standpoint over another. There are those who would replace claims for the pre-eminence of positivist evidence as a basis for practice with an order governed by reflective practice and/or other humanist approaches (Taylor 2003).

Therefore, in arriving at a truly dialectical resolution of the perceived intuitive/analytic dichotomy, it is imperative that commentators realise that they do not of necessity stand on neutral ground themselves (Hamilton & Hirszowicz 1987). Bearing this in mind, commentators engaging in appraisals of either standpoint should give due recognition of their own prejudices. Indeed, this is what I have set out to achieve by using a reflexive style (Porter 2000) in writing this thesis.

2.4 Methodological perspectives & approaches to judgement and decision-making research in nursing

Since the seminal work of Meehl (1954) was first published, psychologists have focused on researching the accuracy of judgements (Ashton 2000, Cooksey 1996a). However, over the latter half of the 20th century psychologists became just as interested in the rationality of the process involved in making judgements and decisions (Kleinmuntz 2000). This has been reflected in developments over the years in research on clinical judgement and decision making in nursing.

Early nursing judgement and decision-making studies, such as that by Aspinall (1979), tended to focus on accuracy in decision-making, and researchers did not tend initially towards descriptive approaches. In the last decade there was a shift to investigating the process of judgement and decision-making as well as accuracy and outcomes (Bakalis & Watson 2005). However, research on accuracy and effectiveness in nursing judgement and decision-making remains paramount (Buckingham & Adams 2000a, Cioffi 2002, and Dowding & Thompson 2003).

Despite interest in rationality, researchers remain concerned with the accuracy of nurses' clinical judgement and decision-making – particularly in the context of evidence-based practice (Hancock & Easen 2005, Currey & Botti 2006, Goransson et al 2006, Paley 2006, Pritchard 2006, Thompson et al 2006). This is because the benefits of being able to accurately measure the impact of clinical nursing decisions on patient outcomes are considerable (Dowding & Thompson 2003). However, measures of judgement accuracy used in nursing research tend to be too simple to accurately capture the complex process involved and tend to be open to systematic errors.

In light of this, Dowding & Thompson (2003) contend, nurse researchers should attempt to account for the uncertainty that characterises clinical judgement in nursing (Thompson 2002), whilst also attempting to precisely measure the accuracy of these judgements. There are challenges in this regard, however, such as the difficulty of determining what constitutes a 'right' or 'wrong' judgement or decision (Rhodes 1991, Connolly 2000). Where there is consensus that a certain judgement or decision is 'right', there is the added problem of accounting for ineffectiveness due to indeterminable factors (Dowding & Thompson 2003). Therefore, my own study takes a descriptive approach, which is seen by Thompson (1999) as particularly suited to the needs of nursing. This represents the first step in determining

what might constitute ‘right’ and ‘wrong’ in terms of psychiatric nursing judgements and decisions in the Irish context. Further research, it is envisaged, could develop the findings to measure accuracy and effectiveness of these judgements and decisions.

As it stands, there is uncertainty regarding exactly what, for the most part, constitutes “accuracy” in Irish psychiatric nursing diagnosis and intervention decisions. This is hardly surprising given the lack of agreement on international standards for nursing diagnoses (Thompson 1999). In the context of the wider nursing research agenda, I view my own descriptive study as complementary and enabling (as opposed to an alternative to) the investigation of the accuracy of nurses’ diagnostic reasoning.

In Chapter Three I outline my study design in detail. For the remainder of this section I will consider other approaches that have proved useful in researching nurses’ clinical judgement and decision-making. Several of these approaches have the potential to build on evidence from my study in order to ascertain the effectiveness and accuracy of psychiatric nurses’ clinical judgement and decision-making.

Dowding & Thompson (2003) view subjective expected utility (SEU) theory as offering one of the best approaches for dealing with the uncertainty that characterises clinical judgement and decision-making in nursing. This is because it offers a method by which large numbers of judgements, decisions and their outcomes can be examined. Whilst Shaban (2005a) agrees that subjective expected utility theory offers an ideal approach to clinical judgement and decision-making, this approach has not been popular in nursing research (Dowding & Thompson 2003).

Social judgement theory is also useful for measuring accuracy in clinical judgement (Dowding 2002, Dowding & Thompson 2003). Social judgement theory views the judgement process in terms of the social reality of a situation, which makes it highly applicable to clinical judgement (Hammond 1955, Wigton 1996). Another benefit is its approach of examining achievement (in terms of accuracy) and concord (in terms of consistency) (Dhimi & Harries 2001), the results of which can be used to inform quality improvement of the types of judgement studied (Hammond et al 1975).

Decision analysis theory can also be applied to studying accuracy in clinical judgement and decision making. It has military and economic origins in the late 1960s and early 1970s, and has been used by nurses and other healthcare professionals since the mid 1970s (Narayan et al 2003). Like SEU, decision analysis theory, is based on Bayesian theory (Kleinmuntz 2000).

As well as approaches such as judgement analysis and decision analysis, nursing research has also drawn on concepts regarding human information processing (Corcoran 1986a, 1986b, Tanner 1987, Tanner et al 1987, Jones 1988, White et al 1992, Carnevali & Thomas 1993, Taylor 1997, Offredy 1998, Ritter 2003). From the perspective of information processing theory, judgement and decision making is a hypothetico-deductive process, focusing in particular at the interaction between the individual and the task at hand (Corcoran-Perry et al 1999). Of interest to researchers coming from this perspective is how individuals collate data, generate and evaluate hypotheses, and interpret cues.

Application of information processing theory to research on nurses' clinical judgement and decision-making was based on earlier research on medical judgement and decision-making (Elstein et al 1978). This involved study of the intricate cognitive processes involved in the clinician's recall and weighing-up of various clinical possibilities when they made diagnostic judgements and decided on, or modified interventions (Carnevali & Thomas 1993, Thompson & Dowding 2002). Mahner & Bunge (1997) view this hypothetico-deductive perspective as the most appropriate approach for clinical decision-making.

In the United States, information processing theory and the hypothetico-deductive approach generally form the main theoretical underpinning for the education of nurse practitioners in clinical judgement and decision-making and are also used extensively by those researching medical problem solving (Ritter 2003). They are used, for example, to explore clinicians' proneness to confirmation bias, which occurs if one hypothesis is concentrated on by the clinician to the detriment of other hypotheses (Buckingham & Adams 2000b). Researchers have also considered clinicians' tendency towards anchoring bias, whereby they tend towards their original hypothesis despite evidence to the contrary (Harbison 2001, Thompson 2002, Hamilton 2004). However, some commentators have argued that the concepts regarding human information processing that underpin the hypothetico-deductive model do not allow for a complete account of what really occurs when a nurse makes a judgement or decision in the clinical setting (Lauri & Salanterä 1995, Szaflarski 1997, Thompson 1999).

Caution needs to be exercised in attempting to resolve issues around uncertainty in clinical judgement and decision-making using approaches grounded solely in positivism. A major limitation is the often tenuous nature of links between interventions and outcomes in nursing (Narayan et al 2003). Also, the 'best' possible decision needs to weigh the influence of societal values, rights and duties, which is not always possible in quantitative

research studies that focus on a singular aspect of the process (Braude 2009, Wang & Mentis 2009).

One solution is to attempt to “balance realism and manageability” (Narayan et al 2003, p240). Whilst focused statistical analysis of nurses’ judgement and decision-making is especially useful in particular situations characterised by uncertainty and/or complexity, it cannot be applied universally to clinical judgement and decision-making in nursing (Dowling & Thompson 2002). This echoes what Rashotte & Carnavale (2004) have written with regard to scientific realism.

Rashotte & Carnavale (2004) have considered how empirically measurable aspects of clinical judgement and decision-making are affected by organic and social realities of human experience that are more difficult to account for. This is particularly the case when professionals are engaging in shared decision-making with service-users and/or their significant others (Narayan et al 2003, Ryland 2005).

Having considered the various approaches to research on clinical judgement and decision-making in nursing, I am mindful of the work of Buckingham & Adams (2000b) in presenting a unifying framework for theories underpinning clinical judgement and decision-making in nursing. Although such frameworks can be useful, not every model of judgement and decision-making is applicable to individual clinical contexts and practice roles (Offredy 1998), with some being suited to certain settings more so than others (Harbison 1991). I am convinced that what is required in this study is a methodology that draws on those perspectives and approaches that are best suited not only to the aims and objectives of the study, but to accommodating the diversity of settings and roles in which study participants practice.

Before considering how best to do this in Chapter Three, I take a closer look at the focus of nursing research. In reviewing the literature I noticed that studies tended to look either at the processes through which nurses arrived at judgements and decisions, or else at the types of knowledge that they used to inform this process. I have divided my further consideration of the literature into two sections accordingly.

2.5 Researching the process of clinical judgement & decision-making in nursing

2.5.1 Knowledge informing the process

As with Dowding & Thompson (2003), Crow et al (1995) see a clinical judgement in nursing as essentially comprising the nurse's assessment of a service-user's condition. Researchers & commentators have considered the types of knowledge that inform this assessment, as well as the clinical decisions that follow on from it. Domain-specific knowledge is integral to the clinical judgement and decision-making of healthcare professionals (Boshuizen & Schmidt 1992, Rashotte & Carnevale 2004).

In nursing assessment involves the identification of particular problems, states or conditions e.g., that someone is dehydrated. This identification or recognition aspect of judgement is seen as 'diagnostic' is not exclusive to the healthcare. The meteorological judgements made by weather forecasters, for example, are also diagnostic insofar as they represent the judgement as to whether or not a certain weather phenomenon is present (Swets 2000).

Because of this similarity, Crow et al (1995) have seen a danger in confusing the medical diagnostic role with the type of diagnostic reasoning that occurs as part of the nursing role. Crow et al (1995) do not argue that the cognitive processes used by nurses to make diagnostic judgements differ from those of doctors. Rather, their concern is that nurse and physician roles in clinical judgement could be wrongly interpreted due to their both being described using similar terminology. However, not all judgements made by nurses are diagnostic. Gerdtz & Bucknall (1999), for example, have cited the example of prioritization of already-diagnosed patients in triage.

Writing about nurses' judgements regarding the behaviours of inpatients in child and adolescent psychiatric units, Delaney (2006, p172) describes the judgment process as an "assessment" that leads to a "diagnostic picture". Psychologists see diagnostic clinical assessment as involving two distinct cognitive components (Krueger et al 2006). These involve identifying a distinct clinical condition on one hand and judging its severity on the other.

These two aspects of nursing judgement are apparent in the work of organisations that are interested in making the work of nurses more visible by formulating standardised

representations of practice. For example, the International Council of Nurses (ICN) (2002, p75) has defined a nursing judgement as “a clinical opinion, an estimate, or determination of professional nursing practice regarding the state of a nursing phenomenon, including the relative quality of the intensity or degree of the manifestation of the nursing phenomenon”. Also, the ICN’s latest version of its International Classification of Nursing Practice includes as one of its seven axes a Judgement Axis dedicated to the classification of clinical judgement in nursing (ICN 2005).

Whilst the North American Nursing Diagnosis Association (NANDA) defines nursing diagnosis in terms of clinical judgement, its definition is not as descriptive of the components of clinical judgement as is that of the ICN. NANDA (1999) defines nursing diagnosis as constituting a “clinical judgement about individual, family or community responses to actual or potential health problems/life processes”. The definition appears to be less concerned with unpacking “judgement” itself and more concerned with the types of phenomena that nursing judgements focus on.

Rashotte & Carnevale (2004) distinguish between diagnostic and interventional decision-making. In doing this they have paid particular attention to clinicians’ use of empirical knowledge, with particular reference to Bunge’s (1983) concept of scientific realism. This approach grounds the clinician’s use of positivistic empiricism firmly in the biological and social context of being human.

What this might entail can be seen in Carnavale’s (2001, p13) statement in an earlier work that the use of empirical knowledge “... is not so much about ‘learning what is right or true’ but is a process of ‘getting it progressively less wrong’”. This involves the clinician coming to each new clinical judgement or decision armed with an experiential practice-based understanding of empirical knowledge that has been developed over previous encounters with similar situations. This accretion of knowledge about an individual is a crucial source of information for nurses in arriving at a judgement or making a decision regarding that person’s care (Crow et al 1995). O’Neill et al (2005, p71) found practitioners’ use of such “pre-encounter data” (the term they use to describe such prior knowledge used with reference to a general knowledge base) to be fundamental to their judgement and decision-making.

It has been suggested that the more knowledge a nurse has, the more cues they will recognise and therefore use in their judgement and decision-making (Moore 1996, Jones 1988, Evans 2005). The nature and volume of cues that are involved in a judgement or

decision contribute to its complexity. This type of complexity can be said to characterise clinical judgement and decision-making of nurses (Corcoran 1986b, Hammond 1988, Carnevali & Thomas 1993, Cioffi & Markham 1997, Cioffi 2001).

Many researchers have used observation to look at how nurses use cues to arrive at judgements and make decisions amid the complexities of 'real-life' clinical settings (King & Macleod Clark 2002, Hedberg & Larsson 2003, McCarthy 2003b, Arslanian-Engoren 2004, Carr 2004, Manias et al 2004a, O'Neill et al 2005, Delaney 2006). Where real-life setting were not accessible, researchers attempted to simulate these using case studies and vignettes (Salantera 2003). Examining nurses' assessment of inpatients in child and adolescent psychiatric units, Delaney (2006) described how intervention choice differs according to differences in how cues are interpreted by nurses.

Carr (2004) and O'Neill et al (2005) have commented on factors affecting nurses' use of cues in decision-making, whilst Manias et al (2004a), Hedberg & Larsson (2003) and King & Macleod Clark (2002) have looked at the nature of those cues. For the most part, nurses used mainly biomedical cues – which might be expected given the general healthcare settings in which their studies took place. Indeed Manias et al (2004a) found that the more medically specialised the area, the more specialised the biomedical cues which are used.

Of importance to these researchers was the way in which cues were presented, interpreted (perceptually or objectively), organised cognitively and weighted by the nurses making the judgement and/or decision (Hammond 1988). In this regard, Lusk & Hammond's (1991) differentiation between primary and secondary cues is helpful in explaining complexity in clinical judgement and decision-making in nursing. Primary cues are those directly discernable by the observer, either from data provided or by direct observation, e.g., a person's facial expression, volume and pitch of speech or hand gestures. Secondary cues, meanwhile, are inferred from combined primary cues, so that a nurse might infer from the primary cues of an individual's furrowed brow, glaring eyes, loud, rapid speech and clenched, raised fists a secondary cue that tells him/her that the person is experiencing anger.

Sociological ideas concerning semiosis (Peirce 1895/1998) are complementary to this cognitive psychological concept of cue recognition. In recognising cues, the nurse is involved in the triadic process of semiosis. As the interpretant, the nurse is drawing on experiential and domain-specific knowledge to attempt to identify and judge the characteristics of the object that is represented by certain signs or cues.

In Chapter One I have already noted the common ground that is covered by sociological thinking around semiosis and social psychological perspectives, e.g., the lens model (Brunswik 1952, Cooksey 1996). The main difference in the application of the two to nursing judgement and decision-making is that research and thinking around semiosis is a predominantly qualitative affair, whilst psychological research of cue recognition takes the form of mathematical and statistical analysis and modelling. As they differ in the perspectives they take on judgement and decision-making, these concepts can serve to complement each other in giving a more rounded appreciation of the processes involved.

2.5.2 The process of making a judgment or decision

Having discussed the types of knowledge that nurses use in their clinical judgement and decision-making, and the way in which this knowledge is used to interpret cues/signs, I now move on to consider the nursing literature on the cognitive and social processes involved. In doing this, I have considered the literature under the headings of the main themes to which the studies have related. These themes reflect the focus in nursing research on the investigation of how ecological factors such as organisational structure, the care environment and interdisciplinary relationships impact on clinical judgement and decision-making. Also apparent is interest in the influence of individual factors such as experience and expertise.

2.5.2.1 Experience, Expertise and Clinical Judgement & Decision-Making

Research has shown that novice nurses are not as adept at decision-making as their more experienced colleagues (Corcoran 1986b, Bucknall & Thomas 1996, Schutzenhoffer & Musser 1996, Tabek et al 1997, Thomas 1997, King & Macleod Clark 2002, Myers & Nikoletti 2003, Hoffman et al 2009), although this has been questioned by some (Hoffman et al 2004). For those grounded in what Thompson (1999, p1223) refers to as the “intuitive-humanist” paradigm (Benner 1984, Benner et al 1996), the apparent benefits of experience are explained in terms of an inextricable link between effective intuitive judgement and decision-making and expertise. However, when considering the seminal work of Benner on nursing expertise and experience, particularly when contrasting her theory to the work of others, it has to be remembered that like Darbyshire (1994), Benner (1984) contends that experience measured in years of practice does not in itself constitute expertise.

Although Benner’s ‘Novice to Expert’ model (1984) does use years of experience to grade nurses as novices or experts, Benner does not use the term ‘experience’ solely to denote the

number of years a nurse has spent in clinical practice. Instead she uses it as a descriptor for a dynamic process of allowing one's knowledge and work to be changed by the new situations met in clinical practice.

Each new situation ideally helps the nurse to enhance their ability to approach clinical situations in a less fragmented manner. This enables them to distinguish relevant data from irrelevant data and make a judgement or decision without a great deal of conscious cognitive effort, e.g., spending time weighing up alternatives (Benner & Tanner 1987, Easen & Wilcockson 1996, Benner et al 1999). This is similar to how researchers such as Brykczynski (1989) and White et al (1992) have conceptualised expertise as a result of their research with nurse practitioners.

White et al (1989) found that expertise was a matter of knowing which cues to pay attention to more so than being skilled at formulating hypotheses. Brykczynski (1989) also found expertise to involve context-specific pattern recognition. However, experience alone might not be adequate in honing this skill, and Flynn & Sinclair (2005) view the refining one's expertise as involving formal further education in addition to the clinical experience discussed by Benner.

Whilst novice nurses may not be highly proficient at decision-making, there is no guarantee that given time they will eventually become expert decision-makers by merit of the clocking up of years of practice alone (Hoffman et al 2004, Thompson 2006). Psychologists studying judgement and decision-making in areas other than nursing often determine expertise in terms of the empirical accuracy of judgement and decisions made by participants as opposed to their level of experience (Swets 2000). Having said this, it is important that experience is not totally discounted as a factor in building up expertise, particularly in light of studies which have linked the two.

In their study, Corcoran-Perry et al (1999) used indicators of expertise besides experience. These involved nurses having been published in their area of expertise, having made presentations in that area, or being regarded as 'expert' by three or more colleagues. However, even with the use of these indicators, Corcoran-Perry et al (1999, p50) desisted from using the 'expert' and 'novice' labels in their work, using "experienced and new, rather than expert and novice".

It can be inferred from the literature that whilst a nurse might not gain enough experience in their first year of practice to reach 'expert' level, neither does having five or more years of practice automatically confer this level of proficiency on a nurse. However, some

researchers (e.g., Ferrario 2004) do use this criterion to describe their samples. Without rating proficiency at clinical decision-making, Corcoran-Perry et al (1999) found that there were more similarities than there were differences between the clinical judgement and decision-making of novice nurses and experienced nurses with some degree of expertise.

Lauri & Salantera (2002) have found that the link between clinical experience and expert decision-making differs from setting to setting, whilst Corcoran (1986c) has described clinical decision-making as varying widely between clinical nurse experts. In line with a previous study (Lauri & Salantera 1998), it was found that there was no correlation between years of experience and the type of decision-making engaged in by nurses working in intensive care settings, with the same being true for nurses working in public health (Lauri & Salantera 2002). However, Lauri & Salantera (2002, p97) did find a link between experience and the type of decision-making approaches used by nurses working in what they termed “long- and short- term care”. It is unclear precisely what type of care settings are indicated by these rather vague descriptors, although they are clearly differentiated in the paper from the public health, psychiatric and intensive care settings.

In designing their novice clinical reasoning model (NCRM) O’Neill et al (2005) viewed the lack of novice expertise at decision-making as being further compounded by the more deliberate, less intuitive and subsequently slower cognitive processing of the novice nurse. In addition to their NCRM, the authors’ more general clinical decision making model (CDMM) did not (by their own admission) take into account the variety of nurses’ educational backgrounds and care settings. These factors have been recognised as important to the study of nurses’ clinical decision-making by Hoffman et al (2004). In addition to this, neither model accounted for accommodation of the range of clinical decisions across the many specialist areas in which nurses work.

Notwithstanding this, O’Neill et al (2005) have made a significant contribution in proposing a model for the distinctive clinical judgement and decision-making of novice nurses and have linked this directly to a general model that accounts for more experienced nurses. Also, addressing the challenges presented to novice nurses as clinical decision-makers, O’Neill et al (2004, 2005, 2006) have offered a prototype system to provide evidence-based clinical information to support novice nurses in their decision-making. Such decision support systems tend to be relied upon more so by novices than by expert nurses (Benner 1984, Flynn & Sinclair 2005).

However, what is apparent from the literature generally is that experience cannot be held up on its own as an indicator of expertise. What constitutes expertise and contributes to its development will vary across settings and roles. Apart from empirical performance indicators around accuracy, indicators of expertise apart from experience can be qualitative in nature, being socially and culturally embedded.

Essentially the attribution of expertise in nursing judgement and decision-making is as complex as clinical judgement and decision-making itself. Ironically, study design has often involved researchers making judgements themselves, or relying on the judgements of others, as to the expertise of participants. Apart from accuracy in performance where appropriate, the measurement and attribution of expertise in the different clinical roles and settings of nursing practice requires recognition of the fact that data on all of the relevant factors will always be available and/or measurable. In addition to this, the environment and socio-cultural context in which expertise is developed and attributed require careful consideration in their own right.

2.5.2.2 Environmental elements influencing nursing judgement & decision-making

The influence of the specific clinical context and environment in which nurses make judgements and decisions is a topic that has received notable attention in the nursing literature (Crow et al 1995). Researchers have tended to either focus on a singular type of clinical setting (Bucknall 2003, Carr 2004), or to examine differences in nurses' judgement and decision-making across various clinical settings (Bucknall & Thomas 1995, Lauri & Salantera 2002 Hedberg & Larsson 2004, Bakalis & Watson 2005). This research into differences across clinical settings is particularly important in light of the links made by some nursing theorists and researchers between environment-specific tasks and the knowledge and cognitive processes peculiar to those tasks (and therefore environments) (Corcoran-Perry et al 1999, Thompson et al 2004, 2006). This reflects a similar focus in the psychological literature, which has drawn in particular on cognitive continuum theory (e.g., Dunwoody et al 2000).

Lauri & Salantera (1995, 1998, 2002) have studied the clinical decision-making process across different types of nursing internationally. They found that different approaches to decision-making are used in different clinical situations because decision-making is essentially a task centred process in which the approach adopted by the clinician depends on the type of task at hand. For data collection, Lauri & Salantera (2002) used a 56-item

instrument based on cognitive continuum theory (Hammond 1996b) and Dreyfus's (1972, 1986) writings on intuition on which Benner (1984) based her work.

Statistical analysis of data collected from nurses (n=1,460) working in Finland, Norway, Northern Ireland, Switzerland, the U.S.A. and Canada demonstrated their use of four approaches to decision-making: intuitive (26% of respondents), intuitive-analytical, analytical-intuitive (combined – 60% of respondents), and analytical (14% of respondents). However, with 60% of respondents falling into the intuitive-analytical and analytical-intuitive categories combined, Lauri & Salanterä (2002) do not give a breakdown of how many nurses were represented by either of these two models individually. Lauri & Salanterä (2002) found that nurses could be shown to use different models in different countries, across different care settings and also at different stages in the decision-making process – although sometimes there were similarities in the approach taken by nurses.

Generally, nurses working in long-term care settings tended more towards analytical decision-making whilst those in acute settings were more inclined to be intuitive in their approach. Across the sample intuitive decision-making tended to be used at the data collection stage whilst analytical decision-making predominated at the data processing and problem identification stage. Decision-making differed not only across settings but was also different internationally within the same type of clinical setting.

For example, whilst Finnish public health nurses tended towards the use of analytical decision-making, Canadian public health nurses were mainly intuitive in their decision-making. Drawing on an earlier study (Lauri et al 1997), Lauri & Salanterä (2002) attribute this result to the differences between national health services and subsequently between professional role and the types of tasks engaged in by nurses. However, this was not always the case. The decision-making of intensive care nurses, for example, was found to be mainly intuitive at the implementation, monitoring and evaluation stage in Finland, Switzerland, Northern Ireland, the U.S.A. and Canada.

One point where this study is unclear is in the types of settings involved. Whereas it is clear what is meant by “psychiatric care” and “intensive care”, it is not made clear exactly what types of settings are incorporated within the categories of “health care” and “long- and short term care” (Lauri & Salanterä 2002, p97). Whilst the reader might initially interpret “long- and short term care” as applying to the two aforementioned clearly defined categories, this is not borne out in the discussion of the results, whereby it appears that data

was collected from “long- and short term care” settings as distinct from the two more clearly labelled settings (Lauri & Salanterä 2002, p97).

It is apparent that “health care” is the label given to the setting populated by “public health nurses”, as the latter appears in the discussion of results whilst the former does not (Lauri & Salanterä 2002, p97). The overall picture given by the results of this study by Lauri & Salanterä (2002) is that decision-making is a complex process which sees nurses differ in their approach according to the environment in which they are operating and the demands of the task at hand. Whilst this instrument enables researchers to uncover evidence of the nature of the decision-making of individuals in this regard, one would have to go beyond the use of the instrument (as did Lauri & Salanterä (2002)) to find evidence of the specific influences on such shifts in approach.

In investigating the importance of the clinical environment as an influence on the clinical judgement and decision-making of nurses Carr (2004), like O’Neill et al (2005), was informed by information processing theory. Carr (2004) has pointed out that it is imperative to bear in mind that there is a great deal more variance between hospital and community practice settings than might be first apparent, and that knowledge gleaned about the decision making process in one setting cannot be assumed to apply to the other (Carr 2004). Community nursing, according to Carr’s (2004, p853) model of clinical reasoning, takes place in settings which generate a high “signal: noise ratio” which makes it more difficult for nurses to clearly detect signals or cues.

Based in the United Kingdom, Carr’s (2004, p852) study employed hermeneutic phenomenology and involved four focus groups (n=45), non-participant observation with follow-on interviewing (n=5), tape recorded interviews (n=18) and four tape-recorded participant group (n= “3 to 5”) reviews of transcripts. Carr (2004) used an information processing type organising framework to explain how nurses recognised and acted on cues according to the environment in which they were working. Because of her interpretive approach, Carr (2004) views her study as having been more sensitive to the ethical and aesthetic elements of clinical judgement and decision-making.

Carr (2004) found that community-based care settings confer a more heterogeneous, less defined role on nurses, to the extent that they described themselves as negotiating this role. Like the high “signal : noise” ratio, this situation was found not to be conducive to clarity and certainty. It also placed demands on nurses’ clinical judgement and decision-making that might not be experienced in hospital settings.

Cook et al (2001) also examined nurses' decision-making in community settings. They found that the nature of community-based psychiatry meant that organisational cohesiveness was essential to the efficient functioning of the multidisciplinary team. The many different agencies, professions and locations involved in such care has the potential to thwart attempts at effective group-decision making involving all members of the team unless efforts are made to ensure that organisational structure accounts for such multiplicity (Cook et al 2001).

It is clear from the literature reviewed that whilst nurses can be said broadly to engage in a mix of intuitive and analytic approaches to judgement and decision-making, this will differ across clinical settings. This is because different settings vary in terms of the structure, complexity and nature of clinical tasks and challenges that they present. Consequently they also differ in how nurses' work is structured, particularly in terms of their role.

In the context of psychiatric nursing in Ireland, this issue is further complicated by the rotation of nurses around settings. The majority of participants in this study work alternately in community and inpatient settings, being rotated from one to another after several weeks or months. Given this, it is difficult in this study to begin to discern links between approaches to clinical judgement and decision-making and specific clinical settings and roles.

Nurses' roles are inextricably linked to their clinical context and care setting. For this reason I move on next to consider what the nursing research literature reveals about how the clinical role of a nurse impacts on their judgement and decision-making. Fundamental to this is the consideration of nursing roles *vis-à-vis* those of other members of the multidisciplinary team.

2.5.2.3 Interdisciplinary elements influencing nursing judgement and decision-making

Studies have shown that relationships between the members of the different professions involved in the delivery of multidisciplinary healthcare impact on their clinical judgement and decision-making (Huckabay & Jagla 1979, Harris 1984, Bourbonnias & Baumann 1985, Foxall et al 1991, McKeron 1991, Stern et al 1991, Jenks 1993, Bucknall & Thomas 1995, Baggs et al 1997, Cott 1997, Bucknall 2003, Coombs 2003). The impact of these relationships is compounded by the fact that the level at which nurses have the autonomy and authority to make decisions impacts on their position and status within the multidisciplinary team, and *vice versa* (Bucknall & Thomas 1997, Bakalis & Watson 2005). Colombo (1997) and Cook et al (2001) have argued that the cohesiveness of

multidisciplinary teamwork in clinical judgement and decision-making is most important in mental health services. Buckingham & Adams (2000a) see research on clinical judgement and decision-making in nursing as vital in helping to improve the standing of nurses as multidisciplinary team members.

Bucknall (2003, p315) found that handovers and medical rounds afforded both medical and nursing staff the opportunity to share information in relation to clinical decision-making. During these interactions, informal “checks” were made in the context of a professional hierarchy of experience and level of appointment. Also, Bucknall (2003) found that the absence of medical staff increased the onus on nurses to contingency plan with regard to clinical decision-making.

This was because nurses would be unable to consult medical team members, although there was reported to be a degree of shared clinical decision-making between nurses and junior doctors. However, this collaboration would only take place after the nurses and junior doctors had built up a relationship of trust and mutual respect over time (Bucknall 2003). Where this did not occur, the absence of shared decision-making resulted in interdisciplinary disharmony.

In line with this, Hopkinson et al (1998) found poor interdisciplinary relationships to be a source of stress for psychiatric nurses. Bucknall (2003) found that the process of decision-making was also shared between nurses and other health professionals such as pharmacists and physiotherapists insofar as a mutual sharing of information regarding patients enabled all involved to engage in more effective decision-making (Bucknall 2003). In both inpatient and community psychiatric nursing this is true particularly with regard to risk assessment for aggression and violence, where the nurse tends to be the focal point for multidisciplinary team information sharing (Doyle & Dolan 2002).

Carr (2004) describes the community nurses in her study as engaging in collaborative, triadic decision-making which involved nurses, service-users and their carers. Triadic decision-making involving a nurse, service-user and significant other was also examined by Dalton (2003, p23), who expanded on Kim’s (1983, 1987) theoretical model by adding the “family caregiver” to the nurse/service-user dyad. The main thrust of Dalton’s (2003) theory is to describe individual and organisational factors that influence triadic decision-making. Each participant brings unique role expectations, personality traits, knowledge and attitudes to the process.

The context in which the triadic decision-making takes place is characterised by the structure of the healthcare organisation involved (Dalton 2003). This includes the system of care delivery used, its processes and the degree to which decision-making is routinised. However, it remains for Dalton's (2003) theory to be tested by further research.

Crow et al (1995) have contended that the processes engaged in by nurses and doctors in clinical judgement and decision-making are distinct from each other. Buckingham & Adams (2000a, 2000b) and Rashotte & Carnavale (2004) point out that this distinction is not very marked. Buckingham & Adams (2000a, 2000b) note the main similarity being the application of a process of classification in both nursing and medical judgement and decision-making.

Furthermore, Rashotte & Carnavale (2004) have suggested that the basis of the decision-making of both professions is based on contextual use of positivistic empiricism. Coombs & Ersser (2004) concur with this insofar as they found that both doctors and nurses use biomedical knowledge to inform their decision-making. However, this scientific knowledge is applied firmly within the context of hierarchical dominance of the medical role.

As also found by Colombo et al (2003), the medical staff participating in the study by Coombs & Ersser (2004) tended not to place a high value on the experiential knowledge drawn on by nurses as useful for decision-making. Nurses in the same study placed a high value on scientific medical knowledge. This reflects the higher regard that society in general holds for the construct of quantitative medical knowledge over that of qualitative nursing knowledge (Davies 1995).

Henneman et al (1995) have identified the need for experiential knowledge to be recognised and used by multidisciplinary teams in a way that promotes successful interdisciplinary collaboration. This is a view shared by Rashotte & Carnavale (2004), who suggest that medicine tends not to recognise the value of constructivist approaches to knowledge, such as reflective practice, to the same degree as do other professions. DiGiulio & Crow (1997) contend that this contrast is due to the medical preference for empirical, theoretical knowledge because of the doctor's reductionist role in reaching a correct diagnosis, compared to the nurse's role of responding to patient needs.

Whilst Thompson (1999) argues that the qualitative, even somewhat ineffable nature of intuitive experiential nursing knowledge could make it difficult to share in the context of collaborative interdisciplinary decision-making, he does see a solution to this problem in cognitive continuum theory. The benefit of this theory, he argues, is that it considers the use

of personal knowledge in the context of social hierarchies (Hamm 1988). This accounts for the acceptance of intuitive knowledge within a multidisciplinary team where it is used in combination with analytical methods and by those with acknowledged expertise.

Colombo et al (2003) found that service-users' sick role and elevated status of the medical profession leads to the dominance of the medical model as the main influence controlling shared decision-making in community psychiatry. They concluded that a more equitable arrangement for the delivery of community mental health is needed if nurses and service-users are to be enabled to make valuable contributions to the shared decision-making process. Coombs & Ersser (2004) found that some areas of nursing knowledge are valued by medical staff, in particular the knowledge gained through interaction with service-users' families. Doctors and nurses were found to vary in their views of the importance to their decision-making of less scientific knowledge areas, such as ethical knowing, with nurses giving more priority to ethical knowledge in their decision-making. The richest source of knowledge to inform clinical judgement and decision-making for nurses identified by Coombs & Ersser (2004), however, was that gained through continuous involvement in patient care.

Kikuchi & Simmons (1999) and Rashotte & Carnavale (2004) view such practical knowledge as being the desirable bedfellow of scientific knowledge in the clinical setting. This is because they view biomedical knowledge as sometimes failing to establish certain truth. Where certain truths are established, they are seen as difficult to apply to a complex clinical situation. Here the concurrent utilisation of inductive reasoning can at least help the clinician work towards ascertaining probable truth.

Mrayyan (2004) and Coombs & Ersser (2004) have found that despite the distinct role that nursing knowledge has to play to decision-making, and the acknowledgement of this fact by doctors and nurses alike, medical knowledge (and therefore medical decision-making) is seen as superior when it comes to important decisions about patient care. Even where nursing knowledge has a unique contribution to make, it is subsumed within a medical framework. This is because nurses have not been empowered to make clinical judgements and decisions to the same extent that their medical colleagues have Coombs & Ersser (2004).

Nurses' clinical judgement and decision-making is embedded in their traditional role as lesser partners in care provision alongside other members of the multidisciplinary team - doctors in particular (Fulton 1997, Cassidy 2004). However, the profile of the nursing input

to care provision is being raised in Ireland with moves being made, for example, towards nurse prescribing (An Bord Altranais 2000b). In the U.K. official policy has also been moving towards enhancing the autonomous role of the nurse in healthcare provision (Department of Health 2002).

One rationale for this is the impact that greater autonomy can have on patient outcomes (Curley 2002, Luyt et al 2002). There is no universal agreement as to exactly what autonomy for nurses in practice entails (Keenan 1998). However, there is general agreement that an improved understanding of the role that level of autonomy plays in nurses' clinical judgement decision-making could help inform the advancement of the nursing profession (Wade 1999, Buckingham & Adams 2000a).

Cook et al (2001), for example, found that community-based psychiatric nurses experienced greater autonomy when they worked in a multidisciplinary team which operated cohesively. This was particularly in terms of cohesiveness in communication, organisational structure and collegial support. This enabled nurses to deliver care that was more user-centred.

The role of psychiatric nurses is very much determined by the setting in which they work as well as their place in the hierarchy of the work team. These factors all influence how they make clinical judgements and decisions. This is not least because they determine the very judgements and decisions that they are mandated to make.

2.6 Conclusion

In concluding this review of the literature it is essential to reconsider it in the context of the study's aims, first discussed in Chapter One:

1. To explore the judgement and decision-making of RPNs working in the Irish Republic, in terms of both the cognitive processes involved and their social context.
2. To consider and apply the findings to psychiatric nursing practice and education, as well as to policy issues and future research in this area. This applies primarily to the Irish context from which the data were generated and, where valid, to psychiatric nursing generally.

The review outlines the wide variation of themes, approaches and opinions that prevail in the literature. The concept of an intuitive-analytic spectrum of clinical judgement and decision-making is a dominant theme, but there is also a pervasive concern with issues such as the nursing role and the social context of nurses' judgement and decision-making. This

mix of social and cognitive elements is apparent only when a wide ranging review of the literature is undertaken.

Specific research questions require a focus on one or other of these elements. However, an approach that focuses on the social over the cognitive or cognitive over the social aspects would, for an exploratory study, obscure a large part of the picture. This can be seen in approaches taken by other researchers.

Buckingham & Adams (2000b), for example, have seen the consideration of intuition as an integral part of how they have explored more socially situated issues such as professional role and attribution of expertise. Such an integrated approach makes possible the study of the influence and interplay of both the social and cognitive elements. At the same time it permits exploration of nurses' clinical judgements and decisions in terms of the dominant theme of the intuitive/analytic spectrum.

To date research has shown that nurses do tend towards intuitive approaches in their clinical judgement and decision-making. Some accept this as an inevitable and unavoidable characteristic of nursing as the art of caring. Others urge a move towards a more evidence-based, actuarial approach.

It is important, as the philosophical literature points out, to maintain a balance of these two perspectives. This is what I intend to do in my own study. I do this by considering both positions as indicative of the wider, sometimes dichotomous, debate regarding the fundamental nature of nursing as art and/or science.

A keen awareness of the wider philosophical discussion should underpin any study of nursing judgement and decision-making, and the literature discussed in these first two chapters has provided that background. This wider discussion is relevant not only to nursing practice, but also to the choice of research methodology for investigating practice. In light of this, I deliberately aim towards a non-dichotomous, eclectic approach to this study.

From the review of the literature, it is apparent that many researchers were successful in their application to nursing of the empirical approach used by psychologists researching judgement and decision-making. This was particularly the case where nurses made judgements and decisions that involved data that were consistently measurable in quantitative terms. Despite the complex nature of psychiatric nursing, there are phenomena that can validly be reduced to purely mathematical terms in order to be studied using judgement or decision analysis.

These methods could be used to examine discrete psychiatric nursing phenomena. However, they would not be appropriate as a means of broadly exploring the judgement and decision-making of psychiatric nurses. As such, this study needs to take account of the socio-cultural context of psychiatric nurses' work, - in particular how the 'goodness' or 'soundness' of judgements and decisions are determined in that context.

I believe that these issues are best addressed by a study that incorporates qualitative investigation of nurses' perceptions of their decision-making (Manias et al 2004a, 2004b). I also believe that there is a need to ground such an inquiry by combining it, where possible, with an actuarial approach. My review of the literature suggests that consideration of the combined cognitive and social factors involved in nurses' clinical judgement and decision-making requires a mix of qualitative and quantitative methods.

I am confident that with an appropriate research methodology that a reasonable attempt to address these issues can be made. This does not affect the overall aims of the study, but it does involve refining of the study objectives. The literature reviewed in the first two chapters addresses the first objective:

- I. To give a comprehensive account of clinical judgement and decision-making in nursing, in particular as it applies to psychiatric nursing

From my discussion of the research processes involved in the study of nurses' clinical judgement and decision-making, the second objective can be refined as follows:

- II. To understand, through a combination of qualitative and quantitative methodologies, how and why RPNs make their clinical judgements and decisions

From my discussion of the nature of nursing judgement and decision-making, in particular how it is best understood, the third objective can be refined thus:

- III. To gain as much insight as possible on the cognitive processes and social context of the clinical judgement and decision-making of RPNs, in particular analysing the interplay between the external social and internal cognitive elements involved.

The fourth objective remains unchanged:

- IV. Having fulfilled the aims and objectives above, to make applications to psychiatric nursing in the Irish republic, with particular reference to its future development.

In summary, the revised aims and objectives in light of the review of the nursing literature are:

AIMS

1. To explore the judgement and decision-making of RPNs working in the Irish Republic, in terms of both the cognitive processes involved and their social context.
2. To consider and apply the findings to psychiatric nursing practice and education, as well as to policy issues and future research in this area. This applies primarily to the Irish context from which the data were generated and, where valid, to psychiatric nursing generally.

OBJECTIVES

- I. To give a comprehensive account of clinical judgement and decision-making in nursing, in particular as it applies to psychiatric nursing
- II. To understand, through a combination of qualitative and quantitative methodologies, how and why RPNs make their clinical judgements and decisions
- III. To gain as much insight as possible on the cognitive processes and social context of the clinical judgement and decision-making of RPNs, in particular analysing the interplay between the external social and internal cognitive elements involved.
- IV. Having fulfilled the aims and objectives above, to make applications to psychiatric nursing in the Irish republic, with particular reference to its future development.

Successful fulfilment of these objectives requires a methodology capable of yielding data and enabling analysis that considers more than the intuitive/analytic nature of nursing judgement and decision-making in its social context. It must also enable the study of those aspects of clinical judgement and decision-making that the literature has identified as important, i.e., role, expertise, interdisciplinary work etc. I believe that this can be achieved with the right combination of research methods. In Chapter Three I discuss how I have set out to achieve this.

Chapter Three – Methodology & Piloting

3.1 Introduction

In my conclusion of Chapter Two, I broached the epistemological and ontological issues pertaining to research on nursing judgement and decision-making. In this chapter I further elaborate on my point made there, that a study design grounded solely in either positivism or postpositivism is not adequate to address the aims and objectives of this study (e.g., Brykczynski 1989, Bryans 2000, Bryans & McIntosh 2000, Sainio et al 2001, Fredelius et al 2002, Coombs 2003, Fonteyn et al 2003, Hellzen 2004, Offredy & Meerabeau 2005, Hastie & Penington 2000). This is not because being grounded in a single approach is defective – indeed it would have the benefit of lending clarity and focus to the research.

Notwithstanding this, the types of issues that can be raised by the data in an exploratory descriptive study such as this one (Koopowitz et al 2003) require analysis that considers the meaning and significance of participants' practices. A singularly quantitative approach cannot achieve this (Banister et al 1994, Abma 2001). Therefore, this study's qualitative approach seeks to accommodate and engage with concepts such as the nurse as *phronimos* or *spoudaios* (Dunne 1993).

However, it is not solely on conceptual bases such as these that my choice of a predominantly qualitative methodology rests. Willingness to use qualitative research methods broadens the potential for a study to incorporate diverse approaches that are required to address the issues at hand. This is true not only for exploratory studies - in research on consensus building (see pp20-21), for example, qualitative research is the standard approach (Bowman & Ambrosini 1997).

Edwards & Potter (1992a) view qualitative research methods that examine the use of language as vital to widening the perspectives that research can offer in areas, such as cognitive psychology, that have traditionally been dominated by quantitative approaches. This does not rule out the use of quantitative research methods or imply the general superiority of qualitative methods (Silverman 1993). Indeed, the focus of this study is such that a broad, inclusive perspective on methodology is required.

3.2 Choice of Method: The need for a dual perspective & methods triangulation

The aim of this study, as stated in Chapter One, was to examine the judgement and decision-making of RPNs working in Ireland. In doing this I intended to explore the judgement and decision-making as involving social and cognitive processes involved. This dual cognitive-social perspective has been a feature of psychology and sociology literature throughout the 20th century (Trotter 1919/2005, Sherif 1936, Festinger 1950, Moscovici 1985, Bandura 1986), and so is a well established theme in psychological research in areas such as personal identity (Wortham 2001), attitudes, attribution and problem solving (Edwards & Potter 1992a, Potter 1996, Potter & Wetherell 1987, Hogan 2002).

This approach to nurses' clinical judgement and decision-making as happening "in social contexts as well as in individual minds" (Hogan 2002, p345) follows on from the work of Blackburn (1972). Here, it was noted that researchers risk uncovering only partial evidence due to the limitation of their research to the methods of a singular discipline. For a topic as complex as human judgement and decision-making, this point is all the more pertinent (Juslin et al 2000).

Denzin (1989) has also recommended that researchers move beyond the limitations of confining themselves to a single research method, advocating the use of whatever applicable theoretical approaches are needed to answer the research question. Such a combination of approaches can also address the shortcomings in terms of validity and potential bias that are inherent in using a single method (Cook & Campbell 1979, Creswell & Plano Clark 2006). By studying phenomena from several viewpoints, the researcher can decrease the likelihood of the type of subjectivity that is inherent where one perspective is dominant (Hanson 2006).

In nursing research this usually involves the combination of qualitative and quantitative methods (Cowman 1993) to deal with complex, socially situated topics (Twinn 2002, Power 2004). In this study my aim is to use methods triangulation to expand on and validate quantitative results using qualitative data analysis (Creswell & Plano Clark 2006, Plano Clark & Creswell 2007). I have done this using a concurrent triangulation design, whereby data collection and subsequent qualitative and quantitative data analysis occur within the same time frame and are given equal weight.

Normally this involves the concurrent collection of two sets of data, one qualitative and the other quantitative (Creswell et al 2003). However, in this study the same data set is analysed using two distinct methods of analysis. Quantitative data analysis (comparative keyword analysis) of the data set is used to inform qualitative analysis of the same data set using conversation analysis-informed discursive analysis.

Discursive analysis is informed by conversation-analytic principles and methods, which are grounded in ethnomethodology. Comparative keyword analysis is a novel quantitative method of data analysis with its origins in the mixing of sociological and linguistic research paradigms (Seale 2006, Seale et al 2006). The data were collected using think aloud protocols & critical incident interviews due to their proven track record in answering similar research questions in psychological research. This also applies to my choice of discursive analysis as a method of analysis.

My use of methods from different research traditions presents challenges involving underpinning philosophies, and issues of ontology and epistemology (Risjord et al 2001, Sale et al 2002). Notwithstanding this, nursing research has traditionally resolved such problems through the application of across-methods triangulation as part of the study design. The researcher has the onus to do this in a way that adequately addresses the relevant philosophical, epistemological, ontological and methodological challenges.

My philosophical grounding in conducting this study is one of pragmatism. Characteristic of this perspective is that my choice of methods is solution-focused, pluralistic, concerned with outcome and addressing a problem grounded in the “real world” of clinical practice (Creswell & Plano Clark 2006, p22). My contention is that triangulation is justified as it represents the best solution within a study of this size and duration to the problems presented by the study’s aims and objectives.

Grounded in pragmatism, I conceptually I view the research process from a social constructionist perspective. This does conflict with the essentialist view that underpins much of cognitive psychology (Gelman 2003). This approach would require me to analyse the data with a view of fitting the study findings into existing models and theories, which would pose problems given that this is not a cognitive psychology research study.

My pragmatist perspective enables me not only to do this (and in Chapters Six I do discuss the findings with reference to these) but also to recognise that the socially-situated, “practice-oriented” nature of the data (Creswell & Plano Clark 2006, p22). This is particularly appropriate given that my approaches to data collection and analysis are not

methods of choice in cognitive psychology, where quantitative methods are almost exclusively preferred. This study design to this study was not my initial plan, but constitutes a solution-focused approach to the research question, borne out of necessity in the context of solving several problems.

3.3 Research Design

The exploratory nature of this study (Newton et al 2007) requires richly descriptive data (Nunkoosing 2005). Live observation of practice was considered, but the ethical and logistical problems around access to participants as they worked with vulnerable individuals proved insurmountable in a study of this size and duration. Also, direct observation is not seen as the most effective way to collect information on ‘invisible’ phenomena such as the cognitive aspects of human judgement and decision making (Schulter et al 2008). A combined ‘think aloud’ and retrospective interviewing approach was used as the best available way to yield the data required (Cioffi & Markham 1997).

3.3.1 The ‘Think Aloud’ Research Design & Critical Interviews

The think aloud approach involves the recording of concurrent verbalisation (Ericsson & Simon 1993) - *in-vivo* recording of participant verbalisations while they are involved in an activity such as problem solving (van Somneren et al 1994). This approach is considered more reliable than retrospective interviewing alone, particularly in terms of accuracy and validity (Fonteyn 1993). It is also the standard method for attempting to access cognitive processes *in-vivo* (Ericsson & Simon 1993, Fonteyn et al 1993, Crutcher 1994, Van Den Haak et al 2003, Cokely & Kelley 2009).

Nursing researchers have used the think aloud approach to study clinical judgement and decision-making (Narayan & Corcoran Perry 1997, Corcoran Perry et al 1999, Azzarelo 2003, Simmons et al 2003, Offredy & Meerebeau 2005, Offredy et al 2008). However, data yielded by the think aloud approach may not represent the normative practice of participants. Therefore, Ericsson & Simon (1993) recommend supplementary retrospective interviewing.

I decided on this approach given its successful use by nursing and midwifery researchers (Cioffi & Markham 1997, Corcoran-Perry et al 1999, Ritter (2003). Retrospective interviews were conducted using the Judgement & Decision-Making Performance in Practice (JDM PiP) schedule (MacNeela et al 2005 – see Appendix A), which provided a

basis for engaging participants in the critical incident technique of retrospective interviewing (Flanagan 1954).

This technique has been used extensively in nursing research (Keating 2002), particularly around clinical judgement and decision making (Benner 1984, Webb & Shakespeare 2008). It is preferable to structured question-answer format interview (Abma 2001). Although a structured format was used by interviewers, this was in an informal, conversational manner that yielded co-authored naturalistic narratives (Och & Capps 1996, Gaeth & Shanteau 2000).

Participants were asked to give an account of a recent case similar to the one that they had just encountered using the think aloud approach. In this way, the JDM PiP schedule (MacNeela et al 2005 – see Appendix A) used critical incident technique to provide information around the normative practice of the participant (Abma 2001) in enough detail to obtain data of the depth and richness required in a descriptive study (Fratilis & Sionis 2006). Critical incident technique is commonly used in this way in clinical judgement and decision-making studies (Farnan et al 2008).

An advantage of critical incident technique is that it involves not only participant recall of events, but critical reflection also (Perry 1997, Keatinge 2002). In this study, the ‘critical’ element of critical incident technique sought to supply a rich meta-narrative by engaging participants in a conversational manner. This expanded on the most relevant aspects of the recalled incidents (Abma 2001).

Critical incident technique tends not to instigate critical discussion of social phenomena such as role and interpersonal interaction (Byrne 2001). However, these aspects could be addressed due to the JDM PiP’s coverage of both social and cognitive aspects of judgement and decision-making. In doing this, the five steps of the technique were followed (Flanagan 1954).

First, the original educational format of the JDM PiP was revised and piloted in broad discussion of social and cognitive aspects of recalled incidents. Secondly, the JDM PiP sought participant recall of events similar to those engaged with in *in-vivo* data collection. Thirdly, the JDM PiP enabled probing around aspects of participant recall and reflection on events relevant to the study aims (Schulter et al 2008).

Sound data analysis is the fourth principle of critical incident technique. Problems around objectivity in critical incident technique were acknowledged by Flanagan (1954) and since then there has been considerable discussion of this in the literature. Flanagan’s (1954) fifth

principle is the discussion and dissemination of study findings. Chapter Six discusses the findings of this research report, whilst Chapter Seven addresses dissemination.

Whilst the collection of *in-vivo* and retrospective data enables an enriched perspective on participant judgement and decision-making, the question remains of precisely what these data represent. Such data are not an open window into the minds of participants (Schegloff 1989). This has implications for the collection and analysis of data that need to be dealt with before engaging in discussion of the validity and reliability of the think aloud approach.

3.3.2 Verbal Data and the Problem of a Naïve View of Language

As well as considering what verbal data can reveal about cognitive processes, they need to be considered in terms of the interactive activity from which they are derived (Potter 1996, Edwards 1997, Taylor 2001). Whilst verbal data do offer the clearest available view on the cognitive formation and processing of information (Schegloff 1989), this view is limited (Edwards & Potter 1992a). Insofar as they are conversational, verbal data offer deeper insight into social organisation than into cognitive processes (Sacks 1992).

The limitations of verbal data do not preclude them from offering some degree of insight into cognitive processes. Austin (1962) and Wittgenstein (1953) have made a clear case for linking how we know with how we use language (Potter 2001). Pursuing this link in research requires analysis to focus not solely on narrative content, but also on its linguistic and paralinguistic features (Misler 1986).

Whilst necessitating a departure from the standard protocol analysis approach to think aloud data, this enables a deeper focus on the link between language and knowledge. Whilst somewhat precarious in its novelty, such a departure does offer the benefit of insight into phenomena such as the expression of inference by participants, and the establishment of mutual understanding as efforts at sense-making (Heritage 1984, Taylor 2001). This approach is rooted in ethnomethodology (Garfinkel 1967), an area that has been drawn successfully in the study of cognitive and affective phenomena (Edwards & Potter 1992a, Edwards 1997).

Taken at face value, language can be interpreted as conveying *bona fide* information (Dekker 2002). This leads to analysis that seeks to simply uncover the machinations of participants' minds, as opposed to the more realistic aim of reaching a better understanding of links between discourse and cognition (Edwards & Potter 1992a, Billig 1997). This, arguably more scientific approach, is underpinned by an understanding of language use as

contextually constitutive rather than as a transparent reflection of actual phenomena (Taylor 2001). Therefore, in this study I view participants' language as a resource that they use in response to certain contingencies within the complex web of social practices in which it is necessarily embedded.

Essentially, the perspective taken in this study is that verbal data cannot be taken to represent participants' telling of 'true' versions of events (Gilbert & Mulkay 1984, Abma 2001, Nunkoosing 2005). Instead I have attempted to understand what participants have communicated in terms of the meaning they attribute to events (Wertsch 1990). This stands in contradistinction to any attempt to simply presuming that the data represent an objective perspective on the actuality of those events.

Any sense of actuality is put at a further remove by the fact that participants' are reconstructing events from memory (Edwards & Potter 1992b). Aware of problems with recall themselves, participants indicate this by way of "metacognitive disclaimers" (Edwards & Potter 1992a, p194). Participants can also lack awareness that the story that they are relating is not an authentic account of events, and may even contradict themselves (West 1990).

However, whilst best not interpreted at face value, participant talk is referential and therefore permits some degree of knowledge to be yielded from its analysis (Taylor 2001). This knowledge allows us to begin to understand how participants make judgements and decisions by first understanding how they represent them discursively. The alternative to this approach is to deny the usefulness of language in exploring human judgement and decision-making, which would be a total departure from the approach that researchers in human judgement and decision-making have taken to date.

Instead, I have strived to take an informed, healthily sceptical and balanced view of what verbal data can reveal. In doing this I have avoided adopting a naïve view of participant narrative as a precise discursive representation of actual cognitive events. However, overcoming a naïve view of the nature of language and verbal data does replace simple problems with more complex ones (Fairclough 1992). Chief among these is the need for analysis to be shown to account for participant reactivity (Gaertner & McLoughlin 1983, Haskell 2009), which poses still further problems for claims that the data validly reflect participants' cognitive processes (Halliday 1978).

Verbal data can be said to represent what the participant chooses to share with the researcher within the social context of being a participant in a research study (Charmaz

1995, Rowbotham 2004, Nunkoosing 2005). This is relatively unproblematic if researcher-participant interaction is the focus of the research study, but poses significant challenges if a study seeks to uncover actual cognitive and/or social processes. It is vital therefore that data collection and analysis permit incisive exploration of the data, taking meta-narrative into account (Gilbert 1980, Hammersley & Atkinson 1985, Horton-Salway 2001), and shedding any “simplistic notions of true original events” being represented by the data (Gilbert & Mulkey 1984, Edwards & Potter 1992a, p187).

3.3.3 Validity and reliability of the think aloud approach

The value of conclusions from think aloud studies rely on “the validity of the think-aloud method, and on the reliability of the coding process” Skaner et al (2005, p3). Much of the commentary on the validity and reliability of the think aloud method focuses on the production of data that are representative of the cognitive processes that are normative for the task in which the participant is engaged. Although Ericsson & Simon (1993) contend that think aloud data are fairly representative of participant’s normative problem solving, they point out that ancillary thoughts and information are also in play.

Lane & Schooler (2004) have suggested that methods such as the think aloud approach can be biased in favour of the detection of cognitive processes that are more easily verbalised. This is a limitation of think aloud method that needs to be taken into account by choosing a method of analysis that seeks to look beyond what is apparent in participant verbalisation. I address this issue in detail in the section on data analysis (see p.80), as I am concerned primarily in this section with data collection.

Like Reicks et al (2003), van Somneren et al (1994, p33) found that cognition appears to be slower during use of the think aloud method, as participants slow down the process in order “to synchronize it with verbalization”. Failure to do this, they report, could result in participants’ verbalisations not keeping abreast with their thought processes, resulting in incomplete reporting. Van Den Haak et al (2003), however, have reported finding no evidence for this. Nevertheless, this is an issue of which the researcher needs to be aware, and one which I will also address in my discussion on data analysis (see p.80).

Although it is an *in-vivo* method of data collection, the think aloud method differs from observation insofar as participants are engaged in a staged task. This increases participant mindfulness of how they are using their working memory, which can lead to incomplete reporting and possible disruption of the entire process (van Somneren et al 1994). Where

this occurs, participants complain of not being able to keep abreast with the process and there can be prolonged silences in verbalisation.

Everyday social communication differs significantly from think aloud monologues (Ericsson & Simon 1993). Social verbalisation between the researcher and participant during data collection can result in the verbalisation taking on a social hue as well as introducing bias (Reicks et al 2003, Hansen 2005). Therefore the researcher is generally not visible to the participant during data collection.

However, Hansen (2005, p518) notes the importance of the participant being “made aware that it is a social situation of some kind in which they are participating”. Therefore, the use of cues involving controlled social interaction that is an integral and standardised part of the task at hand differs from the social chit-chat that is seen as undesirable by Hansen (2005). It might also prove essential in lending a more natural social hue to the task that is important in terms of ecological validity (Gaeth & Shanteau 2000). This is all the more relevant in light of the fact that Lamond et al (1996) found that verbal information was the most common source of information used by nurses in making clinical decisions. Compared to social verbalisation, concurrent verbalisation can lack coherence, be disjointed, and may not be wholly representative of the actual thought processes used in performing the task (Ericsson & Simon 1993). Notwithstanding this, “the urge towards coherence and completeness” should be avoided, with the researcher seeking to capture nothing more or less than participant expression as it occurs.

There is no reason why data yielded by the think aloud method cannot to be related to its social context as much as to purported cognitive processes. However, due to the nature of the work of psychiatric nurses, it would not be possible to collect think aloud data from them as they engage in their everyday work. Not only would this be ethically questionable, but logistically impractical. Therefore, it was necessary to use simulated cases to facilitate the collection of think aloud data.

3.4 The Use of Simulated Cases in Research

Simulated cases are used in research across many disciplines (Stewart 2001, Patomella et al 2004), including nursing (Hughes & Huby 2002). They are particularly useful for collecting comparable data from large numbers of participants in standardised and controlled situations (Gould et al 2001, Hughes & Huby 2002, Gilbert 2004). Simulated cases are especially useful in research on judgement and decision-making in health and social

sciences (Reich et al 1998, Gilbert & Troitzsch 1999), particularly in nursing (Grobe et al 1991, Colombo et al 2003, Ferrario 2004, Dowding et al 2009). In nursing research (Cioffi & Markham 1997, Corcoran-Perry et al 1999, Aitken 2003, Ritter 2003), as in other areas of research (Fredilius et al 2002, Laing & Kamhi 2002, Reicks et al 2003, Van Den Haak et al 2003), simulated cases have often been used for think aloud data collection.

Researchers using simulated cases have tried various approaches to ensure that environmental elements are controlled and accounted for and that cases are presented with both realism and ecological validity. This has included the use of audio and visual aids, such as the presentation of cases in videotaped format (Cohen & Strayer 1996, Bryans 2000, McKinstry 2000, Chau et al 2001, Gilbert 2004) or computer simulation (Payne et al 1990, Salantera et al 2003, Carter et al 2004, Connelly & Bair 2004). Computer simulation has the added benefit of allowing interaction, going some way towards recreating the dynamism of a situation (Buchanan 2003).

In order to increase this sense of dynamism, some researchers (Dresselhaus et al 2000, Van Walsum et al 2004) have used live actors to present simulated clinical cases. Whilst this is ideal in using case simulation for educative purposes (Nunn 2004), it may lead to inconsistencies and therefore lack of comparability across case presentations to individual participants in a research study. Cioffi et al (2005) note, however, that there is not a great deal of evidence – positive or negative – regarding the use of live actors in comparison to other methods of case presentation.

3.4.1 The challenges and limitations of using simulated cases in research

Simulated cases can be used in conjunction with many different types of data collection in qualitative, quantitative or multi-method research (Stake 2000). The biggest challenge in developing and using such cases in research is the need to ensure that they are as realistic as possible in content (Gould et al 2001, Hughes & Huby 2002) and have an ecologically valid presentation format (Lamond et al 1996, Gerdtz & Bucknall 2001, Kneebone et al 2003, Salantera et al 2003). With regard to content, the gold standard is to use actual cases from clinical practice (Lamond et al 1996).

This presents participant with situations that are close to clinical actuality, but in which controls can be applied (Bryans & MacIntosh 2000). The added benefit is that the researcher has access to case types and scenarios that might not be available in the settings

to which s/he has access for the duration of the study (Peabody et al 2004, Yin 2003). Furthermore, these case types can be augmented in ways that would not be achievable in actual clinical practice, such as altering case complexity (Cioffi & Markham 1997, Stake 2000, Cytryn et al 2009). This permits exploration of situations that could not ethically or safely be explored in the observation of clinical practice (Howard et al 2003). The main challenge in devising case simulations for research is to present realistic and believable cases that incorporate the phenomena and variables in which the researcher is interested (Hughes & Huby 2002).

3.5 Pilot Testing of Data Collection Methods

Pilot testing in this study was conducted for the purpose of testing the proposed data collection approach. In my conclusion to Chapter Two, I noted that data collection methods in nursing judgement and decision-making studies should produce data which can speak to both the main cognitive and social issues in nursing judgement and decision-making. For this reason I tested the data collection methods which I devised prior to using them for the main study.

Seven psychiatric nurses participated. Two of these were university lecturers who are currently clinically active, two were mental health nurses undertaking a post graduate diploma in their nursing specialty whilst the remaining two were undertaking a post-registration degree course in nursing. The table on the following page gives a breakdown of participants' relevant demographic details along with the time taken in going through the stages of data collection. In the case of Participant F it is worth noting that English was not the participant's first language. English was the first language of all study participants in the main study, but this was not by purposeful design.

Table 3.1

<i>Participant</i>	<i>Experience</i>	<i>Education</i>	<i>T.A. Time</i>	<i>JDM Pip Time</i>
A Male	10 +	Masters	5 minutes	14 m 50sec
B Male	10 +	Masters	9 minutes	12m 10sec
C Female	10+	Certificate	10m 22sec	12m 32sec
D Female	5-9	Degree	10m 46sec	n/a*
E Female	5-9	Degree	8 minutes	n/a*
F Male	0-4	Certificate	18m 19sec	14m 35sec
G Female	10+	Certificate	6m 40sec	7 minutes

* - *JDM PiP Interview not completed due to participant time constraints*

3.5.1 Think Aloud Data Collection

A pilot case was devised to test the think aloud data collection protocol (see “Pilot Case” in Appendix B). This case involved a man who was referred to a day centre in the mental health services. His referral posed difficulties across several areas ranging from its non-adherence to standard procedures of referral to the suitability of day centre *vis-à-vis* the man’s needs.

A ‘warm-up’ case in the form of a set of nursing notes for a different fictional case was presented to all participants. They reported finding this useful in helping them to get used to verbalising their thoughts in-vivo. However, all participants had to be initially prompted to think aloud for the pilot case proper. It seemed that this often distracted them from reading the case study documents as they would, when prompted to think aloud, read the notes either verbatim or in paraphrase. Participant A was instructed to think aloud during the video sequence. On review of the film of Participant A’s pilot it was apparent that this had distracted his attentiveness to the cues being presented therein and it was decided that other participants would not be asked to think aloud for the video sequence.

Reading of the case material ranged from reading the notes verbatim without comment to a paraphrasing of salient information with critical comments. Comments ranged from making inferences from the information to querying the veracity of the information therein. Inferences and deductions made ranged from noting that the service-user was not likely to be aggressive to making general statements about the person’s condition, e.g., “there is a lapse of concentration and exhaustion”.

Participants’ treatment of the notes fell into two approaches. They either read them from beginning to end and commenting as they went, gradually building up a picture of the case, or else sifting through the notes for specific pieces of information. Some who had engaged in the former approach initially revisited parts of the notes for further information.

Using both approaches, participants expressed formulations regarding the individual’s usual behaviour. These were based on collected evidence of behavioural patterns from the video clips and case documentation, e.g., situations in which the person was aggressive or similar presentations in the past to the current scenario. None of these aforementioned approaches had any particular correlation to the participants’ level of education or experience.

In terms of the presentation of the individual’s past history in the case notes, participants’ made reference to it in establishing a baseline of the person’s usual status to compare his

current presentation against, e.g, “he was doing well”. There was evidence also of participants quickly expressing initial impressions, e.g., the person having a UTI or his daughters being overprotective. These initial impressions were either discarded or developed, and the final judgments made are set out in Table 3.2 overleaf.

In two instances participants misread or misinterpreted documentation. Participant 3 misread an entry in the daily notes that was clearly interpreted by other participants. Where the entry noted that the service-user had had a cup thrown at him, Participant C read this as saying that the cup had been thrown by the service-user himself. Participant D, meanwhile, remarked that the referral policy was of no use and that a discharge policy would have been of more use. They had interpreted the referral policy as covering referral *out* of the service only as opposed to between parts of the service.

It was apparent that participants were for the most part perusing the documentation for the sake of the data collection and might not have done this in a more naturalistic setting. One participant, for example, having viewed the video and read the referral letter, held up the nursing notes and asked the researcher “will I just go through this?” It was also clear that most participants read the documentation critically, i.e., they did not take the information presented as ‘true’ and often doubted its veracity. This ties in with the findings of Crawford et al (1995) who have noted that most nursing documentation is, to some degree, fictional.

After reading through all of the case material all participants gave a summary of the case as they saw it and their judgement regarding the case. Participants were told they would be asked for their judgment regarding the case having “thought aloud” about it, but all volunteered this information, although with some clarity had to be sought about aspects of the judgment, e.g, they may give alternatives and have to be asked which alternative they would decide on. Some participants made judgments beyond the scope of the scenario and task set for them, e.g., noting that the person’s medication should be reviewed.

Whereas all participants but one used the nursing notes and all used the referral letter, use of the referral policy was mixed. Participant G used it to critique the referral letter insofar as it did not fulfil the criteria set in the policy. Participant B did use it to check to see if the referral contravened the policy, but noted that it was “no good to me” in this regard – that is the person could not be said to have been referred contrary to policy.

During the think aloud process participants made reference to similar cases or types of cases that they had encountered. For example, one participant made reference to what happens “when people get older”, whilst another interpreted the referral of the service-user

as indicating that the admission unit “must have been in need of a bed”. Ideal cases were also a source of reference, with participants also noting what “should have” happened, whilst also admitting that scenarios like that presented “can happen”.

All participants, except for Participant C, avoided eye contact with the researcher during think aloud data collection. All participants asked the researcher for clarification of a point of information in the documentation at least once during think aloud data collection. Of special note was Participant F, who did not have English as a first language.

Participant F read slowly and deliberately through the notes, commenting after each segment. Most often these comments did not relate to the scenario at hand but concerned other elements of the person’s overall case, e.g., “Mr Feehy’s sleeping pattern has been fluctuating and will need to be reviewed by the doctor to ensure that his sleeping pattern is stabilised”. Also of note was Participant F, who, having viewed the video remarked “well without looking at any of that [the case documentation] straight off ... that man appears to be very, very unwell” and said that they would need to “talk to the person and to the family” and at this point made their judgement on the case. They then went through the referral letter and referral policy, thinking aloud, but not the nursing notes. They did not, however, change their initial opinion. Participant judgements are outlined in Table 3.2:

Table 3.2

<i>Participant</i>	<i>Judgement</i>
A	Hold on to person & get more information before deciding what to do
B	Hold on to person & get more information before deciding what to do
C	Have patient reviewed by doctor attached to community services with a view to perhaps having them referred back to the admission unit
D	Get more information from referring unit staff and then have person assessed medically with a view to either accepting them and giving them a walking aid or having them referred to A&E.
E	Not fit for day centre, refer on to his own GP
F	Refer him back to the admission unit as he is still mentally unwell
G	Hold on to person & get more information before deciding what to do

3.5.2 JDM PiP Interview

All participants were able to easily relate experiences of cases similar to the one presented. Some participants referred back to the case notes and compared details of the current case to past cases they had come across. With regard to the case type represented, all participants saw this as relating to inappropriate referral. The JDM PiP interview schedule (MacNeela et al 2005 – See Appendix A) also enabled participants to talk about the sources of information used in making judgements and decisions and the way in which this information was processed (intuitively in the main). Observation, experience and prior

knowledge were consistently cited as important in judgment and decision-making across interviews. Prior knowledge related both to certain categories of service-user and individual service-users. Information sources used were consistently referred to as being observed cues and information garnered from talking to service-users and their families.

The JDM PiP was useful also in revealing participants' use of primary cues and secondary cues. Taking Participant C as an example, the primary cues of "voice", "tone", "demeanour", "shouting" and "lingo" were combined to lead to a judgment that a person was "volatile". This was a main factor in deciding on the person's being unsuitable for a particular care setting.

In the case of Participant F, for whom English was not their first language, it was noteworthy that the JDM PiP enabled the deconstruction of a concept that otherwise might have remained obscure. The participant remarked that a patient dealt with in the past was "mentally lazy". The JDM PiP interview enabled this condition to be elaborated on and it was apparent that the person in question lacked motivation. Unlike the think aloud element of data collection, Participant F was able to engage relatively fluently with the JDM PiP, although this did take more time than with other participants.

3.5.3 Summary Report on Data Collection Piloting

The most apparent conclusion from the piloting data collection is the phenomenon of participant performance, particularly with regard to the think aloud process. Participants were nervous initially about being recorded, and being reassured that no-one except the researcher would have access to the tape was important to them. Once recording began, however, participants had no qualms about verbalising freely 'on the record'.

With regard to think aloud data collection, it was apparent that it is vital for the researcher to remain out of view of the participant in order to minimise opportunities for unnecessary participant-researcher interaction. However, some degree of interaction is unavoidable for reminding participants to think aloud and for clarifying details (Gaeth & Shanteau 2000). Otherwise, participants engaged with the case documentation in such a way as to produce audible, usable data.

The JDM PiP (MacNeela et al 2005 – see Appendix A) was particularly effective in generating participant narrative regarding their approach to clinical judgment and decision-making in general. Participants seemed more at ease with this element of the data collection than with the think aloud protocol. Information regarding their approach to judgment and

decision-making, types of information used, and the sources of this information were all readily forthcoming.

Most importantly, as can be seen in Tables 3.1 and 3.2 set out above, these data collection methods are successful in terms of accessing participants' judgements and decisions in simulated practice. It is also apparent that they yield data which can shed light on both cognitive and social aspects of participant judgement and decision-making. This would appear to be due to a combination of realistic cases and the ability of the data collection methods to produce rich narratives on both *in-vivo* and recalled participant judgement and decision-making.

3.6 Main Study Data Collection & Analysis

3.6.1 Introduction

The aim of this descriptive and exploratory study (Koopowitz et al 2003) is to examine the judgement and decision-making of registered psychiatric nurses working in Ireland, in terms of its relationship to its social context. As direct observation of participants' practice was not possible, the collection of think aloud data with retrospective interviews provided the best type of data for this purpose. This data was analysed using comparative keyword analysis and conversation analysis-informed discourse analysis. The comparative keyword analysis of the data forms the basis for the conversation analysis informed discourse analysis of the data by identifying the characteristic aspects of the data.

3.6.2 Sample

Thompson (1999) recommends that researchers investigating clinical judgement and decision-making enhance their contextual understanding of the phenomena involved before engaging in the research. This understanding should inform an approach to sampling that is systematic and nonprobabilistic, with the aim of having a sample that will yield the richest, most robust data about the phenomena in a particular context or across certain contexts (Mays & Pope 1996). This approach is known as theoretical sampling (Thompson 1999), and involves examining the literature around the topic of research, and the research aim and then identifying themes within that literature.

Two of the most prominent themes that pervade not only the nursing literature on judgement and decision-making but also the wider psychological literature are those of

experience/expertise and how judgement and decision-making differs across different environmental settings. Therefore, it was decided to derive a sample from different sites across the Irish Republic that would include nurses with different levels of experience working across both inpatient and community psychiatric services. The population represented in this sample is RPNs working in Ireland.

Flanagan (1954) has recommended that at least 50 incidents be collected in any study using critical incident technique. With each of the 40 participants discussing four cases, over 150 incidents are represented in the data. This is in light of the fact that a brief form of critical incident technique was used for data collection, which is bound to yield shorter narratives than standard length critical incident interviews.

The sample (n=40) from which the data were collected is outlined in Appendix C. All participants were Registered Psychiatric Nurses. Although it was not a criterion of exclusion or inclusion, English is the first language of all participants.

The sample was taken from both community and inpatient services at five sites around the country and across three levels of experience (0-5 years, 6-9 years, 10 years plus). Allocation of staff varies widely between and within Irish mental health services. In some areas staff work in the same clinical setting over years, whereas in others they are rotated on a regular (e.g., annual or six-weekly) or irregular (which may involve anything from being arbitrarily moved after spending years in a setting to being rotated on a daily basis to meet the staffing needs of a service). The mode of rotation (or relative permanence in location) varies so much within the sample that the “community” and “inpatient” descriptors can serve only to indicate the location of participants at the time of data collection. In terms of sample size, the in-depth nature of the analysis of the transcripts using conversation analysis informed discourse analysis (Wooffit 2005) means that forty participants constituted a sample of adequate size (see Table 3.3 below).

Table 3.3

	Community*	Inpatient*
0-5yrs experience	5	9
6-9yrs experience	2	5
10+yrs experience	8	6
Missing Data	4	1
Total	19	21

* Denotes where participant was working at time of data collection. Most participants are regularly rotated between settings

Access to individual sites was negotiated according to the relevant procedures and protocols of each site. In order to preserve the anonymity of participants, I have withheld the identity of the sites from which the sample was selected. The relatively small size and non-uniform nature of Irish mental health services are such that a detailed description of the sites beyond identifying them as “in-patient” and “community” would easily enable their identification.

Informed consent was sought from potential participants by distributing and collecting information sheets and consent forms (see Appendix D). This gave me the opportunity to meet face-to-face with potential participants in order to discuss the study and answer questions. In addition to this, I gave my work telephone number and e-mail address to participants so that they could withdraw their consent at any time.

3.6.3 Ethical considerations

In order to gain approval by the Dublin City University Research Ethics Committee for this study several issues had to be addressed. Firstly, there was a risk that potential participants might have misinterpreted the motivation for studying their clinical judgement and decision-making. This is understandable as participants are making themselves somewhat vulnerable in allowing their personal narratives to be recorded (Cutcliffe & Ramcharan 2002).

Once collected, data become the intellectual property of the researcher to interpret and represent as s/he wills (Nunkoosing 2005). For this reason I made it very clear to participants (See Information Sheet, Appendix D) that no value judgements would be made about their clinical judgement and decision-making. It was made clear to participants that the rationale of the study is to explore the social and cognitive processes involved in their judgements and decisions rather than measuring them against some gold standard.

Participants were made aware that they could withdraw from the study at any point, including the time during which their voice was being recorded for data collection purposes as well as after they have been recorded. They were also made aware that if they did decide to withdraw from the study during or after the collection of this data, that any recording of them or notes/data concerning them would be destroyed. Digital audio recordings of the participants will be listened to only by professional transcribers and are stored securely at the School of Nursing, DCU.

These recordings will be destroyed when the study ends, although the transcripts will be retained. At no point in data collection has it been necessary to record or hold data on participants' addresses or dates of birth. For the purposes of data recording and analysis participants are identified only using an anonymous coding system.

This means that the participants will in no way be identifiable from the transcripts. However, as mentioned in the previous section, the nature of Irish mental health services is such that I had to take care that details given in the discussion of the findings did not enable identification of sites and individuals. For this reason I have deliberately avoided mention in the discussion of the findings of any grades (e.g., Clinical Nurse Specialist) or specialist services that might identify a site or individual.

It was stressed to the Research Ethics Committee that the rationale behind this study in the first instance is that there is a lack of knowledge about the clinical judgement and decision-making of RPNs in Ireland generally. Therefore any potential risks are outweighed by the benefits to healthcare delivery and ultimately its end users.

3.6.4 Development of cases used for data collection

The cases used for data collection were derived from actual clinical data. These were collected as part of the programme of research of which this study is part. Full details of these cases provided in Appendix B, and I will give only a brief overview of them here. The anonymity of the case subjects was assured by changing several demographic details of their presentation, excluding or changing any potential identifying features and adding fictional features. For the sake of ecological validity, the language used to describe the case in the clinical documentation was preserved, insofar as anonymity allowed, in the case presentations.

Nurses make clinical judgements and decisions using verbal and written information, what they observe and their prior knowledge (Corcoran-Perry & Graces 1990, Lamond et al 1996, McCaughan et al 2005). To meet this challenge, case scenarios were devised that could be presented in an audio visual format as well as drawing on paper-based information. The DVD that accompanies this thesis contains the audiovisual scenarios as viewed by participants. The scenario for each case, as per the DVD menu, is indicated in the outlines given in Section 3.6.4.1 below. Case design for the main study was informed by the pilot study as well as by expert panel review. The following sections give an

overview of both in terms of implications for case design and presentation for the main study data collection.

3.6.4.1 Expert Panel Reviews

All cases were reviewed by expert panels of psychiatric nurses, both academics and nurse working in clinical practice. Panel members' clinical backgrounds are given in Appendix Xa. The community-based cases were reviewed by nurses with a community mental health background, whilst nurses with a background in inpatient mental health settings reviewed the inpatient cases.

The panels were given the draft case documentation and film clips in advance of panel review meetings which lasted roughly an hour. At these meetings panel members gave their individual and collaborative evaluations of the cases in terms of the following criteria which I had given them along with the case documentation and film clips:

- The clinical plausibility of the particular case situation
- The degree to which the case materials provided relevant and plausible information
- The relevance of the task around which the case was focused
- The degree of complexity, uncertainty and ambiguity in the case presentations

Case One (Karen) focuses on a woman in her thirties, resident in a psychiatric rehabilitation hostel with a diagnosis of paranoid schizophrenia. In the presented scenario (Scenario 1) she is experiencing distress due to difficulties in her relationship with her sister. In this context she expresses verbal aggression towards a student nurse who has been despatched to encourage Karen to tidy her room.

With regard to this case, the community-based expert panel felt that the cases' focus on family involvement was representative of the type of situations that pose challenges for psychiatric nurses working with hostel residents. One panel member noted that, "It seems like a straightforward case, but there is a lot of complexity to it". The panel agreed that the complexity of the case was such that there were a number of legitimate ways in which participants could respond to the scenario.

Unlike Case Four (Patricia) the panel felt that the description of Karen's schizophrenia was fairly typical and would not constitute a challenge to participants given that most people resident in hostels carry that diagnosis. The challenge instead lay in participants lack personal prior knowledge of Karen in the context of her hostile presentation. In clinical

practice hostel-based nurses would be quite familiar with residents, so this lack of knowledge would add to the difficulty of the case.

However, the information provided on Karen's relationship with her sister, they felt, provided sufficient background for participants to make a relatively well-informed, if difficult decision. The panel felt that eight years was a long time for Karen to have lived in a 'rehabilitation' hotel, but when it was pointed out that the case was derived from an actual clinical case, they conceded that it is often the case that people can end up living in 'rehabilitation' hostels for up to a decade or even longer.

Case Two (Noel) involves a man in his twenties who has been admitted to an acute inpatient psychiatric unit having spent several nights sleeping rough after being evicted by his partner. The presenting scenario (Scenario 2) presents him as anxious, low in mood and exhibiting the signs and symptoms of an undiagnosed serious respiratory tract infection. Other significant features of the case include the fact that he has only recently been discharged from the unit and has a history of selling his prescribed medication to others.

The inpatient psychiatric nursing expert panel felt that although Noel was not so psychologically unwell as to merit admission to an acute inpatient unit, even given his poor physical condition and his "chaotic" social situation. They felt that some indication of suicidal ideation or death wish would be required to warrant his admission as part of a wider crisis intervention, and this feature was added to the case presentation. Although Noel's social situation was identified as the main source of his problems, the panel felt that his deteriorating physical health was the element that was of greater urgency and that the mix of the two would make the case sufficiently challenging for participants. The panel also felt that more detail could be given regarding Noel's family background and social situation, and this was provided in the revised case history.

Case Three (John) features a man in his forties who has been experiencing difficulty in coping with the death of his wife from cancer. His subsequent dependence on alcohol has led to serious financial and social difficulties, including the loss of his job and driving licence. His admission to the acute inpatient psychiatric unit was precipitated by intentional self-poisoning and the presenting scenarios (Scenarios 3a, 3b & 3c) involve the participant in ascertaining John's readiness for a weekend pass out of the unit. Participants were advised that the scenarios occur consecutively in the morning (3a), afternoon (3b) and evening (3c) of the same day.

The inpatient expert panel felt that the video clips successfully gave the impression that John's mood and general mental state did not improve throughout the day. They also were of the opinion that the case details were sufficiently complex to give participants plenty of information to interpret and base a decision on. They felt that the case presented a challenge in terms of participants' lack of personal knowledge of John, and the cases plausible mix of positive (e.g., John's good level of social support) and negative (e.g., his expression of hopelessness) features.

The panel felt that the video clip presented cues that, in the absence of further information and a chance to engage with John, could legitimately be interpreted in a variety of ways. For example John's exclamation that he is "not fucking alright", could be seen in terms of over-reaction, frustration or hostility. They also felt that this cue might overshadow other cues in the case presentation and that participants might anchor their judgements on it.

Case Four (Patricia) is the only case where the person involved is not seen in the accompanying video clip. This was based on the findings of another study in this programme of research that demonstrated that RPNs spend a great deal of time making judgements and decisions regarding the management and organisation of care in situations that do not involve interaction on a one-to-one basis with individuals and their significant others (Scott et al 2006). The review meeting of the multidisciplinary team that is presented in this case scenario (Scenario 4), where Patricia's non-attendance at the clinic is discussed is typical of this kind of work.

Although the panel of community-based nurses saw the "personality disorder" descriptor for Patricia as a "hot label", they felt that nurses were unlikely to make their judgements based on this diagnostic label but on a more holistic assessment of the case. The panel also agreed that the case notes were worded in a manner that reflected the reality of psychiatric nursing documentation in clinical practice. They were of the opinion that the case presented a challenge in that it presented a scenario whereby the ongoing strategy taken by the team towards the case management was patently not working and a new direction was needed.

It was felt that the case's referral from the multidisciplinary team presented a greater challenge than the alternative of referral from a GP. This was because GP referrals are relatively straightforward in comparison to multidisciplinary team referrals. This is because both Irish mental health community services and community mental health nurses' work structures are complex and provide plenty of scope for system-based error.

The panel felt that missing data, and Patricia's atypical presentation – most notably in the early morning wakening cue (usually associated with depression and not personality disorder) would make the case sufficiently complex and challenging for participants. They commented that because the case did not “fit with a script” that it should force participants to engage with it in a critical manner.

Overall, the expert panels felt that the cases did contain the full range of information needed to fully inform the clinical judgements and decisions that would be sought from participants. However, it was explained that this was an integral part of the purposeful design of the cases, in order to introduce a tangible degree of objective uncertainty. It was felt that the cases would pose participants with a challenge and, given the specific changes to be made, were at the same time realistic.

Both panels also felt that the presentation of the cases was ecologically valid and that the scenarios were plausible. The common features identified by the panels that made all of the cases sufficiently challenging and complex were; the lack of prior personal knowledge of the individuals involved, missing data that nurses might expect to find in case presentations, and the presence of atypical features. These had all been deliberately included in the case design for the purpose of ensuring a sufficient degree of complexity.

3.6.4.2 Implications of Pilot Study for Case Design & Presentation

In the pilot study it was noted that participants were somewhat vague in expressing their judgement on the case and that some clarity had to be sought from participants about aspects of the judgment that they had made. Also, some participants gave details of judgments that were outside the scope of the scenario and task that they were given. For this reason it was decided to improve the clarity of case presentation in the main study, primarily by giving the request to participants for specific judgements and decisions in relation to each case in written as well as verbal form.

Clarity with regard to the case documentation given to participants was also an issue in the pilot study. Whilst missing data and ambiguity was a deliberate element of case design at all levels of this study, in the pilot study there was ambiguity around case details that was not planned. Therefore it was decided to increase the clarity of information provided and to specifically ask the expert panels, as detailed in the previous section, for feedback in relation to this element of the case design and presentation.

The film clip for the pilot study data collection presented a case that unfolded over time, with gaps of several hours between one scenario and the next. However, in the film clip,

these scenes followed each other in direct succession and the sense of passing time was not explicitly discerned by all participants. It was decided, therefore, that the film clip for Case Three (John) in the main study data collection would be broken up into three distinct scenarios and participants verbally notified as to how much time had elapsed between scenarios.

3.6.5 Data collection

Data were collected using digital audio recording devices from participants in a suitable setting in their work place as part of their working day. Participants worked through all four simulated cases and associated retrospective interviews in a single sitting where possible. The order of presentation of cases to participants was randomised.

For the think aloud data collection, participants were allowed two viewings of the video clip, with data collection occurring during the second viewing. This was due to the finding of the pilot study that verbal expression during the initial viewing distracted participants from paying attention to the cues presented in the video clips. Recording of this verbal data continued to include the participants' perusal of the case documentation immediately following their second viewing of the video clip.

As in the pilot study, continuous prompting of participants to 'think aloud' was often needed. Data recording was ended after the participant had made their full case formulation in response to the researcher prompts and/or clarifications and it was checked that they had said all that they had wanted to say in relation to the case. Due to the work-based collection of data, however, there were some interruptions.

Where necessary and/or requested, the researcher gave correction or clarification regarding participants' reading of the case documentation. Apart from this there was no communication with participants during think aloud data collection and the researcher sat outside of their field of vision. Although it was not the result of a deliberate exclusion policy in the sample selection, all participants had English as their first language.

As with the pilot study, participants had no major difficulties in recalling and relating experiences of cases in the retrospective interviews. The JDM PiP interview schedule (MacNeela et al 2005 – See Appendix A) proved useful in this regard. It was of particular use in facilitating the discussion of the potential for error in practice, which was not a naturally occurring feature of participant discourse.

Overall, as with the pilot study, participants yielded data in both the think aloud and retrospective interview data collection that proved amenable to analysis. This analysis is described in depth in the following two chapters. In these chapters I demonstrate the extent to which the data could be analysed in order to meet the study aim of enabling insight into the cognitive and social aspects of participant judgement and decision-making.

3.6.6 Data analysis

The conceptual and philosophical basis of data analysis in this study does not view language as being able to offer a completely clear view on cognition (Schegloff 1989). Notwithstanding this, verbal data offer the *clearest* view achievable in the context of this exploratory descriptive study (Koopowitz et al 2003). Achieving the clearest insights from verbal data requires analysis that acknowledges the social context of the cognitive processes involved, as well as the methods of data collection and the analysis itself (Hammersley & Atkinson 1995).

This results in an approach to data analysis which, though sceptical regarding what we truly can know about human judgement and decision-making, strives to uncover all that can be uncovered by contextually appropriate use of the most incisive methods available. What verbal data does enable the researcher to look at most clearly in the context of this study is human judgement and decision-making as a process that, although essentially cognitive, is most clearly visible in interpersonal interaction (Potter 1996, Edwards 1997). This is not to deny the ability to detect any underlying cognitive process, but only to posit that language offers at best a limited view (Edwards & Potter 1992a) into these processes as things-in-themselves (Van Cleve 1999).

The choice of research methods for this study has been determined by the exploratory and descriptive nature of the study (Newton et al 2007) and the complexity of its topic. Exploratory study of a complex topic requires an approach that looks broadly at the content of the data in an effort to focus on the features that are significant in terms of answering the research question (Gleeson & Higgins 2009). To this end I have looked towards corpus linguistics and in particular towards comparative keyword analysis.

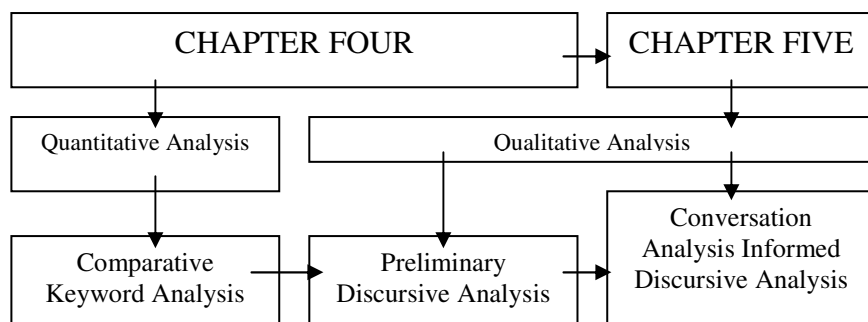
Having identified the features that characterise the study data using comparative keyword analysis, there is a need to analyse their meaning in relation to the research topic and the social context of the data. In my discussion of the value of verbal data, I have drawn to a large extent on the work of Derek Edwards and Jonathan Potter (Potter & Edwards 1990,

Edwards & Potter 1992a, 1992b, Potter 1996, Edwards 1997). I have chosen their discursive psychology approach to discourse analysis as the most applicable of the many available options (Wetherell et al 2001).

In order to minimise the influence of my own preconceptions, I have used the principles of conversation analysis to add to the robustness of my analysis of the data, in what Wooffitt (2005) refers to as a conversation analysis-informed approach. This considerably boosts the rigour of the evidence derived from the data (Seale & Silverman 1997), as a main principle of the conversation analytic approach is that the interpretation of data must draw on the data itself as opposed to solely on the researcher’s insights (Sacks et al 1974, Hutchby & Wooffitt 1998). This involves scrutinising the data in great detail, taking into account the data in their entirety, including para-verbal features and silences (ten Have 1999). I see my identity as ‘the researcher’ as pivotal to giving an account of this study (Taylor 2001), and have therefore approached the description of this study in a reflexive manner throughout.

The schematic diagram in Figure 3.1 overleaf illustrates the process of analysis which is described in overview in the ensuing sections, as well as indicating the chapters of this thesis in which they are discussed in detail.

Figure 3.1 The process of analysis



3.6.6.1 Comparative Keyword Analysis

In nursing research, initial analysis of qualitative data often involves some form of inductive thematic analysis that relies on the researcher’s insights following several careful readings of the data (Polit & Beck 2004). In order to limit the impact of my own subjective interpretation of the data, I have used a novel quantitative data analysis method known as comparative keyword analysis for initial analysis of the data (Seale 2006). This method has been designed to contribute to qualitative data analysis, including discourse analytic approaches.

Comparative keyword analysis involves the use of computer software (such as 'Wordsmith Tools') to run a quantitative analysis of a text or groups of texts in order to identify key words and combinations of words that characterise the text(s) (Seale 2006). This yields a quantitative analysis of the relative frequencies of key words and phrases in the data on which to base qualitative analysis. This is preferable to the researcher relying wholly on his/her intuitive reading the texts to uncover themes, which could result in the researcher reading themes 'into' the text(s) or failing to uncover significant themes in the text(s) (Alonso et al 2002).

Comparative keyword analysis does, however, allow for researcher interpretation of results. This is because the intention is not to entirely rid analysis of the researcher's interpretation of the text(s), but to make a clearer and more transparent account possible, reducing the less desirable subjective elements of such interpretation. It is the stated aim of comparative keyword analysis to enable researchers to lend greater objectivity and rigour to qualitative data analysis (Seale 2006).

Seale (2006) suggests that researchers using conversation analysis use comparative keyword analysis to identify portions of texts that best warrant the full and detailed application of the conversation analysis method. Seale (2006) also recommends the use of a reference corpus against which to compare individual texts or groups of texts. In researching interaction on breast cancer message boards, Seale (2006) and Seale et al (2006) used this comparative approach to discover that women's contributions had significantly more reference to self and relationship than those of men.

This was concluded based on analysis of personal pronoun use as well as of words indicative of relationship. Seale (2006) points out that it is vital that the researcher does not rely wholly on the frequency analysis in this regard, and the contextual occurrence of words and phrases must be checked before confirming their function. For the comparative keyword analysis, I used the 'Wordsmith Tools' software programme recommended by Seale (2006).

I then applied coding to the data. Comparative keyword analysis differs from most qualitative data analysis methods in that coding refers to specific word/phrase groupings rather than portions of the text. Here my subjective discernment was required, and I explicitly account for this in my discussion of the data. An example of such discernment is where Seale (2006) omitted references to support stockings from coding intended to

indicate interpersonal support. This discernment is based on the analysis of keywords-in-context and collocation (Seale et al 2006).

The analysis keywords-in-context involves the use of the concordance function of the software being employed to display a listing of all sentences in which keywords occur. Collocation refers to the occurrence of a word as part of a phrase, and it is this to which the analysis of keywords-in-context looks to confirm the function and meaning of key words and phrases. Once identified, these portions of the text can be further explored using a conversation analysis informed discursive analysis in order to better gauge the social and cognitive work that is being done at these points in the interactive process.

3.6.6.2 Discursive Analysis

Like Gilbert & Mulkey (1984), Edwards & Potter (1992a) contend that where research aims to shed light on cognitive processes, successful analysis of data needs to take account of social and discursive elements. This involves approaching the data from a combined cognitive psychology / discourse analysis perspective in order to extract greater veracity from the data than simply approaching it with the assumption of face veridicality that has been characteristic of many cognitive studies (Edwards & Potter 1992a). Discourse analysis recognises that a participant, in relating information to a researcher, is not merely providing data (Shotter 1989).

Instead they are engaged cognitively and socially in a dynamic (with the researcher) discursive reconstruction of events (Edwards & Potter 1992b). Accounting for this co-authoring (Ochs & Capps 1996) of participants' narratives adds rigour to the analysis (Nunkoosing 2005, Fratilis & Sionis 2006). Within social (and in particular discursive) psychology, discursive analysis has been developed by Potter & Wetherell (1987) (influenced by the work of Sacks, Schegloff, and especially by Gilbert & Mulkey 1984) as a critical approach to qualitative data analysis.

This form of analysis, although often referred to as discourse analysis, is distinct from the Foucauldian forms of discourse analysis (Stevenson 2004, Buus 2005) developed in sociology (Wooffit 2005). For the purpose of clarity I will use the term 'discursive analysis' (Seymour-Smith et al 2002) to distinguish the method that I have used from the more widely applied forms of discourse analysis with their roots in the sociological research tradition. With a firm basis in ethnomethodology and social constructionist thinking (Edwards & Middleton 1986), discursive analysis looks at conversational interaction mainly in terms of its functions.

Discursive analysis brings a social perspective to phenomena that are usually viewed from a purely cognitive perspective (Edwards & Middleton 1986). It achieves this through examining the discursive practices by which they are represented. In doing so, it often comes up against and is informed by important socially-situated influences and issues that are overlooked when a mainly cognitive approach is taken (Potter & Wetherell 1987).

This does carry certain implications and assumptions. As has been discussed throughout this chapter so far, the conceptualisation of language that has generally informed research into cognition could be seen as somewhat naïve, insofar as the speech of participants is thought to reliably represent their cognitive processes (Potter & Edwards 1990). Therefore, in order to avoid decontextualisation of speech, the researcher employing discursive analysis is reluctant to view verbal data as offering a plain and unprejudiced view of reality. This reluctance has led me to use discursive analysis to consider the broader perspective of the data under analysis - viewing them not just as language, but as conversation. This approach is used to study how language is used to act socially, e.g. in forming consensus (Potter & Edwards 1990). This means that phenomena often considered solely from a cognitive perspective (e.g. attribution) are approached primarily in the context of social action.

This broader perspective is possible partly because discursive analysis can draw on the analytic techniques used by conversation analysts to study the functions of conversation (Seymour-Smith 2002, Wooffitt 2005). These techniques involve a focus on how utterances are shaped, particularly in terms of how they can be seen to follow on from previous utterances and serve as precursors to ensuing utterances. Although discursive analysis is concerned mainly with the function of conversation in a broader sense, this interest is well served by analysis that builds its case from the bottom-up. This is in contrast to the top-down approach of Foucauldian approaches to the discourse analysis that take societal issues such as power and inequity as their starting point (Wooffitt 2005).

3.6.6.3 Conversation Analysis

Discursive analysis tends to draw on the principles and techniques of conversation analysis developed from the background of Garfinkel's (1967) work with ethnomethodology (Wooffitt 2005). Although conversation analysis was originally devised to study everyday talk, it can be applied to more formal interactive processes such as interviews (Drew & Heritage 1992). Given the conversational nature of the data in this study, I intend to conduct a discursive analysis that is explicitly informed by the principles and techniques of

conversation analysis. The purpose of adopting this approach is to make use of a conversation analytic approach to enable closer examination of the finer details of human interaction than discursive analysis alone would permit.

Although relatively popular in social psychology and sociological research, conversation analysis has not been used a great deal to look at judgement and decision-making in nursing research (England 2005, Shakespeare & Clare 2005) or in health and social care research generally (Shaban 2005b). Conversation analysis focuses on the unfolding of the sequence of conversational interaction (Heritage 1984, Schegloff 1987). It shares common roots with discursive analysis in the work of Sacks et al (1974).

Unlike other forms of qualitative analysis, the primary focus of conversation analysis is on the conversation as represented in its audio recording (Hutchby & Wooffitt 1998, Wooffitt 2005). Transcripts are secondary aids to analysis, and are mainly used to illustrate the phenomena under analysis in detail (ten Have 1999). To this end conversation analysis has its own set of transcription notation devices (Jefferson 2004 - see Appendix E).

As already noted, it is a key principle of conversation analysis to reduce - insofar as possible - the role of the researcher's intuition in data analysis (Wooffitt 2005). This is made possible by the in-depth nature of the transcription notation, which permits as valid a textual representation of the detailed examination of actual conversations as can be achieved for illustrative purposes (Hutchby & Wooffitt 1998). These serve as a background against which to check claims made by the researcher.

The overall focus of conversation analysis is on the sequential nature of conversation (Heritage 1984, Jefferson 1986, ten Have 1999). By examining phenomena such as turn-taking, silences, interjections and paired-action sequences (e.g., I: "Hi, how are you?" R: "Fine thanks."), conversation analysis aims to uncover the function of the talk under analysis (Drew & Heritage 1992). This complements discursive analysis insofar as it reduces the potential for the researcher to mistakenly make intuitive assumptions based on reference solely to standard textual transcripts. Conversation analysis constantly diverts the researcher from forming grander ideas about themes represented in the transcripts without considering the actual conversations they represent and the complex minutiae of interaction of which they are comprised. This goes as far as any method of which I am aware to ensure that observations made by a researcher are grounded firmly in the conversational data as it was recorded.

3.6.6.4 Reflexivity

Reflexivity goes some way towards addressing the challenges posed by researcher bias (Porter 2000). This involves the researcher acknowledging any personal stake holding, subjective opinions and/or values with regard to the research and its subject matter (Taylor 2001). It also involves the researcher's recognition of his/her personal influence on how data is collected and analysed (Nunkoosing 2005) particularly his/her awareness of the influence of affective reactions to the data, participants or other aspects of the study (Power 2004).

Approaches such as conversation analysis and discursive analysis facilitate reflexive perspectives on analysis. This enables clear insight into the scientific process of investigation itself as an activity of the researcher, which adds further to the validity and rigour of the analysis (Gilbert & Mulkay 1984, Edwards & Potter 1992b). Therefore, I see an important role for meta-analytic reflexivity (Horton-Salway 2001) in bolstering the rigour of this study's findings.

I believe that reflexivity is also an important component of the study with regard to my interpretation of the data in light of my familiarity, as a registered psychiatric nurse, with much of the broad interpretative repertoire of the participants. This is important as I exercised considerable power over the data analysis, in particular how my interaction with participants is represented in this thesis (Glesne & Peshkin 1992). My own approach to reflexivity has been influenced by that of Abma (2001, p265), who sees the need to acknowledge the researcher's stance of having an "open (not empty) mind".

I have facilitated this process primarily by writing in the first person (Porter 2000) throughout this thesis. In the introductory chapter I set out my own personal interest and links to the research topic. Where it is apparent that my gender, profession or other personal factors have influenced data collection I have acknowledged this also.

However, in doing this I realise that personal factors, including gender, can influence participants in such a wide variety of ways (Taylor 2001) as to make accounting for such influences a task that would warrant a study of this scope in its own right. Nonetheless, I have taken account of these factors as they are apparent and have written reflexively about data analysis, evidence and findings with the aim of enhancing their trustworthiness and credibility (Hall & Callery 2001).

3.6.7 Rigour

The criteria used to evaluate the rigour of qualitative research methodologies are diverse and depend on the philosophical underpinning of the study (Liamputtong Rice & Ezzy 1999). For this reason, there is no universal consensus on how best to ensure validity and reliability in qualitative research (Carter & Porter 2000). Some qualitative researchers argue that concepts such as reliability and validity do not belong nor apply to their approach to research (Power 2004, Tobin & Begley 2004).

Qualitative research is often seen as lacking standardisation and being over reliant on the insights/abilities of the researcher (Carr 1994). However, both of these arguments make the mistake of confusing underpinning philosophy with method (Bryman 2002). Also, there is a danger that in pursuit of philosophical and methodological purism, the researcher can overlook opportunities to promote rigour in a philosophically and methodologically pluralist way (Whittlemore et al 2001).

In a discipline-specific study such as this one, certain concepts might not be fully appreciated or understood due to a lack of what Baynham (2000, p18) describes as a “discipline-internal awareness of what counts as knowledge and what counts as an authoritative disciplinary position” especially, “the awareness of internal diversity and conflict, as realized in the politics of the discipline”. I share the same professional qualification and general clinical experience as the participants in my study, and throughout these chapters I refer reflexively to the insights that resulted from this. However, I do recognise the potential for blurring between bias and “discipline-internal awareness”.

This situation is similar to that described by Carr (1994), whereby the qualitative researcher’s immersion in the context of the data is seen as increasing the potential for data analysis that is representative of the community and phenomena being studied. However, this immersion in context can threaten validity if it prevents the researchers from interpreting data in a meaningful way (Sandelowski 1986, Hilton 1987). This is where strategies to address bias in data interpretation and analysis can be helpful, insofar as they offer an approach to data analysis that clearly demonstrates the basis of the inferences made, and enable the study to be repeated by other researchers.

I contend that the triangulation of methods in this study offers two strategies to minimise bias in this situation. In the first instance there is the clarity lent by the principle of conversation analysis to interpret the data from its own standpoint as opposed to relying on

the subjective insights of the researcher. Secondly, the main themes of interest are identified quantitatively using comparative keyword analysis, again depending on my subjective interpretation only to the degree that it would be required in the interpretation of any quantitative form of analysis. I believe that these strategies go as far as practicable in a study of this size to ensure the minimisation of bias, without at the same time unnecessarily limiting my own contribution from my standpoint as a registered psychiatric nurse.

With regard to my use of the quantitative approach of comparative keyword analysis, I acknowledge that some commentators would regard its positivist approach to rigour as not being compatible with the qualitative approaches I use, insofar as its rigid application of criteria to establish reliability and validity could thwart the creative essence of the qualitative components of the study (Sandelowski 1993). The statistical generalisability sought by such an approach is quite different, for example, from the conceptual or theoretical generalisability that is sought in approaches such as discourse analysis (Mason 1996). Notwithstanding this, I do recognise that qualitative research must be credible and trustworthy (DePoy & Gitlin 1998). Its reliance on the somewhat opaque issues of the researcher's analytic ability and pre-understanding of the data can be seen as an obstacle to this (Gilbert & Mulkay 1984). It is for the sake of completeness, therefore, as well as of rigour that I have combined these approaches in this study.

There are many approaches to generalisation in studies where mixed methods are used, and unlike quantitative studies the aim is not to generalise for the population represented by the sample. Descriptive research seeks to describe patterns evident in the data, from which the reader-practitioner then makes their own generalisations to their own context (Wolcott 1994, Larsson 2009). This differs from other qualitative research approaches to generalisation, such as maximising variation and generalisation based on similarity of context.

Another threat to validity and reliability in this study, and indeed any study employing retrospective interviewing, is that of hindsight bias (Guba & Lincoln 1981, Farnan et al 2008). This is addressed to some degree by the fact that the retrospective interviews are adjuncts to *in-vivo* data collection, so that the study is not wholly reliant on data that is subject to hindsight bias for information regarding participants' normative practices. Also, participants were asked to recall the most recent incident of the type being used in the study in order to further limit the likelihood of hindsight bias (Jones 1995).

However, hindsight bias will always remain a limitation to some degree where retrospective interviewing is concerned, and the onus is on the researcher to be aware of this when it comes to data collection and analysis. The critical incident technique is preferable to other methods of retrospective interviewing when it comes to limiting hindsight bias. This is because of the structured and focused way in which it takes participants through the recall of incidents (Kemppainen 2000), particularly with the aide of a tool such as the JDM PiP (MacNeela et al 2005). Nevertheless, the limitation that some degree of hindsight bias does remain with this technique must be accepted (Norman et al 1992, Keatinge 2002).

Chapter Four

Findings of Comparative Keyword Analysis

4.1 Introduction

In this Chapter I set out the findings of the comparative keyword analysis of the study corpus. This method of analysis involved the identification of keywords in the study corpus using the WordSmith software programme. These keywords were identified as characterising the study corpus by measuring their frequency within it and comparing it with their frequency in a similar corpus (Seale & Charteris-Black 2010).

Preliminary discursive analysis was applied to the keywords generated by this quantitative analysis with the purpose of determining the functions served by these words in participants' narration of their clinical judgement and decision-making. Further exploration of these functions was carried out through the conversation analysis-informed discursive analysis of the data. This is discussed in Chapter Five.

In this study, linguistic analysis was a means to an end, and not an end in itself. This is reflected in the focus on linguistic features primarily for what they indicate about participants' discursive representation of their judgement and decision-making. To this end discussion of the functions of the keywords is focused in terms of how they served participants' representation of their clinical judgement and decision-making.

The purpose of comparative keyword analysis in this study was to discover, using rigorous quantitative measurement, features that could be said to characterise the study corpus (Seale & Charteris-Black 2010). This was achieved by comparing word frequencies in the corpus to those in the "task oriented" or "context governed" element of the British National Corpus (BNC). The BNC is a vast corpus of data that is representative of everyday speech in English across the British Isles. The narratives in the study corpus are most similar to the narrative types represented in the BNC task oriented subcorpus.

Therefore, the words that occur most frequently in the study corpus cannot be said to uniquely characteristic of the study data if they occur with similar frequency in the BNC task oriented subcorpus. Words that occur frequently across both corpora are simply characteristic of task oriented speech. However, those words that occur frequently in the

study corpus and not in the BNC task oriented subcorpus can be said to be uniquely characteristic of the study corpus.

The strength of this approach is that none of the keywords that are shown to characterise the study corpus were chosen by me in the first instance. They were chosen solely based on their identification by the process of statistical comparison of the corpora. Their consideration here is based first and foremost on the scientific fact that they are used significantly more frequently in the study corpus than in a 6,153,571 word collection of similar corpora.

My choice entered into the process only to filter out words such as “decision”, the more frequent occurrence of which was due to its use mainly by the interviewer. My interest is in those words whose frequency cannot be accounted for by the genre of the corpus. The preliminary discursive analysis described in this chapter represents my initial attempt at explaining their frequency.

Rigorous application of comparative keyword analysis, or any quantitative comparison of two corpora, requires comparison of like-with-like and testing for statistical significance (Rayson et al 2004). In comparing like-with-like, rigour relies on the qualitative and quantitative similarity of the corpora being compared. The rigour of claims of statistical significance, as in all research approaches, hinges on the suitability of the tests used and their proper application.

4.2 Comparing Corpora

The most similar corpus to the study corpus is the ‘context-governed’ or ‘task oriented’ speech subcorpus of the BNC. The two are similar in terms of temporality and socio-cultural background (Leech et al 2001). The task oriented subcorpus of the BNC comprises narratives such as interviews and medical consultations (Burnard 2007).

Given similarity of content, the next issue to be dealt with in comparing the two corpora was their difference in size. The BNC context governed subcorpus stands at 6,153,571 words (Burnard 2007) whilst the corpus produced in this study totals 515,630 words. Comparing smaller study corpora with larger standard corpora is common practice in corpus linguistics (Rayson et al 2004). The size difference is accounted for by tests of statistical significance applied in the comparison of word frequencies across the two corpora.

The purpose served by a large standard corpus is to act as a normative standard against which to compare the smaller study corpus (Rayson et al 2004). This ensures that general attributes of (in this case task-oriented) speech are not wrongly identified as being characteristic of the study corpus. As a result, keywords can validly be said to be characteristic of the study data.

A statistical test is needed to test the null hypothesis that the two corpora are no different in terms of word frequency (Rayson et al 2004). The chi-squared statistic is used commonly to this end (Woods et al 1986). However, the fact that the chi-squared statistic assumes normal distribution is problematic given the relatively small size of the study corpus in comparison to the standard corpus.

Therefore, I have used log-likelihood ratio as an alternative test (Dunning 1993). The log-likelihood ratio test is suited to multinomial and binomial distributions, which makes it more suited to comparisons involving a relatively small study corpus. The differences in size between the corpora also led me to set the p-value for the test at $p < 0.0001$. For this value, the critical value of the log likelihood (LL) test is 15.13. All of the results outlined in Appendix F are well within this range.

As with all statistical tests, it is vital that results are not viewed in terms of statistical significance alone (Sterne & Davey-Smith 2001). Therefore, I have also interpreted the results in terms of practical significance. For example, given the context of the study corpus it is hardly surprising that the term “decision” has a high critical value.

However, in this chapter I do not discuss the discursive function of the word “decision”. This is because its frequency in the study corpus was almost exclusively due to its use by the interviewer. Therefore, it cannot be said to characterise the data in terms of its function as part of participant discourse.

Nevertheless, “decision” was the keyword that had the most obvious semantic link to clinical judgement and decision-making. Its critical value therefore served as a benchmark in that words with higher critical values than “decision” can be seen to be especially characteristic of the data. However, I have taken care not to uncritically dismiss words with lower critical values than “decision”.

4.3 Findings of Comparative Keyword Analysis & Preliminary Discursive Analysis

Although comparative keyword analysis indicates which words and phrases characterise a corpus, as with any set of results from quantitative or statistical analysis, it falls to the researcher to interpret them. Indeed, comparative keyword analysis must take into account the genre of the corpus and the purpose of analysis (Seale & Charteris-Black 2010). For this I have relied on my knowledge of the background and context of the study corpus.

As with the word “decision”, the keyword “hospital” was not considered in the preliminary discursive analysis. This was because its occurrence is due to the genre of the narratives, in particular their background in healthcare. Likewise the keywords “decision” and “can” are not considered, as they were used mainly by the interviewer and therefore cannot be said to characterise the narratives of study participants.

Personal pronouns, most notably “he” and “she”, have a statistically significant higher frequency in the dataset than in the context governed corpus of the BNC. Given that the dataset is wholly comprised of talk about individuals, this is to be expected. Therefore, personal pronouns are discussed here in relation to their collocation with other keywords.

In the sections that follow I consider each keyword in its own right without forcing any framework on the data. I discuss the use of the keywords by participants in terms of the discursive functions they can be seen to fulfil in talking about their judgement and decision-making. I refrain from drawing any overall conclusions until the end of the chapter, where I summarise and draw together what is apparent from participant use of the keywords.

4.3.1 Use of “looking”

The word “looking” is versatile, and is used in the study corpus in a variety of contexts to denote different activities. These range from literally looking at an object to abstract consideration of a case. Given that the data mainly comprise descriptive case histories, the frequent appearance of “looking” in collocation with the personal pronouns “he” and “she” is to be expected.

Whereas in the retrospective interviews “looking at” serves a wide range of purposes, in the think aloud data participants mainly use the phrase for self referential description of their *in-vivo* attendance the case. Sometimes the phrase “looking at” introduces a participant’s formulation of a case, whereas in other instances it denotes closer attention to a source of

information in their consideration of a think aloud case. These sources vary across the wide range of cues presented in the video clips and accompanying documentation.

In the retrospective interviews, participants' most notable use of "you're looking" is when talking about cues that they commonly use in assessing a particular type of case. The use of "you're" serves to generalise, denoting talk about a standard case type whereby "you" would generally look for "x". Where this occurs, the generalising function of "you" can also be seen in other phrases apart from "you're looking" (as demonstrated by the use of *italics* in the excerpt below).

- "Generally when people present with clinical depression, they have signs and symptoms like low mood, low self-esteem, sleep disturbance maybe loss of appetite, you know and *you're* observing all them things, you know *you're* just and ***you're looking*** at their whole activity of daily living, how they're coping."
Participant 38, Case 3, JDM PiP

The phrase "re looking" occurs mainly as part of "you're looking" or "we're looking". "You're looking" appears mainly in the retrospective interview data. The phrase "we're looking" is found mainly in participants' talk around case formulation in the think aloud data. Use of the first person plural serves the function of building implicit consensus between participant and researcher regarding the meaning of phenomena (Wales 1996):

- "And ***we're looking at*** intervention-wise *we're* looking at nurse in close observation area, fifteen minute checks, medicine as per chart and try and encourage Noel to maybe express himself and maybe kind talk a little bit more about his feelings and anxieties and at the same time provide some level of reassurance."
Participant 6, Case 2, Think Aloud

The excerpts considered above demonstrate how participant use of the word "looking" is characterised by its incorporation into phrases alongside "we're" and "you're". These show that the important discursive function served by "looking" relies on its combination with personal pronouns. This is further demonstrated in the subtle shift from "I would say" to "we're looking" and on to "we've heard" in the excerpt below.

This is an example of discursive building of consensus by incorporating the implicit assent of the researcher into the expression of a judgement by the use of the first person plural:

- "So the key to this lady here, 36 year old single woman, suffers from paranoid schizophrenia, she has an enduring chronic illness so quite obviously you know with an enduring chronic illness there are acute phases and plus they've residual negative symptoms, which can be characterised by this type but not usually with the anger, so what *I* would say here is ***we're looking*** at a relapse of this lady. *We've* heard that this behaviour is 2 days old."
Participant 9, Case 1, Think Aloud

The verb “to look” is highly versatile; its main function in the study corpus is to mark participant attentiveness to certain aspects of a case. Its collocation with personal pronouns to generalise matters gives insight into how participants deal with cases in terms of the typical. It is also used with subtlety by participants to seek and build consensus with the researcher.

4.3.2 Use of “felt”

The word “felt” occurs mainly in the retrospective interview data. Participants use the word both metacognitively and with reference to the thinking of others. In self reference this tends to be to express evaluative judgements:

- IR: “And why did you think that that was a good idea, to have her on the high observation?”
P36: “Because at the time I **felt** that she was a risk, that she had voiced suicidal thoughts.”
Participant 36, Case 2, JDM PiP Interview

In the example above, the participant uses the first person singular in direct response to a specific question from the interviewer about their own opinion and rationale. However, participants’ use of “felt” to express evaluative judgements is often in combination with the first person plural. As with the similar use of first person pronouns in conjunction with “looking”, the function here appears related to wider business of participant identification with the judgement of the team as their own, also evinced by the use of the word “us”:

- “Yeah I suppose really, he just seemed to be going through a grieving process really, which would be also you know, to *us* it would have suggested sort of a, a reactive type depression too. You know reactive depression to the situation he was in, so I suppose that’s where a lot of our assessment and judgement would have come from. And I suppose at the end of the week, **we felt** that, that hadn’t adequately been addressed, that hadn’t adequately been dealt with and he was still going back out into essentially the same situation, where *we* had no real focus, no clear plan for the man.”
Participant 17, Case 4 JDM PiP Interview

Overall, where participants use “felt” to talk about judgements it is with reference to judgements and decisions made by themselves and the wider work group. As with “looking”, personal pronoun use is instrumental in the discursive function of the keyword. In this case the combination serves to indicate ownership of judgement, which here can be seen to belong at once to the participant and their work group.

4.3.3 Use of “know”

In the study corpus the word “know” serves mainly as part of the discourse marker, “you know”. Participants also use it to mark uncertainty, mainly in the forms “don’t know” and “didn’t know”. Transcripts were checked for use of “dunno” - no occurrences were found. As well as functioning as “discourse glue” (Stede & Schmitz 2000, p129), “you know” serves to build consensus (mainly in the think aloud data) and check understanding (mainly in the retrospective data):

- “...so maybe an option for this patient might be, **you know**, a day centre or some other thing that she could go to daily so that, **you know** what I mean.”
Participant 33, Case 4, Think Aloud
- “There are other things obviously that I, **you know**, I mightn’t get to make decisions in but I suppose on that side of things, **you know**, we just, we’d go about our work and organise our groups and we can make them sort of decisions, with the way we want to do them groups or who might benefit from them. So we have, we’re able to make our decisions that way.”
Participant 5 Case 3 JDM PiP

4.3.4 Use of “maybe”

The word “maybe” is used self-referentially by participants, e.g., “I suppose maybe”, to denote uncertainty or express hesitancy. Often, “maybe” fulfils these functions in collocation with the discourse marker “you know” in the phrases “you know maybe” and “maybe you know”. Use of “maybe” with reference to others is mainly in the think aloud data, e.g., “maybe she’s”.

Specifically, “maybe” is used to express uncertainty about aspects of the case at hand. Where the phrases “you know maybe” and “maybe you know” are used as markers of hesitancy, this tends to be where there is implicit criticism of others. The use of these phrases to ‘soften’ criticism, making it less pointed and explicit (Seale & Charteris-Black 2010), occurs exclusively in the retrospective interview data. In these instances this function is shared with other markers of uncertainty such as “I think” and other phrases incorporating “maybe”, as *italicised* in the following excerpt,

- “Ahm, well my own opinion *would have been* that *maybe* that his family had enabled him, do **you know maybe** enabled him to, well obviously I’m presuming they sought help for him, but *maybe* Joe Bloggs didn’t want help, but in enabling him to live the way he was living, I think help was too late, *maybe*, in coming to Joe. Had he been allowed hit his rock bottom, you know, for instance had his, had his drinking been *maybe*, and this was his first time, *I believe*, to be hospitalised.”
Participant 35, Case 2, JDM PiP Interview

“You know maybe” and “maybe you know” are also used by participants as metacognitive markers of uncertainty apart from hesitancy. For the most part this occurs in the retrospective interview data:

- “Also I suppose I was concerned by his fanaticism, you know born again, making everything right and I felt in a way that the interview with me was almost confessional, he was telling me all about the dog and all of this but then when he was laughing I was thinking, **you know maybe** it wasn’t true at all.”
Participant 29, Case 2, JDM PiP Interview

The following excerpt demonstrates the versatility of “I suppose maybe” in marking uncertainty and hesitancy simultaneously:

- IR: “Ok yeah but would he show then, I guess like physiological symptoms?”
P5: “Of anxiety?”
IR: “Yeah”
P5: “No, again it was a very different case, I suppose when I think about it, I haven’t seen one like that before, not particularly, but **I suppose maybe** in his short answers and in his tone of voice and the quickness of his voice, maybe that was, showing his anxiety through that way and his, you know, not wanting to really be involved in anything there.”
Participant 5, Case 4, JDM PiP Interview

Use of the first person makes a supposition more personal than does use of the more general “maybe you know” or “you know maybe”. As with “maybe you know” and “you know maybe”, “I suppose maybe” is used to mark hesitancy where participants’ talk involves criticism of practice:

- “I couldn’t see it as being mistakes to be quite honest, because everybody, **I suppose maybe**, maybe it shouldn’t have been let go onto the Tuesday, I suppose you could say well you know why wasn’t, when she didn’t turn up Monday morning, how come somebody didn’t you know alert people at that stage. But I couldn’t see it as being, I couldn’t really say there was any mistakes made to be honest, I’m not just standing up for services now I’m just kind of thinking about the whole setup the whole scenario you know.”
Participant 32, Case 4, JDM PiP Interview

Participants use the phrase “maybe a little bit” to immediately preface terms that could be interpreted as negative or derogatory. This is what Heritage (1984) has noted in medical discourse as the language of diminution, the function of which is to soften a message that could have been perceived of as harsh or insensitive (Seale & Charteris-Black 2010):

- “Maybe a little bit unrealistic”
Participant 26, Case 1, JDM PiP Interview
- “maybe a little bit ambivalent about life”
Participant 32, Case 3, Think Aloud

- “maybe a little bit naive”
Participant 27, Case 4, JDM PiP Interview

The phrases “maybe he’s” and “maybe she’s” occur mainly in the think aloud data. They express uncertainty regarding an individual’s general condition or state of mind. The fact that “he’s” and “she’s” are in the present tense reflects the more frequent use of these phrases in the think aloud data, where participants were dealing with the case *in-vivo*:

- “**Maybe he’s** in bed to avoid all the activity on the unit such as other patients intruding on his space, so he maybe seeking solitude during the day and then it’s affecting his sleep pattern at night, but he does appear to be suffering from low mood, possibly a reactive type depression from his significant loss.”
Participant 10, Case 3, Think Aloud

In the case of the retrospective interview data, “maybe he’s” and “maybe she’s” are used with reference to events that are past, but a condition that is ongoing. For example, in the excerpt below the participant uses the present tense “maybe he’s” to suppose that the man is not comfortable with other people sitting around – indicating that this is the case as much at the time of speaking as it was at the time of the event being recalled. The man’s discomfort is not represented as a one-off feeling, but the way that he typically feels in such circumstances:

- “So you know this would have been a man that would have lived all alone all his life and you know **maybe he’s** not comfortable with other people sitting around watching him eating and because he has this awful tremor now as well, you know”
Participant 33, Case 1, JDM PiP Interview

Overall, the use of “maybe” in several key phrases is to express uncertainty. This function is similar to that of other words such as “think” and “know”. As with other expressions of uncertainty in the study corpus, “maybe” is often used in retrospective interview narratives as a way of marking hesitancy on the part of a participant to make comments that might be viewed negatively.

The evidence of the use of “maybe”, as with other words that I will discuss, clearly demonstrates the distinction between hesitancy and expression of subjective uncertainty in the study corpus. In expressing subjective uncertainty, a participant communicates that they are not sure of a point. This differs discursively from their hesitance in saying something. Expression of uncertainty, e.g., not being sure of someone’s condition, has a more direct relation to participants’ clinical judgement and decision-making than has hesitancy. Nevertheless, hesitancy provides valuable insight in terms of the values and norms underpinning participant discourse – that is, what it is appropriate to say or not to say. It

also speaks somewhat to the rigour of the data, insofar as it demonstrates that participants do not always appear comfortable with the revelatory nature of their narratives.

4.3.5 Use of “suppose”

All occurrences of “suppose” in the data are as part of the phrase “I suppose”. It acts mainly as a marker of hesitancy or uncertainty, sometimes at the opening of a case formulation. Here the function of “suppose” is to limit the discursive ‘owning’ of the formulation. Although participants give detailed case summaries, these are often qualified with this type of discursive face-saving.

The following excerpt shows how ‘supposing’ acts in a self-protective manner - working alongside similar words and phrases (*italicised*) to disown claims to authoritative truth. The deletion test (Stede & Schmitz 2000) used to identify discourse markers could be applied here. Deletion of the italicised words would still result in a narrative that makes sense, albeit with a more authoritative tone:

- “***I suppose*** non-compliance, *I mean* the person *probably* went home and didn’t take their medication, weren’t being supervised taking their medication whereas in the day hospital they can be supervised taking their medication. *I mean* the patient was paranoid about their husband, thought he was trying to poison them and yet she was discharged back to the situation and the scenario, the social stresses.”
Participant 1, Case 1, JDM PiP Interview

The “and I suppose” construct often indicates a narrowing of focus, or development along a more specific path in the case formulation. In the following excerpt, the narrative about delusions is narrowed to imply that they are paranoid in nature. Note the *italicised* diminutive qualifiers:

- “Well yes, *I suppose* she, she had real delusions, she was *probably* depressed but she had real delusions. **And *I suppose*** quite paranoid and all that as well.”
Participant 7, Case 2, JDM PiP Interview

In the example below, the idea of physical illness is developed in terms of its implications for the service-user’s mental state along with a rationale for this. Here there is less expression of uncertainty resulting in a more confident tone, as evident in the lack of diminutive qualifiers:

- “And he was physically ill as well, **and *I suppose*** when he was physically ill, that would have been altering his mental state as well, because it was things like lack of oxygen, so he was confused and stuff like that.”
Participant 5, Case 1 JDM PiP Interview

In the next excerpt, the participant is talking about how the service-user presented - “tearful”, “seemed also quite normal”, not seeming to be “feeling the effects of loss” as well as giving background information in terms of his broken marriage and subsequent relationship with his wife and children. The “and I suppose” phrase adds the factor of the man’s anger to the case, which leads directly to a narrowing the overall formulation down to assessment of risk of self-harm. Deletable markers of uncertainty are *italicised*. Note also the single marker of certainty (underlined) – the role of this word in the study corpus is discussed in section 4.3.9. The presence of markers of both certainty and uncertainty are an example of confidence about one aspect of a case amid more general uncertainty.

- “*I’m actually kind of stuck for words now he, I suppose* the tearfulness, he you know, it seemed also quite normal in a way but you know he did seem to be feeling the effects of loss really. You know ok it was a breakdown in a twenty year marriage *or fifteen, I can’t remember* but you know his wife was obviously still in the family home, he had moved out, he still had young children, the youngest they were teenagers *I think*. Which you know he wasn’t really having any access to **and I suppose** there was, you know a lot of anger there as well, which *I suppose* you know at the end of the day, you know it would, you’d view as increasing risk factors for self-harm *as much as anything else* really.”

Participant 17, Case 4, JDM PiP Interview

As with “I suppose”, “I suppose I” often introduces ideas about a case. However, the key differentiating factor between use of “I suppose I” and “I suppose” is explicit self reference. The function of “I suppose I” appears similar to that of “think” in terms of expressing hesitancy, in particular where the account of self given appears less than ideal in terms of self presentation (Goffman 1969). Note the markers of hesitancy in *italics* and underlined diminutive qualifier (Skelton & Hobbs 1999), all of which are deletable.

- “Again **I suppose I**, *maybe* too much of a slant on it at the start in the sense that *maybe* it was a little bit more me telling him rather than him agreeing but he had to agree to it if he wanted to move the situation on.”

Participant 9, Case 1, JDM PiP Interview

In the study corpus, the function of “I suppose” is highly context dependent. Generally it serves to limit truth claims in the introduction or conclusion of a formulation of a case in the retrospective interview data. Depending on context, it tends to be a part of a wider discursive marking of uncertainty and hesitancy. In many of these instances this is where the narrative becomes more focused or where a novel element has been introduced.

4.3.6 Use of “might”

In the think aloud data, the phrase “might have been” is used as part of speculative discourse about situations characterised by uncertainty. In the retrospective interview data it features in participant talk about what might be called ‘less than ideal’ clinical practice, particularly where allusion is made to error. This is especially where participants seem hesitant to talk in definitive and categorical terms about actual, potential or even hypothetical errors or substandard practice.

The following excerpts from the retrospective interview data show the use of “might have been” in the discussion of potential for error. Note the *italicised* markers of hesitancy and the diminutive qualifier in the lines where potential error is addressed. They stand in contrast to the more confident tone of the rest of the conversation:

- IR: “And from the practitioner perspective, from the perspective of nurses involved in the case, could they have made any mistakes or?”
P34: “I don’t think in that way really.”
IR: “Right, well not did they make any mistakes, but could they have made mistakes or this, room for error?”
P34: “Room for error?”
IR: “Let’s say someone maybe just qualified first week on the ward?”
P34: “Well *maybe* keeping her here **might have been** an error *I think*, you know.”
IR: “Right, what would have happened if she would have been kept?”
P34: “Family, well the family would have been just kind of distraught.”
Participant 34, Case 1, JDM PiP Interview

In the excerpt above P34 seems reluctant to discuss the possibility of error. When the interviewer persists, error was framed as what “might have” happened if the patient had remained in hospital. Where allusion is made to actual error or substandard practice in the retrospective data, “might have been” serves a similar function, as in the following excerpt. Note the presence also of the diminutive qualifier:

- “And he would, I won’t say become lost in his argument but he actually would become quiet and still for, it might be seconds, you know it wasn’t a long time at any time, it might be a few seconds. And sometimes, that was disrupted by the doctor actually saying you know, ‘what can you see?’ ‘what are you looking at?’, you know. Which **might have been**, might have come in a little bit too quick, instead of taking a little bit more time and giving him more time.”
Participant 17, Case 3, JDM PiP Interview

Below, P14 admits that there “might have been” prejudice” on behalf of staff. Note again the presence of deletable *markers of hesitancy* and a diminutive qualifier in broaching the topic, with the tone becoming more confident as the narrative develops:

- IR: “I’m very interested as well, these people who are ‘dodgy characters’, what was it about them that set alarm bells off?”

P14: “Just the look of them really, not specifically their clothes or anything. They weren’t too happy talking to me or any of the nursing staff. They were just in and out and they seemed to help themselves to the ward, going around, they’d walk into this room, that room and the other and it’s be inappropriate really walking into patients’ activity area and things like that. *I don’t know* it’s just a judgement call really.”

IR: “It just wasn’t right?”

P14: “Yeah, there was just something not right about them. *I suppose* there **might have been** a bit of prejudice in that we’d read his chart and we’d read that he’d hung around with a lot of people who abused substances as well and we knew he’d no brothers so we know they weren’t his brothers that they were these friends, so we had to keep a close eye on them.”

Participant 14, Case 3, JDM PiP

The phrase “that might have” is characterised by its function of denoting uncertainty regarding causal judgement. In the following example it is used in tandem with a deletable diminutive qualifiers:

- “So he wasn’t allowed to go out for the last 2 or 3 days, so I had a kind of feeling **that might have** put him into the situation to act out because when he was going out he was at least getting some fresh air and he liked riding the bike.”

Participant 13, Case 1, JDM PiP Interview

In both the think aloud and retrospective interview data, where “might” is collocated with “he” and “she” it is to express uncertainty. For the most part this involves descriptions of people’s cognitive processes or affective states. Indeed, this is a matter about which a certain amount of uncertainty is predicated by the essentially opaque nature of these phenomena:

- “She’s no social interaction, she doesn’t want to go to the day centre, she doesn’t want to be bothered with washing herself and that can happen with paranoid schizophrenics and **she might** be paranoid as well about staff.”

Participant 34, Case 1, Think Aloud

Whereas “he might be” and “she might be” refer to individuals, “they might be” alludes to types of people. This occurs almost exclusively in the retrospective interview data:

- “He looked like he was craving alcohol. He was not sleeping, you know he was on Librium and I think when one is under the influence of alcohol, their inhibitions are lower and **they might be** more prone to suicide or to self harm.”

Participant 3, Case 1, JDM PiP Interview

As with many of the other keywords accounted for so far, “might” can be linked to the expression of uncertainty and hesitancy. It is also used to make reference to typical cases, denote hesitancy, or express general uncertainty. This also involves the use of diminutive

qualifiers and other markers of uncertainty. Where uncertainty is expressed it is in relation to elements of the case under consideration, whereas hesitancy is noticeable where delicate issues such as errors in practice arise.

4.3.7 Use of “think”

With 26 potential meanings “think” is a highly versatile and ambiguous verb (Fontanet 2004). In general English usage it serves the function of expressing hesitancy with regard to expressing forthright opinion, whether to be covert or to express uncertainty (Thomson & Martinett 1991). In the study corpus, the phrases “do you think”, “you think of”, “you to think” and “think of a” occur almost exclusively in the interviewer’s speech in terms of their interrogative function.

As with “maybe”, participant use of “think” is mainly to express uncertainty. This in narratives that feature other phrases denoting uncertainty (*italicised*) - e.g., “maybe”, “kind of”, “I don’t know”:

- P39: “***I think*** it would be important to *maybe* talk to the sister and kind of tease out a little bit, and *maybe* explain to her how much it does impinge on her mental health if her sister doesn’t come as planned”
Participant 39. Case 1, Think Aloud
- P40: “Ok well basically this young man is 19 years of age, extremely psychotic came into us about, ***I think*** about two months ago, *I’m thinking* two months ago, has a history of drug abuse. *I’m not saying* he has a drug induced psychosis, ***I think*** it was always there. ***I think*** maybe there was, ***I think maybe*** dabbling in drugs *may* have brought it on but ***I think*** it was always, *it could have* been always there, even before he was dabbling.”
Participant 40, Case 1, JDM Pip

In other instances what appears to be subjective uncertainty about a case could be hesitance at disclosing what might be perceived as less than ideal practice. Again there is concomitant use of words and phrases linked to uncertainty – e.g., “might have”, “maybe”, “suppose”. However, here the function appears to be to allow the participant to hold back from relating potentially controversial (and disputable) situations as factual. Of particular interest is the initial response to the interviewer’s query in the second paragraph of text, where the participant sandwiches the definitive “I’ve seen it happen” in between the less committed, “I think it can happen”. Note here also *markers of uncertainty* and diminutive qualifier, all of which are deletable.

- “P21: *I think* sometimes when people come in, *I think* the day she came in it *might* have gone differently as well, she could have been medicated straight away against her will, brought down to a room and kind of a more aggressive management of it. IR: How could that happen as opposed to what did happen? P21: *I think* it can happen, I’ve seen it happen, *I think* it can happen when *maybe* tensions are heightened and things are, you know *maybe* a few less experienced people, more less experienced people on a ward than usual or people who don’t know what to do in a certain situation and people *maybe* aren’t confident in themselves and trying to kind of plamas someone into taking oral medication.”
Participant 21, JDM PiP, Case 2

“Think” is used mainly for metacognitive expression, mainly of subjective uncertainty. This is evident from its combination with other markers of uncertainty and diminutive qualifiers. At this level of analysis there are no discernable links to any specific cognitive processes. As with other keywords, this is in relation to uncertainty about aspects of the case at hand as well as in terms of hesitancy to give discursive commitment to a narrative that potentially disparages nursing practice or other aspects of health service delivery.

4.3.8 Use of “could”

Participants use the modal verb “could” mainly in the phrases “it could be” and “could be a”, either in recall or *in-vivo*, to indicate speculation. This features in both the think aloud and retrospective interview data along with other markers of uncertainty (*italicised*):

- “Tremor, dry mouth, palpitations, *it could be* just an anxiety attack, *it might be* an acute anxiety attack at present.”
Participant 10, Case 2, Think Aloud
- “Well with him having an opportunity to go off and kill himself before he was in hospital *I think* it could have been just that he wanted to kill himself, yes, and he wanted his mother to come across his body as a type of revenge *maybe*, or some kind of anger thing or he just wanted to come back to the house so *it could be* a failed suicide and his mother would know about it and it’s a cry out for help.”
Participant 14, Case 3, JDM PiP

In contrast to its function in expressing speculation, as shown above, “could” is also used in the phrase “you could see” to point to aspects of a case as being plainly evident. The generalising function of “you” (used instead of “I”) in this phrase points to the typical nature of the judgements involved. As with use of the word “looking”, the typification formula - with this type of case “you” could generally see “x” – can be applied.

Therefore, rather than being something that the participant uniquely perceives, it is generalised into something plainly observable. In the think aloud data this is used in immediate retrospective reference to cues from the video clips. In the retrospective

interview data it is used with reference to cues that were apparent at the time that the case was unfolding.

- “We found him quite drowsy like and we had concerns and he had been, he was faced out toward the window but **you could see** from behind that he had been fecally incontinent.”

Participant 27, Case 3, JDM PiP Interview

- “He seemed quite agitated. **You could see** he was kind of looking behind him all the time the other guy was pacing around.”

Participant 12, Case 3, Think Aloud

The phrases “she could have” and “he could have” are used to express speculation (usually in the retrospective interview data):

- “And we think that **he could have** been you know the usual flushing them down the toilet and, so we got Largactil 250 written up for him four times a day, we had to increase it from I think it was 200 to 250, four times a day, that’s only barely touching him.”

Participant 40, Case 1, JDM PiP Interview

These phrases are also used to express speculation about what might have happened under another set of circumstances, almost always concerning risk of intentional self harm and/or suicide:

P30: “He wouldn't have came and admitted the truth to us himself. So if we hadn't got that **he could have** gone home that evening and easily have done something to himself.”

Participant 30, Case 1, JDM PiP Interview

In overview, as a modal verb, “could” is used in a similar way to other keywords in expressing uncertainty in the context of both contingency and speculation about elements of the case presentation. “Could” is also used to mark hesitancy (Jaworski et al 2003) to commit to negative opinions about health service professionals and systems. Like other keywords, its use in collocation with the second person pronoun “you” serves to generalise and typify an aspect of a case. These features are evident across both the think aloud and retrospective interview data.

4.3.9 Use of “obviously”

The word “obviously” is used in various phrases along with third person pronouns to express judgement about an individual’s condition, most often their mental state. It is used in this way mostly in the think aloud data, although not exclusively. In most instances across both the think aloud and retrospective data, the reasons why the person is “obviously” in a certain condition are given. Whilst several other keywords involved with

reasoning and uncertainty have already been examined, “obviously” stands out as being clearly linked to the expression certainty:

- “He’s **obviously** in distress: self referral, partner’s flat, sleeping rough, low mood.”
Participant 45, Case 2, Think Aloud

There are times where “obviously” is used to state a judgement, about which the participant then begins to deliberate in terms of rationale. Paradoxically, where a definite judgement is given in this way there can also be expression of uncertainty. In the example below, this expression of uncertainty is marked not only by consideration of different cues, but by explicit metacognitive reference to uncertainty (underlined), which uses the second person plural to incorporate the researcher:

- “She’s **obviously** not feeling well enough to get up. **Obviously** the suggestion by the student nurse here to help her is not an unreasonable one because I feel she has approached it in a way that she wants to assist her in some way to help her, but **obviously** Karen is very angry, she could be unwell, she could be psychotic, she could be, we don’t know exactly what’s going on here...”
Participant 9, Case 1, Think Aloud

In some instances judgement is expressed without reference to cues. However, on closer inspection, some potential influencing factors are discernable. In the next example, time seems to be the main factor that P27 focuses on in terms of eligibility for pass. No reason is given for the judgement that “John” is still grieving, but the use of the word “still” points to a temporal element.

This appears more likely in that the preceding judgement that “possibly it could be a bit early for a pass” is by the participant’s own indication based solely on the amount of time that has passed. Likewise, the judgement that John is “obviously still grieving” appears to have been based on information derived from the notes relating to the time since his wife’s death. This is far from certain of course, but is an example of how close consideration of participants’ language in context can shed light on otherwise less tangible aspects of their judgement and decision-making. However, in almost all instances participants verbalised the rationale for their judgments by listing or describing associated cues:

- “And possibly it could be a bit early for a pass, initially not matter what the presentation is, it could be, in my opinion could be a bit early for pass, the fact then that, flicking through the notes that his wife has passed away and he could, he’s **obviously** still grieving for her like.”
Participant 27, Case 3, Think Aloud

In the example below, P26 relates their judgement that the fictional “Noel” is “not too happy to talk ... reluctant to converse at any level”. No direct reason is given for this judgement, but the mention between these two expressions that “he’s obviously feeling low” discursively links his reluctance to talk to his low mood.

- “He’s **obviously** not too happy to talk; he’s **obviously** feeling low and reluctant to converse at any level.”

Participant 26, Case 2, Think Aloud

I have already pointed out participants’ use of the words “looking”, “maybe”, “might” and “could” to refer to features that they represent as typical. The word “obviously” is also used in this way mainly, but not exclusively, in the think aloud data. In the following excerpt, P14 expressed the judgement that “Noel” is “obviously fairly cute to the services, he knows how to play them”.

I am familiar with the ‘type’ of individual referred to here, having worked with numerous people who would ‘fit the bill’. However, this is not the ‘type’ of individual that I had in mind when I wrote Case 2. It would appear that this judgement is linked to Noel’s history of selling drugs, although the link is not made explicit by P14. Note also the lack of markers of uncertainty in these excerpts.

- “He has a history of selling drugs. He’s **obviously** fairly cute to the services, he knows how to play them, so you’ve got to watch out for that as well.”

Participant 14, Case 2, Think Aloud

- “He’s **obviously** abusing some of his medication like the Xanax. He’s selling it on the streets.”

Participant 3, Case 2, Think Aloud

In the second example above a similar judgement was made that Noel is “obviously abusing some of his medication”. Again, in writing Case 2 this is not what I had intended as the case with Noel, who sold his medication because he needed the money. Had he been “abusing” it he would have been seeking more on top of his prescription stock – which would be insufficient to support an ongoing benzodiazepine habit.

However, some participants expressed inferences about the ‘type’ of person represented by a fictional case character that cannot be judged as certainly ‘right’ or ‘wrong’. As with the case above, these judgements involved assumption about ‘types’ of people based on prior experience. These inferences did not conflict with the intentionality behind cases as constructed for the purposes of the study.

However, neither did these assumptions reflect aspects of the fictional characters that I deliberately sought to convey. In the first example given below, judgement about John's premorbid sociability was based on the fact that he is a taxi driver:

- "... he hasn't gone out since Christmas and I mean he is a taxi driver so **obviously** he is quite sociable you know he is always meeting people and he seems to be on his own and just is not talking to people which is not healthy..."
Participant 8, Case 3, Think Aloud
- "Probably what's happening is that he's sleeping a bit during the day and **obviously** not sleeping at night which is typical of what happens."
Participant 20, Case 3, Think Aloud

In the second example, P20 makes a judgement regarding John's sleep pattern that I did not intend to be conveyed by the combined cues presented in the video clips and documentation. However, it did not conflict with the clinical picture envisaged in the writing of John's case. What is of note is participants' addition of details based on their expressed perceptions of what they consider 'typical'. In the retrospective interview data there are less instances of this use of "obviously", but it is not totally absent.

In addition to expressing certainty about judgements that are often associated with references to typical features, "obviously" is used with reference to decisions about intervention. Whereas in the think aloud data decisions are talked about in terms of what "obviously" needs to be done next, in the retrospective data they are referred to as what "obviously" needs to happen as part of management of the case:

- "It looks, I mean if she has been getting her medication the way its prescribed she **obviously** needs to be reviewed by the psychiatrist and all of this needs to be reported back because it won't be able to go on the way it is."
Participant 4, Case 1, Think Aloud
- "Because of the history of bipolar and because that from time to time she became quite elated to the extent that she'd be very, very high really, almost kind of total personality change at the clinic and then **obviously** her medication had to be reviewed. Then **obviously** they had to provide a structured kind of programme for her so I had to get her out of the house and do things because I just find that she's in the house a lot, so **obviously** she was referred to [name of day hospital omitted]"
Participant 20, Case 2, JDM PiP Interview

Where participant decisions are concerned, the expression of subjective certainty in the use of the word "obviously" is not always linked to a clear rationale. That this is routinely 'what is done' in such a case appears to be sufficient grounds to warrant such clear expression of subjective certainty. The steps to be taken are "obviously" what the person needs.

The word “obviously” fulfils several discursive functions related to the theme of uncertainty that characterises the study corpus. In participant expression of judgement it expresses a degree of subjective certainty. Whether this is actual subjective certainty is not clear (Edwards & Potter 1992), but regardless of their internal mental state participants do use the word to convey such certainty.

This is partly achieved by linking the judgements, tacitly or explicitly, to cues. With decisions, proposed or recalled interventions are portrayed as routine. As with several other keywords, the word “obviously” characterises talk about ‘typical’ cases.

4.3.10 Use of “just”

The phrases “you know just”, “just you know” and “just kind of” are collocations of “just” and the discourse markers “you know” and “kind of”. The phrases “if you just” and “that’s just” are highly versatile and have many uses, none of which are characteristically linked to judgement and decision-making in the study corpus. The same is true for “he’s just” and “she’s just”, which are used mainly in the think aloud data.

The word “just” has already been seen, in conjunction with other keywords in phrases, to play a part in what Heritage (1984) refers to as the language of diminution. This is not to say that use of “just” serves only to discursively negate or minimise. Diminution is the study corpus also has a discursive role in communicating the quantitative, as well as qualitative, limitation of phenomena.

The examples below show how participants use “just” in summarising, so that the message “it was just x” can be read as “it was mainly x” or “it could be summed up as simply x”. This occurs mainly in the recall of cases in the retrospective interview data.

In the example below the problem-intervention scenario set out by P5 could be summed up as ‘lack of motivation/encouragement’. Although the description of the man’s problem and the subsequent interventions are quite detailed, it is summed up by saying that it “was just a lack of motivation” and that what was needed most was “Just lots of encouragement”. The discussion of the problem and its solution hinge on and are limited by these two notions.

- “**Just** lots of encouragement with him you know, trying to encourage him to you know, if you were on night duty, trying to encourage him to get into the, to go to bed early, because he’s going to find it harder to get up in the morning and then he’s not going to be able to stay in the bed all day, so it’s really not doing him any good to be staying up. Is there any reason, finding out was there any reason that he wanted to stay in the bed and there generally wasn’t any reason for wanting too. It **was just** lack of motivation, so then trying to give him something to be motivated

during the day, you know say like, ok well if you're up, you know and you have your breakfast and that and stuff like that, maybe, you know. Maybe he'd be able to do something today, maybe go down to the therapy or maybe go out for a walk, or whatever like that do you know, that sort of thing.”

Participant 5, Case 1, JDM PiP Interview

In the next example, the man's state is summed up by saying that he “was just angry”. This is expanded on in terms of his being irritable. Other potential aspects are not mentioned, e.g., boredom, interpersonal relationships etc. – “he was just angry”:

- “You can almost see it, when he did become irritable, I could see it in his whole being that he **was just** angry. It's hard to explain, just eh, you could see he was being irritable to people. I was doing a quiz and he said ‘ah come on Michelle stop molly coddling them’. And if I wasn't moving fast enough doing certain things you could see it was irritating him.”

Participant 4, Case 3, JDM PiP Interview

The phrase “just didn't” serves the same function of limiting a phenomenon, but in a negative sense. The excerpt below demonstrates this in a case presentation that has a similar limiting of the problem-intervention as is seen with Participant 5 above. This can be seen in the use of “just didn't” with reference to both the problem and intervention.

- “Well if that was over looked she wouldn't have a home help, that would be something there, it just wouldn't happen, that would be, because she wouldn't, regardless of what you asked her did she want she'd say no, even though she was crying out needing it, she **just didn't** want to accept help. So you know you had to be aware of that, you **just didn't** ask the question that way or if you did she was going to say no anyway you know so you had to.”

Participant 28, Case 2, JDM PiP Interview

“Just” is a versatile word with many meanings and uses. As part of the language of diminution participants use it to discursively narrow down the complexity of a case. This is seen mainly in recall of cases in the retrospective interview data with regard to both problems encountered and interventions engaged in.

4.3.11 Use of “if”

The pairing “if you” featured commonly in both the think aloud and retrospective interview data. Although used frequently by the interviewer in posing questions, it is mainly used by participants. The phrase, like other keywords, also serves to generalise matters in collocation with the personal pronoun “you”:

- “You know **if you** really were in control of your emotions and you were really trying to deal with the situation as best you could, you'd be more inclined to hope that he would take himself out of the situation.”

Participant 9, Case 3, Think Aloud

- “Em and em I suppose one of the I think one of the greatest things **if you** have some kind of a confidant that you can talk about a problem but he had nobody only me and that was weekly sessions”
Participant 16, Case 2, JDM PiP Interview

In some cases this generalising function involves generalisation not about actions, but about a particular type of person or case:

- “Once you are discharged then really **if you** have poor social circumstances mm, you know things can be against you, there’s a big chance you’ll come back in.”
Participant 12, Case 4, JDM PiP Interview

The “if you” pairing is also used to generalise situations involving health professionals:

- “He seems like someone that would be, he would open up more maybe **if you** talk to him he might come out with some more information”
Participant 39, Case 3, Think Aloud

In the retrospective interview data, “if you” features in participant accounts of what they report saying to an individual with reference to an issue of choice or contingency. This is characterised by the control of the professional over a regimen. In the first example the power of the professional is very subtly constructed, whereas in the second example it is more blatant.

- “And then assuming that the husband or herself would be willing to consent to a visit like, outlining to her again like, ‘Look its important that you attend to outpatient facilities, and you know like while you done well hospital **if you** don’t comply there’s a chance you might have to come back into hospital, you might be there longer the next time’, that kind of thing and outlining to her all the positives, all the out patients services that are available like and maybe if the day hospital isn’t for her, that something else might be for her like you know.”
Participant 27, Case 4, Think Aloud
- “So it was kind of like a reward system. You might say to him, he might come in at 2 o’clock during the day, see he’s been in bed all day and he wants to ring somebody so you tell him that if, you know, **If you** get dressed and go out for a walk and come back to me in an hour’, that type of thing, you know.”
Participant 12, Case 1, JDM PiP Interview

The following excerpt is an example of a more user-oriented approach. Note that it is not an account of actual events, but of what “should have” happened. There is a very distinct function of empowerment in this account, which is not a distinguishing feature of the two accounts of actual practice above, or the data generally:

- “He seemed to have grown up in Christian Brothers school I think it was and he was in prison for years as well and he’s been in psychiatric hospitals and maybe we could have given him a bit more planning as regards, put him onto social workers

and things like that, show him his options and things like that, you can get this hostel here or try for maybe rent supplements and some things like that **if you're** going to be working and things like that. Just basics, this is how you're going to get on your feet. There's an opportunity here **if you** want it, go and grab it. Maybe that wasn't offered to him as readily as it should have been."

Participant 14, Case 4, JDM PiP Interview

As the corpus represents vernacular speech, the third person plural pronoun "they" is commonly used to refer to an individual. This is not in the same way that "he" or "she" was used. When used in the singular sense, "they" is used to refer to a typical individual:

- P7: "But it would be basically the care that you would put them under, you know, where you would be observing them for, for you know **if they** were severely depressed."

Participant 7, Case 3, JDM PiP

The pairing of "if" with "he", "she" or "they" is also often involved in participant talk about contingency. In this case the use of "if" involves the setting out of two or more different ways in which matters were likely to unfold in a case and what the likely response might have been. For the most part participants are setting out different options or contingencies depending on choices or decisions made by service-users or other health professionals. This occurs in both the think aloud and retrospective interview data:

- "People should try and engage with her maybe at home or you know **if she** isn't happy with that that they would ask her to meet in a health centre."
- "So you know you can offer them a couple of follow up appointments **if they** don't attend but really I think the policy here is that they're offered 3 follow up appointments and **if they** don't attend then they're just discharged back to the community people."

Participant 29, Case 4, Think Aloud

Participant 22, Case 4, JDM PiP Interview

The combination of "if" with "he", "she" or "they" also occur in the retrospective interview data where participants were talk about an individual's condition. This is similar to its contingency function, in that it sets out alternatives. However, the main emphasis is on "if" the person was in *this* or *that* state rather than on choice.

In situations involving choice and contingency, "if" relates how a person might have played an active part in the situation. Here it referred to the action of a particular condition upon them, of which they were passive recipients – they were in *this* state or *that* state, but not by choice:

- “If all of those things, **if they** are too psychotic to be able to do the work, **if they** are too depressed, all those things would come into the decisions about whether this person, whether this therapy would be the right therapy for this person.”
Participant 29, Case 4, JDM PiP Interview

Participants also use “if” paired with “he” and “she” to talk about potential consequences. Perhaps due to the nature of the case, this is seen mainly in the think aloud data for Case Three, which involved an element of risk around granting weekend pass to “John”:

- “He’s questionably still is irritable enough to do something **if he** got out of hospital so really I wouldn’t advise a weekend, a full weekend pass unaccompanied for him.”
Participant 9, Case 3, Think Aloud

Use of “if” along with “he” and “she” to talk about risk in terms of consequences of actions also featured to a lesser extent in the retrospective interview data:

- “The guy is in basically because **if he’s** let out on his own he would completely go; he’d go off and go as far as taking drugs and he’d be a huge danger to himself and possibly others as well.”
Participant 14, Case 1, JDM PiP Interview

Participants paired “if” with “he” and “she” to express uncertainty about aspects of a case (Cheng 2002). This is seen almost exclusively in *in-vivo* consideration of cases in the think aloud data. This invariably involves the use of “don’t know” as the main expression of uncertainty, of which “if he” or “if she” is a collocate, e.g.,

- “I don’t know **if she** was really fit to go **if she** had kind of ideas about this.”
Participant 34, Case 4, Think Aloud

In both the retrospective interview and think aloud data, “if” combined with “he” and “she” plays a part in setting out a chain of reasoning. This is expressed in terms of “if x, then y”. To illustrate this in the following excerpt, I have use italics to represent the “then y” part of the structure:

- “I’d say it could be one of two things, it could be yes, it could be genuine paranoia based on her history, **if she’s** not cleaning herself *she could be paranoid about the water* but you won’t know that until there’s a proper assessment done”
Participant 40, Case 1, Think Aloud

Whereas with “if he” and “if she”, contingency is associated with individual choice and responsibility, the phrase “if there’s” was involved with situational contingency, e.g.,

- “I suppose really would be to actually try and push for some sort of follow up care really, you’re unlikely to get a CPN, but what you may do is get you know an outpatients kind of appointment, you generally will have a lot more success in

getting those **if there's** a little bit of a gap between say discharge and starting their next therapeutic treatment programme.”

Participant 17, Case 4, JDM PiP Interview

As it is fundamentally linked to cause and contingency, the word “if” serves functions related to these aspects of judgement and decision-making in participant’s talk. In particular it is involved with talk around uncertainty, choice and risk. Secondary issues arose, e.g., power where choice is talked about, or consequences where risk is mentioned.

There is frequent pairing of “if” with personal pronouns. This is either to talk specifically about an individual or to generalise about types of individuals. Where generalisation is made, it is in the context of participants’ representation of typical cases.

4.3.12 Use of “because”

As well as in explaining the rationale for their own actions, participants also use “because” in conjunction with “he” or “she” to talk about what is represented as having motivated the actions of others. This occurs almost exclusively in the retrospective interview data. Here participants discuss the motivations of others with a remarkable degree of certainty.

Assessing mental state is an important skill in psychiatric nursing (Barker 2004). This partly involves making inferences based on the observation of individuals’ behaviour. The following excerpt illustrates this process insofar as P37 reports that they were certain that the fictional “Karen” is angry because of the sound of her voice:

- “And I think maybe avoid you know, for the moment anyway avoid the hygiene and avoid the room, just to find out, or to listen to her what’s going on, **because she’s** certainly very angry, she sounds very angry.”

Participant 37, Case 1, Think Aloud

In my clinical experience, the perceived ability to know the thoughts, feelings and motivations of others is seen as a core skill by psychiatric nurses. It is also found in certain models of counselling and psychotherapeutic intervention in terms of becoming familiar with an individual’s internal frame of reference (e.g., Nelson-Jones 2005). In my experience this has been taught as a psychiatric nursing skill both in the classroom and in clinical practice.

Although guessing at the motivations of others is normative for lay people, here it is situated firmly in the professional nursing practice. Claiming the ability to know with no small degree of subjective certainty, and in a clinical context, the motivations of others may seem remarkable. However, the degree to which this is normative in psychiatric nursing is

evident in the confident and matter of fact way that the “because he” and “because she” phrasing is used in the examples below.

The lack of any markers of uncertainty in the excerpt below is indicative of the degree of subjective certainty expressed by P39 with regard to what a person had been thinking. It could well be that the person had, at a stage in the relationship not discussed in the data, divulged these thoughts to the participant. Nevertheless, this is not revealed in the course of the narrative, and regardless of the mechanism of discovery on the part of the participant, expressing knowledge of the motivations of others appears normative for them:

- “When she was, compliant with medication she would do quite well but when her mood would start to go low, instead of recognising the need for help, she would stop her medication **because she** would think, ‘this is it, there’s no point now you know, it’s just going to be the same cycle again’ and, you know, so she would stop her medication which would automatically make everything worse.”

Participant 39, Case 4, JDM PiP Interview

There are hints to the mechanism of knowing the motivations, thoughts and feelings of others in the data, particularly in the think aloud data. In the following excerpt, P25 pleads ignorance of whether or not the fictional “John” is having “thoughts of suicide”, “because he’s not talking to the nurse.” The inference here is that this would be the normative mechanism through which they would attain such knowledge.

- “This guy was admitted with an overdose and he’s saying he has no suicide wish but on admission he O/Ds, so there were thoughts of suicide. At the moment I don’t know **because he’s** not talking to the nurse.”

Participant 25, Case 3, Think Aloud

In some instances in the retrospective interview data there is indirect representation of this process of gaining ‘knowledge’ of the thoughts of others. In the following example, P29 talks about attaining of knowledge of a woman’s thoughts and patterns of thinking through a form of cognitive behavioural therapy. Although not explicitly stated, use of cognitive behavioural therapy is apparent from the description of P29’s structured engagement with her around anxiety, panic and the use of terms like “de-catastrophise”, “evidence” and “basic tools”.

- “She had shown the evidence that she understood the formulation of the panic. She was able to make sense of that. She was able to make sense of why she panicked so all she had to do was to keep a track of her thoughts and de-catastrophise **because her** thoughts would be, oh I’ve got pain in my stomach it must be cancer. So she would then, she knew then to look at what’s the evidence, the evidence doesn’t support this, what might be another thing, what else could it be, oh it could be just a

cramp. She knew what to do, she had the basic tools. So I based my decision on that, my decision to discharge her on that.”

Participant 29, Case 4, JDM PiP Interview

Participants also use “because he” and “because she” to talk about probable cause. Note the initial use of a *diminutive qualifier* and metacognitive disclaimer:

- “This time round while there’s still *a little bit of* anxiety there it seems to be, I mean low mood would be what he would have presented with originally but it seems to be low mood precipitated by the fact that he’s actually sitting around doing nothing all day, you know that its not just that he has fallen into a depression **because he** has allowed himself get into a depression because of avoiding doing anything else with his life.”

Participant 22, Case 2, JDM PiP Interview

As well as positively attributing causes to presenting conditions, participants also use this phrasing to talk about why they discounted ideas about an individual’s condition:

- “Well my gut feeling that it wasn’t depression was **because she**, she was at the table and she was eating her breakfast and she was slouched over but she was still smiling up at me when she was talking.”

Participant 4, Case 1, JDM PiP Interview

The word “because” commonly features in participant narratives collocated with “I think”. Here “because” does not serve to alter the function of “I think”, nor engage it in any novel function beyond those already discussed. It does, however, situate the expression of uncertainty by “I think” in the context of cause and effect.

The discursive functions of interest with which “because” was associated are ascription of cause-and-effect and provision of rationale for decisions, particularly in relation to interventions. When collocated with other words, “because” was used with them to achieve complex discursive ends. This included combination with discourse markers as well as with words with discrete functions related to clinical judgement and decision-making.

4.3.13 Use of “then”

The most common use of “then” in the data is in the phrase “and then”, which acts as a chronological marker and a conjunctive. The phrase also serves the function of attributing consequences. This occurs invariably in the retrospective interview data, and tends to be in terms of psychopathology (as in the first example below) or interventions/actions (as in the second excerpt below).

Essentially what is expressed in these instances is a cause-and-effect relationship similar to that discussed using “because”. The difference here is the specific temporal element, where

the cause follows on chronologically from the effect. This stems from the main function of “and then” as a chronological marker.

- “Well her primary complaint would have been it would have been the alcohol, the alcohol yes **and then** the low mood would be secondary to that, that’s the diagnosis’s that she, you know was made.”
Participant 32, Case 2, JDM PiP Interview
- “Very paranoid with the staff, I sat with her for a long time, did what she kind of said, told me to do, that kind of thing **and then** she began to trust me.”
Participant 34, Case 1, JDM PiP Interview

The phrase “there and then” describes phenomena as instantaneous, and is used in the retrospective interview data in relation to actions taken. These situations vary and the degree of pressure and urgency are relative to the overall narrative – as can be seen in the differing degrees of pressure and urgency that an objective observer might attribute to the two examples below. However, for the participant, relative to the case at hand these were prompt actions taken instantaneously.

- “So that, my first reaction **there and then** *is* to stop my assessment, because *you* really had to deal with the physical and so I got the A&E nurses back into the room and said well you know this patient needs to be looked at again.”
Participant 31, Case 2, JDM PiP Interview
- “I took his pulse right **there and then** and that was okay. So he seemed fairly relaxed and calm and he didn’t seem to be under any distress, he wasn’t finding it hard to breathe.”
Participant 4, Case 2, JDM PiP Interview

In the first excerpt “there and then” is followed immediately by “is”. The use of “is” rather than “was” denotes that rather than merely describing a past decision, this represents the participants’ normative course of habitual action. This made more apparent in the generalising function of “you” in the same sentence.

In summary, the two distinct functions served by “then”, to express cause-and-effect and denote prompt intervention, have a strong temporal component. In certain instances its use is associated with the description of prompt, routinised action without much deliberation. In others it has the discursive effect of structuring an account so as to delineate cause and effect in a chronological manner.

4.3.14 Use of “even”

The word “even” is used mainly in the phrase “even though”. In the think aloud data, this phrase is used to present a cue or cues that would appear contrary to the participant’s

conclusive formulation. The cue(s) is then implicitly discounted by the fact that the judgement prevails despite it:

- “**Even though** he’s pleasant I’m not happy about him at the moment **even though** he seems generally to be okay but I just think he’s coasting and that he will do something at the weekend.”
Participant 29, Case 3, Think Aloud

This is similar to its more prevalent use in the retrospective interview data to mark instances whereby a phenomenon is represented as atypical. In the first examples below, it is used to note that although an aspect of the case might have lead one to expect a certain situation, the opposite was true. This implies that the expected situation constitutes what is typical. In the first example, the typical case is that a woman living with her son would not be socially isolated:

- “Well what we’ve done with her, because she was so socially isolated, **even though** she was living with her son, she was kind of out working all the time and the son’s girlfriend was there as well so they weren’t around that much.”
Participant 26, Case 2, JDM PiP Interview
- “She wasn’t really no, because you don’t see many, you don’t see many people with just pure anxiety, **even though** her mood was low it was kind her anxiety that was causing her to be low, and you don’t see many OCD* or anything like that in hospitals anymore, it’s mostly people that would attend the clinics, they would be out in the community and that kind of thing.”
* *Obsessive Compulsive Disorder*
Participant 39, Case 1, JDM PiP Interview

The second example above deals with the common combination of anxiety and depression (Gelder et al 2005). Sometimes people are given a diagnosis of anxiety depression where both conditions are perceived as appearing equivalent in severity (although more often one or the other does predominate). The typical case for P39 would appear to be that of low mood with a less significant anxiety component. Here the atypical case involved a strong anxiety component with concomitant low mood.

In the final example below, the typical presentation seems to be that people who are experiencing low mood recognise this as problematic, seek help and are not averse to coming into hospital for treatment. The atypical case, presented here, is someone who refuses hospital treatment and also appears to be more preoccupied with their physical ill health. P22 seems also to see this aspect as atypical in people with low mood.

- “She presented kind of passive death wish, said this kind of thing, I’d be better off dead, she was referred to our services here in [name of town admitted], she was assessed, that was all fine, refused to come in for admission, **even though** as we

would have seen it her mood would have been quite low but she just wasn't willing to admit this herself and everything revolved around the physical problems that she was having.”

Participant 22, Case 4, JDM PiP Interview

Overall, in the retrospective interview narrative the phrase “even though” is used as a contrastive device. This is a subtle discursive act that gives insight into what participants present as typical and atypical. In the think aloud data the same phrase notes cues which are then discounted as contrary to the participant's final formulation.

4.3.14 Use of “ll” & “will”

Participants use “ll” and “will” at points in the case narrative where action is imperative. This need for action constitutes a rule that is either applied by the participant to a particular instance, or stated as a general principle. In the narratives, actors other than the participant also state or apply the rule, e.g., significant others, colleagues or service users.

However, it is important to realise that the data represent the participant's own account. Regardless of how individuals actually viewed the situation, how they represent this in the narrative serves primarily to make the participant's point that the action/rule is essential at this point. In the retrospective interview data, actions taken in the story are framed as imperative using the phrase “will have to”.

This serves to implicitly state a rule that governed the situation. Without exception, this has to do with justifying the curtailment of people's liberty/choice:

- “I said I know it's quite troubling for people but I said we would have to actually legally detain him. Her answer to that was, ‘Give me the form and I will sign it’. She said, ‘My son is very unwell’, she said, ‘I **will have to**, treat him’, she said, ‘we have to get him well’, she said, ‘he cannot come home the way he is’, she said, ‘I'm frightened of him in here’, she said, ‘what would it be like at home?’”

Participant 17, Case 3, JDM PiP Interview

The function of this phrasing is to explain that although it is not ideal to deprive people of liberty and choice; in some instances it is necessary. The phrase is used in other instances to relate similar rules about situations where there was a course of action that was imperative, for example in the think aloud data:

- “I suppose she's taking the oral medication but then if she doesn't attend the day hospital or she doesn't attend the clinic, we **will have to** do home visits on her. It would be important to do, because of the self harm, the increased risk of self harm.”

Participant 3, Case 4, Think Aloud

There is a similarity here to narratives dealing with the deprivation of choice/liberty in that where intervention was being stepped up to a more intrusive level of engagement it was not done lightly and needed to be justified by the context – in this case risk of self harm. The phrase “will have to” is also used to state general principles regarding intervention, particularly - but not exclusively - around curtailment of liberty/choice, e.g.,

- “Liberty pops up with each patient and we discuss liberty and things like that, whether they might have brought something back to the unit the night before that they shouldn’t have, alcohol or drugs or whatever and liberty **will have to** be stopped in that case.”

Participant 14, Case 1, JDM PiP Interview

The word “will” and its abbreviated form “ll” have 12 distinct functions in general discourse (Thomson & Martinett 1990). This is reflected in their disparate use in the study corpus. However, the word “will” does serve the distinct function - as part of the phrase “will have to” – of indicating a generally applied rule. This is either mentioned as such or is implied in the course of the case narratives.

4.3.15 Use of “mean”

The word “mean” occurs most often as part of the pair “I mean” which serves distinctive discursive functions in the phrases, “you know what I mean” and “but I mean”. Apart from these two phrases, “I mean” acts generally as a discourse marker in the same manner as “you know”. The phrase “I mean” is also used by participants to mark elaboration on a statement.

This is evident in that it could be replaced at any point by the phrase “for example”. As such it marks places in participant narratives where the account became more detailed:

- “Opinions, everybody else’s opinion can I suppose impact on your decision too and then we would always kind of, **I mean** I would never make a decision without running it past the doctors the you know the house officer and consultant like they would pass it on to the consultant and like they often, they would come back and say well no I don’t think it’s a good idea for such and such a reason.”

Participant 32, Case 4, JDM PiP Interview

In the retrospective data participants use “do you know what I mean” to check understanding when describing a case. The phrase tends to be used at a point in the account where details have the potential to confuse the listener. This involves intricacies in chronological order or other elements that introduce complexity into the narrative. To a

degree its use is attributable to an individual's discursive style, and some participants use it more so than others.

- “You see but yeah, one wonders, you see it depends, it mightn't have gone ok and it certainly would have gone differently if it had happened on a Thursday when I was off as opposed to the Wednesday when I was on, do **you know what I mean** and that's not to say it wouldn't have gone well but it would have gone differently, it would have gone differently and maybe it is that his ability on the day was only, he'd only ability to connect with one, he couldn't connect with a crowd and in fact it irritated him something wickedly.”

Participant 18, Case 1, JDM PiP Interview

The phrase “but I mean” serves the purpose of prefacing negative, mainly critical, statements. This tends to involve an opinion that could be seen as derogatory and which the participant might be hesitant to divulge:

- “She was meeting friends, I don't know if they were druggy friends or whatever but her drug screens came back negative after her weekend leave, but I just learned that the relationship wasn't a trustworthy relationship between myself and herself and, I shouldn't have really believed her you know, so I, I just learned that kind of after six weeks like you know, it was just, we were building a relationship and I thought we had a good relationship established **but I mean**, she's just a complete liar really at the end of it.”

Participant 34, Case 3, JDM PiP Interview.

The pair “I mean” is the basis of several versatile phrases that characterise the study corpus. Two of the phrases have notable discursive functions. The phrase “you know what I mean” is the most commonly used phrase containing “I mean”, and is used to check understanding. The phrase “but I mean” is used as a marker of hesitancy, prefacing comments that could be seen as negative.

4.3.16 Discourse Markers

I have referred at several points already in this chapter to participant use of discourse markers (Schiffrin 1987). Discourse markers are also referred to in the literature as discourse particles (Stede & Schmitz 2000). Their use characterise the study corpus to an extent that warrants a brief discussion at this point.

The main role in of discourse markers in conversation is not to directly convey content-related information, but to fulfil a pragmatic function in the ongoing interaction. When used as discourse markers, words carry a meaning that is different or contrary to their standard meaning (Stede & Schmitz 2000). The purpose of this study is not to investigate the

discourse of participants *per se*, but to analyse it with the intention of learning about the social and cognitive processes involved in nurses' judgement and decision-making.

Therefore, analysis of use of discourse markers is relevant in this study only insofar as it serves as a means to this end. Schiffrin (1987) has outlined the following words as the standard discourse markers in English. This list is not exhaustive, and other phrases recognised as discourse markers include "although" and "in that case" (Alonso et al 2002):

- Well
- And
- But
- Or
- So
- Because
- Now
- Then
- I mean
- You know

Given the substantial amount of co-authored narrative (Ochs & Capps 1996, Frailis & Sionis 2006) in the study corpus, and its conversational style, a higher frequency of discourse marker use is to be expected (Abma 2001). However, the characterisation of the study corpus by discourse marker use is not explained solely in terms of its genre as co-authored narrative. Because the corpus against which it was compared was also featured conversational, co-authored discourse, a statistically significant difference in discourse marker use between the two cannot be explained by genre alone.

In Chapter Three I pointed out that it was a principle of the analytic approach being taken in this study that interpretation of the data should draw on what the data itself has already demonstrated, and not on my own speculation independent of the evidence (Sacks et al 1974). Therefore, in offering an explanation for this characteristic of the study corpus by high frequency of discourse marker use, I am cognisant of the need to consider only what I already know about the corpus. There are two common functions of discourse marker use that I have already demonstrated as characterising the study corpus.

First, participants have been shown, through several discursive strategies, to use a style of narration that is subtle and implicit in description and attribution. Like the strategies already described, discourse markers serve the purpose of making speech less explicit and more implicit (Oliveira et al 2007). This can serve the purpose of positioning the speaker as non-authoritative and less expert than their co-author.

The study corpus is also characterized by the use of several discursive strategies, mainly involving personal pronoun use, to generalise matters and closely identify both participant and researcher with judgements and decisions. Discourse markers also serve to identify a speaker with their observations, and to make these universally applicable (Oliveira 2007). The study corpus is characterised by this discursive strategy, and it is therefore reasonable to attribute the increased frequency of discourse marker use to this style of narration.

If the aim of the study was to focus on participants' use of language *per se* I would at this point engage in an in depth demonstration, with examples, of discourse marker use in the study corpus. However, as I wish to maintain my focus on what the evidence can reveal about participants' clinical judgement and decision making, I will at this point move on to summarise the findings of this chapter.

4.4 Summary of Findings of Comparative Keyword Analysis & Preliminary Discursive Analysis

This concluding section does not constitute the sum total of the findings of this study. For this reason, the findings summarised here may appear inconclusive. This is because they are intended only to form the basis for further analysis of the data using conversation-analysis informed discursive analysis.

This is discussed in Chapter Five, where I will refer back to how the matters raised in this chapter served as the starting point for that analysis. Many of the features identified at this level of analysis were explored further in the next stage of analysis, as is shown in the following chapter.

Preliminary discursive analysis of the functions of keywords generated by comparative keyword analysis shows that quantitatively measurable differences are discernable when participant discussion of clinical judgement and decision-making is compared to context-governed speech, including interviews and medical consultations. More specifically, it can be shown that these differences are characterised by certain features that serve particular functions. These are summarised in Table 4.1 overleaf.

In addition to setting out the main functions of the keywords, the table indicates whether or not their function is dependent on their collocation with personal pronouns. This dependence is semantic, not syntactic. That is, the keywords depend on pronouns not to make grammatical sense, but to carry out a particular function.

Some keywords are not dependent on personal pronouns, but do have their function modified by collocation with them. For all cases where this occurs a brief explanatory note is given as to how function is changed by collocation with personal pronouns. Functions are mapped to data type only where they are mainly or equally found there.

Table 4.1 Summary of Comparative Keyword Analysis

Keyword	Characteristic Functions in Think Aloud Data	Function Modified or Dependent on Collocation with Personal Pronouns?	Characteristic Functions in Retrospective Interview Data	Function Modified or Dependent on Collocation with Personal Pronouns?
Looking	1. Indicating focus of attention 2. Building consensus 3. Indicating typicality	1. No 2. Yes 3. Yes – generalises function	1. Indicates focus of attention 2. Indicating typicality	1. Yes – generalises function 2. Yes – generalises function
Felt			1. Expressing evaluative judgment	1. Yes – generalises function
Know	1. Discourse marker 2. Building consensus	1. Yes 2. Yes	1. Discourse marker 2. Checking understanding	1. Yes 2. Yes
Maybe	1. Diminution 2. Expressing uncertainty	1. No 2. No	1. Diminution 2. Expressing uncertainty 3. Expressing hesitancy	1. No 2. Yes – indicates typicality 3. No
Suppose			1. Expressing hesitancy 2. Discursive deliberation of case formulation	1. Yes 2. No
Might	1. Expressing uncertainty	1. No	1. Expressing uncertainty 2. Expressing hesitancy	1. Yes – indicates typicality 2. No
Think	1. Expressing uncertainty	1. No	1. Expressing uncertainty 2. Expressing hesitancy	1. No 2. No
Could	1. Expressing uncertainty 2. Indicating focus of attention	1. No 2. Yes – generalises and indicates typicality	1. Expressing uncertainty, particularly in the context of contingency 2. Indicating focus of attention	1. No 2. Yes – generalises and indicates typicality

Obviously	1. Indicating typicality in terms of both presentation and intervention 2. Expressing certainty	1. No 2. No	1. Indicating typicality in terms of both presentation and intervention	1. No
Just	1. Discourse marker	1. No	1. Discourse marker 2. Reduction of complexity by diminutive limitation	1. No 2. No
If	1. Generalisation in terms of both presentation and intervention 2. Setting out choice and/or contingency	1. Yes 2. Yes – indicates typicality	1. Generalisation in terms of both presentation and intervention 2. Setting out choice and/or contingency	1. Yes 2. Yes – indicates typicality
Because			1. Thoughtful deliberation of case details	1. No
Then			1. Thoughtful deliberation of case details 2. Denoting prompt intervention	1. No 2. No
Even	1. Discursive deliberation of case formulation	1. No	1. Indicating atypicality	
Will	1. Denoting imperative intervention, mainly involving curtailment of liberty/choice	1. Yes – incorporates implicit consensus of researcher	1. Denoting imperative intervention, mainly involving curtailment of liberty/choice	1. No
Mean	1. Discourse marker	1. Yes	1. Discourse marker 2. Marking elaboration 3. Checking interviewer understanding of intricate explanations 4. Prefacing & softening critical statements	1. Yes 2. Yes 3. Yes 4. Yes

These functions form the basis for conversation analysis-informed discursive analysis of the study corpus, discussed in Chapter Five. In conclusion here, I provide a brief overview of what these functions reveal about the data in terms of participant judgement and decision-making. This will be with reference to the evidence that has been shown to underpin them throughout this chapter.

Based on the functions outlined in Table 4.1 above, the following features of the data are clearly discernable:

- Participant reasoning
- Expression of certainty & uncertainty
- Contingency and choice

4.4.1 Participant reasoning

By participant reasoning I am making reference to how participants took time to consider various aspects of a case. This is apparent in the detail and length of the associated narrative. In think aloud data this is *in-vivo*, whereas in the retrospective interview data it involves a revisiting and reformulation of a judgement or decision.

Comparative keyword analysis of the data shows that participants appear deliberative in their reasoning. Phrases such as “looking at” were used by participants’ to denote their attentiveness to and consideration of particular aspects of a case presentation. However, this contrasted with the relatively quick and unexpanded manner in which some judgements and decisions were delivered.

Often in the think aloud data a complete judgement or decision prefaces a subsequent narrative giving explanatory details. These instances, evinced in particular by the use of the word “obviously”, give some insight regarding participant use of prior knowledge to interpret the information that they had attended to. Certain phrases, such as “looking at”, are particularly helpful in pointing towards participants’ reference to cues which they then linked to subsequent judgements or decisions.

The word “obviously” was also used by participants in reference to fairly confident decisions made in a routinised manner. The work practices related to these decisions appear habitual and are carried out without much need for consideration. They are simply ‘the done thing’.

As with “I felt”, the phrases “looking at” and “you’re looking / ‘re looking” are strongly associated with this approach, in particular in participants’ reference to case types in the

retrospective interview data. This, along with several other discursive features in the data, points towards participant reasoning as initially intuitive. Initial judgements and decisions were made with relative opacity, rapidity and with reference to the typical.

Reference to typical and/or atypical cases does occur at times alongside expressions of uncertainty, although narratives also feature quite confident reference to typical cases, especially using the word “obviously”. The common thread that runs through participants’ use of these phrases is their pairing with pronouns, in particular the third person pronouns “we” and “they”. These pronouns also play a strong part in participant expression of their identity with their professional role (Lerner 1993), and there appears to be a link with participants’ description of the habitual, routine way in which they make judgements and decisions and their close identification with their work role. There also appears to be a link between the belongingness to a professional group that comes with such identification with role and quickness to view individuals as typically ‘other’.

4.4.2 Expression of Certainty & Uncertainty

Several keywords that are easily associated with certainty/uncertainty arose from the comparative keyword analysis of the study corpus. Some of these words and phrases are highly versatile and are also associated with other phenomena (e.g., language of diminution, discourse markers and establishing consensus with the researcher). Where words serve a function with regard to certainty/uncertainty, this tends to be either by way of marking hesitancy or expressing subjective uncertainty, or expressing subjective certainty. Hesitancy to engage in critique of practice is more evident in the retrospective interview data than hesitancy due to apparent cognitive uncertainty. However, participants make direct metacognitive references to uncertainty in the context of not knowing, and phrases containing words such as “maybe”, “think” and “know” make reference to cognitive as well as social phenomena. These words are used to express varying degrees of certainty/uncertainty.

The word “obviously” has particular association with expressions of confidence and certainty. Other words associated with certainty/uncertainty include “if” and “because”, particularly with regard to participant expression of thoughtful deliberation regarding details of the case. This is apparent both from absence of expressions associated with uncertainty and direct, matter-of-fact expressions of inference using words such as “because”.

The subject of certainty/uncertainty is a microcosm of the wider complexity of the interplay between cognitive and social elements of participant judgement and decision-making. On analysis of what at first appeared to be mere uncertainty, it is plain that there were two distinct modes of expression of uncertainty evident in participants' discourse. These are:

1. Hesitancy - the expression of uncertainty linked to the context-based hesitancy to criticise others or to discuss the potential for error, and
2. Uncertainty - the expression of subjective uncertainty, by way of metacognitive and other discursive markers.

4.4.3 Contingency and choice

Phrases which are used to talk about matters of contingency are also linked to the building of consensus. Contingency, consensus and choice are also related to participant discussion of uncertainty and reference to typical cases. As it comprises co-authored narratives (Ochs & Capps 1996), the study corpus features many instances of consensus building whereby participants seek the implicit consent of the researcher as they construct or reconstruct a case formulation (Fratilis & Sionis 2006).

Think aloud data collection involved *in-vivo* case formulation, whereas the retrospective interviewing required participants to revisit their formulations of past cases. The seeking of consent and use of some words and phrases also associated with hesitancy and uncertainty (e.g., "I suppose") demonstrate expression of tentativeness in this regard, whereas others are more expressive of subjective certainty (e.g., "obviously"). Participant narratives also provide insight into the process of building consensus with people using the mental health services, fellow nurses and other health professionals. Different values and perceptions appear to govern this process depending on the social group to which people are seen as belonging, with particular reference to what proposed as typical for members of these groups.

Chapter Five - Findings of Conversation Analysis-Informed Discursive Analysis

5.1 Introduction

In this chapter I discuss the findings of analysis in terms of the main features that are seen to characterise the study corpus. These were derived from the preliminary discursive analysis of keywords generated by a comparative keyword analysis of the data, as outlined in Chapter Four. They are

- Participant reasoning
- Expression of certainty & uncertainty
- Contingency & choice

In Chapter Four the evidence that points towards these features as they characterise the study corpus was discussed. I now discuss each of these in turn with reference to conversation analysis-informed discursive analysis of the data. I use the principles of conversation analysis to afford a closer examination of the data than is possible using discursive analysis alone.

As discussed in the methodology section, I use the Jefferson (2004) notation system to illustrate the salient features of the data for the main excerpts being used to illustrate points (see Appendix E). The purpose of this system of notation is to enable ease of reference to the salient points of interest in excerpts. Some ancillary excerpts are not annotated as they merely serve to illustrate points being made in support of the findings, and do not therefore require consideration of their interactional and prosodic features. For these excerpts I will use bold type to highlight words or phrases of interest.

5.2 Participant Reasoning

In Chapter Four, I described how preliminary discursive analysis based on a comparative keyword analysis shows certain words and phrases to be associated with participant reasoning. In this Chapter I detail what further analysis demonstrates regarding the same phenomena in terms of the overall discourse of participants' narratives. In the section that follows I explain how in doing this I discovered a strong link between participants' apparent use of intuition, their reference to typical cases, and also how this relates to their more deliberate consideration of the details of a case.

5.2.1 Intuition, Deliberate Consideration & Typicality

By intuition, I refer to “thoughts and preferences that come to mind quickly and without much reflection” Kahneman (2003a, p697). The most obvious aspect of participant reasoning is the apparently intuitive way in which judgements and decisions are made. This was discovered on further exploration of the implicit references of to certain case features and interventions as typical (as detailed in the previous chapter).

The basing of intuitive judgement on what is perceived as typical is a topic which has been the focus of an increasing level of social psychology research over the last 15 years (Wegner et al 2006). Certain words and phrases that characterise the study corpus are indicative of participant reference to typical cases in terms of people and situations. Gaertner & McLaughlin (1983, p23) viewed this approach to judgement in terms of stereotyping.

Gaertner & McLaughlin (1983) have cautioned researchers to avoid methodologies that purport to measure such intuitive strategies without accounting for participant reactivity to researchers’ probing. The methods of this study fulfil this criterion insofar as participant reference to typical cases can be seen at points in the data where neither researcher or participant were consciously or deliberately seeking to explore this phenomenon. The analysis detailed in Chapter Four demonstrated how participants’ discursive representation of typicality in the study corpus is linked to use of the following keywords (see Table 4.1, p123):

- Looking
- Maybe
- Might
- Could
- Obviously
- Even

Participants use these keywords when talking about certain ‘types’ of individuals that they work with or interventions that they routinely carry out. Closer examination of the data using conversation analysis-informed discursive analysis reveals that these people tend to be discussed with reference to diagnostic categories. Where this is the case, participants make reference to prior knowledge regarding other individuals that they have encountered with a similar diagnosis.

Analysis also demonstrates that reference to typical cases is associated with participant expression of subjective certainty. This evidence builds on the link first made in the preliminary analysis between reference to typicality and expression of subjective certainty where participants use the keyword “obviously”. However, participant expression of subjective uncertainty was also linked with keywords which are associated with typicality. The expression of subjective certainty and uncertainty in the same narrative demonstrates the complexity of participants’ representation of their reasoning. The presence of markers of both certainty and uncertainty in the same narrative exemplifies participants’ expression of confidence about one aspect of a case amidst more general expressed uncertainty. This feature of the data is developed further in this chapter in the section on certainty/uncertainty.

In discussing the main aspects of the evidence for participant reference to the typical, in particular how this can be seen to relate to use of prior knowledge, I refer to Case 4. In doing this I provide an in-depth illustration of how ‘types of people’ feature in participant talk. This is supplemented by section 5.2.1.2., which outlines in broader terms how participant consideration of all cases is illustrative of this way of using of prior knowledge.

5.2.1.1 Types of people in the retrospective interview data: Case 4 as an example

In the retrospective interview data, the phrase “they might be” is used to make general allusions about types of people. The important word here is “they”. In contrast to “he might be”, “she might be”, which are used in reference to specific individuals, “they might be” refers to types of individuals.

These generalisations appear to represent a tendency, based on clinical experience, to refer to types of people (McCarthy 2003a, 2003b). The excerpt below demonstrates how the phrase “they might be” acts as a primary marker of this way of referring to people in participant discourse:

1. P28 .hhh †Well I †supp*ose it’s, it’s just to see ah, you know (0.2) ah::, I:
2. feel that sometimes when people are .h (0.4) aware that you’re comin’ the first
3. time they might be puttin’ on the good front .hh (0.4) ehm (0.3) people tend to
4. ehm .h (1) you †know, they’re †apprehensive, what your reasons is for calling
5. .h (0.5) they tend to want to have the house tidy eh (0.5) .h you know and
6. they’re (0.5) they’re worryin’ what you’re going to ask them or (0.4) .h †what
7. (0.1) your impression is going to be of them .h (0.4) and (.) sometimes they’re
8. more at ease the second time and you get a truer picture of (0.4) of things rather
9. than the first time because .h (0.5) well anybody if somebody’s comin’ to your
10. house for the first time you’re .h (0.5) you †might be a little bit apprehensive if,
11. (.) you †know you were wonderin’ why are they comin’ and .hh (0.5) what’s their

12. (0.3) agenda and what are they going to tell me=
 13. IR: [“Right”
 14. P28 =and (0.5.)
 15. IR: [Right
 16. P28 .hh all that, so it usually the second time, y-you know the more you get to know
 17. people .hh (0.7) th-they kind of let †down their †guard a †little bit and you kind
 18. of get to (.) to see a different †side (.) °to †things°.”
 19. IR: [“Right”
Participant 28, Case 4, JDM PiP Interview

Of primary interest in this excerpt is the generalisation performed by the personal pronouns “you” and “they”, particularly in the phrases “they might be” and “you might be”. Other phrases are associated with participant reference to the typicality of the case in a secondary manner, without using personal pronouns. However, as they are not statistically significant in terms of their frequency in the study corpus, their use cannot be said to be a characteristic of the study corpus.

In the example above, these phrases are:

- “sometimes when people”
- “tend to”
- “anybody if somebody’s”

I discuss these before considering the role of other phrases in ascribing typicality. “Sometimes” is an adverb of frequency, followed here by “when”. This particular use of the simple present tense (adverb of frequency + when) is used in English to express “routine or habitual actions” (Thomson & Martinet 1986, p160). That routine, habitual actions are being referred to here is also obvious from the use, twice, of the word “tend”.

Also directly indicative of discursive construction of the case as typical is the double occurrence of the irregular plural form of person - “people”. It is semantically equivalent to the third person plural pronoun, “they”. This equivalency of “people” and “they” as references to class or type can also be seen in the use of the phrase “they can’t”.

This is not limited to consideration of Case 4. In the following excerpt from Case 3, for example, all occurrences of “they” and “people” (apart from a single italicised instance) referred to “people” who were “not sleeping at night”. In the first sentence P12 is talking about people who are “not sleeping at night”. In the second sentence, apparently to provide further illustration of their point, P12 narrowed their reference to a subset of this category, i.e., to people who “can’t sleep” and are resident in a unit with “13 or 14” other “people”:

- “Well I mean like if **people** aren’t sleeping what happens is if **they** are not sleeping at night sometimes **they** are sleeping during the day. Mm, I mean in a unit, I know it’s different in a unit where there’s 13 or 14 **people** where **they** tend to get up every one else’s nose because **they** can’t sleep. And then **they** start getting irritated themselves during the day because **they**’re tired. **They** are tired but **they** can’t sleep so **they** start getting angry.”

Participant 12, Case 3, JDM PiP Interview

In speech generally, “they” and “people” are representative of the typical in terms of the equivalency of both words in expressing regularity (Thomson & Martinet 1986, p79). This is seen in the semantic equation: “they say = people say, it is said”. Both “they” and “people” can be used in the most widely universal sense or to a very specific group of individuals, depending on context (Leech 1989).

In the context of P28’s excerpt (given again below for ease of reference), both refer to people whom the nurse was visiting at home for “the first time”. P28 is a community-based registered psychiatric nurse with over 10 years of experience, working in a clinical nurse specialist role.

1. P28: .hhh †Well I †supp*ose it’s, it’s just to see ah, you know (0.2) ah:., I:
2. feel that sometimes when people are .h (0.4) aware that you’re comin’ the first
3. time they might be puttin’ on the good front .h (0.4) ehm (0.3) people tend to
4. ehm .h (1) you †know, they’re †apprehensive, what your reasons is for calling
5. .h (0.5) they tend to want to have the house tidy eh (0.5) .hh you know and
6. they’re (0.5) they’re worryin’ what you’re going to ask them or (0.4) .h †what
7. (0.1) your impression is going to be of them .h

The pauses in P28’s delivery coupled with slight inspirations serve to delineate the distinct elements in the narrative. The start of the utterance (line 1) serves as an immediate response to the researcher’s question, perhaps allowing P28 time to gather his/her thoughts (Clark & Clark 1977). The inspiration and raised pitch here (line 1) are markers of initiality, indicating the start of P28’s turn (Bolinger 1989, Hutchby & Wooffitt 2008).

Following the first pause (line 1), P28 makes an introductory statement (line 2) followed by a 0.4 second pause and slight inspiration. P28 then delivers the narrative, point by point, punctuating points with brief pauses and inspirations, stressing words that convey the salient elements of each point. The pauses here are stalls, which are thought to indicate a speaker’s planning of their next utterance (Clark & Clark 1977). Specifically, this is thought to involve processing of content to ensure it is error-free (Hieke 1981, Kahneman 2003).

This seems to point towards thoughtful consideration of the case following on from an initial more intuitive judgement (Wegener et al 2006). The thoughtfully applied points of information stemming from the introductory “people are” are as follows:

- People put “on the good front” on a first visit (lines 2 and 3)
- People are “apprehensive” regarding the nurse’s “reasons ... for calling” (line 4)
- People “tend to want to have the house tidy” (line 5)
- People worry about “what you’re going to ask them” (line 6)
- People worry about what the nurse’s “impression is going to be of them”

The “people” reference here is to individuals on the community nurse’s caseload, whom they were visiting at home for “the first time” and who were “aware” of the impending visit. Drawing on my own knowledge and experience of community mental health services, I can verify that this is not in reference to a special subtype of visit. This is because it is standard practice that community mental health nurses pre-arrange domiciliary visits. This is also evident in the think aloud data from other participants for the same case, e.g.,

- “Ok, I’d pick up the phone and ring her, just find out what’s going on, does she need any help, does she want a home visit”
Participant 37, Case 4, Think Aloud

In my experience, the sole exception to this would be where contact could not be made and there was a concern about the individuals’ well-being, which would be unusual and not routine. This is also evident from the data from other participants considering Case 4, e.g.,

- “If I don’t get him today now, see I was away all week on holidays so if I don’t get him today I’ll have to contact his community nurse again to go out and make a home visit and if he isn’t willing to engage you have to discharge. You give him a long time, you give him a couple of weeks before you take that action but because you’ve so many waiting to come in that are actually urgent, you know if someone doesn’t want to engage with us, we can’t do anything really.”
Participant 2, Case 4, JDM PiP Interview

P28 reports that “people” being visited at home for the first time are typically apprehensive, worried and concerned about what the nurse will think of them. Expanding on this, P28 goes on to talk about the second home visit:

7. (0.1) your impression is going to be of them .h (0.4) and (.) sometimes they’re
8. more at ease the second time and you get a truer picture of (0.4) of things rather
9. than the first time because .h (0.5) well anybody if somebody’s comin’ to your
10. house for the first time you’re .h (0.5) you †might be a little bit apprehensive if,
11. (.) you ‡know you were wonderin’ why are they comin’ and .hh (0.5) what’s their
12. (0.3) agenda and what are they going to tell me=

13. IR: [Right
 14. =and (0.5.)
 15. IR: [Right
 16. .hh all that, so it usually the second time, y-you know the more you get to know 17.
 people .hh (0.7) th-they kind of let †down their †guard a †little bit and you kind 18.
 of get to (.) to see a different †side (.) ° to †things°.”
 19. IR: [Right
Participant 28, Case 4, JDM PiP Interview

Here the wider population is appealed to, with emphasis on “anybody” (line 9) and the person’s reaction to the visit is thus normalised. The repeated referral to the visit as a first-time (lines 2/3, 9 & 10) domiciliary visit built the picture of an awkward social situation that was not conducive to psychiatric assessment. The second visit (lines 8 and 16) is characterised by the person being more at ease (line 8) and letting their guard down a little bit (line 17), which enabled the nurse to see a different side to things (line 18) and get a truer picture (line 8).

The drift downwards in pitch and volume seen in line 18 is associated with the ending of an utterance rather than having any peculiar salience regarding the content (Cooper & Sorenson 1981, Bolinger 1989). However, the emphasis and rising of pitch in line 17 serves to indicate the importance associated with people letting their guard down, albeit with some degree of tentativeness (Bolinger 1989). Overall in this home visitation narrative, P28 attributes causality more so to the awkward social situation than both parties found themselves in than to any peculiar personal traits of the individuals being visited. This is underlined by the comment:

9. than the first time because .h (0.5) well anybody if somebody’s comin’ to your
 10. house for the first time you’re .h (0.5) you †might be a little bit apprehensive if,
 11. (.) you †know you were wonderin’ why are they comin’ and .h (0.5) what’s their
 12. (0.3) agenda and what are they going to tell me

With this comment P28 normalises the person’s anxieties around the home visit as being what might be expected from anybody in that situation (line 9). Also, P28’s use of the first person situates the narrative from the service-user’s perspective (line 12) and is indicative of some degree of empathic identification with the individuals involved in this situation. However, despite apparent parity between speaker and subject being evident in this normalisation, the narrative is firmly situated in the context of the professional-layperson relationship.

If knowledge itself is power, power here resides firmly with P28. It would appear that as an experienced specialist mental health professional P28 comes to this situation with the prior knowledge that:

- People’s anxieties around a first home visit are not necessarily indicative of psychopathology and normally recede over time
- A full assessment is not usually achievable on a first visit because of this
- Further visits are needed for a “truer picture” to emerge

These considerations are part of the professional business of getting to know people (line 16) beyond first impressions and seeing a different side to them (line 18). This is a business in which knowledge-based power and control are firmly in the hands of the nurse as an experienced specialist. As such, their judgements and decisions and the power to make them takes precedence over those of the service-user. In saying this I make no value judgement, but emphasise that the parity expressed in the empathic/normalising functions of the narrative do not appear to affect the exercising of professional power and control as part of the nursing role.

In my experience, assessment is the essential function of the home visit, and this can also be seen in the think aloud data for Case 4 from across participants, e.g.,

- “...make a home visit to see how she’s doing and to speak with her husband and see how he feels...”
Participant 26, Case 4, Think Aloud
- “As a community nurse I would be checking up, I would be doing a house visit, go out and see what’s going on out there. Sometimes from a community perspective you get a better idea how a person is functioning in the home setting. You can see what’s going on.”
Participant 25, Case 4, Think Aloud

P28’s narrative shows how expectations of what is typical for normative first and subsequent home visits aided their clinical judgement and decision-making by ensuring that there was not an over-reliance on first impressions. This was based on their habitual acceptance that assessment judgements are formed over time as a relationship develops in which people become more amenable to assessment. By implication, someone remaining guarded (line 17) after several visits would no longer be responding in a way that might be expected by “anybody” (line 9) and would therefore constitute an atypical presentation. This back-to-back relationship between typicality and atypicality has already been demonstrated in the preliminary analysis described in Chapter Four.

5.2.1.2 Use of prior knowledge in the retrospective interview data

In the retrospective interview data, references to prior knowledge are organised within the context of diagnostic categories. Having used Case 4 in the previous section to consider participant talk concerning ‘types of people’, I will use all cases (1, 2, 3 & 4) to discuss participant use of prior knowledge, which is characterised by reference to diagnostic categories. I will also show how, across these cases, the use of diagnostic categories by participants differs from their use by psychiatrists in their roles as diagnosticians.

This feature appears mainly in the retrospective interview data where participants were asked to discuss cases that they had recently encountered. As diagnostic labels were given in the case information provided to participants, I cannot make valid claims for spontaneous participant use of diagnostic categories in the think aloud data. In the excerpt below there was equivalency between “them”/“they” and “people”.

1. P38: >What d’y’think with, I s’pose I s’pose the< th’easiest way t’explain it is
 2. (1) what is no:r:mal (0.7) you know it’s not normal for people (0.6) to kind
 3. of isolatin themselves and withdrawin from (0.9) >from, from< other
 4. IR: [mm
 5. people and not havin’ any interaction with people and(0.6) and you know
 6. IR: [mm
 7. (1.3) them (.) the-the- (0.5) >them there< people are (0.4) depressed, or
 8. else (0.6) if they’re sufferin with schizophrenia >or som’nl’tthat<
 9. ((something like that)) that (0.9) >it’s just that it’s that it’s the schizo-<
 10. schizophrenia’s that’s causing them to (0.5), you know that they can’t
 11. IR: [mm
 12. (0.5) mix with people, that they’re paranoid or suspicious you know? (0.9)
 13. IR: [mm
 14. And >it’s it’s it’s a< different kind of a (0.5) thing but >people with then
 15. IR: [mm
 16. with< depression (1) it would be too quick for them t:o (0.6) have
 17. [mm
 18. recovered >within<, you know within a few days.”
- Participant 38, Case 3, JDM PiP Interview*

The centrality in the narrative of P38’s statement regarding normality is underlined by their emphasis and elongation of the word “normal” (line 2) and the bracketing of the word by pauses of a second and 0.7 seconds. Reference to people with a diagnosis of schizophrenia or depression is made throughout by the use of “they”/“them”. The stalls in delivery of the narrative after the central theme of normality/abnormality is introduced are indicative of thoughtful consideration (Clark & Clark 1977, Hieke 1981, Wegener et al 2006).

Individuals with schizophrenia are represented as distinct from those who are diagnosed with depression, but both were organised discursively as the type of “people” (lines 2, 5

and 13) who isolate themselves and withdraw socially (line 3). This group mainly comprises people with depression (line 7), but people with schizophrenia are also found here albeit with differences in other areas of their presentation. The organising principle around which all of centres is, “what is normal”.

In the narrative, diagnostic categories serve as an aid to explaining why people behave in a certain way and to aid prognosis for such behaviour in terms of recovery (lines 15 and 17). This inverts the medical organisation of diagnostic models in psychiatry, whereby category-based diagnosis is served by behavioural indicators. This discursive use of diagnostic categories appears to be shaped by the focus of P38’s role in working with people in terms of their behavioural problems.

In the excerpt below where P39 recalls a case resembling Case 1, there is the equivalent use of “they” and “people”:

1. IR: And was she your typical case? (0.6) Or this was this was a totally sep-
2. P39: [↑E::h::mmm
3. (0.6) She †wa:sn't †really no, because you don't see many, ehm (1) you don't see
4. many people with (0.1) >j- eh=just< (0.3) pure anxiety, y'know what I
5. mean?=Even though her mood was low it was kind of her anxiety that was
6. causing her to be low, and you don't see many OCD or anything like that in
7. hospitals anymore, it's mostly people .h that would attend the clinics, that would
8. be out in the the community and >that kind of thing< (0.2) .hh So she wa:sn't
9. †really a typical case (0.2) .hh but saying that, anxiety management and >stuff
10. like that< would be >something that< could benefit an awful lot of people, be they
11. IR: [mm
12. depressed or be they anxious or y'know, even someone that (0.3) that's (.) ehmm
13. (0.2) .hh you know, i-i- in the acute stages of mania it's not somethin' that's
14. beneficial, but (.) as as thei:r (.) their condition is improving it is certainly
15. something that a lot of people could use.”

* *Obsessive Compulsive Disorder*

Participant 39, Case 1, JDM PiP Interview

The example above deals with the common combination of anxiety and depression where both appear to be of equivalent severity, although more often one or the other predominates (Gelder et al 2005). As already seen in Chapter Four, “even though” is used here as a contrastive device (line 5), indicating that a typical case in this instance would involve low mood with a less predominant anxiety component. Stress on the word “low” (line 5) serves to indicate its salience. The atypical aspect of the case presented here lies in the presence of a strong anxiety component along with low mood.

In line 4, stress on the word “anxiety” and the hesitancy phenomena that precede its utterance are indications of thoughtful attribution of “pure anxiety”. The ensuing talk

around anxiety management is a departure from the initial case presentation, as indicated by the summing up (lines 8 and 9) of the description of the case. The hesitancy phenomena (elongation, pauses and inspiration) indicate thought about fresh content (Clark & Clark 1977, Hieke 1981), in this case around anxiety management and its application to other cases.

The use of “even though” as a contrastive device can also be seen in the excerpt below. Here the typical presentation seems to be that people who experience low mood recognise this as problematic, seek help and are not averse to coming into hospital for treatment if needs be. This is derived from the atypical case, presented here, of someone for whom anxiety symptoms predominate, who refuses hospital treatment and appears to be preoccupied with their physical ill health.

1. P22: She presented (.) eh::hm (1.5) kind of passive death wish, eh::h you know, said,
 2. >y’know this kind of thing< I’d be better off dead. (1.6) She was referred to (0.2)
 3. IR: [mhm]
 4. P22: =our own <services> (.) e:hmm (0.7) here, in [name of town admitted]. (0.5) She
 5. was eh assessed, that was all fine. Refused (.) to come in for admission, even
 6. ↓thou:gh, y’↓know=>we< as we would have seen ↓it her mood, would ha’been
 7. quite low (0.7) but she >jus’ wasn’ willing to admit this herself like y’know<
 8. everything revolved around the physical problems that she was havin’
- Participant 22, Case 4, JDM PiP Interview*

This example differs from the others considered so far in that there is an absence of the generalisation function performed by “they” and “people”. Instead, the contrastive function of “even though” (lines 5/6) and use of the general symptomological phrases “passive death wish” (line 1) and “mood” (line 6) along with the phrase “this kind of thing” (line 2) point towards presentation of a typical case. As with the other examples given so far, hesitancy phenomena such as stalls (lines 1, 2, 4 and 7) and filled pauses (lines 1, 4) indicate thoughtful consideration of the case.

The phrase “would be very” is not alone in marking expression of typicality in the study corpus, and other phrases such as “they might be” and “if you” commonly operate in this way. The key words in these phrases are “if”, “might”, and “would” as markers of contingency. However, “would” appeared a great deal in the study corpus (6,047 times, representing 1.17% of the entire corpus) and is not always associated with reference to the typical. Its collocation with certain words (in this instance “very”) is the best indicator, therefore, of its use to talk about such cases.

(line 2) and more stress on the fact that she is “↑not” able to hide her condition. The subtext of this description of rapid recognition is P9’s construction of his/her own expertise.

From the outset, P9’s construction of expertise is closely linked to their narrative on the ease of recognising that someone is unwell - their opening utterance concluding with the statement that “Karen” is not able to cover up or mask their condition (line 2) because she is “↑not able to keep it from me” (line 4). P9 goes on to mention the “↑plenty o’ Karens who I’ve walked into” (lines 4/6). Rapid recognition of a typical case and discursive construction of expertise also go hand in hand in P9’s description of their use of the concept of baseline functioning (lines 9/10).

The “I always call” attribution of baseline functioning is followed by a definition which is delivered in the prosodic style of a textbook definition, “Baseline function is”. This concept is then linked to diagnostic categories, with diagnosis determining the cardinal features on which to judge baseline functioning. P9 engages in self repair (Schegloff et al 1977, Fox et al 1996) in line 15 after initially introducing the topic of baseline functioning as it applies to “a schizophrenic”.

Even though P9 initially pronounces “a schizophrenic” perfectly, they very quickly move to repair their labelling with two rapid bursts of mispronunciation divided by a 0.2 second pause, followed immediately by the more politically correct “schizophrenic illness”. Such self-correcting repair in utterances that can be seen as inappropriate is a complex but common discursive task (Pomerantz 1992). In terms of such a task, the label “schizophrenic” constitutes the repairable trouble source, its mispronounced repeat the repair initiation, and the corrected “schizophrenic illness” the repairing segment (Rieger 2003). Despite using diagnostic categories as the basis for making quick judgements about baseline functioning, using them to discursively categorise the person as opposed to their “illness” is obviously seen as troublesome.

Such features of the data give considerable insight into participant’s discursive construction of phenomena such as expertise. However, a limitation of this study, its data and methods of analysis is that only the construction of such features is amenable to meaningful analysis (Edwards & Potter 1992a). The evidence here points clearly to participant construction of expertise, and cannot be demonstrated to point towards participant expertise *per se*. As well as being of relevance with regard to the relationship between participant confidence, subjective certainty and uncertainty (explored further in Chapter Six), it is also important

from a methodological perspective, in terms of what does, and does not, constitute evidence of expertise.

Whereas the use of “would be very” as illustrated above demonstrates participant use of domain specific knowledge (Boshuizen & Schmidt 1992), the following examples show a similar strategy that draws on prior knowledge of an individual’s typical behaviour or condition. Such “pre-encounter data” has already been recognised as a key element in nurses’ judgement and decision-making (Crow et al 1995, O’Neill et al 2005, p71). The following examples from the study corpus show reference to such knowledge marked by “would be very”.

In this phrase, the word “would” is the primary marker of reference to typical cases, as illustrated clearly in the first example below. Indirect reference to prior knowledge takes the form of the use of the words “normal” and “normally”. The key difference in this example, however, is reference to what is typical on the basis of personal social pre-encounter knowledge rather than diagnostic categories.

1. P20: hhhh The †family were †very †distressed †by †it (.) a:nd i-now the normal
 2. family is that they would have dinner at a certain time (0.1) and >it’d=be=a< kind
 3. of normal family to go=into. This was that they had to bring: two of the other
 4. brothers were in the house which normally wouldn’t be, so I come in to find all
 5. the family are there. (0.4) Ehm, they’re looking at their mother in=a chair who’s=
 6. IR: [mhm
 7. P20: =just (.) behaving very inappropriately. (0.3) .h=Eh=f- i-ehh- It’s her mental
 8. distress really herself (0.4) eh in a=lot=of anguish (0.3) I mean ehm, (0.5) so
 9. therefore and not sleeping at night, disturbing the others (0.2) and (0.1) one son
 10. who >kind=of:=i-< would be very disturbed by that (0.3) which actually would
 11. mean he would, might: >eh=require an admission< (0.4) So: it really would mean
 12. that in order for, (0.2) that >the=mother would need=to be< definitely taken >out
 13. of the house< (0.2) so=that (0.6) things could >kind=of< (0.4) >y’know<
 14. function, >like=tha’the< others would >be=able to< kind of get on better (0.3)
 15. together. It was causing a=lot of stress and tension in the house.”
- Participant 20, Case 3, JDM PiP Interview*

In this discussion of a case similar to Case 3 (“John”), P20 begins the utterance by noting how very distressed the family were. She then goes onto describe how she knew this by comparison to the reference points of that family both normally (lines 1 and 2) and as a “normal family” (line 3). There is reference here to two ways in which the family are typical.

P20 initially refers to how this family normally present (lines 1 and 2) before, after a brief pause relating that this is a normal family (line 3). So as well as representing them as a

typical family, P20 represents them as being typically themselves. As a typical family, P20 represents them as meeting expectations in terms of societal norms. Because they are typically themselves, the family meet these expectations based on P20's pre-encounter knowledge of them.

P20 then goes on to explain that all of the family were in the house (line 5), with particular reference to two of the brothers who would not normally be there (line 4). The presence of the family is the main feature described as having alerted P20 to the unusualness of the situation (line 4) and after a brief pause, she identifies their mother's condition as the cause of the gathering (line 5/7).

Line 7 sees a topic shift from the unusual nature of the family being gathered in the house to the mother's condition that is the focus of their gathering. The pause following the conclusion of the previous utterance (line 7) and filled pause marking the start of the new utterance (line 7) both act as segmentation markers to signal this shift (Bestgen 1998). However, the new topic of the mother's mental distress is considered firmly against the background of family life. Following the topic shift, P20 begins to unpack the mother's mental distress (lines 8 and 9). The use of pauses and stress on words can be seen to break this down as follows:

- She was in a lot of anguish
- She was not sleeping which was disturbing the other family members

Having got this far, P20 begins to recontextualise the mother's mental distress in terms of its impact on the family (lines 9 and 10). This subtle second topic shift comes after P20 relates how the mother was disturbing the others (line 9). After a pause, the conjunction "and" is used, and P20 pauses again before narrowing the focus from the others to one son in particular (line 9). Some hesitancy phenomena also mark this shift as the narrative proceeds (line 10). Once recontextualised to the original subject matter of the discourse, the account considers the disruption that the mother's mental distress brought to the normal functioning of the family.

The main point of this recontextualisation, and indeed the message being related in this excerpt, is that the mother needed to be taken out of the house (lines 12 and 13). This is emphasised not only by its bracketing with pauses and the speed of its delivery, but by the relatively slower delivery of the words "definitely taken" (line 12). This communicates subjective certainty on P20's part, given the disruption of normal family life, that the right decision had been made.

The aspects of normal family life that were disrupted due to the ongoing presence of the mother in her mental distress, according to P20, and therefore effectively formed the basis for her move from the house were:

- Familial distress (line 1)
- Disruption of sleep (line 9)
- Disturbing of one son to the extent that he might have become unwell himself (lines 9, 10 and 11)
- Family members not getting on well together (line 14)
- Familial stress and tension (line 15)

Although the mother's own distress and anguish are mentioned (line 8), the main motivation for action here is plainly the disruption of the typical picture, derived from pre-encounter data, of this family's normal functioning as a normal family.

In the example below from P31's consideration of a case similar to Case 2 ("Noel"), they refer to "an alcoholic". The work of generalisation regarding this category is initially performed by the pronoun "they". It operates here as a subject pronoun (Thomson & Martinet 1986), its subject being that of the typical case – a person going through alcohol withdrawal, with concomitant problems involving physical health and living conditions.

1. P31: †Well he said that he'd been drinkin' about you know ah about=
2. >†I=think=it=was< (0.5) †ten to fourteen pints a day (0.5) and (0.4)
3. IR: [° m°
4. P31: that=eh=he=w- (0.5) I †think he had †gotten a (0.2) >†he'd=he'd< been, he'd
5. been †doin' really well (0.6) because he was an >al=he=he=w=rec=he< said he
6. was an alcoholic, which was really a big thing, you know_ehm and ehm it's=
7. IR: [yeah [mm
8. P31: =always a great (1.1) I know it's not a great thing to hear, but it's a thing that >it<
9. IR: [yeah
10. P31: †it gives you mo:re (.) leeway, because they recognise they have a problem (0.4)
11. IR: [mhm
12. P31: right there, so you're not goin=ta (0.2) the person who says I don't have a
13. problem, there's nothin' wrong with me, I just had a bad night out 'n' that kinda
14. IR: [yeah [yeah
15. P31: stuff (0.4) I had a bad pint (0.2) 'tis another thing, y'know. (0.1) So uhm (1) this
16. (.) this=guy recognised (0.2) and he'd been †doin' really well (0.3) he'd been in
17. a couple o' the ehm (0.6) the centres (0.5) a couple o' years ago, he'd been
18. IR: [° m°
19. P31: clean=n=sober for couple of years and he'd gotten into ehm (0.5) a (.)
20. relationship and, the relationship had, (0.4) not worked out (0.8) and he (0.4)
21. just, you know, (0.2) kinda, (0.3) †lost the run of himself and went back
22. †drinkin' (.) and lost all his kind of, (0.7) the things >he w- he w- he was< he 23.
- was doin' so well at, (0.6) which is really=n-normal for an alcoholic, it's

24. kind=of=the life cycle, (0.6) you know there's always dips (0.5) in the road
 25. IR: [° m°
 26. P31: where they don't do well and they come through, >y'know< they're in kinduva
 27. (.) alcoholic crisis almost. (0.4) And=so, (0.7) with him that was what
 28. IR: [right
 29. P31: ↓happened (0.4) and he >so, so he, so< I †asked him how many (0.2) >be=hon-
 30. how=many< pints he was †drinkin', ehm (0.4) when his last drink ↓was (0.4)
 31. ehm (0.3) what he was drinkin' (0.3) >y'know< sometimes (0.4) the spirits are a
 32. IR: [° m°
 33. P31: bit (.) h:arder (0.3) on the body than, than like, the beer, the beer is (0.3) ehm
 34. (0.9) you know ehm (1) any medical problems as well because if you have an
 35. alcoholic, (0.2) you're dealing with (0.5) >a=lo'=of< medical problems like
 36. ehm (0.2) >t't< (0.3) hypertension anyway (0.6) from (.) th'alcohol over the
 37. ye:ars, (0.3) ah you're dealing with like a dysfunctional liver, (0.5) yeah=so
 38. IR: [° m°
 39. P31: there's medical problems around that. (0.4) You know they'll have, †sometimes
 40. IR: [° right°
 41. P31: they'll have, I mean I know it's not (0.2) with (0.2) alcohol that they'll have
 42. †asthma, things like that, (0.2) so sometimes they're living rough, and things
 43. IR: [mhm
 44. P31: (0.4) >you know like< (0.3) this ehm (.) gentleman here (0.7) if you're living
 45. rough you tend to be more prone to kind of (0.4) flus and bronchitis=so
 46. †physically (0.8) you're not doin' well, (0.8) overall no ma- apart from being in
 47. detox as well, so.
 48. IR: [right
Participant 31, Case 2, JDM PiP Interview

P31 initially discusses the individual in terms of his presentation. The main points are delivered bracketed by silent pauses (line 2) and filled pauses (lines 5 and 6). They also feature metacognitive disclaimers (lines 2 and 4) with regard to P31's certainty (line 2). These main points were that the man:

- Was drinking ten to fourteen pints a day
- Had described himself as an “alcoholic”

The pauses, filled and silent, serve to bracket out and highlight the man's self-description and his level of intake as salient points of the case description. The metacognitive disclaimers, one delivered rapidly (line 2) and the other bracketed with pauses and marked out with a raise in pitch (line 4) are most likely to indicate P31's attempts at recall of these points (Edwards & Potter 1992). Again, as with P28, this appears to indicate thoughtful consideration of the case following on from the initial rapid recognition of its base elements (Wegener et al 2006).

What is being considered here, however, is the verbal and paraverbal representation of a complex cognitive activity and not a matter of an either/or choice between thoughtful

consideration versus continued intuitive handling of the case. This is evident in the self repair (Schegloff et al 1977, Fox et al 1996) performed by P31 following their attribution of the man's description of himself as an "alcoholic" as something that's really "great" (line 8). What appears to be occurring here is not so much the attempted resistance of negative automatic thoughts (Nelson et al 1996) as a rethinking of choice of words.

The source of the trouble in P31's talk here is their ascription of the adjective "great" to the man's self-description as "alcoholic". That this is troublesome is apparent in the 1.1 second silence following the utterance of the adjective. Repair is immediately initiated with the statement "I know its not a great thing to hear" with emphasis on "great".

Unlike P9's self repair (see p.140), P31's self-correcting repair segment involves explicit and deliberate justification of their use of terminology. This involves reference to expectations of certain typical features from people with alcohol dependence (lines 10 to 15) and their recognition of this as a problem. This is subsequently applied to the case at hand (line 16).

Up until this point reference had been to an individual, using the personal pronoun "he" (lines 1 to 5), with use of the personal pronoun "I" by P31 in self reference. In line 10 there is a switch to the subject pronoun "they", as well as a switch from P31's self-referring "I" to "you" in reference to nurses generally. This generalisation shifts the focus from particular individuals to the typical, whereby P31 relates her experiences of how people with alcohol problems generally describe those problems (lines 12 to 15).

The best case scenario, which justifies the "great" descriptor, is where the person recognises that they have a problem (line 10), thus giving the nurse more leeway with them. Alternatives to this, which are by inference not so great, are people saying:

- I don't have a problem (lines 12/13)
- there's nothing wrong with me (line 13)
- I just had a bad night out (line 13)
- I had a bad pint (line 15)

Use of the personal pronouns "I" and "me" in lines 12 to 15 gives the effect of reported direct speech. There is subtle discursive construction here of experience by reference to utterances that had actually been heard by P31. This, added to the relative smoothness of delivery of the examples (only the concluding one is bracketed by pauses – line 15), serves to demonstrate the ease with which P31 can recall exemplars.

This gives the impression of a wealth and recency of experience in this regard and is an example of the paraverbal construction of expertise. Therefore, P31 justifies their attribution of “great” to the man’s self-description as an “alcoholic” by drawing on their apparent expertise and experience to give examples of cases that are not so “great” by merit of their failure to recognise that they have a problem. P31’s narrative construction of professional expertise permits them to view someone’s self description as “alcoholic” as a good thing, even though generally this is not a good thing to hear. It is precisely the context of expert engagement with so many people in this position who do not recognise that they have a problem, that a self description of “alcoholic” can actually be “great”.

It is not my contention here that P31 deliberately purposed to use her supposed expertise as repair for a verbal slip. What is evident here again is participants’ discursive construction of expertise. Whilst not proof of actual expertise, it does have a bearing on participants’ perception of their own expertise, which is an important factor in the relationship between overconfidence, certainty and uncertainty. This is explored fully in Chapter Six.

Next, the subject matter of the typical case is applied specifically to the case at hand - unlike others, “this guy” (line 16) recognised his problem and consequently did “really well”. More salient points of the individual case are then related, again pauses and stress on certain words identify the separate salient points – the man:

- Attended some treatment centres (line 17)
- Was clean and sober for two years (line 19)
- Was involved in a relationship (lines 19/20)
 - that did not work out (line 20)
- Lost the run of himself and went back drinking (lines 21/22)
- Lost all the things he was doing so well at (lines 22/23)

P31’s careful construction of the narrative is evident from hesitancy phenomena such as silent pauses throughout, filled pauses (line 19 and 22), and stress on words to lend prominence to certain important aspects of the case (“centres” in line 17, “relationship” in line 20 and “lost” in lines 21 and 22). After these details are imparted, P31 reverts to reference to the typical (line 23). The purpose of this is to relate that the cycle represented in the narrative is typical of what always happens - doing really well (lines 16 to 20), something not working out (line 20) and subsequent loss of doing well and return to drinking (lines 21 to 23), are “normal for an alcoholic” (line 23).

The descriptor “alcoholic crisis” (line 27) was applied to the central crisis of the cycle. The application of this term was tentative, as evident from the diminutive qualifiers (Skelton & Hobbs 1999) “kinduva” (line 26) and “almost” (line 27). Whereas P31 used the subject pronoun “they” to refer to the general population of alcoholics to whom this applies, the personal pronoun “him” was used to apply expectations of the typical to the individual (line 27).

P31’s recall of their assessment interview with the individual (line 29) serves as a context for consideration of some of the important features of alcoholism that generally need to be assessed:

- How many pints are being drunk (line 30)
- When the last drink was (line 30)
- What is being drunk (line 31)
 - Spirits or beer (lines 31/33)
- Medical problems (line 34)

Although these are related in the context of the recall of an individual assessment (line 29), P31 subsequently recontextualises the narrative into general application when they generalise both nurse (referred to using “you”) and “alcoholic” (line 35). This is done at the point of medical problems (line 34), which serves as the point of departure into a more general narrative whereby P31 relates that alcoholics:

- Have a lot of medical problems from the alcohol (line 35) such as
 - hypertension (line 36)
 - dysfunctional liver (line 37)
- Have medical problems not related to the alcohol (line 41), but from living rough (line 44/45), such as
 - Asthma (line 42)
 - Flus (line 45)
 - Bronchitis (line 45)

The brief reference to the example of this “gentleman here” (line 44) is followed by reference to what is typical with regard to physical ill health and living rough. What is addressed here is that which is typical in a wider sense however - not just for those with alcohol problems. This can be seen by the use of “you” as opposed to “they” (lines 44, 45 and 46), which by inference (based on its previous use in this narrative) incorporates people

generally by merit of the fact that it includes in its terms of reference both P31 and the researcher as nurses. The second indication of its general application is seen in the use of the qualifier “apart from” (line 46) to distinguish its subject matter from people in alcohol withdrawal. So effectively, P31 conveys the fact that anyone living rough would have these physical problems, adding that people in alcohol withdrawal are therefore even more prone to them.

5.2.1.3 Interim Summary

Having given a detailed account of the evidence in relation to participant reasoning, I will at this point give an interim summary of these findings before proceeding on to relate the evidence for participant expression of subjective certainty and uncertainty. The preliminary discursive analysis based on comparative keyword analysis, accounted for in Chapter Four, found that reference to typicality was one of the most common discursive functions of the keywords that characterised the study corpus. Further analysis, using conversation analysis-informed discursive analysis, confirms this characteristic of the retrospective interview data in particular, and expands on this finding with more in-depth analysis.

This analysis shows that reference to the typical in the retrospective interview data is mainly in terms of reference to diagnosis of mental or behavioural disorder. This is based on participant use of domain specific and pre-encounter knowledge, but not for the purpose of diagnosis. Instead, anchoring themselves with certainty on the typicality afforded by a diagnostic label, participants relate how they apply knowledge of the typical to make judgements and decisions about the case at hand.

The application of domain specific knowledge from a medico-psychiatric perspective is not direct, and takes account of the social context as well as including reference to participants’ own pre-encounter knowledge of the individual. Participants express subjective certainty insofar as their narrative is anchored in reference to knowledge and expectations based on what was seen as typical. Analysis also shows that expressions of confidence and the exercise of professional power are linked to participant reliability on prior knowledge and what they perceive as their expertise.

Paraverbal and verbal evidence points towards participants’ deliberate and thoughtful consideration of cases, at least in terms of their reformulation. This is especially true where a case is characterised by atypical features. The atypical has already been considered in Chapter Four, and is shown here again as a feature of participants’ discursive representation

of their judgement and decision-making that appears to be the flip side of the coin, as it were, of typicality.

As this is an interim summary, I will at this point refrain from drawing any further conclusions from the evidence. I have already indicated where aspects of the evidence relating to participant reasoning are indicative of the expression of certainty and participant overconfidence. I will now move on to consider the findings of the conversation analysis-informed discursive analysis of the data in relation to the expression of subjective certainty and uncertainty.

5.3 Expression of Certainty & Uncertainty

- “I suppose maybe with my experience you’re already formulating that idea of what’s going on even before I had this, which has been reasonably accurate so far.”
Participant 9, Case 3, Think Aloud

Thompson & Dowding (2002, p15) define uncertainty in the context of clinical judgement and decision-making in nursing as “the inability to predict with accuracy what is going to happen”. As exemplified by the short excerpt above, it is in the nature of nursing practice that nurses tend to express certainty about much of their clinical judgement and decision-making (Flemming & Fenton 2002). However explicitly participants express certainty, implicit subjective uncertainty around judgement and decision-making is a characteristic of the study corpus that is most readily evident in think aloud data.

As seen in the previous section on participant reasoning, and building on the findings of preliminary analysis described in Chapter Four, there is further evidence that the expression of both subjective certainty and uncertainty in the study data is most clearly associated with talk that related to typical cases and diagnosis. This is seen most clearly in the think aloud data, complementing findings in the previous section which drew heavily on the retrospective interview data. Participant expression of certainty and uncertainty in the retrospective interview data is more implicit and less tangible.

Conversation analysis informed discursive analysis confirms the preliminary finding that the main marker of expressed subjective certainty in the study corpus in this regard is the word “obviously”. As a sentence adverb, “obviously” modifies a sentence to indicate that what is being stated is the speaker’s opinion (Thomson & Martinet 1986). Such opinions are held with varying levels of subjective certainty. As well as marking subjective certainty in the study corpus the word “obviously” marks reference to the typical. This finding builds

on the link between typicality and the expression of certainty already described in the previous section on participant reasoning.

5.3.1 The Think Aloud Data

In the think aloud data, expression of uncertainty tends to be associated with participants' seeking of information regarding the diagnosis of the fictional person in the case at hand. This can be seen in participant organisation of the case around the individual's diagnosis. Case 2 ("Noel") is the best example of this, where diagnosis was implied in the case materials, but not explicitly provided.

The think aloud data represents participants working through unfamiliar case scenarios involving fictionalised characters with whom they have no prior knowledge. In the absence of specific pre-encounter data, participants look to the person's diagnosis to formulate a quick initial assessment. As diagnosis was not made explicit in Case 2, participants turned alternatively to the familiarity offered by recalled knowledge of similar cases.

In addition to the word "obviously" there are other linguistic features that also evidence this, as the following excerpt illustrates:

((video playing in background, sound of fictional "Noel" coughing constantly))

1. †Okay †so (0.6) °I †think° >hh< one of e:h Noel's major problems would be ehm
2. (0.5) h'didn't=seem to be coping very well (1.3) eh:m (.) eh=as regards 'is life
3. skills (0.7) people skills and things like †that< °I=mean° (1) He's unemployed,
4. livin: †rough >there for three< †nights: eh:m (1.2) He=s-seems t'be blamin' that
5. on 'is †girlfriend=that 'is girlfriend kicked 'im †out: (0.7) Most people if their
6. †girlfriend kicked 'em out >they woulda< (1.3) they would have other resources
7. y'know even to put themselves †up somewhere for a †night, but >h-he=h-he=h-
8. he< he seems to be unemployed he >didn't seem t'ave=any< †motivation (0.9) to
9. gain (0.3) eh †employment. (1.2) Ehm, I think all that mighta led (0.3) p'rhaps,
10. (0.6) >speculatin' with all that i-< this lack >o' motivation 'n' things mighta< led
11. his girlfriend t-to: (0.8) split=up with=him p'rhaps, ehm. (1.7) †Eh:=as †regards
12. the rest of his condition he (0.7) °w:-° >jus=Noel=seems=to=have< a resp'r'ry
13. tract infection (1) eh p'rhaps=due=to: (0.2) ehm (0.3) livin' on the streets for three
14. nights=so †that needs careful monit'ring (1.1) eh throughout the †night. (0.8)
15. †Ehmm (0.2) 'e: says (.) he was gonna throw himself in the river. (1.2) Ehmm
16. (0.4) †well=that's=fair=enough (0.6) y'know=it's=a=good=thing=that=he came
17. t'wards the †services, but i:it gotta=be in the back o' your mind as well that he
18. could be playin' (0.6) 'e=could be playin a game with the services=as well,
19. y'know he's=it's lookin he (1) to use the services for a †bed, and 'e=has a history
20. of selling (.) drugs >jus=lookin=through =his=notes=there< so, (0.5) he's
21. obviously fairly cute to the services=in >'e he< knows how to play them, (0.3) so
22. y'gotta, y'gotta watch out for that as well. (0.8) But=I=me:an (0.4) that's all
23. secondary though because he >eh< by lookin' at him he does need to be in
24. hospital at the moment (1) but eh that, that will play on your mind eh further on

25. down the line, eh prior to discharge, but at the moment we just need to get him
26. well physically (1) ehhm (0.8) and eh mentally and=and get='im motivated.
Participant 14, Case 2, Think Aloud

The word “obviously” serves as a contrastive device in this narrative. Throughout the narrative metacognitive disclaimers, verbal markers and paraverbal features express subjective uncertainty and hesitancy. In doing this they seem not so much to explicitly communicate objective uncertainty as to discursively express the varying degrees of subjective uncertainty of P14’s perception/opinion (e.g., the introductory “I think” in line 1) in contrast to what is certainly apparent (e.g., the reading from the case notes in line 20).

I provide an outline below of these markers before discussing their functions in more detail:

Metacognitive disclaimers:

- I think (line 1, 9) (Thomson & Martinett 1986)
- speculating (line 10)

Verbal markers (Leech 1989):

- seem/seems (lines 2, 4, 8, 12)
- perhaps (lines 9, 11, 13)
- might (line 9, 10)
- could (line 18)

Paraverbal features:

- Noticeably quieter speech (lines 1, 3 & 12) (Speer 2001)
- Hesitancy phenomena (throughout) (Clark & Clark 1977, Hieke 1981)
- Anacrusis (lines 16, 20)
- Stress (line 21) (Bolinger 1989)

The degree of P14’s expressed subjective certainty is most apparent in their statements of inference as fact. For example, P14’s statement that the fictional “Noel” has a history of selling drugs is factual insofar as the information provided in the simulated case notes can be taken as such (line 20). Following on from this, the inference is drawn and similarly stated as fact, that Noel is obviously cute to the services and knows how to play them (line 21). This is achieved through the use of factual language, which makes explicit and implicit claims for the veracity of its content (Potter 1996).

The expression of certainty in the narrative was achieved through paraverbal communication as well as the verbal features outlined above. Hesitancy phenomena featured throughout both the retrospective interview and think aloud data. Whether they

serve functions related to conveying certainty, uncertainty or being hesitant about the appropriateness of the content can be difficult to gauge apart from the context supplied by other paraverbal features and the narrative content.

The rapidity of the delivery of P14's reference to the case notes (line 20) as a source of factual information gives prominence (Bolinger 1989) to this source. This serves to situate it in the narrative as underpinning the inferences that followed from it - namely that Noel is cute to the services and knows how to play them (line 21). This certainty stands in contrast to the degree of uncertainty apparent in the preceding part of the narrative.

Prior to the reference to the case notes (line 20), which P14's conclusions about Noel appear to hinge on, P14 states that Noel could be playing a game with the services (line 18). The repetition and silent pause here could be seen as characteristic of turn-related phenomena in conversation (Schegloff 2006). Whereas the retrospective interview narratives clearly feature the researcher as co-author, the think aloud data are more akin to monologues, and were deliberately constructed as such as part of the study design.

Therefore, rather than serving an interactive function (e.g., prolonging or maintaining their turn in conversation), P14's repetition following a silent pause is more likely to indicate thoughtful consideration of the next part of the utterance (Wegener et al 2006). There follows on from this the suggestion that Noel was looking to use the services for a bed (line 19), after which follows the reference to the case notes.

Consequently (line 22) the role of the nurse is to watch out for this kind of behaviour. The importance attributed to this responsibility can be seen in P14's tone of certainty in the description of Noel's playing of the services. This is particularly apparent in their repetition of "y'gotta" (line 22).

Prior to P14's reading of this information from the case notes they express consideration of this possibility (lines 17-19). On reading about the history of drug use, the speculation that Noel could be (line 18) playing the services is brought to the forefront (line 17). This expression of certainty colours P14's overall formulation of the case.

Looking at P20's consideration of Case 1 (where a clear diagnosis of paranoid schizophrenia is given in the simulation) diagnosis is mentioned early on in their formulation and then returned to as an organising principle. Even though the overall formulation is adjusted as other elements of the case presentation are considered, these remain "on top of", "with", or "as part and parcel of" what is arguably (perhaps with the exception of personality disorder) the most 'loaded' diagnosis in psychiatry:

1. Ehm, (0.1) okay she's a paranoid †schizophrenic (0.3) but †has had no evidence
 2. of ehm (0.1) >of no active psychosis in the last four †years< (0.7) ehm (0.4)
 3. †hasn't any >em< significant mood problem only >s-sometimes obviously has a
 4. low mood< (0.6) h. (0.2) †Ehm=hh (0.3) >poor social contacts< other than h- a
 5. sister, (0.2) ehm (0.9) so the biggest (.) problem >that=I see there< is a limited
 6. time >that=she=has< with her mother, (0.1) hh. >so=there< seems to be a difficult
 7. mother daughter relationship. (0.7) Ehm either (.) that was there when she was a
 8. child, (0.3) which sometimes happens, (0.7) pt (0.4) maybe a mother out at work::
 9. (0.2) †that's difficult sometimes this mother daughter †relationship h. (0.3) but
 10. definitely seems to have ehm, got worse over the years. (0.5) h. Ehm, (0.7)
 11. >maybe the mother finds it difficult< ehm, (0.4) to deal with her daughter >who is
 12. who is< a paranoid=schizophrenic hhh. (0.6) b'cause=of wanting to be
 13. emotionally attached as a mother to=a daughter but can't because of the illness,
 14. with >schizophrenia< sometimes people find it very hard (0.3) hh. to actually, eh
 15. relate with people, especially the people that are the=closest to them, (0.3) hh. so
 16. the †mother may need a bit of hhhh (1) eh=help there.
- Participant 20, Case 1, Think Aloud*

This excerpt shows how information regarding a person's diagnosis offers some degree of subjective certainty in terms of an organising framework which provides direction as to how to proceed and what to expect. This is similar to the discursive evidence already considered for participants basing their judgement and decision-making on regularly used knowledge that they draw on time and time again. Participants can be seen to make direct reference to their use of recent or familiar situations/cases to make sense of the case before them.

5.3.2 The Retrospective Interview Data

In the previous section I demonstrated how, in the think aloud data, participants reference to typical cases is linked to their expression of uncertainty. Due to the nature of the data, this could be associated with a lack of pre-encounter data. In the retrospective interview data, on the other hand, participants deal with their own familiar cases.

As part of retrospective data collection, participants were asked to recall a case similar to Case 4 ("Patricia"), which is characterised by a referral with scant information and lack of personal pre-encounter data. This is the best example of a case type in the retrospective interview data where lack of information was met by participants with recourse to the typical. As the cases in the retrospective interview data are recalled rather than *in-vivo*, a different way of talking about the typical *vis-à-vis* certainty/uncertainty is seen.

Unlike the think aloud data, which features talk around simulated cases, the retrospective interview data incorporate descriptive accounts of socially embedded practices in

judgement and decision-making. In analysing these narratives, I have drawn on my own previous experiences (of culturally embedded thinking and practice in psychiatric nursing) and domain specific knowledge (e.g., about depression) to identify application of knowledge of what is typical. The following is one such example from the narration of the case where the participant's clinical judgement seems based more so on culturally embedded, routinised thinking than on analytic reasoning:

1. P30: †Well more than (0.6) his †mental condition, he was very: depressed (0.7) but
2. had like (0.2) come over this >obviously< (0.3) after bein' discharged=he was
3. at a .h (1) a medium ehm, (0.4) >t't=eh< (0.1) w:e: (0.1) obser-we noticed=an'
4. observed that he wasn't (0.6) ve:ry: willin' to take his medication (0.9) which
5. we hadn't (1.1) got any information about either. (0.2) It just gave us
6. >information about what medication he was< on. (0.8) <But> (0.4) af- <on>
7. IR: [° mm°]
8. P30: >givin' him his medication he didn't want=to=take it until we'd †gone but we had
9. like kinda told him we have to .h (0.5) stay here until you take it, >it's only
10. procedure an' that=kind=o=thing< .h (0.5) So: >we kind of=observed that he
11. didn't want to take his< †medication? .h (0.7) So obviously there was very poor
12. insight. (1.4) Eh:m he didn't think he needed to do anythin' .h (0.5) he didn't even
13. know why the day centre was there, he was very negative about it and said well,
14. >"w:hat's th_i here for, what's the point in comin' here<?" ((accusative)) (1.1)
15. IR: [Right]
16. P30: "Sure=w:hat d'you do only do crosswords an' (0.2) exercises? Sure what good is
17. that?" (1.2) >D'you †know? Very negative an' negative< (1.9) 17. goin like for
18. IR: [Right]
19. P30: all the rest o' the clients, it was very negative for them as †well, like it wasn't
20. †helpin' them.

Participant 30, Case 4, JDM PiP Interview

Lack of insight as described in this instance is not characteristic of depression unless it is severe and accompanied by psychosis (World Health Organisation 1992, Gelder et al 2005). Indeed it is most often encountered where people are experiencing a significant degree of psychosis. It could feature in an unusual presentation of depression, but P30 does not describe the man's depression in this narrative as atypical.

However, in this excerpt I did recognise a common notion of typicality (with which I am familiar from my own practice experience) that is applied where someone is experiencing psychosis. This is perhaps best described as: "reluctance to comply = lack of insight". The underlying assumption being that the person, as one colleague used to put it, is "so sick that they don't know how sick they are".

However, the more commonplace experience of depression described in the case above is not such that lack of insight would typically be ascribed to the person. What appears to

have been applied in this instance is application of the principle of “reluctance to comply = lack of insight”. That its application is with subjective certainty is evidenced by use of “obviously” in line 11.

In my own clinical experience this approach by psychiatric nurses is not uncommon, serving as a convenient explanation for what is in essence a complex problem that might otherwise require intensive engagement and intervention. However, viewing the man’s reluctance to comply with his treatment regimen as an aspect of his condition which is typical of such cases serves to nullify the need for such engagement. The need for an individualised approach is thus negated as a matter of routine.

5.3.3 Interim Summary

As with the previous section, I will now give a brief interim summary. Whereas the previous section on participant reasoning drew heavily on the retrospective interview data, this section dealt with findings based mainly on the think aloud data. Several aspects of the evidence set out in this section confirms findings already discussed in the previous section and in Chapter Four.

Analysis again points towards the expression of subjective certainty amidst uncertainty. There is also evidence of clear association of references to the typical with the expression of certainty. This was particularly clear in those parts of the narrative where the word “obviously” is used, due to its discursive function in relation to both the expression of certainty and reference to the typical.

The expression of uncertainty was found to be more tangible where there is a lack of pre-encounter data and diagnosis is not given. This is because diagnosis can be seen to operate as an organising principle for the application of domain specific knowledge. Where diagnosis is available, certainty is expressed to the degree that it could be interpreted as overconfidence.

Expression of subjective certainty was found to be associated with decisions regarding intervention as well as judgement regarding condition. This is similar to the findings in the preliminary analysis regarding routinised intervention as imperative action. There would appear to be a link to perception of role here, insofar as certain actions or interventions seem to be routinised, habitual responses to certain typical situations or individuals.

5.4 Contingency & choice

I use the term contingency to refer to instances of judgement and decision-making whereby options for action are assessed with regard to context and consequence. This is, for the most part, a feature of narratives in the retrospective interview data. It does not occur in response to specific requests by the interviewer for recall of episodes characterised by contingency, but is freely described by participants without prompting. These narratives are replete with instances whereby professional power is implicitly and explicitly exercised in the offering of choice and marking out of contingency.

In the retrospective interview data, participant narratives relate problematical real world events where there were many options and potential consequences. The think aloud data differ from these intricately unfolding narratives. For this reason, the retrospective interview data are a much richer source of instances of contingency. However, these are not completely absent from the think aloud data, which I will discuss in conclusion.

5.4.1 Contingency & Control of Choice in the Retrospective Interview Data

The excerpts that follow demonstrate how the construction of shared meaning by nurses can be a powerful means of control. These examples are all from discussion of a case similar to Case 1, characterised by situations involving contingency and requiring intervention. The narratives are clear exemplars of the extent to which control is an issue in contemporary Irish psychiatric nursing practice.

In the examples drawn from community mental health services, the power of the professional is subtly constructed. In the examples from inpatient settings, the construction is cruder. The construction of shared meaning between nurse and service-user is represented by participants as a process over which the nurse very much has control.

The exercise of professional power by participants has already been noted in the discussion of participant reasoning. In that context its bases were professional knowledge and expertise. These give participants an advantage in ‘managing’ individuals, in particular giving them license to make certain assumptions with regard to typicality and how to respond to it.

Psychiatric institutions are commonly perceived of as large inpatient facilities dealt with in classic texts such as Goffman’s (1963) “Asylums”. Whilst such total institutions are no

longer the mainstay of psychiatric services, psychiatric services are nonetheless social institutions. It is in this specific institutional context of community mental health services that the following narrative is grounded.

In this narrative, P26 discusses principles that commonly guide therapeutic engagement of service-users on their caseload. Although this social context is at some remove from the total institution of the asylum, the professional control associated with that setting appears to have been retained to some degree. Social context and location of service delivery, it would appear, have a bearing on how this control is exercised – not on its presence or absence. This is because it is not a function of the clinical setting, but of the social role of the psychiatric nurse.

1. P26: Yeah well=you †wouldn't really put=a <ti:mefra:me> on it because (0.6)
2. IR: [N:o [Right [Yeah
3. P26: h. eh:m that kinda scares them=off.
4. IR: [Y:eah: I=was=just=thinkin' that yeah
5. P26: [Y'know, >it=can=be<
6. IR: [heh heh heh
7. P26: if=you say=to=them, †okay in the next \$ †year you're †goin' to †be:
8. IR: [heh heh heh heh ha ha ha ha >ha ha ha ha ha ha ha ha ha ha ha ha ha ha ha<
9. P26: \$ y'know whatever, so you just kind=of=say=ehm, 'Well, ok (0.4) eh:m
10. IR: [hhhhhh. <yeah, yeah>
11. P26: (1.3) >d'y'know< your, your biggest problem at the=moment is: (1.8)
12. IR: [mmm
13. P26: †boredom, (0.2) >whatever< lack of (1.2) °something to do° so: y-you just
14. IR: [mmmm [m: m: m:
15. P26: work on †that an=then when you=have that (.) resolved (0.4) h. you work
16. IR: [mm
- 17.: P26: on the †next: (.) thing y'know you †prioritise °problems and (0.6) ehm
18. IR: [aw right [mmm [†yeah [mm
19. P26: ehm work on >li-which=you=would< a:lways kinda say to=them, because
20. (0.5) you=know you'd never kinda build their hopes up too high, because
21. IR: [mm
22. P26: (0.9) th-if they get knocked back, (0.5) >°it=can=be °< really set them back
23. IR: [hmmmm
24. P26: you=know so: you=kind=of=I always †say to them, y'know you (0.4)
25. IR: [yeah
26. P26: <you don't take giant leaps, y'> you learn to walk before you can run kind
27. IR: [mm
28. P26: of y'know, you do this in <small little steps=n,> you=know even if ehm
29. IR: [m:
30. P26: (0.7) you do have=a: (0.2) mishap and=things >y'know=I< †actually (0.6)
31. this particular chap he=he started a course before=and had a breakdown in
32. the †middle of it,
33. IR: [oh right
34. P26: [you know so †that was >°a major but°< (0.4) we

35. IR: [°yeah° [m m m m
36. P26: †kinda picked up <where we> left off and y'know, we (0.9) worked on it
37. IR: [m m m [yeah
38. P26: again so (.)
39. IR: [°yeah°
40. P26: [>like< you=know you have=to kind=of (1.5) †prepare them
41. IR: [yeah
42. P26: for tha-those kind of little pitfalls y'know
43. IR: [°yeah, I suppose so, yeah°
44. P26: [°yeah you can't be too°
45. IR: [°yeah°

Participant 26, Case 1, JDM PiP Interview

Here, before engaging with the individual who has been referred to them, the nurse has already decided not to offer them a timeframe (line 1). This curtailment of choice is intended to avoid scaring them off (line 3). The interviewer's apparent display of mutual understanding (Hutchby & Wooffitt 2008) of the participant's perspective (line 4), leads P26 to begin to expand on it.

However, at the transition relevance place, as P26 begins their next turn, the interviewer initiates a 24-part laugh unit (Glenn 2003). P26 does not join in the laughter, although she does speak in a bemused tone of voice (lines 7/9) as the interviewer speeds up his laugh. The interviewer's laughter speeds up as he orients to P26's continuation of her turn without joining his laughter.

At this point his laughter also changes in sound (from the longer "heh" to the shorter "ha") before being concluded by a standard inbreath particle (Glenn 2003) and a second expression of mutual understanding, "<yeah, yeah>" (line 10). This repair signals the interviewer's continued desire to understand and listen. For the remainder of P26's turn, the interviewer continues to communicate this desire verbally ("yeah", "oh right") and paraverbally ("mmm") and does not renew his laughter. This also constitutes repair, given P26's failure to join in the laughter (Glenn 2003).

The individual is told what their biggest problem is at that moment (line 11). The nurse, generally speaking, is then represented as carrying out both the prioritisation of the individuals' problems and the work of resolving them. The generalisation of this approach as part of the nursing role is seen in the use of the second person singular pronoun "you" (lines 1, 7, 9, 13, 15, 17, 19, 20, 24 & 40). A vital aspect of this work is to set limits on the service-users' hopes (line 22), with the contingency of avoiding their getting knocked back, with the rationale that it can really set them back (line 24).

The person is not just instructed, but taught general principles. Again the generalisation of this approach to therapeutic engagement can be seen in use of the second person singular, this time to build a general picture of the service-user's role (lines 7, 24, 26, 28 & 30). This is structured in terms of representations of the nurse giving direct speech instruction to the service-user.

The use of the first person plural pronoun, "we", would appear to represent shared construction of meaning (Margutti 2007) and sharing of power (lines 34 & 36). However it soon becomes apparent that this is very much a process where the responsibility and power lie with the professional. It is they who ultimately bear the responsibility to prepare service-users for little pitfalls (line 42).

The second example relates to an inpatient setting, with clearer social and historical links to the total institution of the asylum. Here P12 openly refers to the system of contingency that they operate as being "like a reward system":

1. P12: †Well=yeah=I †remember a †couple o' †people ‡now. (0.7) >I=am=I'm<
2. thinkin' o' one person off hand at the moment who used to spend an awful lot
3. IR: [°yeah°
4. P12: o=time in ‡bed. (0.8) Now >this=is=the< the outcome wasn't a success, (0.7)
5. but=I remember (0.6) you=know, that this was discussed that he was, (0.2) a
6. person with poor motivation, an=he was quite young, he was only in his mid
7. twenties, (0.5) h. sittin in bed all day, very lazy, difficult to motivate. (1.6) Ehm.
8. (1.2) †Uhm. (0.4) †There=was a †number of things †drivin=im, d'y'know,
9. different kind=of, (0.7) ‡attendin' diff'rent, attendin op-occupational therapy
10. IR: [mm
- 11.P12: durin' the day while he was an inpatient. (1) E:hm (1.8) we used to do stuff kinda
12. like a reward scheme for=im, (0.7) I-you=know, like a kind=of=a system whereby
13. if=he did somethin, (0.2) if=he went ou' an' did somethin' for a ‡day (0.3)
14. IR: [mhm
- 15.P12: >he-ge-< he'd get somethin in return (0.5) 'cause he was that difficult to
16. IR: [yeah
- 17.P12: motivate, so=it was kind=of like a reward ‡system. (0.7) You know, you might
18. say ‡to=im ehm, (0.6) he might come ‡in (0.4) d-at ‡two o'clock durin' the
19. ‡day, (.) see=he's been in bed all ‡day and he wants to ring ‡somebody, (0.5)
20. so=y'tell him >that=if< y'know, (.) if you get dressed an' go out=for a walk, (1.5)
21. and come back to me in an ‡hou:r, (0.5) that type o' thing, you=know? (0.5) <Or>
22. IR: [m:
- 23.P12: (0.4) the usual barterin' for cigarettes, (0.5) >°y°know.< (1.3) Ehm (1.3) †And
24. IR: [\$ h.yeah:
- 25.P12: you'd be †kinda discussin' it with=the with=eh, with=his team as well=sometimes
26. you'd get psychiatrist would look at=it an' go, well maybe he's on too much
27. <medication.> (1) Maybe we'll look at changin' the ‡meds, givin=them at
28. different ‡times, (0.7) you=know? (0.7) >aw-eh< y'know? (1.2) †Sometimes it
29. IR: [‡yeah

- 30.P12: could be, >sometimes you find people are stayin in bed< because they're a bit,
 31. kind of, (0.9) >sometimes< it can be 'cause >they'd've< ↓depression or they've
 32. a lack=of energy, (0.6) sometimes they can be startin' to go the other way
 33. IR: [yeah
 34.P12: that=they're goin, (1.7) they're goin' a little bit: kind=of, d'y'know, they could be
 35. schizophrenic or bipolar- they could be going a >little< bit paranoid or a little bit
 36. IR: [°m°
 37.P12: kind of pt (0.2) h. startin' to behave strangely, gettin' notions about other people
 38. IR: [°m°
 39.P12: or somethin' like that: (0.1) They don't wanna leave their=room, this type o'
 40. IR: [yeah
 41.P12: thing, you=know?
 42. IR: [mhm

Participant 12, Case 1, JDM PiP Interview

The individual wanted something, in this case to make a telephone call (line 19). However, his being permitted this was contingent on his obeying the nurses' suggestion that he got dressed and went out for a walk (line 20) in line with the nurse's suggested time limit (line 20). This is not an isolated practice, but is the type of thing (line 21) that might (lines 17 & 18) happen regularly to ensure compliance with certain behaviours. The noncompliance that the reward system (line 17) addresses is clearly distinguished from psychopathological features (lines 28 to 41).

The fact that no contention or conflict is reported in association with this system (line 12), along with its discussion in a narrative that also covers multi-disciplinary team review (line 25) and medication management (line 27), would appear to indicate that in P12's experience it is a process which is engaged in routinely by psychiatric nurses. It is interesting to note that P12 is a nurse who falls into the 0-5 year experience category. They would not have worked as a nurse in the more institutionalised settings common in the 20th century, being a graduate of 21st century third level nurse education.

The situation described in the next excerpt, an episode of control and restraint, is by its very nature one where power lies with the psychiatric nurse. The choices offered are reliant on very limited contingencies, i.e., either lie down (lines 9 & 14), or if you refuse that (line 17), be held down (line 23). Despite the fact that the options are quite limited here, the contingencies are discursively constructed in such a way to present the man with the illusion of choice (lines 2, 16 & 26) and the consequent burden of responsibility (lines 15 & 16):

1. P40: °The° †strange thing †was, I >remember< (.) goin=up to=him and ↓sayin'
2. ↓to=him, (1.1) <you got two choices.> (2.2) >And this=was when=he was,< °like°
3. (1.5) <hallucinatin> right, left an' <centre.> (0.8) >He=says< what †are they?

4. (0.4) >An=I said< ↓well, (2.2) we have to give you=an injection, (2.6) >°An=I
5. said,< you've got=a choice of takin' your tablets <↓or:ally.> (0.8) >°He°=said,<
6. ↓what do=you ↓mean, >°An=I° said< you can take these tablets here=in my
7. ↓hand. (1.4) Am ↓not takin' them ↓fuckin' tablets. (0.3) >°An=I° said< that's
8. fine °↓I=said ↓that's ↓fine.° (0.7) hh. I=said you got two choices ↓now, (0.1)
9. >°Look=there's°< you either (1.4) lie down on your side, (1.5) and †like your
10. watchin' your body language, <you're watchin' your eye †contact, you're
11. IR: [°m°:
12.P40: watchin' your <↓tone.> (0.2) >°Your°< tone has=to=be ↓firm but ↓fair. (1.8) Eh:m
13. IR: [°m°
14.P40: (2.2) >°I=said°< you either (0.2) lie down on your side by ↓choice, (0.6) >°I=said°<
15. you've=got †complete control over the †situation, (1.1) <and you ↓take the
16. ↓injection (0.7) ↓by ↓choice.> (0.7) †Your †choice, (0.5) not ours. (1.5) Or
17. >if=if=or=or:< if you †refuse that, >I=said,< you leave us in no <↓position> (1.1)
18. <and=I=remember> (.) pointing out: (0.6) this chap, (0.4) this ↓chap, (0.7)
19. 'n' <↓this ↓chap,> (0.5) colleagues (0.2) who are standin' in the distance, (1.6)
20. IR: [°m°
21.P40: 'cause you †don't=want him to feel threatened either, (0.1) °y-you=know.° (0.9) h.
22. IR: [yeah
23.P40: (1.3) >°An=I said,< (0.4) we will have to hold ↓you down. (2.1) >°He=said°
24. †what d'you< mean? I=said, (0.3) we don't ↓want to †do ↓it:, (1) >°I=said°< we
25. will have=to hold you down (1.6) <if you're refusin' to take> (1.7) °an injection°
26. by †choice (1.8) >I=said< we're goin' to=have °to ↓give it to=ye.° (2.8) >°okay,
27. IR: [mm
28.P40: fair=enough.< (0.6) †This=is in †all the †madness, (1.5) †obviously there's
29. †other interventions and
30. IR: [†So sometimes †rational and sometimes ↓not rational
31. P40: [°Y-° [†Yeah
32. IR: Yeah.

Participant 40, Case 1, JDM PiP Interview

P40 acknowledges that this was neither the only approach available (lines 28 & 29), nor entirely desirable (lines 21 & 24). This narrative shows how shared meaning was built with the apparent purpose of allowing the man to save face by appearing to consent to something that he ultimately has no choice over. Building on the initial notion that the man had complete control over the situation (line 15), P40 spelt out his limited options more directly whilst retaining the illusion of choice (lines 24, 25 & 26).

These three narratives cover the full range of the exercise power and control in psychiatric nursing – from voluntary engagement in an open partnership in a community setting to actual physical manhandling and injection of an individual in an inpatient setting. What is somewhat disconcerting is that the same type of discursive construction of choice as a cover for professional power and control features throughout the entire range of narratives. Essentially, the same social construction of illusory choice features in counselling-type

community engagement as in the discursive management of the physical restraint of individuals under lock and key.

This points towards the covert exercise of power as a basic and integral element of the role of the psychiatric nurse (Walsh et al 2008). That it is embedded in narratives featuring contingency across the full range of settings and types of engagement underlines its centrality. Its implicit expression by participants, who appear oblivious to the central place it occupies in their narratives, is further evidence of how innate and fundamental this feature is in the fabric of psychiatric nursing.

5.4.2 Contingency & Sharing of Power: Retrospective Interview Data

The following two excerpts are exemplars of a less controlling approach that is also apparent in the retrospective interview data. In the first excerpt, unlike the limited offering of choice or construction of the illusion of choice evident in the previous section, the nurse does not merely offer a limited choice between alternatives, but choice itself. This takes the form of suggesting several options (lines 14 to 19) which convey the message that the scope of choice on offer is not limited to these examples of what is possible.

P16 communicates this by representing their talk-in-practice, making a subtle shift (line 9) to address the service-user directly. This shift is managed in the context of P16 describing how they would approach the situation, specifically where they mention that they “say listen” – “listen” being the first word addressed hypothetically to the service-user. P16 follows on not by imparting an imperative or condition to the woman, but by putting a question to her in order to address a contingency stemming from the woman’s own situation (lines 9 & 10).

The shift back to addressing the interviewer (line 10) is managed using hesitancy phenomena and discourse markers: “(0.8) you=know that maybe, (1.1) >an=eh<”. After a slight pause and use of the discourse marker “you know” by way of introduction, P16 makes the shift back to addressing the hypothetical service-user in order to represent their routine talk-in-practice. The suggestions that ensue (lines 14 to 19) are offered firmly within the contingency of the woman being unsure of what the nurse could offer as part of her role (line 12).

The emphasis on “they” and “I” in “they’re not sure what I’m able to=do” (line 12) underscores the collaborative nature of the process being described. This sets the role of the nurse in the context of a relationship between two individuals, which is in contrast to the

alternative of discursively centring an individual's engagement with services on the services themselves (for examples of this see the previous section and section 5.4.3). This is in the context of P16's overall narrative description of their role, which is implicitly described as involving genuine facilitation of recovery as opposed to merely providing direction for recovery. This involves offering choices that are contingent on the woman's own personal circumstances and condition, for example, finding herself in particular difficulty (lines 16 to 19).

This context is also important in terms of P16's use of a combination of diminutive qualifiers (Skelton & Hobbs 1999) - "just kind=of" (line 14) - and discourse markers - "you=know" (line 14)- in offering suggestions. The reason that these discursive features work in other contexts as powerful conversational tools of subtle coercion (Heritage 1984) is because they also function well as markers of sincere accommodation.

These function alongside markers of contingency to signal deference to the woman's parity of control over options: asking "would=it=be okay if" (line 14); using, with emphasis qualifiers such as, "if you †want" (line 15), "if that †suits you?" (line 16); P16 offers the woman control over the initiation of contact, suggesting that she can ring the woman (line 15), whilst the woman can also ring her (line 18).

1. IR: Right
 2.P16: Eh, >that's something that=am< actually very=aware of myself. (0.6) You=know
 3. IR: [°ok°
 4.P16: so=I s'pose I would †always, you know, put in my †diary now, (0.2) y'know
 5. >will=be every< two weeks or something, (0.3) phone (0.3) whoever. (0.7) †Just
 6. IR: [°ok°
 7.P16: to check †in=to see how they †are=if †they can't make it to †me that I=would I
 8. would try and ehm, (0.5) you=know, (1.1) come †up with=a plan, (0.3) and say
 9. listen, (0.1) you=know, if you can't come down here, what: >what=other way can
 10. we work< that, (0.8) you=know that maybe, (1.1) >an=eh< †suggesting maybe a
 11. IR: [°m°
 12.P16: few things, because they're not sure what †I'm able to=do. (0.6) >You=know I'm
 13. IR: [Right
 14.P16: just kind=of suggesting a few things that would=it=be< okay if, (0.5) you=know,
 15. I can meet you †somewhere if you †want to? (0.3) Or I can †ring you? (0.3)
 16. †Every so †often if that †suits you? (0.2) Or if you are in difficulty >like=if say
 17. the person is< going through, eh, a very difficult separation >as=well< from her
 18. husband, (0.6) <a:nd,> it's quite nasty, you can ring me if you've any problems or
 19. any difficulties.

Participant 16, Case 4, JDM PiP Interview

In the excerpt below P37's description of collaborative engagement centres around their assertion that the individual is very much their own therapist (lines 10/12). P37's role is not

to wield power or offer contingent rewards, but to freely and openly encourage the person and to affirm that they are “workin’ fine” (line 12), “doin’ oka:y” (lines 12 & 13), and “doin’ >really, really< well” (lines 16/18). Continued engagement was offered contingent only on the individual’s choice (lines 15 & 16).

P37 uses the discursive strategy, common throughout the corpus, of deftly switching from addressing the interviewer to addressing a hypothetical service-user. This switch is achieved by means of a pause (line 3) or hesitancy phenomena (line 10). As in other narratives, P37 uses this strategy to represent her talk-in-practice. The importance of this talk for analysis is not that it can be said to actually representative of actual talk-in-practice, but that it represents how the participant sees that talk as constitutive of their role (Widdicombe 1998).

The nurse’s therapeutic agency here is to give the individual “this notion” that they’re “↑fine”. The implication of the word “notion” is that if someone is attending mental health services they might not perceive their condition as “↑fine”. In this context, that the choice of “notion” here represents an attempt to instil self efficacy (Cutler 2005) rather than deceive the person is apparent from the tenor of the overall narrative.

In contrast to the excerpt in section 5.4.3, where the imperative to attend and engage with the mental health services is paramount, P37 plays down the need for the person to engage on a weekly basis (line 4). Her view of the person extends beyond “the fifty minutes” in which they consult with her. During this time she may be their therapist, but beyond that they are their own “↓therapist <outside>”.

The playing down of the need to engage with the services and the nurse as therapist is not done in such a way, however, to discourage the individual from attending as they see a need. In line 16 the hypothetical person is told that another session “isn’t a problem” if they feel that they need it. P37 is quite explicit that the strategy here is not to coerce people into being independent but to give them “empowerment to take° control” (line 20).

- 1.P37: >Y’see it’s almost like< you HHH. HHH. (0.3) you=know you (0.6) give them
2. IR: [yeah [yeah
3. this notion that (0.4) you’re ↑fine, >you=know there’s lots of things happenin’
4. out there, you don’t need to< come in here (0.2) >°every week.< (0.8) ↓It’s so
5. IR: [mm
- 6.P37: true, because° everyone’s got a life (.) they’re livin’ (1.4) outside the fifty minutes
7. IR: [hm
- 8.P37: every week. (0.5) >So=it’d be< b-really ↑brilliant if I thought=it kept things goin’
9. IR: [yeah
- 10.P37: for that=so it’s kind=of ↑givin’ ↑back that, that=you <are> (1) very much your

11. IR: [hm
 12.P37: own, (0.1) ↓ °therapist <outside> and you're° workin' fine, an' you're doin'
 13. oka:y:
 14. IR: [yeah
 15.P37: [y'know=uhm (0.4) >say how=I'm=still goin to be< around if you needed
 16. another s-session, that=isn't a problem, (1.3) °but you're doin' >really, really°<
 17. IR: [mhm
 18.P37: well.
 19. IR: [mhm
 20.P37: [°So it's ↑kind of (0.3) givin that empowerment to take° control, and take
 21. IR: [yeah [°m°
 22.P37: responsibility for ↑leavin' it for a month.
 23. IR: [mhm
Participant 37, Case 3, JDM PiP Interview

Of course the fact that participants describe the offering of choice to individuals is not necessarily indicative that this is what occurs in practice. What is of interest here, however, is not the veracity of the narratives where choice is offered. The focus of analysis is on the discursive construction of choice and the offer of choice.

Where choice and contingency are discussed in the retrospective interview data, the construction of shared meaning is apparent as a function of professional power. Choices and contingencies are offered to people in a specific social context where the nurse plays a specific social role. Depending on their perceived role they may construct a shared meaning with a service-user with the aim of subtly limiting their choices and/or gaining their compliance.

Participants who describe engaging people in this way represent their actions as being in the best interests of those individuals, no differently than those who offered a wider range of choice and empowerment to people. Construction of shared meaning to limit choice appears not to be seen by participants as a cynical exercise of power over others, but an important part of the beneficent operation of their role as a psychiatric nurse. The ability to construct shared meaning for subtly coercive purposes is, by implication, presented as an important skill of the psychiatric nurse.

5.4.3 Contingency & Control of Choice: Think Aloud Data

The example below is from P27's consideration of Case 4 in the think aloud data. This case is set in the context of community mental health services. Although not to the extent of the retrospective interview data, the think aloud data did feature instances where the power of the professional featured in the careful construction of shared meaning with the specific

aim of attaining compliance. Frequent exhalation is a general feature of P27's conversational style. Exhalations permeate the entire narrative, and so it is difficult to attach any peculiar function to them with regard to the point being addressed in this excerpt.

In line 3, after explaining the assumed context of the speech, P27 subtly switches to address the hypothetical Patricia directly. In doing this they formulate contingencies and present them in no uncertain terms:

1. <And ehm> (1.2) then †assumin' that the husband, or=herself
2. would be willing to (0.2) h. consent to=a visit like, (0.4) h. outlinin to=her †again
3. (0.9) like look (0.2) h. it's important that=you (.) attend to outpatient (.) <facilities
4. and> (0.2) h. y'know like, (0.4) ye-ehm k-while you=you done †well in hospital,
5. (0.4) h. if you do:n't comply there's a chance you might have to come back into
6. ho:spital, (0.1) h. you might be there lo:nger the next time, (0.4) that kinda thing,
7. <and> outlinin' to=her (0.5) †all the †positives, all the <outpatient=services
8. that're> †are available †like, (0.4) <and> (0.2) maybe if the day hospital isn't for
9. her, (0.3) that somethin=else might be for her †like (0.3) you=know, and
10. discussin wit=her an' h. (0.2) >maybe she doesn=like the day hospital< because,
11. (0.2) one or two clients annoy=her there or, (0.6) maybe it's too near her local
12. area, she feels there's h. (0.3) confidentiality issues †like, h. (0.2) †maybe
13. getting' to the bottom of why she's not attendin' it †like, (0.3) be it over the
14. phone †or, (0.3) face=to=face when you'd meet her †or the husband †like, you
15. †know?

Participant 27, Case 4, Think Aloud

The potential negative consequences for Patricia are not related in terms of her own experience of internal psychological processes – not even in terms of relapse or re-occurrence of psychopathology. Instead the negative consequences are related in terms of social action mediated by health professionals in the form of readmission to, and a longer stay in, hospital (lines 5 & 6). Similarly, the positives (line 7) are not presented in terms of internal psychological benefits such as an enhanced sense of wellbeing, but are provided through the operation of the apparatus of the psychiatric services (lines 7 to 13).

In lines 5 and 6, coercion is achieved through emphasis on the potential negative consequences of non-compliance: “if you do:n't comply... you might have to come back into ho:spital ... you might be there lo:nger”. The use of this discursive tactic for coercion by psychiatric nurses has also been identified by Gilbert et al (2008, p95), whereby service-user participants described it in terms of being “hypnotised” “brainwashed” and “playing the game”.

There is a ‘game’ element to the strategy used by P27 here in that a ‘carrot and stick’ approach is used. After presenting potential negative consequences, P27 places emphasis on “↑all the ↑positives” that are available to the hypothetical Patricia should she comply. Attendance by Patricia at “the day hospital” (line 8), or something else that might be for her (line 9) is contrasted with the potential for a long spell in hospital (line 6).

When she is seen as doing “↓well” (line 4), this is also expressed with emphasis on engagement with the services, i.e., doing “↓well in hospital” (line 4), as opposed to simply “doing well” or a more meaningful and personal form of recovery. Where internal psychological aspects are touched on, there is a distinct social element governing their exploration. Dislike of the day hospital is seen as likely to be due to the social stigma attached to attending (lines 11 & 12) or poor social relations with others attending there (line 11).

Exploring underpinning personal issues is seen in terms of getting to the bottom of non-attendance (line 13) and continues with the tenor of the overall narrative towards attaining her compliance/attendance. The focus on attendance at the day hospital is emphasised in the use of the phrase “why she’s not attendin’ it ↓like”. As the impersonal pronoun object of the verb ‘attending’, “it” serves to make the day hospital, as opposed to Patricia, the focus of attendance. The alternative “why she’s not attendin’ ↓like” would have made Patricia the focus of attendance.

Overall in this example, the drive for compliance is not predicated on potential positive outcomes for the mental health of the individual, but by their perceived need to be engaged by the psychiatric services. As in the retrospective interview data, the operation of role-determined, services-centred professional power is also evident in the think aloud data. This is not expressed as an unfortunate corollary to how the mental health services are structured or a necessary evil in the work of the psychiatric nurse. Instead it is conveyed as an approach which genuinely has the best interests of the individual in view.

5.4.4 Contingency, choice and role

In this section I discuss the findings of the conversation analysis informed discursive analysis in relation to contingency, choice and role. Contingencies here take the form of situations where choices are required. In this case, the choices I discuss are those of the nurse as opposed to those of individuals availing of the mental health services.

In its recall and portrayal of participants' everyday work life, the retrospective interview data offers the clearest evidence in the study corpus regarding the role of participants as it relates to their clinical judgement and decision-making. The think aloud data, on the other hand, represents participants operating outside of their naturalistic work setting. Talk around choice of intervention best exemplifies participants' expression of their roles, particularly with regard to those interventions that are represented as exceptional as opposed to routine.

In this section I refer to participant narratives that relate to choices made in interventional decision-making (characterised by Case 1). Also, I have made some comments with regard to narratives featuring discussion of Cases similar to Case 3 and Case 4. Participants can be seen to talk about interventions in a general way, as something that 'everyone' does. This is seen in the use of "we" when talking about an activity, or "you" to generalise an activity.

The first example below illustrates this and shows how careful consideration in participants' talk about activities can reveal aspects of the institutional culture and roles from which they have arisen. In this excerpt P38 talks about choice of intervention as a group effort, repeatedly using the first person plural pronoun "we" alongside the second person singular pronoun "you". In doing this P38 closely identifies themselves both with the local work group and the wider profession. Whereas the use of "we" indicates group decision-making by the local work group, use of "you" serves to generalise the issue further as representing what "you", as a psychiatric nurse, would do in such a situation.

1. P38: I †suppose the †issues >and it can=be an=and=they're kind=of ongoing' issues
2. anyways,< (0.2) h.
3. IR: [mm
4. P38: [is >people's personal hygiene,< (0.6) you=know, which can
5. IR: [hmm
6. P38: impact on †other people. (.) <And,> we have to make a decision, (0.9) >at some
7. IR: [hm
8. P38: stage and say to=the< person, (0.3) you know, (0.4) ehm, (0.1) well this=is very,
9. †this >is=is=a very=very< important issue. (0.5)
10. IR: [hmm
11. P38: [<And you need (0.6) to:> (0.3)
12. look after your personal hygiene. (0.4)
13. IR: [hmm
14. P38: [you=know, (0.3) and †we need to ensure
15. that you †do it, because the=co- the consequences (0.6) h. <for> (0.6) for both
16. (0.4) †yourself, and the=other (0.5) people, >both patients< and †ourselves, (0.5)
17. is that, (0.4) >you=know how=it,< it makes the whole environment, (0.4) and,
18. (0.7) a:t some, at some stage, >as=well< it'd †all depend really, (0.2) if the
19. person=is a voluntary patient, (0.4) <then (0.6) y:: your> (0.6) your hands are tied

20. in one sense. (0.3) But still, (0.4) you=know, (0.3) you >have to say to the
 21. person, ↓well< (0.4) y'know, (0.8) this=is what is normal and what we expect an'
 22. what people >ex=expect< and you have=to (0.2) put as much pressure (0.2) as
 23. you ↑can (0.7) on the person to <actually (0.4) comply with, with what would=be
 24. (0.3) seen as bein (0.4) normal kind=of eh, hygiene standards and know, y'know
 25. >and,< (0.1) because they ↑don't (0.4) >they've really leavin' on=people=n'
 26. themselves ↓at=risk.

Participant 38, Case 1, JDM PiP Interview

Closer consideration reveals the construction here of the role of the local work group as well as the role of the psychiatric nurse generally. Responsibility is clearly attributed to the local work group in this situation. That the onus is on them, including P38 as a member, to act is clear from the phrasing “we have to” (line 6) and “we need to” (line 14).

The imperative nature that such phrasing gives to this responsibility conveys the message that this is simply what you must do as a psychiatric nurse. The participant's use of “we” here blurs the distinction between themselves and other psychiatric nurses by establishing common identity (Bramley 2001). This common identity serves as the basis on which the invocation of the collective imperative serves to occlude the participant's individual responsibility.

Rapley & Antaki (1996) the phrase “we have to” serving a similar function in their conversation analytic study of the acquiescence of individuals with intellectual disability in a residential care setting. The phrase initially appeared to imply acquiescence on the part of speakers, but closer consideration taking into account the wider narrative and context showed that the phrase was indicative of “routine rubber stamping” (Rapley & Antaki 1996, p217). Similarly, Shepherd (2006) found that the phrases “we have to” and “we need to” function to vaguely attribute responsibility to a corporate body as opposed to any one individual.

The preliminary discursive analysis of keywords derived from comparative keyword analysis (see Chapter Four) also demonstrated how talk about interventions is indicative of their routine and habitual manner. This contrasts with interventions being represented as stemming from thoughtful deliberation and analysis. In the context of the institution of psychiatric nursing to which participants belong, the professional responsibility assumed in the narrative represents the paternalistic role that has been shown to characterise that institution (Breeze 1998, Roberts 2004).

Paternalism manifests here in the person being told what they need to do (lines 11 & 12). This is in the context of the participant adopting the discursive stance of talking directly to

“the person” availing of their services from line 8 through to line 17. This stance is entered into explicitly in line 8 where the participant, having in line 6 taken on a corporate identity through the use of the first person plural “we have to make a decision”, continues to exercise that identity by continuing on: “at some stage and say to=the< person” (line 8).

P38 initiates their representation of this corporate speech to the person with hesitancy phenomena which act as a transition from the preceding narrative “(0.3) you know, (0.4) ehm, (0.1)” (line 8). As in line 21, the pre-placed appositional “well”, usually used to start a dispreferred turn - a turn the hearer is likely not to find agreeable (Pomerantz 1984). Both here and in line 21 there are also hesitancy phenomena (repetition in lines 8 & 9 and in line 21, pauses and the discourse marker “(0.4) y’know, (0.8)”, characteristic of the initiation of a dispreferred turn. Whatever claim can objectively be made about its veracity in representing actual talk=in=practice, it is apparent that P38 constructs this element of the narrative as representative of what would actually be said in such an instance.

After the service-user is told that they need to look after their personal hygiene (lines 11 & 12), the provision is added that the professionals need to ensure that they do it (lines 14/15). This is in order to avoid certain consequences (line 15). Here the team and the individual are portrayed as having, and communicating, an understanding of the situation that the person being addressed seems to lack.

The emphasis on “need” in Line 11, followed by a brief pause, emphasises the importance of the individual looking after their personal hygiene. It is conveyed as a necessity as opposed to something that their can be any negotiation, choice or option about. The role of the team in this is underlined by the emphasis, using raised pitch, on “↑we” (Line 14) and “↑do it” in Line 15, to encapsulate the phrase, “↑we need to ensure that you ↑do it”.

Reverting from the representation of talk-in-practice directed towards a service-user to the interview narrative is subtly managed (Lines 17 and 18). The transition begins when the participant reverts to addressing the interviewer with the rapid utterance, after a brief pause, of “>you=know how=it,<”. The subsequent phrase “it makes the whole environment” is ambiguous in that it could be addressed to either the interviewer or hypothetical service-user. In effect, as a transitional phrase, it is addressed to both.

The end of the transition is marked by a brief pause, the conjunctive “and” and a longer pause before reverting to the explanatory narrative addressed to the interviewer (line 18). Again this is indicative of purposeful construction of this element of the narrative to represent actual talk-in-practice. Whatever the objective representation of the speech to

actual talk-in-practice, it is presented as such by the participant. Following on from this, addressing the interviewer, P38 presents the team as having the responsibility, having enlightened the person as to normalcy (line 21), to pressure them towards compliance (lines 22/23).

This is described as being firmly in the context of the responsibility of the psychiatric nurse, as indicated by use of the second person pronoun, you (lines 19, 20, 22 & 23). As a psychiatric nurse “you” have to tell the person “what is normal” (lines 20/21), and you have to put “as much pressure as you can” on the person to “actually comply” (lines 22/23). These subtle nuances of the exercise of professional power are made explicit in the statement that if the person is a voluntary patient then your hands are tied in one sense (lines 18/19/20).

Here, use of the word “your” gives general application of this contingency to the psychiatric nursing role. The general principle here is that where a nurse’s hands are tied like this (line 19) then they have a responsibility to bring as much pressure as they can (lines 22/23) on the person to comply with what would be seen as normal (line 21). What would happen in the case of an involuntarily detained person is not discussed, but the inference is that with hands untied the nurse’s exercising of power might be less subtle.

The slowing down of the rate of speech and the hesitancy phenomena in line 19 indicate trouble, as P38 seeks the best way to express the limits that a person’s voluntary status places on the power of the psychiatric nurse. To the eventual statement that “your hands are tied in one sense” contains the diminutive qualifier “in one sense” and is followed by further hesitancy phenomena in line 20. This ambiguity is followed in lines 20 & 21 by the speedily delivered, confident caveat that “you >have to say to the person, ↓well<”.

This generalised imperative prefaces the rationale behind the exercising of professional power. After more hesitancy and the discourse marker “y’know”, P38 reverts to speech which is ostensibly directed at the hypothetical person, as indicated by the introductory “you have to say to the person” (line 21). They are informed that “this=is what is normal and what we expect an’ what people >ex=expect<” (line 21 & 22).

There is a subtle transition from this representation of talk-in-practice to narrative addressed to the interviewer in the phrase “and you have=to”. Following on from the previous statement the “you” addressed here may appear to be the service-user, but the immediately ensuing “put as much pressure as you can on the person” shows it to refer to the nurse generally. The role of the nurse here is explicitly to enforce normalcy.

This perception of role emerges in an institutional and professional context whereby many psychiatric nurses work in non-specialised roles with little or no autonomy. This can be frustrating, as the following excerpt from a participant working in an inpatient setting plainly shows:

1. >↑Uhm< ↑at ↑fir- no:, not with that particular case, as the ↓longer I was on the
2. ward, it kind=of, I:=I >did get=a bit< frustrated with ↓not bein' able=to h (0.3)
3. make a decision ↓a=and, >yeah< ↑yeah=it does actually get a=bit frustratin' when
4. you can't just, h (0.3) make=a decision and go with that decision, if you \$
5. understand what=I mean. (0.3) h. <Ehm,> (1.3) You=know, the other people
6. [°mm° [°yeah°
7. make the decision and then, (0.3) °you° kinda go with that. Like I understand h.
8. (0.3) that when you=have less experience, it's a good way of <learning,> you
9. know, seeing how other people make their decisions, but=at the same time when
10. (0.7) h. you kind=of have an idea=in your mind of ↓what °m-° (0.6) you=know,
11. might be=a good idea, (0.3) it can be frustrating not to be able to (0.7) to carry
12. [°yeah°
13. ↓on with that.

Participant 5, Case 1, JDM PiP Interview

The repetitive references to “decision” in lines 3 & 4 are not instances of next-turn repetition (Haeyeon 2002), as the excerpt here is in response to the question “And does that make you feel in anyway - were you very frustrated, or did you have any kind of feelings yourself?” That P5 explicitly relates being “frustrated” with “↓not bein' able=to h (0.3) make a decision”, and the use of the word “frustrated” here could be seen as simply repeating the interviewer’s assertion. However, their emphasis on “↓not” and audible exhalation prior to both instances of “make a decision” (lines 3 & 4) is a combination that has been linked to the paraverbal expression of frustration by Trinder et al (2010).

A slight pause and audible exhalation, followed by a the relatively slow “Ehm” and a pause of 1.3 seconds (line 5) marks the end of P5’s initial expression of frustration. After the interviewer responds “mm” and “yeah” P5 goes on to acknowledge, without significant rise or fall in pitch, that with less experience (lines 7 & 8) than others watching others make decisions can be a “good way of learning” (lines 8 & 9). After this they go onto say “but=at the same time when”, and after a brief pause and an audible exhalation they revert to using pitch for emphasis as they explain how frustrating it can be to have “↓what” might be a “good idea” and “not to be able to (0.7) to carry ↓on with that”.

As seen in the review of the literature in Chapter Two, the autonomous role of some staff seems to be predicated mainly by their work setting. In the following excerpt we see this in the case of a hostel-based nurse:

1. P13: †So †like, (.)†in=the, †sometimes in the hostels, when you have, oh patients like,
 2. (0.8) hh. they are a kind=of far from the hospital, and you ↓don't have ↓proper
 3. s:upport from=or, because on the ward you have your colleagues, h. who will
 4. ↓help you to make a ↓decision. (0.3) But in the hostels you=are at your ↓own, or,
 5. either one of your ↓colleague will be with you. ↓And, >some< because of the
 6. night times we are just at y=our ↓own with the care ↓staff. (0.3) h.=And all
 7. decisions you ↓have=to take ↓yourself. (0.6) You have to ↓think an=you have to
 8. IR: [°right°
 9. P13: ↓see the situation an' take=a quick decision.
- Participant 13, Case 1, JDM PiP*

Working alone in this context is constructed as situational autonomy due to how work is structured rather than being chosen or attributed autonomy due to expertise. That this is less than ideal is evident from P13's emphasis on lack of "↓proper" support (line 2) in contrast with the ward where "you have your colleagues" (line 3) to "↓help you" (line 4). The problem is not complete lack of support, but lack of "proper" (line 2) support. Even if you are with a "↓colleague" (line 5) or "care ↓staff" (line 6), "all decisions you ↓have=to take ↓yourself" (lines 6 & 7).

The essence of what is being said here is best captured in P13's unfinished statement are left "at your ↓own" (line 4). The phrase that they appear to be delivering here is "at your own discretion", which is the only term used in common parlance that completes "at your own..." However, this is aborted with "or" and the presence of the colleague or care staff is referred to in order to explain that although the nurse is not completely alone, they are without the nursing work team.

As a result "you have to ↓think an=you have to ↓see the situation an' take=a quick decision" (lines 7 & 9). The repeated use of "you have to", with emphasis on having to "↓see" and "↓think" and "an' take=a quick decision" implies that this is not normative. Working in a team would appear to preclude the need to individually spot cues, think about them and make a speedy decision. By inference, P13 is more comfortable with the "↓proper" support of (line 2) peer-aided decision-making in which there is less time pressure and no onus on the individual to identify or process cues.

Throughout the study corpus, rather than a being a routine part of everyday work, autonomous decision-making is represented as something that must be done from time to time due to one's role or a situation one finds oneself in. Again it is apparent that autonomy is context-driven and related to role rather than based on personal expert status:

1. P25: †I=have to bring up at the meeting to close his <case> (.) >So< again it was a
 2. IR: [uhuh
 3. P25: (0.1) the doctor=who made=the decision, >he= said=that< ehm:, (0.3) close the
 4. case, if=he=d, if=he (0.8) does=not ↓attend (0.2) his outpatients’ clinic
 5. appointment, ↓then we’ll=we’ll address it further. (0.1)
 6. IR: [okay
 7. P25: [Because he’s (0.4)
 8. >I- c-°< level three >which means< low risk, (1)
 9. IR: [mhm, mhm,
 10. P25: [Because he did not
 11. attend his appointments and because I=did all I ↓could (0.5) do at the time, (0.4)
 12. >he said=I, it di-< it didn’t warrant any further investigation ↓now. If he ↓was a
 13. level two >ab- which< a patient, (1.3) that, that means a patient ↓needs, (0.4)
 14. more interventions, >it’s kind=of, the helpin’s of a nurse.< (0.8)
 15. IR: [okay, yeah
 16. P25: [°Though°, it
 17. might warrant, eh, a house visit, stuff like ↓that, (0.4) y’know, >to see if the
 18. IR: [yes, okay
 19. P25: patient is okay,< so it depends (0.7) how they’re graded ↓initially.
 20. IR: [>So right,< [°yes, the°
- Participant 25, Case 4, JDM PiP Interview*

The use of the phrase “have to” (line 1) has already been shown, both in Chapter Four (Section 4.3.14) and in this Chapter (for example, in the first excerpt of this section) to express that an unwritten principle governs one’s role in a given situation as opposed to individual initiative in decision-making. P25 raises the issue so that the doctor can decide whether to close the case, based on the contingency of the man’s non-attendance at the clinic (lines 3&4). This indicates the limited nature of the P25’s role with regard to decision-making. The attribution of the use of the first person plural “we’ll” (line 5) to the doctor, extends his decision-making and contingency planning as incorporating those present at the meeting (Richards 2008).

Not only is this accepted as normative insofar as it is not remarked on as unusual or objectionable, but P25 further identifies with the doctor’s decision by going on to explain the rationale behind it (lines 7 to 12). The three main elements of this rationale are marked by the prefacing of each one with an emphasised “because” – because the man has been determined as “low risk”; because he did not attend his appointments; and because P25 did all they could. What P25 describes here is not their intentional feeding into the doctor’s decision, but of an interpretation of their intervention as being “all” that could be done acting as one element amongst several that inform the decision.

The extent to which P25's description of decision-making is governed by organisationally-based principles rather than autonomous reasoning can be seen in the contingency they construct beginning with "If" in line 12. If the man had been at level two in terms of risk assessment, this would determine his needing "more interventions" (line 14), including "the helpin's of a nurse" which might involve a "house visit" (line 17) to see if he is "okay" (line 19). That the care that service-users receive is predicated on "how they're graded initially" (line 19) indicates some form of system-aided (Hammond 1996a) judgement is at work in P25's work setting.

There are examples of service-user decision-making in the retrospective interview element of the study corpus. In these narratives it is the service-user who is represented as bearing a degree of responsibility as an autonomous agent for the situation in which they find themselves. In such situations, however, the nurse is never totally relieved of responsibility. Responsibility is also attributed to factors other than the service-user, for example to their psychopathology as something apart from them. In the excerpt below, the service-user is explicitly represented as an autonomous decision-maker (lines 8 & 9). However, P29's use of the demonstrative adjective to describe the man's decision as "this decision" (as opposed to using the indefinite article, that is, "a decision") serves to emphasise the "decision" in an unfavourable light (Thomson & Martinet 1986).

Adding to this is emphasis achieved by the stress on the central syllable of the word "decision", communicating P29's non-approval of this decision". However, despite the man's autonomous decision, responsibility for his man's troubles is also attributed to "the=OCD" (obsessive compulsive disorder) (line 12). The use of the definite article to describe the man's disorder (as opposed to "his OCD") alongside the description of "the=OCD" coming "back with a ↓vengance" serves to give life to the disorder in anthropomorphic terms.

The significance of this in terms of autonomy is that the man is conveyed as being at the mercy of something apart from him. This stands in contrast with P29's expression of their own responsibility for the man, reporting emphatically that they "felt ba:d" (line 4), and held the responsibility of performing an adequate suicide assessment (line 5). The appending of, and emphasis on, "↓myself" here amplifies the focus on P29's own role (Bramley 2001):

1. P29: †Oh, (0.3) h-he=I, he wasn't suicidal °an' he'd°. (0.7) Yeah. No, >there=wasn't<
2. IR: [Right
3. P29: suicidal, he=was, (0.1) the reason I had explored why he'd ↓done it, ↓because I
4. was quite (1) pt shock=I was kinda shocked in a way, 'n=I felt ba:d, I (.)
5. >wondered if I hadn't done,< (0.3) an adequate (0.3) suicide assessment ↓myself.
6. (0.9) <Ehm,> (0.7) but, (0.7) I=I think that, (0.7) even if I had it wouldn't've
7. IR: [°right°
8. P29: mattered, >because I think,< (0.4) ↓it (0.3) was whipped up, (0.8) you=know, he
9. made this decision to=see the hypnotherapist, an' ↓then, (0.4) >whatever< it
10. <↓was> about that session, (0.7) you know, it just, (0.7) freaked him. (1) And
11. IR: [°hm°
12. P29: ↓then, (.) the=OCD: (1.2) came back with a ↓vengeance, >°c'se°< he hadn't had,
13. much, (0.5) much=of that (0.2) when I'd been seein=him previously. (0.4) h. It
14. IR: [°hm°
15. P29: just came=back with=a >vengeance,< he got so anxious that, (0.6) >I †think
16. it=was a < †cry for †help, (0.9) more than, (0.7) eh=a suicide attempt as such,
17. IR: [°yeah°
18. P29: because he just, (0.1) had the rope and, (0.6) whether=he would've done it,
19. °>I=dunno°<, (0.4) but, (0.4) you=know >°he=was°< did=it at ho:me=in (0.3) full
20. view of, >°y'know°, people=were< arou:nd. (1.1)
21. IR: [yeah, yeah,
22. P29: [<Ehm,> (1.5) so yeah, so
23. ehm, (0.9) >I=I< had assessed him again, an=he would be sayin' ↓no he would'n
24. ↓do=it an' it was ↓just in the flurry (0.9) of all the anxiety an' worry >that he
25. was< a pervert.
Participant 29, Case 3, JDM PiP

5.4.5 Interim Summary

As with the previous sections, I give an interim summary here with regard to the evidence regarding contingency and choice as characteristic of the study data. Contingency and choice, in particular the control of choice, are two inextricably related features of the study corpus that evince professionally mandated control as a social function of the psychiatric nursing role. This control is most visible in the construction of shared meaning as a way to control choice.

In community-based scenarios, the control of choice is more subtle, whereas in inpatient settings it is a cruder affair. The fact that controlling behaviour is represented as normative regardless of setting is indicative of the construction of shared meaning as a function of professional power as opposed to its being a function of a physically located institution. However, some participants do describe offering genuine choices to individuals, which points towards a tension in Irish psychiatric nursing practice between the controlling and custodial role with its services-centred approach, and the person-centred approach of what one would hope is the coming order (DoHC 2006, Walsh et al 2008).

However, as the evidence in relation to participants' choice of interventions shows, in Irish psychiatric nursing it would appear that interventions are determined by the common perception of role within the dominant culture of the profession. The evidence strongly suggests that this role is one where decisions are made more on the basis of custom and practice than on individual consideration. These decisions are underpinned by routinised paternalism that appears to be enabled by mental health legislation and psychiatric nurses working in settings where they have little or no professional autonomy.

5.5 Conclusion

This chapter has given an account of the study findings in relation to the three main features of the study corpus identified in the preliminary analysis that was described in Chapter Four. Throughout the chapter I have given interim summaries for each of these sections, and I will not repeat those in detail here. Instead I conclude by briefly setting out the overall shape of the findings, which I will go on to discuss in detail in Chapter Six.

Taking a critical and reflexive approach to data collection and analysis has enabled me to use a mix of quantitative and qualitative analysis of verbal and paraverbal discourse markers to demonstrate how:

- Atypical case presentations see participants refer more deliberately to experiential and domain-specific knowledge, whilst participant reasoning is more routinised and habitual when faced with typical scenarios. This involves a combination of experiential and domain-specific knowledge, most notably the contextual application of psychiatric knowledge governed by diagnostic categorisation. This serves as an anchoring point for subsequent thoughtful consideration of a case. Participants appear to view this ability to quickly draw with subjective certainty on prior knowledge as an indicator of their own expertise.
- Participants tend to express subjective certainty amidst a background of uncertainty. Verbal and paraverbal expression of certainty is clearly associated with cases and situations that are seen as typical, to the extent where it can at times be interpreted in terms of overconfidence. Where diagnosis is not present to act as an organising principle for the application of domain-specific knowledge and there is a lack of pre-encounter data, uncertainty is more likely to be expressed verbally and paraverbally.

- Participants' judgement and decision-making shows a tension between person-centred engagement featuring real choices for individuals and a more controlling, paternalistic approach. This is most apparent in situations involving choice and contingency. Which approach is taken appears linked to participant perception of the psychiatric nursing role, with professional control being apparent as a social function of that role. It is this perception of role, in combination with their perception of service-users that enables them to engage in discursive coercion of individuals, which is more subtle in community settings. Nurses' own interventional choices are limited by the paternalistic culture in which they work, even more so in settings where there is decreased professional autonomy. Routinised paternalism appears to be the rule, with deliberate choice of interventions being an exception that is exercised mainly in situations where it is required by contingency.

Chapter Six – Discussion

6.1 Introduction

The aim of this study, as set out in Chapter One, is to explore the clinical judgement and decision-making of participants in terms of both the cognitive processes involved and their social context. As demonstrated in the preceding chapters, the study's combination of tried and tested approaches to data collection and novel application of recently developed methods of analysis to these data have proven capable of yielding useful insights into participants' clinical judgement and decision-making. This is partly due to its mix of social and cognitive perspectives on participants' judgement and decision-making.

The previous two chapters described the evidence from two different levels of analysis of the data. It is the purpose of this chapter to discuss these findings in light of the literature on judgement and decision-making and to set out what they contribute in theoretical terms. The implications for practice and other applications of the findings are considered in Chapter Seven.

The study findings stand against the background of the vast literature on dual-process models of judgement and decision-making (Hammond 1988, 1996a, Kahneman 2003, Evans 2008). However, the real strength of the findings lies in the fact that the study methodology is concerned primarily with participants' "discursive praxis" (Crawford et al 2002, p295). I have not naïvely attempted to claim that surface level analysis of participants' descriptions of their judgement and decision-making fully represents their actual internal mental states (Edwards & Potter 1992a).

At the outset of this thesis I underlined the importance of reflexivity to my research efforts. I have applied this throughout the thesis through my discussion of the study using the first person. I have been vocal regarding my beliefs and personal perception of issues as relevant, and I believe that it is vital to continue to engage in this critical reflexive commentary throughout these closing chapters. This is for the sake of the transparency, clarity for the reader and also to attempt to reduce any metacognitive ambiguity on my part. I am not entirely sceptical about the usefulness of the analysis of participants' retrospective narratives and think aloud protocols for revealing cognitive and social elements of their clinical judgement and decision-making. Instead I am cautious about what the narratives can be said to represent. Where I do make claims with regard to participants' cognitive or

social worlds, these are based on more than an uncritical reading of their narratives at face value.

For the ease of the readers' comprehension I gave interim summaries of the findings throughout Chapter Five, with a final overview set out in discrete bulleted points. Therefore I will not repeat the findings here again, but instead will discuss them in relation to the literature on clinical judgement and decision-making. This discussion takes account of the fact that the findings are conceptually interrelated.

The bullet-pointed list which concluded the previous chapter is the clearest and simplest achievable overview of the findings, and in this chapter I move on to consider the complex interrelationship between them. This includes discussion of the relevance of the social and cognitive processes with reference to how the two main data types within the study - retrospective interview and think aloud data - represent distinct cognitive and social activities. This is because whereas both data types involve co-authoring of participants' narratives (Ochs & Capps 1996) by the interviewer, this is a more explicit and distinct feature of retrospective interview data (Fratila & Sionis 2006).

6.2 The role of prior experiential and domain-specific knowledge in participant judgement & decision-making

Participants' narratives involve a significant degree of reference to their combination of domain-specific (Boshuizen & Schmidt 1992) theoretical and experiential prior knowledge (Benner 1984) in making clinical judgements and decisions (Rashotte & Carnevale 2004). Their initial reference to prior knowledge of typical features in dealing with cases appears intuitive and routinised. This facilitates a subsequent process of dealing with the case that is more deliberate.

This is not to say that participants switch between completely rational reasoning to irrational intuitive strategies in their judgement and decision-making. Rather, their approach is indicative of a mix of intuition and analytic thinking. At times one mode is more noticeable than the other.

This mix of intuition and analytic reasoning has been explained by other nursing researchers in terms of Hammond's (1988, 1996a) cognitive continuum theory (Offredy et al 2008, Beckstead 2009). Intuitive judgement as set out in the cognitive continuum is an individual affair, and this is apparent in the study data. Participants' use of intuition is

evident in their automatic application of domain-specific and experiential knowledge. When their thinking is more analytic, more reasoned, deliberate narrative accounts result. However, whilst the cognitive continuum views peer-aided judgement as a step away from intuition and towards more analytic thinking, this is not the case with participants in this study. Close identification with peers in the judgement and decision-making of participants is characterised by a reliance on practice and custom that results in routinised paternalism. To understand this further, it is important to consider the social context in which this occurs (Hammond 1996a).

From the perspective of cognitive psychology, the social context of the knowledge that participants use represents that world in which they have learned to apply that knowledge (Hammond 1988). From a sociological perspective it is the world into which they have been socialised in terms not only of application of knowledge, but also of adaptation of role (Berger & Luckman 1967). Although these represent two discrete ways of looking at participant judgement and decision-making which do not of necessity overlap fully, combining their perspectives offers a more rounded picture of how participants used knowledge.

6.2.1 The social context of the knowledge used by participants

Participants' reference to diagnoses and psychiatric symptomology in their clinical assessments could be seen as a beneficial conceptual adherence to standardised norms in clinical judgement (Garb 2005). However, it might also be seen as a reductionist approach, narrowing the scope of clinical judgement to focus on medico-psychiatric concepts to the exclusion of other salient elements (Crowe 2000). However, participants in this study do not rigorously apply diagnostic criteria in an empirical or biodeterministic way that excludes other perspectives.

Instead their narratives demonstrate an overlapping combination of lay and nursing knowledge to reach what they represent as a balanced assessment of the individual and the situation in which they found themselves. Crowe et al (2008) have described this approach as formulation, as opposed to a diagnosis. Crowe et al (2008) describe formulation as a way that psychiatric nurses involve the valuing of an individual in their assessment, which is more important than accurate determination of what certain signs and symptoms represent in terms of medico-psychiatric classification.

This way of applying knowledge to problem solving is an essential feature of professional practice (Higgs et al 2001, Thompson 2002). However, although it was possible to simulate aspects of everyday practice in collection of the think aloud data, participants did not have the benefit of knowledge drawn from a personal acquaintance with the individuals involved. In this context the only pre-encounter knowledge that they brought to their judgement and decision-making was general, domain-specific and experiential knowledge, exemplified in their reference to typical features of cases.

In the retrospective data participants' make clear reference to their specific pre-encounter knowledge of individuals. Across all participants and cases it is clear from the data that the knowledge used by participants in this study is centred on a combination of theoretical knowledge drawn from psychiatry and specific and/or general pre-encounter data (Carnevali et al 1984). Participants use this combination as the basis of a narrative framework within which they could explain the causes and implications of presenting behaviours (Klein 1989).

Whilst the potential consequences of these behaviours are explored in participant narratives, this exploration is not characterised by reference to specific clinical outcomes. Instead, participants deal with the contingencies around these potential consequences with a lack of subjective certainty (Dowding & Thompson 2009a) and an element of speculation, which are evident in implicit discursive markers rather than in explicit reference. Whilst participants explicitly express confidence and certainty, their formulations are speculative, with reference to their experience of similar individuals and/or situations.

This is indicative of how participants' judgement and decision-making leans more heavily on experiential knowledge than on theoretical knowledge (Thompson 2002). When making reference to types of individual, for example, participants at times mention their experience of a certain type of individual without attaching a particular label to them, or grounding their observation in any discernable framework of 'text-book' or other theoretical knowledge. Participants do, however, make clear reference throughout the narratives to individuals' diagnoses, and use these as central organising points for their discussion of cases.

However, it is not a matter of participants referring to either experiential knowledge or theoretical knowledge. That the two work together can be seen in the peppering of participants' mainly vernacular narration of their experiences with references to psychiatric diagnostic categories (e.g. "paranoid schizophrenia") and associated symptomological

phrasing (e.g., “negative symptoms”). Rather than pointing towards attempts at medical diagnosis of mental and behavioural disorder, this represents participant use of domain-specific knowledge (Boshuizen & Schmidt 1992) to interpret what they had witnessed.

Reference from both sociological and cognitive psychological perspectives is useful in understanding this aspect of the data. From a cognitive perspective, participant interpretation of cues can be understood in the context of Brunswik’s (1952) lens model. From a sociological perspective it can be understood in the context of Peirce’s (1895/1998) model of semiosis.

From the perspective of the lens model (Brunswik 1952), participants can be understood as striving to make sense of multiple fallible indicators in an environment characterised by uncertainty (Hammond 1993). The knowledge used to interpret these indicators, or cues, helps participants to make sense of them. How accurate the consequent judgements are is something that is beyond the scope of this study. However, this study can provide important information regarding the types of cues used by participants to make these judgements.

From the perspective of semiosis, the concern is less with quantitative measurement of accuracy and more with what participants’ qualitative understanding of what certain cues or indicators represent (Sebeok 2001). This is determined by the type of knowledge that they use to interpret them. This knowledge – whether experiential or theoretical – is firmly embedded in the social and cultural understandings into which participants have been socialised.

Although the lens model is concerned solely with quantitative measurement of interrelationship between cues and participant accuracy, and semiosis with qualitative meaning derived from cues, there is a distinct overlap between the two approaches. This overlap lies in consideration of what sociologists refer to as the correspondence and stability of signs or cues (Glassman & Kang 2007), and what psychologists refer to as relative weighting of cues across participants (Dawes 2000). Both are concerned with the commonality between participants in terms of their interpretation of cues.

Where participants draw on common sources of experiential and theoretical knowledge, the expectation might be that the interpretation of cues in terms of weighting would have a high degree of correspondence. Although measurement of such correspondence is beyond the scope of this study, it is plain from the findings that participants are operating from the same background in terms of knowledge used to interpret cues. This explains something of

a hive mentality characterised by routinised paternalism as opposed to a more analytic peer-aided approach to interventional decision-making, as well as the invariable use of diagnosis as an organising principle for the application of domain specific-knowledge and pre-encounter data.

Also of relevance to this mix of experiential and domain-specific knowledge is what it reveals about how participants perceived individuals. This perception of others involves the reflexive, interpersonal and often intuitive aspects their clinical assessment of individuals (Allport 1968, Schneider et al 1979, Bandura 1986, Kruglanski & Orehek 2007). The role played by prior knowledge of individuals and types of individuals here raises issues with regard to error, intuitive bias and the valuing of individuals that are dealt with throughout this chapter (Thompson & Dowding 2009c).

Although differing in function from explicit medical diagnosis, participants' assessments of individuals show similarities to what is known about doctors' and clinical psychologists' combination of experience and theoretical knowledge in making diagnoses (Patel et al 1994, Garb 2005). Although they do not make diagnoses, participants in this study do use them as central anchors in dealing with cases in a way that combined theoretical and practical knowledge (Crowe et al 2008) in an approach that appeared strongly intuitive (Thompson & Dowding 2009c). Participants anchor with relative immediacy (Ferrario 2003) on diagnosis as the core organising point in addressing judgement and decision tasks. Participants' mix of theoretical and experiential knowledge is distinctly professional and applied to nursing practice. As has long been found with their medical counterparts (Byrne & Long 1976), participants contextualise the service-user's world and issues from their own disciplinary perspective. Many of the problems they encounter are interpreted within the context of the body of disciplinary knowledge of psychiatry and psychiatric nursing.

In their contextualised interpretation of information, participants' exhibit a common feature of human judgement (Kruglanski & Orehek 2007), which researchers in nursing have explained using concepts such as pattern recognition (Ritter 2003). However, Crowe (2000) views the assessment of individuals in the context of diagnostic categories as an attempt to artificially order what is in essence a chaotic and distressing experience for the person seeking help. In doing this, participants can be interpreted as demonstrating a routinised focus on certain aspects of individual's experiences as salient whilst excluding, on the basis of disciplinary and professional knowledge, experiences that the person suffering from mental distress may view as highly relevant.

Participant reliance on diagnostic categories and symptomological concepts as organising principles in their narratives needs to be considered in the context of socialisation into a subordinate nursing role. Participants work in mental health services that are for the most part governed by psychiatrists (DoHC 2006). However, there is no evidence that they apply these categories and concepts in the narrow and exclusive manner described by Crowe (2000).

Where participants' accounts of individuals' presenting conditions uses language grounded in medical psychiatry, this is embedded in talk from outside the psychiatric repertoire. Narrative representations of case formulations feature a mix of lay and nursing terminology to describe family life, how individuals reportedly feel, and details of their work and leisure activities (Crowe et al 2008). This is to be expected in the context of the social, cultural and disciplinary realities of contemporary Irish psychiatric nursing practice.

Within this context, the individual's diagnosis and consequent attribution of the sick role can be seen to underpin participants' discursive construction of the individuals' identity in the study data. These two factors combine as fertile ground for the paternalistic treatment of individuals who are represented as inherently in need of help. This treatment stems from the construction of an identity that is characterised by the inability to be fully autonomous and responsible.

Further evidence that participant narratives are not characteristically medico-psychiatric is their lack of reference to predetermined, measurable outcomes. Participant judgement and decision-making appears more driven by a beneficent concern for individuals' best interests than clinical outcomes. The rights of individuals are represented as being respected and it is made clear that their best interests are paramount.

Whilst the data are not characterised by explicit talk around the ethical and moral aspects involved, issues involving autonomy and beneficence are apparent from the analysis of the data. Again, individuals who are experiencing psychological difficulties are represented as - by merit of their diagnosis - inherently vulnerable, powerless and in need of direction. Participants actively determine the best interests of these people without expressing any significant subjective uncertainty or ambiguity.

As in my own study, Deady (2005) found that this view of individuals and the subsequent view of the nurse as responsible for them in a paternalistic manner were not explicitly related, but subtly expressed in participant discourse. Both his findings and my own are demonstrative of the tacit, habitualised nature of paternalism and the implicit and routine

representation of individuals as helpless. There is no evidence that participants purposively determine to engage with people in this way - it is simply the routine way in which they relate to people with a diagnosis of mental or behavioural disorder.

From a sociological perspective, such habitualisation of identities and practices are seen to be representative the social order of which they are part (Berger & Luckman 1967), and the distinct way in which knowledge is categorised and used within that social order. From a social psychology perspective, this approach by participants towards categorisation and use of knowledge derived from social experience would be seen as evidence of their use of intuitive strategies (Garb 2005). Both of these perspectives align with the finding of this and other studies, that the paternalistic approach is an integral element of how psychiatric nurses in Ireland view their professional role (Deady 2005).

6.2.2 The intuitive use of knowledge by participants

In their recall of events in the retrospective interview data participants make both explicit and implicit reference to intuitive use of knowledge (Ritter 2003) However, this cannot be taken as necessarily indicative of its actual use by them in their everyday clinical practice (Edwards & Potter 1992, Hastie & Dawes 2001). More valid evidence regarding the actual approaches participants use comes from the *in-vivo* judgement and decision-making of participants in the think aloud data.

As simulated cases were used for *in-vivo* data collection, participants lacked personal pre-encounter knowledge of the individuals about whom they were asked to make judgements and decisions. Lacking this data, they resort to reference to the typical. This is evident in their reference to similarities between the simulated cases and familiar case types drawn from their own experience.

Participants' interpretation of these similarities as typically representative of certain familiar phenomena is characteristic of the automatic activation of experiential knowledge. This is a key component of intuitive judgement, particularly where there is uncertainty (Lipshitz & Strauss 1997, Marewski et al 2009). Whilst laboratory-based experimentation has been fundamental in uncovering and understanding such processes, it does not fully account for their use in everyday settings (Neisser 1976). This study has, to some degree, provided a basis for exploring participants' intuitive approaches to judgement and decision-making with reference to their everyday work practices, which the following section will discuss in more detail.

6.3 Intuition & Habitualisation

Participants make, or discuss making, relatively quick initial judgements and decisions without expressing thoughts or reflection on how they arrived at them. This is indicative of the opacity of the cognitive processes involved in an intuitive approach (Lamond & Thompson 2000, Kahneman 2003a, Thompson & Dowding 2009c). There is no evidence that participants are wholly intuitive in their judgement and decision-making - this approach is characteristic of the way that they formulate their initial judgements and decisions about the cases used in the study.

Participants' rapid responses appear to represent their reduction of the complexity of the tasks presented to them with the speedy processing of information (Gigerenzer & Goldstein 1996, Thompson & Dowding 2009c). This is particularly so with cases that participants described as familiar or typical. Participants are able to draw quick conclusions on initial case presentation because they had dealt with this type of case on previous occasions (Klein 1989, Mischel & Shoda 1995).

Accrued knowledge about similar individuals and scenarios is often compared quickly and automatically to the case at hand (Higgins 1996) rather than by conscious cue-by-cue deliberation (Klein 1998, Wittenbrink et al 1998). Individuals are assigned to a category and certain traits and behaviours are ascribed to them (Rothbart et al 1978). This automatic categorisation of information has been widely discussed in relation to the concept of the stereotyping (Klein 1998, Colman 2009) as a way of simplifying and speeding up judgements about individuals and scenarios (Higgins & Brendl 1995, Wittenbrink et al 1998).

This is most clearly evident in participants' reference to diagnosis as an organising principle for more deliberate consideration and application of pre-encounter data and domain specific knowledge to cases. This enables participants to make quick predictive judgements based on their recollection of how this type of person had behaved in similar situations in the past (Wittenbrink et al 1998) and so to formulate subjectively less uncertain, clearer expressions of judgements and decisions (Orasanu & Connolly 1993, Lipshitz 1994, Higgins & Brendl 1995). This reduction of subjective uncertainty is an important aspect of participants' use of intuition (Thompson & Dowding 2009c) which I discuss in more detail in Section 6.4, but which I need to leave aside for the moment to permit discussion the basic features of participants' use of intuition in more depth.

The quick and routine way in which participants' describe their initial judgements allows room for greater attention to detailed and demanding aspects of cases. Sociologists refer to this phenomenon as habituation, describing how activities that are engaged in on a frequent basis become routinised, being carried out without much conscious effort (Berger & Luckmann 1967). Habituation is characteristic of both low-skilled and highly specialised work and is essential to efficient work systems.

Despite its undeniable usefulness (Marewski et al 2009), the routinised, intuitive style of judgement and decision-making evident in participant narratives has been found to be significantly prone to error (Thompson & Dowding 2009b), even in expert medical decision-making (Hall 2002). Nonetheless, the benefits of cognitive shortcuts to nursing practice are evident in how participants' rapid, routine handling of judgement and decision tasks enables them to give more focused attention to more cognitively demanding tasks. Cognitive continuum theory (Hamm 1988, Hammond 2000a) is useful for explaining this, particularly in relation to task structure (Fowler 1997) and the devotion of more time and energy to less familiar aspects of cases (Cader et al 2005).

Both the social constructionist concept of habituation and cognitive continuum theory explain how routinisation of tasks is a necessary prerequisite for the emergence of roles in any social institution (Berger & Luckmann 1967, Widick 2003). In the study corpus, this is evident in how participants talk about activities as general – referring, for example, to a particular intervention as something that 'everyone' does. At a more discrete level of discursive analysis habituation can be seen in participants' use of the first person plural in self-reference, or in the discursive function of second person pronouns to generalise activity.

Interventions are represented as habituated to the extent that participants describe them as being what 'anyone' would automatically do in a given situation. In doing this participants can be seen to draw on their working knowledge of the types of tasks and environments represented in the simulated cases (Patel et al 1994). This working knowledge, combined with the overarching influence of psychiatric diagnosis, theoretical knowledge and general pre-encounter data, facilitates rapid intuitive judgement and decision-making.

This represents a highly-contextualised application of domain-specific knowledge, which has been associated with expert judgement and decision-making (Klein et al 1993, Ericsson & Leman 1996). As well as facilitating experienced practitioners' quick identification of commonly encountered phenomena (Patel & Groen 1986) this approach enables them to

deal with uncertainty (Lipshitz & Strauss 1997, Klein 1998). I will discuss this aspect of participants' judgement and decision-making in the following section.

6.4 Certainty, Uncertainty, Overconfidence & Error

Drawing on Hammond (1996b), Thompson & Dowding (2009a) distinguish between subjective uncertainty and objective uncertainty. Objective uncertainty is the actual, quantifiable degree of uncertainty in a given situation, whereas subjective uncertainty is the degree of uncertainty internally experienced by an individual. To this, my study adds the important interpretative distinction between participants' expressed subjective uncertainty and their experienced subjective uncertainty. This distinction is made in the context of the wider recognition of the need to differentiate between expressed and actual mental processes (Edwards & Potter 1992a).

My analysis of the use of verbal and paraverbal markers of certainty and uncertainty shows participants' narratives to be characterised by the expression of subjective certainty in the midst of objective uncertainty. In using qualitative data analysis I have been keenly aware that the dominant focus in judgement and decision-making research is on research subjects and topics that are more amenable to quantitative measurement. Gaeth & Shanteau (2000), for example, used agricultural soil judges not to learn more about soil judgement *per se*, but to generate quantitative data to shed light on human judgement generally.

However, everyday human judgement is normatively expressed in non-numerical, qualitative terms such as "I think that" (Tversky & Kahneman 1974, p1124). In my own study data, there is no evidence that participants deal with uncertainty in terms of specific numerical representation - such as, "Is patient X likely to die in the next 12 hours?" (Thompson & Dowding 2009a, p12). This characteristic feature of the data is perhaps unfortunate insofar as it does not lend to objective quantitative measurement of the gap between objective and subjective uncertainty.

Human representation of judgements in quantitative terms such as odds or probabilities occurs only "occasionally" (Tversky & Kahneman 1974, p1124), and is not normative even in applied judgement problems (Gaeth & Shanteau 2000). Despite this, most research on certainty, uncertainty and overconfidence involves quantitative approaches (Juslin et al 2000) which are seen as limited in this regard (Klayman et al 1999). Experimental research has been recognised as successful in identifying and understanding intuitive phenomena *per*

se, but findings can have limited application to natural settings (Chapman & Elstein 2000, Haskell 2009). This is particularly the case for psychiatric nursing (Wang & Mentes 2009). Participant narratives are characterised by the qualitative expression of certainty amidst objective uncertainty. This needs to be considered in terms of the propensity for error commonly associated with the intuitive, habitual and routinised manner in which participants make clinical judgements and decisions. Participants' confident expression of certainty in their clinical judgement and decision-making takes place in a context characterised by objective uncertainty and complexity.

This is evident in the fact that their work is such that there is often no single solution to be sought and found (Cioffi 1998, 2001, Thompson & Dowding 2002). Also, in this study (as in the normal course of their work) there is no way for participants to quickly quantify every available option. Especially apparent is the relative paucity of relevant information which participants have to hand when making clinical judgements and decisions (Lichtenstein & Fischhoff 1977, Thompson & Dowding 2009a). Indeed, the cases used for data collection in this study were specially formulated in view of how subjective uncertainty stems from an incomplete picture of the case at hand (Orasanu & Fischer 1997). Regardless of the level of objective uncertainty inherent in their work, participants - like all nurses - tend to express subjective confidence about much of their clinical judgement and decision-making (Flemming & Fenton 2002, Thompson & Dowding 2009c). This is exemplified by one participants comment that:

“I suppose maybe with my experience you're already formulating that idea of what's going on even before I had this [reference to case notes], which has been reasonably accurate so far.”

Participant 9, Case 3, Think Aloud

This comment is representative of the overconfidence that characterises not only the judgement and decision making narratives of participants in this study, but that of humans generally (Dawes 2000, Thompson 2002, Sieck & Arkes 2005, Kvidera & Koutstaal 2008), particularly where intuition is involved (Kahneman 2003, Thompson & Dowding 2009c). In the think aloud data, the similarity of presenting cases to a participants' expressed perception of case types (e.g., a case where someone is perceived as taking advantage of the psychiatric services) tends to be accompanied by the expression of subjective certainty. Participants readily identify those types of cases that they commonly encounter and therefore can quickly recognise. Interventions are rapidly chosen as a matter of course is

and represented as the most obvious and appropriate intervention for a certain type of presentation.

As has found to be the norm in rapid decision-making (Kahneman 2003), a participant's quickly chosen intervention tends to be the only choice mentioned in their narrative (Kahneman 2003). This is indicative of participant confidence. Whereas going through the different options might be seen as unconfident 'dithering', it does not follow that the confident expression of a single, definitive choice is underpinned by actual subjective certainty. What it more likely points toward is recognition or representativeness (Klein 1989, Cohen & Freeman 1997, Klein 1998, Goldstein & Gigerenzer 2002, Cahan & Snapiri 2008, Cytryn et al 2009).

This intuitive strategy also explains participants' rapid identification of cases as diverging from the norm and therefore warranting more focused attention. In this way, drawing on knowledge framed by medical constructs such as diagnostic categories to represent types of cases, participants mark out cases as potentially more difficult or less difficult to deal with (Kaempf et al 1996). They also quickly single out of aspects of cases as representative of social constructs, such as the "normal family".

Although participants' rapid recognition of case features as typical does not centre on diagnosis-related elements alone, diagnosis is the point around which other aspects tend to be discursively organised. Across the study data, where participants' refer to prior knowledge in this way, their verbal and paraverbal markers of certainty communicate authority and confidence. This amounts to the implicit expression by participants of their faith in the robustness of their own combination of experience and domain-specific knowledge in making decisions and judgements.

This is part of participants' wider discursive construction of their expertise, which can also be seen in their self-reference to the ability to quickly and confidently recognise typical aspects of cases. This ability to quickly identify typical features has been associated with expertise (Brannon & Carson 2003), particularly where there is time pressure and uncertainty (Klein 1998). However, expertise cannot be attributed to participants solely on the basis of their demonstration of rapid recognition.

Rapid recognition of a feature of a case as representative of particular phenomenon is not necessarily a reliable indicator that this is so (Tversky & Kahneman 1974). Also, the reliability of experience as an indicator of expertise is highly questionable (Shanteau 1992), especially in nursing (Christensen & Hewitt-Taylor 2006). Rather than representing

expertise, participants' apparent 'effectiveness-with-ease' (Strack 1992) is characteristic of the use of what Hammond (2000b, p60) has described as "precisely those cognitive activities that deceive us".

Although objective uncertainty can only be reduced to a certain level (Hammond 1996b), individuals use intuitive thinking to reduce their experience of subjective uncertainty (Klein 1998). The use of intuition has been linked to overconfidence in judgement and decision-making (Henrion & Fischhoff 1986), and in this regard participants can certainly be seen as overconfident (Thompson & Dowding 2009a, 2009b, 2009d). The expression of confidence by participants in this study is an example of the use of intuition as a strategy by which uncertainty is subjectively reduced and suppressed.

Participants' expression of confidence is detectable by the absence of verbal and paraverbal markers of subjective uncertainty that they use elsewhere in their narratives. This applies both to participants' *in-vivo* judgement and decision-making (Lichtenstein et al 1982, Dawes 1988, Morgan & Henrion 1990) and their reformulation of cases from memory (Ross 1989, Lipshitz & Strauss 1997, Thompson & Dowding 2009d). The relationship between participants' expressed confidence and their reliance on intuitive strategies is in line with what we know of how nurses and midwives deal with uncertainty in their judgement and decision-making (Cioffi & Markham 1997, Cioffi 2001, 2002).

Participants' use of intuition serves the purpose of reducing the cognitive load of their judgement and decision-making where there is uncertainty (Cioffi 2000, Hammond 2000b). The downside of this strategy is that it increases their reliance on illogical and potentially erroneous preconceived notions (Cioffi & Markham 1997). However, the effects of intuitive thinking on participant accuracy are not quantitatively measured in this study, as is the norm in the study of applied judgement problems (Gaeth & Shanteau 2000).

This is mainly because, as with applied judgement research generally, precisely what constitutes error in the case of participants can be difficult to quantify in empirical terms (Gaeth & Shanteau 2000). Also, without recourse to the statistical testing of accuracy using normative Bayesian models or subjective expected utilities, measurable definitions of what constitutes error for the purposes of experimental testing and retesting can be difficult (Lipshitz 1997). However, the negative influence that reliance on intuition has on the rationality of participants' judgement and decision-making is apparent.

Participants' expressions of confidence and subjective certainty frame their clinical judgement and decision-making in more optimistic terms than is warranted by the

approaches they use (Croskerry 2002). My novel method for detecting verbal markers of uncertainty, certainty and confidence is all the more important in view of the fact that the expression of subjective certainty and confidence in intuitive judgement and decision-making has strong positive associations with error (Klein et al 1993). Although psychiatric nurses' practice is not always as measurable in quantitative terms as that of other health professionals, this study's identification of qualitative markers of explicit and implicit expression of uncertainty and certainty is an important contribution to the study of their clinical judgement and decision-making.

The most significant contribution of my study with regard to subjective uncertainty and overconfidence is the novel and rigorous methods I have used to detect the use of approaches that are contextually error-prone. This should be viewed as an addition to actuarial approaches such as clearly defined and measurable nursing outcomes (Doyle & Dolan 2002, Randell et al 2007). I will now consider this detection of participants' use of intuition, overconfidence, and the scope for error that accompanies it, in the context of the nature of the complexities of their work (Orasanu & Connolly 1993, Dawes 1994).

6.5 Complexity & the interplay of analytic & intuitive thinking

Whatever the actual merits of an intuitive approach to clinical judgement and decision-making, participants appear to find it useful for reducing subjective uncertainty. However, as it does not at the same time reduce objective certainty, this can increase the risk of error (Hammond 1993). My use of the term "error" here does not refer solely to the failure to make empirically accurate judgements and decisions, but includes 'getting it wrong' qualitatively.

In making clinical judgements and decisions, participants can be seen to rely on their pre-understanding of individuals and/or types of individuals. The dominance of this intuitive use of knowledge can increase the scope for error by precluding due consideration of the situation that the person is in (Gilbert & Jones 1986). It can also result in socially undesirable consequences (Park & Rothbart 1982, Chen et al 1996) the most obvious being participants' routinised paternalism towards individuals with a psychiatric diagnosis.

There is little or no evidence of critical deliberation on the part of participants around their choice of habitualised 'interventions' such as reward-based attempts at behavioural conditioning, subtle coercion and automatic limiting of choice. These interventions are represented as habitual, normative and integral to the role of the psychiatric nurse. Where

individuals do express awareness of the possibility that their judgements and decisions may be socially inappropriate, or of the potential for error inherent in complex cases, they tend to deliver more deliberative and analytic narratives (Bargh 1996, Kaempf et al 1996).

For example, participants engage in slower, more detailed discussion where case features are seen not to relate to the type of person or situation that are more frequent and/or recent. This thoughtful discussion of cases is always pursuant to initial quick judgements and involves consideration of the presenting cues in the context of the activated knowledge on which these judgements are based. The evidence to on which these observations are based ranges from the level of detail with which a case is discussed (Neisser 1967) to paraverbal phenomena such as markers of hesitancy.

Depending on the data type, through this focusing of effort, participants formulate (in the think aloud data) or reformulate (in the retrospective interview data) hypotheses. Across both data types, participants more readily explain their judgements and decisions regarding what are presented as straightforward, typical cases (Klein 1989). In general, more complex, atypical cases require more time and are explained in more detail, although in the retrospective interviews some participants' reformulate typical, routine cases with thoughtful representation of the salient features of the case.

Participants' deliberative processing of information can be explained by participant resistance to automaticity. Research has shown that this can occur not only as unusual presentations require it (Kaempf et al 1996), but also when an individual makes a values-based choice to do so (Wegener & Petty 1995, Stapel & Winkelman 1998, Wittenbrink 1998, Wegener et al 2006). It is to be expected that participants' values, as well as their expectancy regarding the potential outcomes of a situation, strongly influence their judgement (Bandura 1986, Beach 1990, Widick 2003, Wang & Mentis 2009).

However, the fact that participants focus with effort on the contrast between presenting cues and activated knowledge does not in itself guarantee that assessment is empirically accurate (Higgins 1996) or qualitatively 'right'. The values underpinning participants' perspectives on the cases may not be congruent with those of others involved (in the case of retrospective interviews) (Trout 2009), or with societal and professional values (in the case of the think aloud data). Participants' values are best derived from their narratives (Kaempf et al 1996), which draw on their clinical experience (Klein 1989).

These are organised around diagnostic and symptomological concepts that have strong grounding in the medical model of psychiatry. On the basis of these, participants tell how

they engaged in informed anticipation of the likely course of events to select what they saw as the most appropriate interventions (Klein 1998). Participants' normative expectations, grounded in psychiatric medicine, are the standard against which presenting cases are assessed.

However, participants do not solely base their expectations on psychiatric domain-specific knowledge, but also on more qualitative, personal ways of knowing. As described by O'Neill (2005), in participants' judgement and decision-making narratives, theoretical knowledge and personal knowledge can be seen working together, in a non-dichotomous fashion. Each informs and makes sense of the other.

Examples of non-theoretical pre-encounter data referred to by participants in their explanatory narratives include knowledge of people gleaned from verbal reports from other nurses and from personal relationships. Participants' use of this personal knowledge in tandem with domain-specific, theoretical knowledge helps them to make sense of the presenting cues. Participants demonstrate selective attention (Kahneman 1973) to cues in that after paying attention initially to cues, some are attended to further and others dismissed or played down in significance.

Participants also combine lay and psychiatric knowledge to identify as absent, and seek out, aspects of a case presentation that they would normally make reference to in their judgement and decision-making. It is this context that participants identify presentations as unusual or atypical. In considering this process, it is important to remember that participants' knowledge activation is distinct from their actual use of knowledge - activated knowledge is not always used in making a judgement (Wittenbrink et al 1998).

This is because participants, like all individuals, are more likely to identify phenomena to which they have greater accessibility to in terms of knowledge activation (Tversky & Kahneman 1973, Higgins 1996, Kahneman 2003). This knowledge is more likely to influence participant judgement than is equally relevant data that is not so readily available (Thompson 2002). As psychiatric nurses operating within a medical model of healthcare provision, it is not surprising therefore that participants' consistently refer to knowledge from the field of psychiatry.

This knowledge is borrowed by participants from the psychiatric profession and interpreted and applied in lay terms in order to deal with the problems of everyday life that are faced by service-users. However, attempting to explain everyday problems in medico-psychiatric terms has its drawbacks. Participants' perception of what is happening in cases differs from

what is actually occurring due to their over-reliance knowledge that is more readily available and familiar (Higgins & Brendl 1995). Indeed studies suggest that information confirming a stereotype is more readily available for recall than data that is likely to disconfirm it (Rothbart et al 1979, Evans 2008).

Participants narratives indicate that they work thoughtfully through cases, drawing on, interpreting and applying a combination of psychiatric and lay repertoires of knowledge. Their thoughtful narration of events tends to be firmly grounded in the diagnostic categories to which the individuals involved had been allocated. Therefore, it is clear that it is not a question of participants using deliberate reflection and intuition each in absolute exclusion to the other.

Even when participants work discursively through cases in an analytic manner, there is evidence that they apply knowledge in an intuitive manner. This complex interplay between intuitive and analytic strategies is typical of nursing judgement and decision-making (Lauri et al 1997, 2001), and it is difficult to tease both elements apart. I have been conscious of the need to avoid forcing a falsely 'clear cut' distinction between the two in analysis and discussion of the data.

For this reason, nurse researchers tend to favour the perspective of approaches like cognitive continuum theory (Hammond 1996a, Lamond & Thompson 2000, Lauri & Salanterä 2002, Offredy et al 2008) as more representative of nurses' clinical judgement and decision-making than dual systems models (Evans 2008). I believe that because of their non-dichotomous approach, such theoretical perspectives also fit best with the evidence from this study. However, the design of this study does not provide the basis for confirming or rejecting a hypothesis that the findings fit into the conceptual box of non-dichotomous theories over and above others.

6.6 Semiosis & the control of choice

Participants' narratives amply illustrate their control over the choices available to individuals availing of their services, which is achieved by discursively controlling the shared construction of meaning (semiosis) with them. This process can be seen to hinge on participants' perceptions of others, including individuals using the mental health services, their significant others, healthcare workers and other professionals (Ciofi 2000, O'Shea 2008). This control occurs in the context of a collaborative process which offers an

opportunity for authentic sharing of understanding between participants and others, particularly in terms of role and associated expectations.

The separation of this process into social and cognitive elements is a construct of the academic disciplines. As can be seen in the norms and values expressed in the narratives, these elements are naturally interdependent. Participants' judgements and decisions are not based solely on external cues, but also on shared, internalised social values (Festinger 1950, Wang & Mentis 2009). Cognisance of the intricate social-cognitive interplay in clinical judgement and decision-making is particularly important in understanding the nature of shared decision-making in health care (Epstein et al 2005, Johansson et al 2005, Wirtz et al 2006, Halpern 2007).

Where participants describe habitually and implicitly sharing understanding with others, there is no cause for remark and no explicit expression of values. This sharing of understanding can be understood in terms of cognitive phenomena (Hardin & Higgins 1996), in particular with regard to perception. Shared reality and construction of shared meaning is not confined to participants' thoughtful sharing of the decision-making process with others - automaticity and intuitive thinking are involved.

At the same time the authentic valuing of the individuality of those using the mental health services is explicitly expressed as normative. This is discursively linked to the empathic identification of a shared humanity and shared meaning in everyday events. Participants sometimes identify with individuals in situations where they might be expected to act more negatively towards them, for example, hostel residents who break the institutional rules.

In such instances an individual's behaviour is represented as indicative of their common humanity rather than as typical of a particular type of patient. There is however, a limit to the extent to which participants identify with service-users, seen most clearly in their habitualised tendency towards paternalism. There are no discernable features in terms of location of cases or demographics that are associated with either tendency. Paternalistic control of situations is visible in community as well as inpatient scenarios.

Where participants do identify with others, this involves discursively incorporating them into their own social group rather than assigning them to an out-group (Brewer 1991). This is an example of how participants, as individual judges and decision-makers operating in isolation, display the influence of social norms and values (Moscovici 1985, Wang & Mentis 2009). In this regard, participant narratives are demonstrative of a shared reality between participants, and to varying degrees with other health professionals.

This sharing of a discipline-based reality points towards the extent to which participants internalise their professional role and identity, and is very much part of the social institution of psychiatric nursing. This came across most strongly in the analysis of the data in participants' use of the first person plural pronoun "we". This pronoun is used in self reference as participants give an account of their own judgements and decisions.

Participants use personal pronouns to mark out their work as a collective effort (Lerner 1993) - that of the psychiatric nurse. The implication of "we" as a self reference is that what is being described are not merely the actions of an individual, but of 'everynurse'. In the *in-vivo* judgement and decision-making of the think aloud data, "we" serves to include the interviewer (who was also a nurse for all but two participants) in the judgement and decision-making process.

This is indicative of the natural inclination of participants to collectivise their judgement and decision-making. Participant pronoun use builds consensus and subtly gains the interviewer's assent-by-silence to the participants' judgement and decision-making. Essentially this constitutes *in-vivo* construction of shared understanding (Lerner 1993).

This building of shared understanding through the construction of shared meaning relates to two distinct issues that have been underlined in Chapters Four and Five. First, participants identify with their professional role to the extent that they talk about their own judgements and decisions as being corporate. Corporate judgements and decisions are discussed as if they were the participants' own.

Second, in sharing the judgement and decision-making process with service-users, participants can be seen to disempower them (Walsh et al 2008). This is not an end in itself – analysis of the data demonstrates participants' representation of these individuals as inherently disempowered by merit of their diagnosis in the first instance. Instead they follow that well-documented habitual, routinised paternalism that has been shown to be characteristic of those helping the mentally and behaviourally disordered since the days when doctors first took on permanent roles in the asylums of the 19th century (Foucault 1965).

At the same time participants' close identification with social role can be understood as a function of healthy team-working. This is true insofar as lack of homogeneity in a social group hinders the smooth operation of the team (Vallaster 2005), as is evident where participants' perception of the task at hand is not shared with others. Here, critique of

another's perceptions and subsequent actions are couched in disclaiming and diminutive language (Heritage 1984).

This is indicative of the high value placed on the preservation of social homogeneity in the face of difference. Also evident here is the value placed on communication between participants and others for the development and preservation of the shared understanding (White 2002) that underpins this social homogeneity. Other studies have also found this to be the case particularly in pressured healthcare work environments (Slade et al 2008).

Non-acceptance of diversity can result in antagonism (Vielhaber Hermon 1996, Vallaster 2005), and in situations that feature ambiguity due to lack of social homogeneity (e.g., the multidisciplinary team) participants' talk about seeking input not only from fellow nurses but from other healthcare professionals (McCaughan 2002). The positive aspect of such close identification with and reliance on others is that rather than working in isolation, participants draw on a collective and multidisciplinary body of experiential knowledge (McCaughan 2002). This sharing of experiential knowledge points towards a certain degree of shared meaning between participants and their colleagues (Steinberg 2004).

This shared meaning is conjunctural, arising from conjoined social practices and circumstances that involve those using the services as well as health professionals. It is also contingent, with specific events resulting in the construction of specific contextual meanings. This is best illustrated with reference to one participant's narration of an instance whereby they and their colleagues restrained and secluded an individual.

For the participant, the accepted meaning and limitations of 'choice' are quite different from the wider societal understanding of 'choice'. In this instance, shared meaning of the word "choice" is hampered by the fact that "choice", as well as other words and phrases, represent different phenomena and contingencies for those involved (Hamm 1991). This is to be expected due to the general lack of human awareness about the nature of linguistic ambiguity.

This is perhaps why the participant attributes their failure to reach consensus with the individual to factors other than differences in basic interpretation of words (Fischhoff 2000). Even in narrating the event they appear oblivious to the fact that the "choice" offered to the person was really no choice at all. This and other examples from the study corpus detailed in Chapters Four & Five, show that human communication is characterised by ambiguity even in the most straightforward situations (Fischhoff 2000).

The sharing of a certain perception of reality with others is a vital element of participants' judgement and decision-making (Chen et al 1996). However, where the sharing of understanding is limited to participants' colleagues, it results in a diminished level of identification with service-users (Allen 1998). So whilst shared understanding is desirable in psychiatric nursing practice (Volpe et al 1996), its usefulness is contingent on its being shared with all involved in an episode of care.

There is a distinct link here between identification with professional role and the disempowering of others. The disempowering of others is achieved by participants through the inauthentic building of shared meaning using dynamic social processes (Steinberg 2004). This is plainly discernable in participants' descriptions of how they exercise power in their specific institutional context.

This exercising of power is represented by participants as vicarious as opposed to controlling. Power is not exercised as an aggressive act of overt domination. Service-users are not represented as controlled or vanquished, but as inherently powerless and vulnerable. These powerless individuals are represented as needing someone with the knowledge and power to act in their best interests. Their need of professional help is discursively represented as evidence of innate, fundamental powerlessness. This, rather than their identity as a "difficult patient" (Breeze & Repper 1998, p1301), underpins participants' paternalistic coercion of individuals.

In this context, as suggested by Barnard & Sandelowski (2001), participants represent their exercise of power as genuinely beneficent and not at all self-serving. Subtle coercion of individuals is discursively constructed as a fundamental function of their psychiatric nursing role. As with the family supervisors studied by van Nijnatten et al (2001), this is on the basis of the discriminating power that participants' professional role bestows upon them. Exercise of this power is underpinned by the perception that powerlessness is an innate element of the personhood of the service-user.

Participants represent themselves as powerful professionals "separate" from those using the mental health services (Shattell et al 2008). This is problematic insofar as the two are supposedly working in partnership. As in the study by van Nijnatten et al (2001), what is lacking in this partnership is the authentic sharing of meaning.

Instead, shared meaning operates as a function of professional power. This is seen most clearly where choice and contingency were discussed in the retrospective interview data element of the study corpus. There the operation of power and control as a function of the

social role of the psychiatric nurse can be seen, in certain social contexts, to underpin offers of choice and the discursive management of contingency.

Where participants' perception of their role and that of the service-user enables it, there is nurse-led construction of shared meaning. In this, participants represent their role in terms of what is expected from themselves and others (Sarbin & Allen 1968). Their role is shown to endow them with certain rights and privileges, as well as placing them under certain obligations towards others.

This taking-on of role, both by participants and others, forms the basis for the interactive processes narrated in the study corpus (Krauss & Fussell 1996). These processes essentially involve participants 'being nurses', for which they need others to be 'service-users'. This process is governed by participants' subtly-masked perception of duty to limit service-user's choices in their best interests, e.g., in order to gain their compliance.

In the retrospective interview data this occurs under the guise of a process of shared decision-making whereby participants represent themselves as working collaboratively with service-users. They offer open-ended options and present themselves as open to new information and diverse outcomes. However discursive analysis reveals this 'collaboration' to be governed by ulterior motives, for example, the covert attaining of compliance.

Participants who engage individuals in this way represent their actions as being in the best interests of the other person. This is underpinned by expressions of beneficence which cannot be differentiated from those of participants who offer people a more authentic form of choice and empowerment. Participants do not seem to view their control of the construction of shared meaning to limit the choices of others in negative terms.

Participants represent their ability to construct shared meaning for subtly coercive purposes as a fundamental psychiatric nursing skill. The perceived need to engage in subtle coercion seems to hinge on participants' understanding of their role vis-à-vis the type of person they are working with. This is inextricably linked to participants' intuitive judgements of individuals as representing a certain type of individual who is to be routinely engaged with in a particular way.

There is a link here between the use of intuition as explained by concepts such as stereotyping, pattern recognition and representative/recognition heuristics, and the concept of social position (Stryker & Statham 1985, Chen et al 1996). Covert coercion appears to be seen as a valid form of engagement with certain types of individual, for example hostel

residents - but not others, for example nurses. Participants represent this approach as a normative element of their role as psychiatric nurses (Brewer & Brown 1998).

This way of relating to people appears internalised to the extent that rather than being represented as an intentional acting out of professional role, it is habitual (Stryker & Statham 1985). In this way, participants' identity as psychiatric nurses confers on them the right to deal with people in a manner that they might, in other contexts, construe as socially undesirable and even unethical. Indeed other studies have linked this strong sense of social identity to stereotypical perception of others (Tajfel 1981, Brewer & Brown 1998).

In both the sociological and psychological literature, this is discussed in terms of an individual's perceptions of social group membership – for themselves and others. Social groupings are a vital underpinning of the automatic cognitive mechanism of stereotyping others (Stryker & Stratham 1985). Whereas traditionally the study of stereotyping explored its social motivation, from the cognitive perspective it can just as fully be accounted for as a relatively value-free process of cognitive shortcutting (Fiske & Taylor 1984).

Participants' perception of themselves as 'nurse' and the other as 'patient' or 'client' is at the core of the exercise of covertly coercive power and control. As an inherent part of their social role, coercion by participants is in line with the expected performance of role by the other. As such, it has become normative, routine and habitual in the participants' practice.

6.7 Conclusion

From analysis of the study data, participants can be seen to make quick intuitive judgements as well as taking time and effort to explore matters further to decide what to do next (Trope 1986). Participants use a more deliberative approach especially when faced with atypical presentations (Kahneman 2003, Evans 2008). Overall their initial judgements are characteristically quick and routine, followed by more deliberate, thoughtful reasoning. This is evident in both the think aloud and retrospective interview data. The deliberate, thoughtful approach of participants could be interpreted as their performance in response to being interviewed or asked to think aloud. However, these approaches have been used for decades as valid means of gaining insight into human judgement and decision-making, and participants did engage freely in rich narrative representation of their judgement and decision-making without much difficulty or prompting.

The quick and routine way in which participants approach cases can be explained in cognitive terms with reference to the vast literature on intuition. From a sociological

perspective the same process can be accounted for with reference to habituation and social role. In this chapter I have explained how such concepts can be seen to relate to features of participants' judgement and decision-making, such as confidence and uncertainty.

Although the ability to quickly apply a combination of experience and domain-specific knowledge is seen as an indicator of expertise, the cognitive strategies used to do this are potentially irrational and erroneous intuitive (Tversky & Kahneman 1974, Nisbett & Ross 1980, Thompson & Dowding 2009d). Participants' expression of effectiveness-with-ease and certainty, where there is objective and subjective uncertainty, is an important finding of this study. More important is the novel combination and application of recently developed methods of analysis. These enable the detection of the consistent use of verbal markers of subjective uncertainty in narratives in which participants express confidence (Cheng 2002, Jaworski et al 2003).

Participants' combination of a thoughtful approach with intuition is no guarantee that they can avoid the errors or biases inherent in intuitive judgement (Kahneman 2003). Although this study did not set out to empirically measure error or bias, it is noteworthy that participants' reflection on their initial judgements does not cause them to deviate from their focus on an individual's diagnosis as a central point of reference. Depending on one's philosophical approach to psychiatry and mental health care generally, this could be viewed positively (Garb 2005) or negatively (Crowe 2000).

Participants' routinised approach to judgement and decision-making is based on an adaptation of psychiatric diagnostics that combines domain-specific knowledge with skilled know-how. This illustrates how the medical model of psychiatry underpins the culture of the institution of psychiatric nursing. As well as determining the aspects of a case to which participants attend, this medico-psychiatric underpinning determines participants' representation of their role.

The nurses' immersion in their role and their perception of the service-user as 'other' determines for them what is seen as cognitively achievable and socially acceptable. Subtle coercion, beneficent manipulation and even dismissiveness all feature in the way that participants make clinical judgements and decisions only because their way of valuing individuals permits it. In light of this, it is not unreasonable to suggest that the psychiatric nurses' view of what exactly constitutes a service-user's best interests can be at a remove from the individual's own perception.

This tension appears to be upheld in the view of the psychiatric nurse by the degree to which they see the service-user as an inherently damaged and powerless 'other'. This view is in itself upheld by the medical/psychiatric lens through which participants intuitively assess the 'other'. The medical and psychiatric nature of the role of the psychiatric nurse acts doubly, therefore, in the coercion and subtle disempowerment of those seeking help. Other studies have found similar non-therapeutic use of professional power to be characteristic of the psychiatric nursing (Walsh et al 2008) and other 'caring' roles (van Nijnatten et al 2001).

How participants understand their role and duty of care determines how they perceive others and the degree to which they engage in authentically mutual collaboration with them. Mutual collaboration is not always authentic, that is; participants do not always engage on equal terms with service-users. However, as also found by Breeze & Reppert (1998) and van Nijnatten et al (2001), subtle manipulation and coercion of people and situations by participants is underpinned by a participant representation of their role and duty as one of helping those who are powerless to help themselves. Participants do not deliberately seek to disempower others as an end in itself.

In this chapter I have drawn on the nursing and wider literature from across several decades, paying particular attention to seminal pieces of work that have informed my discussion, alongside more recent publications. Having described what analysis has revealed about participant judgement and decision-making, it remains to discuss the implications of this in relation to contemporary psychiatric nursing practice, both in Ireland and in general. I will do this in Chapter Seven, making reference specifically to methodological and other research considerations, implications for those using the services, and implications for psychiatric nursing practice and education. I will refer to health and social policy throughout as it pertains to each topic.

Chapter Seven

Implications, Recommendations & Limitations

7.1 Introduction

In Chapter One of this study I noted that international psychiatric nursing research does not always find direct application to the clinical context of Irish psychiatric nursing and mental health service provision. In this chapter I discuss the implications of my findings with particular reference to national policy (DoHC 2006) and relevant research, in order to critically locate the study findings in Irish psychiatric nursing and psychiatric nursing generally. I do this across several areas for which the study findings have implications and make recommendations on these.

In doing this, it is necessary to revisit the study's aims and objectives as refined and restated at the end of Chapter Two:

Aims

1. To explore the judgement and decision-making of RPNs working in the Irish Republic, in terms of both the cognitive processes involved and their social context.
2. To consider and apply the findings to psychiatric nursing practice and education, as well as to policy issues and future research in this area. This applies primarily to the Irish context from which the data were generated and, where valid, to psychiatric nursing generally.

Objectives

1. To give a comprehensive account of clinical judgement and decision-making in nursing, in particular as it applies to psychiatric nursing
2. To understand, through a combination of qualitative and quantitative methodologies, how and why RPNs make their clinical judgements and decisions
3. To gain as much insight as possible on the cognitive processes and social context of the clinical judgement and decision-making of RPNs, in particular analysing the interplay between the external social and internal cognitive elements involved.
4. Having fulfilled the aims and objectives above, to make applications to psychiatric nursing in the Irish republic, with particular reference to its future development.

In discussing the study's implications, recommendations and limitations, I address the three main aspects of the study's aims and objectives:

- The cognitive processes involved in nurses' judgement and decision-making
- The social context of nurses' judgement and decision-making
- The interplay between these cognitive and social elements

This is done in terms of their applications to, and implications for the current state of, and future developments in:

- Research
- Practice
- Policy
- Education

In particular, I make reference to the role of the psychiatric nurse. This is because of the focus of government policy on this role (DoHC 2006) and also because of the centrality of participants' role in understanding and applying the study findings.

7.2 Implications & Recommendations for Further Research

One of the main purposes of an exploratory descriptive study such as this one is to provide direction for further research (Gleeson & Higgins 2009). In this chapter and in Chapter Six I have mentioned several areas in which further research could build on the findings of this study. I will discuss these here, in addition to considering further application of the methods used in the study to the study of judgement and decision-making.

As with human judgement and decision-making generally (Funder 1987, Hammond 1996b), error in nurses' clinical judgement and decision-making is an important focus of research (Thompson 2002, Thompson & Dowding 2009b). This usually involves generating quantitative evidence in relation to practice-based errors in cognitive processing. The nature of my study's design means that it differs from this approach.

Evidence of participant error in this study is in terms of qualitative mismatch between nurses' perceptions and what other studies have reported as the values of those seeking psychiatric nursing care (Noble et al 2001, Mental Health Commission 2005, Department of Health 2006, Dunne 2006). In addition to this, there is evidence of mismatch between the values that participants expressed and those that are evident in their accounts of practice.

Although expressed qualitatively in this study, future studies could consider ways of reducing this type of mismatch to some form of quantitative measurement.

Researchers whose main interest is in human judgement and decision-making *per se* tend towards quantitative methodologies that focus on the specific cognitive aspects of judgement and decision-making. Within their disciplines and among the scientific community generally, these approaches are valued above those that are qualitative or use mixed methods (Cahan & Snapiri 2008). These methods could prove useful in further research that explores accuracy and error in psychiatric nursing by providing a means for looking at nurses' performance in tasks such as the completion of depression rating scales, or predictive judgements of likelihood of significant events such as suicide (Garb 2005).

Throughout this thesis I have outlined the usefulness of approaches grounded in social judgement theory for understanding nurses' clinical judgement and decision-making. Although not applied directly in this exploratory descriptive study, cognitive continuum theory and the lens model are particularly useful for investigating the accuracy of clinical judgement and decision-making. However, applying these approaches to some aspects of psychiatric nursing can be problematic due to issues such as the lack of clarity surrounding the links between interventions and outcomes and the difficulties with reducing the work of psychiatric nurses to discrete quantifiable and measurable phenomena.

Regardless of the use of a qualitative or quantitative approach, the mismatch between nurses' expressed values and those evident in their practice is an area that warrants further investigation, as does the mismatch between the values expressed by nurses and service-users (Wang & Mentis 2009). However, many of the elements of psychiatric nursing practice and associated phenomena discussed in this study are not as amenable to investigation in this way. This is particularly the case for nurses' use of intuitive judgement and decision-making strategies, which although not impervious to investigation, does pose methodological challenges (Thompson & Dowding 2002).

My study has shown how challenges like this can be addressed by an eclectic approach to study design. Using a pluralist approach to research in order to shed light on the salient issues regarding the judgement and decision-making of psychiatric nurses is not novel (Tees et al 2007). To this end, researchers need to look beyond the dichotomy of qualitative versus quantitative, and romantic versus empiricist (Garb 2005) schools, stepping outside the conceptual arena to which they may have become accustomed to seek more authentic ways in which to ask and answer research questions.

One approach which this study introduces for overcoming limits imposed by dichotomous thinking is the overlapping of aspects of sociological theory and cognitive psychology in order to better understand how cues are understood and interpreted (Dawes 2000, Glassman & Kang 2007). Although not without its tensions, such innovative combination of different theoretical perspectives can provide the basis for overcoming some of the difficulties in applying quantitative measurement to the judgement and decision-making of psychiatric nurses. My study's combination of cognitive and social perspectives to explore participants' judgement and decision-making essentially involves viewing participants' cognitive processes as socially situated.

This meant viewing participant use of language as a form of social action (Potter 1996, 2001). My attentiveness to the meta-narrative of the data was vital to this. Such an approach is not novel, and has been a key principle in methods of analysing verbal data, e.g., conversation analysis (Atkinson & Heritage 1984, Heritage 1984) and data analysis in discursive psychology (Edwards & Potter 1992a).

Its usefulness in my own study was most discernable in its ability to detect participant expression of hesitancy and subjective uncertainty. This was achieved through novel application of methods of analysis not usually applied to this type of data in this field of research. Repeated application of the methodology with a more clearly defined population, e.g., Clinical Nurse Specialists in psychiatric nursing, might be of use in answering more specific research questions around particular areas such as expertise.

Expertise is one of several topics about which this study yielded evidence that, whilst relevant, stopped short of giving a fully conclusive picture. Participants could be seen to discursively construct their expertise, but comparing this to their actual expertise was beyond the scope of the study. Research that compares nurses' actual performance in terms of expertise to their discursive claims of expertise would be of interest particularly in the context of other issues that arose in this study, such as overconfidence, development of expertise and certainty/uncertainty in judgement and decision-making.

Participant expression of subjective certainty amidst uncertainty was another key feature of the data in this study that points towards opportunities for further research. The approach used to yield the verbal and paraverbal evidence for this element of the findings could find application in studies with a more specific cognitive focus. This would require a departure, however, from the usual approach of such research.

In order to yield discursive evidence regarding cognitive processes, it is necessary to start from an initial focus on participants' language as data representative of social as well as cognitive processes (Potter 1996, 2001). This is because speech has the obvious function of communicating information (its "referential denotative function") and the less obvious function of social action (its "performative-pragmatic function") (Oliveira et al 2007, p121). Therefore, awareness of social context is not mere familiarity with how, when and by whom language is produced, but attention to how the unfolding of the conversation itself creates, maintains or disrupts a particular social order (Taylor 2001).

In this way, as this study has demonstrated, valid evidence regarding cognitive processes can be generated by taking an indirect, more socially and qualitatively situated perspective than is usually the case with studies on cognition. This constitutes a humanistic view of positivistic knowledge, as proposed by commentators such as Gould (1996) and Bunge (1983). This view should not be limited to research methods and philosophies, but also involve a broader consideration of who is involved in research.

It has been recognised for some time now that the inclusion of people availing of mental health services needs to move beyond the planning and delivery of care and provision of education and training, into the area of research and evaluation of practice (Campbell & Lindow 1997, Noble et al 2001). Studies of how psychiatric nurses make clinical judgements and decisions would benefit from the participation of researchers who have experience of using mental health services. This would enhance the validity and rigour of any study, in particular those with a predominantly qualitative approach.

For example, analysis of real-world interactions between nurses and the people for whom they provide care could only benefit in terms of validity and rigour if the analysis itself was shared between representatives of both constituencies (Perakyla & Vehvilainen 2003). This is of particular relevance given the findings of this study with regard to how psychiatric nurses can approach people with mental health problems. It stands in contradistinction to the paternalism represented in the study data that has dominated psychiatric nursing for most of the 20th century. If psychiatric nursing researchers expect practitioners to engage in authentic construction of shared meaning with individuals availing of mental health services, they need to lead the way by doing the same in their research (McGowan et al 2009).

7.3 Implications for Psychiatric Nursing Practice and Those Using Mental Health Services

This study was designed to elicit information about nurses' normative practice as opposed to information about individuals using mental health services. However, the role of the psychiatric nurse is fundamentally *vis-à-vis* those availing of mental health services. For this reason it is vital to discuss the implications of the study findings for these individuals as well as for psychiatric nursing practice.

I had initially envisaged setting out these implications two separate sections. However, on reflection and in particular in light of the findings, I became aware that separating one from the other would represent an unhelpful dichotomous compartmentalisation of the study's implications. The practice of psychiatric nurses cannot be considered in isolation, because although individuals using mental health services may or may not (to varying degrees) need the input of psychiatric nurses, without individuals who need their assistance psychiatric nurses are without a *raison d'être* (Jackson & Stevenson 2000).

A desire to improve the clinical competency of nurses and promote evidence-based care has driven recent research on clinical judgement and decision-making in nursing, and it is my intention in conducting this study to make a meaningful contribution to that body of work. There has been increased attention in recent research studies on the accuracy of nurses' judgements and decisions in the context of the need for practice that is more evidence-based (Talbert & Talbert 2007, Kelechi & Bonham 2008, Thomson et al 2008, Miller et al 2008, Erci & Sureyya 2008, Thompson & Dowding 2009b). This focus on evidence-based practice also extends to psychiatric nursing (McKenna 2003).

The broad perspective (Burns & Grove 2005) taken by this exploratory descriptive study (Gleeson & Higgins 2009) has seen it focus on the social situatedness, process and rationality of participants' clinical judgement and decision-making as opposed to the specific measurement of accuracy. The purpose and design of this study has not required the same focus on accuracy, clinical competency and evidence-based practice that has been sought in quantitative investigations of specific aspects of nursing practice. However, this study has considered participants' clinical judgement and decision-making in terms of rationality and internal consistency.

In doing this, I have been aware that neither internal consistency nor subjective rationality is an indication of the accuracy or correctness of judgement and decision-making (Tversky

& Kahneman 1974). I have also been aware that judgements and decisions are highly personal in nature, and depend not only on the cognitive functioning of the individual, but also on the values that they hold (Festinger 1950, Bandura 1986, Wang & Mentes 2009). Clinical competency is strongly related both to nurses' proficiency in clinical judgement and decision-making and their values (Cioffi & Markham 1997, Wang & Mentes 2009).

This study's discursive analysis of participants' expression of values that underpin their practice demonstrated their identification with the immediate social group to which they belong, as well as with wider society. These values determine what participants implicate as being 'good' or 'sound' judgements and decisions, as well as 'good' or 'sound' ways of arriving at judgements and decisions. Here, the observations of Dowding & Thompson (2003, 2009) regarding the difficulty of ascertaining precisely what the 'right' interventions or outcomes are in nursing can be seen to be applicable to psychiatric nursing in particular. Indeed, this difficulty is not unique to participants in this study, or nurses generally, but applies to all human judgement and decision-making (Lerner & Tetlock 1999). This is because humans tend to express uncertainty about the likely outcomes of the decisions they make (Tversky & Fox 1995) – with experts being no exception (Larkin et al 1980). This general shortcoming in how we make judgements and decisions has focused researchers on better understanding and reducing instances of error in human judgement and decision-making – where it is clear what constitutes error.

Being sure of the 'right' intervention or outcome in psychiatric nursing is compounded by the fact that what were once regarded as basic tenets of mental health service provision are increasingly subject to constant and robust questioning by mental health professionals, academics and service-users (Jackson & Stevenson 2000, Clarke 2003). The appropriateness of subjecting individuals to the medical model of psychiatric care has come under particular scrutiny (Department of Health 2006, Tee et al 2007, Barker et al 2008, Crowe et al 2008, Cutcliffe & Links 2008, Buchanan-Barker & Barker 2009). What constitutes the 'right' judgement or decision in an individual nurse's practice will be determined by their overall approach to mental health care. A nurse operating from the perspective of recovery and person-centred care will view this quite differently from a nurse who view matters from a biodeterministic perspective.

Participants, whose narratives express their groundedness in the medical model, discursively constructed this as an empowering and even emancipatory approach that hinges on shared decision-making. However, discursive analysis of these narratives

demonstrates that whilst this shared decision-making did involve acting in someone's 'best interests', this tended to entail subtle coercion of individuals in a process of linguistic entrapment (Crawford et al 1995, van Nijnatten et al 2001). Far from cynically exercising power, participants appear so habitualised into a mode of practice that I describe as routinised paternalism, that they appear to be as unaware of its socially coercive nature as they are their intuitive cognitive processes.

Dunne (2006) has found that the nature of mental health service provision necessitates the involvement of psychiatric nurses in limiting individuals' choices, e.g., in their care of legally detained patients. The concept of the service-user as central to the caring process can be seen as contrary to this controlling function of the nurses' role. This conflict is not novel, and has its origins in medicine (Balint 1964, Byrne & Long 1976). For example, central to Balint's (1964) critique of medical practice was physicians' discursive control of consultations.

However, individuals who engage with psychiatric nurses expect a "positive and nurturing" experience (Moyle 2003). The Mental Health Commission (2005), for example, has reported that carers and families of service-users see their relationship with the community mental health nurse as an important source of support. People reported that the readiness of nurses to listen to their concerns and nurses' expressions of a sincere interest in understanding their needs were particularly helpful.

Although identified as characteristic of psychiatric nursing by Dunne (2006), this "caring mentality" was not experienced by everyone who participated in her study. Indeed, the subtle coercion and routinised paternalism evident in my own study data are difficult to align with "the caring mentality" (Mental Health Commission 2005, p92) valued by individuals seeking therapeutic engagement with nurses (Dunne 2006). The evidence generated by this study suggests that the problem stems from a lack of shared understanding between nurses and service-users as to what constitutes a therapeutic relationship.

Dunne (2006) has cited the structuring of the work of psychiatric nurses as posing a particular obstacle in this regard (Dunne 2006). Rather than being the fault of nurses or evidence of their unwillingness or inability to care, the lack of authentic therapeutic engagement is indicative of the nature of the institutional order of the mental health services in which participants work (Berger & Luckmann 1967). Indeed, the contemporary view of the role of the nurse as a therapeutic agent has yet to be fully realised in the Irish

context, where psychiatric nurses are still emerging from their traditional paternalistic role as custodians.

The fact that in this study, participants' coercive strategies go hand-in-hand with their expression of a desire to act in the best interests of others is indicative of this. Paternalism is well documented in the literature as a pervasive feature of the cultures of psychiatric nursing (Breeze 1998) and nursing generally (Zomorodi & Foley 2009), and this study adds to that body of evidence. Although the appropriateness of paternalism in mental health care generally is a matter of debate (Cutcliffe & Links 2008), the associated tendency for coercive interventions is ranked amongst its less desirable elements (Sjostrand & Helgesson 2008, Buchanan-Barker & Barker 2009).

In this study, paternalistic coercion is evident where participants describe shared decision-making with people availing of the mental health services. Shared values are central to shared decision-making (Woodbridge & Fulford 2004). The evidence in this study suggests that there is a mismatch between the values that underpin participants' descriptions of their practice and what other studies have reported as the values of those seeking psychiatric nursing care (Noble et al 2001, Mental Health Commission 2005, Department of Health 2006, Dunne 2006).

This results in engagement with individuals in which the role of the nurse is to administer and oversee routinised interventions, and that of the service-user is to adhere to these prescribed regimens. This ongoing dominance of paternalism in Irish psychiatric nursing was also detected by Deady (2005), who also identified the structuring of the work of nurses as partly responsible. Dunne (2006) recommends a reconsideration of the therapeutic role of psychiatric nurses by looking constructively at how psychiatric nurses' work is structured – particularly with regard to their administrative role.

The current structuring of psychiatric nurses' role and work is such that it tends not to recognise and value their therapeutic input in terms of interpersonal work that they do. Therefore, it appears that the valuing of authentic therapeutic engagement is lacking not only in nursing practice, but also from a managerial and organisational perspective. It is my hope that in publishing findings from this study that I can help to raise awareness among nurses and others involved in mental health service delivery of:

- the need for a more authentic expression of “the caring mentality”
- the need for recognition, and devaluing, of routinised paternalism as a valid underpinning of psychiatric nursing practice;

- how the the non person-centred structuring of both the psychiatric nursing role and nurses' everyday work is actively hindering therapeutic engagement;
- the responsibilities of nurses and mental health service providers to recognise and work to change non-person centred practices and structures in their work.

By demonstrating both how subtle coercion works as a discursive strategy at conversational level, and how it acts as an indicator of the degree to which paternalism permeates the delivery of mental health service, I intend to make both nurses and those working with them more aware of its presence. My hope is that this provides the opportunity for both those effecting and being affected by covert paternalistic coercion to limit its influence. To this end I aim to make these findings accessible to those who avail of mental health services as well as to those who provide them.

Although participants' exercise of power is not completely beyond their control, and cannot be explained solely as a structural feature of their work organisation and culture (Breeze & Reppert 1998, Shattell et al 2008), it is important that individual nurses, or even the profession as a whole are not castigated for this approach. Reflecting on my own professional practice as a psychiatric nurse, and sharing understanding of that role with my peers, I would venture to suggest that psychiatric nurses are, alongside service-users, victims of the system of care delivery. From the evidence provided by this study, I concur with Breeze & Reppert (1998) that the way in which the work of psychiatric nurses is structured impacts negatively on their ability to provide person-centred care.

This is especially true given the duty of care and paternalistic beneficence that is expected of nurses, both by their employers and society at large. This study has demonstrated how organisational and societal expectations place nurses in a situation where subtle coercion becomes an intrinsic part of being a nurse. However, the issue of covert coercion and use of power in psychiatric nursing needs to be discussed not merely with reference to nurses' therapeutic role, nor only as a problem for the psychiatric nursing profession, but as an indicator of how society would have certain individuals dealt with.

The general public, politicians and media commentators may bemoan how psychiatric nurses engage with individuals, but in this role they are but the proxies of wider society. Subtle coercion and beneficent control are not unique to psychiatric nursing and their acceptance as a normative feature of society also needs to be addressed (Chomsky 1989). However, this is not to dismiss the need for psychiatric nurses to consider these issues in terms of the functions the profession generally and in the context of individual practice.

Questionable regard for the personhood of the 'other' is intrinsic to the controlling function and aptitude of psychiatric nurses (Breeze & Reppert 1998). This study demonstrates how control of others can be portrayed as necessary due to their status as damaged and inherently disempowered individuals - and by implication somewhat different or even lesser as persons. This appears to underpin the routine way in which participants exercised covert coercion and control.

7.4 Implications for Government Policy & Psychiatric Nursing

Government policy for the future of psychiatric nursing in Ireland is set out in the policy document "Vision for Change" (Department of Health & Children 2006). This strategy considers the changes needed to provide a more person-centred mode of mental health service provision in the Irish Republic along with the necessary changes envisioned in the role played by psychiatric nurses. For the most part this involves the psychiatric nursing role becoming more specialised with regard to therapeutic engagement. Writing from a social constructionist perspective, Berger & Luckmann (1967) have described how work roles represent the institutional order of which they are a part.

In this context, this study has shown that participants work in mental health services where the requirements of broader systems of service provision often over-ride individual expertise and needs. This was especially evident in the degree to which participants' roles can be seen to be largely routine and habitual in nature. Participants' close identification with these roles could also be seen in how their use of personal pronouns represents nursing practice as a corporate affair.

Whilst the Department of Health & Children (2006) has identified the need to move beyond this situation, participant identification with this type of role is such that concrete approaches that challenge the current social order and dramatically restructure the work of psychiatric nurses are required if this is to be achieved. Such approaches need to be informed by a comprehensive understanding of the current roles in which psychiatric nurses find themselves and the thinking that underpins those roles. Many nurses currently occupy roles that involve routinised domestic and administrative work that limits the potential for more autonomous, therapeutic work (DoHC 2006).

Given this situation it is easy to see how nurses operate from a services-centred as opposed to person-centred perspective. This could be seen in the study data in the generalising functions participants' use of phrases such as "will have to", "we can't" and "if you". The

example of “if you” in particular pointed towards the association between generalised or habitualised aspects of role and the representation of individuals as ‘typical’.

In “A Vision for Change” (DoHC 2006) the tension between nurses’ roles under the traditional, albeit changing, institutional order and that which the policy document sees as the coming order is apparent. In the ideal community psychiatric service, nurses are not envisioned as having domestic and administrative roles, but working as members of the Community Mental Health Team alongside fellow health and social care workers (Mental Health Commission 2005, DoHC 2006). To maximise the effectiveness and ability of nurses to engage in person-centred therapeutic practice, it is proposed that each nurse would have a maximum caseload of 12 service-users.

Caseload management is seen as constituting a “core skill” (DoHC 2006, p79), competency for which may vary depending on nurses’ education and training. Moving beyond the routinised and habitual approaches to practice evident in this study is a prerequisite for the development of this core skill. However, despite the recommendations (DoHC 2006) for more specialised nurses with smaller caseloads currently there is one advanced nurse practitioner and fewer than 500 clinical nurse specialists working in the Irish psychiatric services (DoHC 2006, National Council for the Development of Nursing & Midwifery 2008).

Even when government finances were relatively healthy, there were not enough psychiatric nurses to meet the manpower demands of the Vision for Change policy (O’Shea 2008). Given that the current global and national economic situation is not likely to improve in the short to mid-term (Bergsten 2009), government policy on the psychiatric nursing role needs to be more creative and innovative than it has been. Unless the development of mental health service provision (and of psychiatric nursing practice in particular) is to stagnate, the only option currently available is a dramatic restructuring of how the psychiatric nursing workforce is deployed.

This is against a background where Sir Robert Naylor, who manages the leading hospital in the UK and is most likely to be the next head of its National Health Service (NHS), has outlined that such restructuring needs to take place across all areas of statutory healthcare provision in light of the current economic outlook (Bowcott 2010). He foresees that this will involve significant retraining and redeployment of clinical staff. Although not employees of the NHS, I believe that it is clear how the professional role participants in my

study (and the quality of care available to the public) would be greatly enhanced by the application of such a strategy in the Irish context.

Coming not from an economic, but a therapeutic perspective, Dunne (2006) has pointed out that the therapeutic aspect of the nursing role in the Irish Republic needs to be reconsidered in the context of how nursing work is structured. Indeed, performance in clinical judgement and decision-making needs to be considered in terms of the structural features of the work of which it is part (Orasanu & Conolly 1993, Klein 1998). It is perhaps to be expected that psychiatric nurses' delivery of care might fall short of what is expected by the public given that the current structuring of their work is rooted in the medical model of psychiatric service provision as developed through the custodial asylum system.

These roots differ significantly from the direction now envisaged for the profession (Mental Health Commission 2005, DoHC 2006). The only feasible way forward in this regard is to relieve psychiatric nurses of administrative and domestic duties, replacing them with workers who are just as capable, but less expensive to remunerate. This not only represents better value for money, but would free up psychiatric nurses for retraining and redeployment to provide person-centred, therapeutic services of significant value to those who use the mental health services – services that are either not currently available or of limited availability.

Given the slow pace of change in Irish mental health services (Sheridan 2008), I realise that whilst this is the direction that needs to be taken, progress cannot be expected in the short term. In the meantime, the collective action of individual managers, educators and practitioners in psychiatric nursing is the only real means by which steps can be taken towards a profession that is genuinely more person-centred. The establishment of new professional bodies such as the Irish Institute of Mental Health Nursing is indicative of the direction that needs to be taken.

This body is new and has yet to organise its first conference, but is already engaged in petitioning and campaigning against what it sees as the paternalistic and coercive nature of Irish mental health law and service provision. However, as in other professions, caution needs to be exercised lest in the drive towards specialisation for person-centred purposes evolves into the pursuit of technical skills and abilities to deliver certain outcomes. Considering similar developments in the teaching profession, Dunne (1993) reminds us of the ancient Greek concepts of the 'good' practitioner as a *phronimos*, with a sound outlook

and a *spoudimos*, having practical wisdom. Any development of nurses as individual practitioners, or the profession as a whole, needs to take this wider view into account.

In terms of the findings of this study, this means that educational preparation for more specialised, person-centred and therapeutic psychiatric nursing practice should not focus solely on the attainment of technical proficiency. The evidence provided in this study is indicative of some of the values-based issues that psychiatric nurses need to face in preparation for a more person-centred role. These show that the preparation of any psychiatric nurse for more specialised practice should involve a rethinking and refocusing with regard to the philosophy and values that underpin their practice, particularly as these relate to the perception and valuing of individuals using mental health services.

7.5 Implications for Psychiatric Nursing Education & Continuing Professional Development

The more aware health professionals become of their clinical judgement and decision-making strategies, the more able they are to develop them (Cioffi & Markham 1997). Analysis of the study corpus revealed participant judgement and decision-making to be routinised and intuitive. This is to be expected insofar as the context in which registered psychiatric nurses' judgement and decision-making skills are honed is one of a demanding, high pressured work environment with significant time limitations.

The complexity and uncertainty of such an environment are conducive to the use of intuitive judgement and decision-making strategies (Cioffi & Markham 1997). An intuitive approach may increase the scope for error, although this study has shown how the work of Irish psychiatric nurses is such that 'getting it wrong' is as much a matter of values as of inaccuracy (Woodbridge & Fulford 2004, Tees et al 2007). Critiquing this aspect of participants practice from an educational perspective requires education that looks not only at concepts such as heuristics, stereotyping, prototypes and exemplars, but consider the wider social context of psychiatric nursing practice.

In considering this study's implications for education of psychiatric nurses, their use of intuition needs to be considered alongside issues such as the extent to which they share meaning with service-users, as well as how they use professional power. Also important is nurses' perception of those who avail of mental health services. Participants' in this study described others as typically similar to each other (e.g., "schizophrenics"), yet different from the in-group to which they themselves belonged.

This creates a distance not just in terms of shared values and understanding, but in terms of shared humanity. The research literature would explain participants' viewing of individuals in this way as having been assimilated through a process of experiential and theoretical learning (Gilhooly 1990). This is also the case in the medical profession.

Participants' intuitive judgements and decisions have their basis in their medical categorisation of mental health problems. However, there is no evidence in the data that participants use diagnostic labelling to explicitly borrow and wield power from medical psychiatry (Hamilton & Manias 2006). These labels simply serve as convenient discursive strategies for organising information in the narrative formulation of clinical judgements and decisions. Power and coercion do feature in this process, but there is no discernable link of a linear causal nature to the use of diagnostic categories in this regard.

Is the solution to this problem then to make the educational preparation of psychiatric nurses less 'medical'? Perhaps limiting the influence of medical psychiatry in professional education and training might help mitigate the tendency for psychiatric nurses to act as the 'sorcerer's apprentice'? The situation does not appear to be this straightforward.

Participant use of diagnostic labels appears to be a routinised part of their practice. This seems to be a value-neutral socio-cognitive response of participants to the clinical situations in which they find themselves in day-to-day practice. Where power and coercion function as part of this response, the evidence points towards its being an inherent feature of the socio-cultural context of Irish psychiatric nursing and mental health service provision within which this style of judgement and decision-making is learned.

I have been working to address these issues in nurse education, and clinically-based learning at undergraduate and postgraduate levels with my research supervisors. This has resulted primarily in our development and delivery of a core module (NS5001) on clinical judgement and decision-making at postgraduate level in DCU (See Appendix G). Elements of this module have fed into the refining of learning outcomes and teaching content in an established undergraduate module on assessment in psychiatric nursing (NS241).

These modules have been revised to make use of problem-based, case-based learning approaches that have proved successful in medical education (Patel et al 1993). In addition to this, I have begun to receive unofficial referrals through the Irish Nursing Board (An Bord Altranais) to assist Nurse Practice Development Co-ordinators who have been appointed the task of follow-up with individual practitioners subsequent to fitness to practice inquiries. The delicate nature of these referrals precludes their discussion here,

except to note that work with these individuals has also taken the shape of a problem-based, case-based learning tailored to suit each situation.

My experience of this approach has been that using case work raises practitioners' awareness of the processes involved in their clinical judgement and decision-making (Shakespeare 2006). In addition to this they are led to consider the role that values play in how they currently approach judgement and decision-making. This is made possible by reflection on real life cases in which they have been involved (Robinson & Shakespeare 1995).

This is a commonly used approach to help narrow the gap between clinical experience and formal education in nurse education (Ivarsson & Nilsson 2009). Essential to this process of reflection is that students not only reflect on their practice, but think about their thinking (Kuiper & Pesut 2004). This is facilitated by classroom based discussion of cases as well as written reflection, which involves not only metacognitive elements, but also consideration of social issues such as the otherwise unacknowledged values that permeate students' work culture.

The mismatch between the values inherent in the culture of psychiatric nursing and what is valued by people seeking mental health care points towards a need for their involvement in the professional education, undergraduate and continuing, of psychiatric nurses. The need for and benefits of this approach been identified in the research and policy literature (Khoo et al 2004, Tew et al 2004, Department of Health 2006, Davies & Lunn 2009). I am fortunate in this regard, as several members of staff of my school with whom I work in developing and delivering our undergraduate and postgraduate programmes have had substantial experience of using mental health services.

This has enabled students to challenge their views on what constitutes 'good' judgement and decision-making, not just in psychiatric nursing, but in other areas of nursing (Gambra & Leon 2002). As well as learning about the need for accuracy and reducing the scope for error by understanding the application of evidence-based practice (Garb 2005), students learn about the importance of valuing the uniqueness of individuals they work with and the situations they find themselves in. This constitutes part of a broader humanistic perspective (Petit dit Dariel 2009) on nurse education represented in the undergraduate and postgraduate frameworks of which the modules are part.

7.6 Study Limitations

As already mentioned at several points throughout this thesis, the exploratory descriptive nature of this study limits its consideration of psychiatric nurses' judgement and decision-making to broad issues (Gleeson & Higgins 2009). The predominantly qualitative nature of the approach involved is such that findings cannot be generalised or said to be predictive of behaviour in the same way that they might be from a large scale quantitative study (Wilks 2004). A further limitation of the study design is that it does not allow for incisive insight into any one area of participant judgement and decision-making, e.g., assessment of risk of self harm.

The nature of the data is such that the conclusions that can be drawn from their analysis are also limited in comparison to those that could be made using data generated by an observational study. This is because participant narratives represent participant reconstruction of events in order to give a presentation of themselves (Goffman 1969, Silverstein 1995, Nunkoosing 2005) and their role (Berger & Luckmann 1967, Gilbert 1980) in a particular light. Furthermore, as well as narrative reconstruction of events, the retrospective data involved participant recall. The subjective uncertainty involved in this process is particularly apparent from the use of qualifiers such as "I think", "maybe" and "suppose" in constructing the narratives, as well as metacognitive disclaimers (e.g., participants saying that they are "stuck for words") (Edwards & Potter 1992a).

It must be recognised, therefore, that the nature of data collection has resulted in accounts that are somewhat removed from actuality (Gilbert & Mulkay 1984, Edwards & Potter 1992a, Kvale 1996). These data cannot be said to validly represent what actually happened, nor even what the participant perceives as having happened (Schegloff 1989). What they do represent is how the participant chose to describe to the researcher, based on recall, what they perceived as having happened (Edwards & Potter 1992a).

If this study had set out to study precisely 'what happened', or to measure accuracy in participant judgement and decision-making, it would be left at some remove from its aims and objectives. However, the study did not set out to answer particular hypothetical questions or offer solutions to specific problems (Nunkoosing 2005, Tachibana 2005). Instead, both the retrospective narratives and *in-vivo* data are intended to shed light on what is normative in the clinical judgement and decision making of participants.

However, the primary aim of this study is to explore the clinical judgement and decision-making of participants (Taylor 2001). Whilst viewing participants' narratives as a resource to look at how they make judgements and decisions, I also recognise that robust analysis requires me to be wary of claims to be able to see past the language itself into the cognitive processes of participants. To this end, my analysis has considered issues ranging from how meanings are constituted in participant narrative to less contextual phenomena such as participant expression of opinion.

In order to make this analysis as robust as possible, I have used methods of analysis that rely on indirect and paraverbal expression as much as they depend on my interpretation of participants' direct expression. The validity of this approach can be seen in the fact that participants' expression of, for example, hesitancy and uncertainty, tends to be implicit rather than explicit. Indeed, key findings hinge on this approach as much as they do on participants' explicit reconstruction of events and selves in retrospective data and presentation of themselves and their normative practice in *in-vivo* data.

Whilst I do share the same professional background as participants, I remain cognisant of the fact that I have engaged with them as an outsider (Taylor 2001). In particular, I am aware of the potential for perceived inequalities in power, status and expertise due to my role as an academic and researcher. This may account to some degree for the hesitancy of participants to discuss some aspects of their practice – a phenomenon that has been discussed in detail in the preceding chapters.

7.7 Conclusion & Summary of Recommendations

In conclusion, this study reveals that amid the complexities of the social and cognitive interplay of forces that shape the judgement and decision-making of registered psychiatric nurses, areas can be discerned that are key to the development of their roles and capabilities. The study participants' expressions of confidence indicate a considerable degree of trust in their own initial causal inferences (Hastie & Pennington 2000). These inferences are based on domain specific information that strongly features prior knowledge derived from pre-encounter data (Crow et al 1995, O'Neill et al 2005, p71) and from theoretical knowledge.

Numerous studies have shown this complex cognitive activity to be characterised by uncertainty and complicated by factors such as the limitations of memory (Carnevali & Thomas 1993, Kaempf et al 1996, Klein 1998, Thompson & Dowding 2002, Garb 2005).

Given the routinised and habitual nature of participants' practice, their expressions of confidence can be seen as widening the scope for error. Although error in this context is not necessarily always a matter of inaccuracy or lack of empirical precision, it warrants attention.

Whilst further research focusing on the nature of error as encountered in the psychiatric nursing role in the Irish context would be required for more specific comment with regard to the profession, individual practitioners can be enabled examine their own roles with a view towards improvement. This would serve, in particular, to lessen the scope for value-based error, as well as exploring nurses' awareness of what this might mean. Some participants in the study, for example, describe the covert curtailing of choice and exercise of coercion as part of the beneficent function of their role.

A blame-free forum is required in which to address these issues in individual practice. In the previous section I have discussed how educational preparation that enables individual practitioners to examine their routinised, intuitive approaches to clinical judgement and decision-making is also required. To complement this, approaches such as informal peer-level clinical supervision could enable practitioners to continue to engage with this process after they complete their undergraduate or postgraduate studies (Shanley & Stevenson 2006). This could facilitate the ongoing examination of how individual practitioners' habitualisation and routinisation of judgement and decision tasks could serve as a springboard for specialisation rather than a self-perpetuating treadmill of non-developing practice.

In summary I list the following recommendations, some of which I hope to help address in the context of my own future work. It is also my intention to promote these recommendations through my dissemination of the findings of this research study. In line with Flanagan's (1954) recommendations for researchers using critical incident technique, this dissemination will target both the academic community and the community of practitioners (with mindfulness regarding confidentiality) from which the data were collected. The recommendations from this study are as follows:

- Research should be undertaken that investigates and further defines the nature of error in psychiatric nursing. The findings of this study about the value-based nature of approaches to practice that are less than ideal could be a starting point for research to measure the degree, extent and potential consequences of this type of error.

- The usefulness of verbal and paraverbal markers of subjective certainty, uncertainty and hesitancy in this study points towards the need to explore their usefulness in other areas of judgement and decision-making research.
- Further research, following on from this exploratory study, should look at psychiatric nurses' judgement and decision-making with the inclusion of service-users at all levels.
- By directly considering the impact of values on clinical judgement and decision-making, psychiatric nurse education should tackle the issue of how individuals using mental health services can be valued as persons as opposed to being discursively constructed as powerless and controllable 'others'.
- Any attempts to reform psychiatric nursing practice should:
 - Question the wider societal function that psychiatric nurses are asked to perform *vis-à-vis* their proxy role in mental health services.
 - Consider not merely the role and work of psychiatric nurses, but the systems and structures of mental health service provision which shape them.
 - Avoid technicist approaches to specialisation which might further distance the nurse from those who seek their assistance in recovery.
- The potential benefits of clinical supervision for psychiatric nurses should be explored, not merely at a higher policy level, but in a tangible and practicable manner at the lowest local levels of service provision (Stevenson 2005).
- Education in clinical judgement and decision-making in undergraduate and postgraduate nurse education should be used as an opportunity for nurses to examine and challenge the values that underpin their practice as well as serving to increase their proficiency as accurate and rational practitioners.

Of course these points for action would require adequate professional and policy drivers (Covell & Ritchie 2009). Although it is beyond the scope of this conclusion to suggest precise mechanisms, I believe that it is not overly optimistic to view any necessary reconfiguration of mental health service provision as an opportunity to challenge the status quo in this regard. A time of global change where new ways forward are being sought in all avenues of society may offer exactly the type of opportunities needed for Irish psychiatric nurses to seriously re-evaluate their roles.

References & Appendices

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Appendix A

***JDM PiP Interview Schedule
(MacNeela et al 2005)***

JDM PiP

Case Study Version

Dr Pádraig Mac Neela

Choice of Case

1. *Time*: Should be within past month, and reflect the dominant patient characteristics in the associated simulation case (e.g., acute crisis, functional impairment)
2. *Challenge*: Aim for clinical complexity and high demand on capacity
3. *Representativeness*: Full set of interviews should reflect clinical dimensions of the case type, and also individual / group decision making, organisational angle, better / poorer outcome than expected

Elicit narrative of the incident (beginning-middle-end, 5 minutes)

Classify: Case type, patient type

1. Was this a typical incident? In what ways was it difficult?

- ***Probe for the problems posed in this incident, priorities and goals***

2. How would you describe this patient's condition? What terms come to mind when you think of this patient?

Prompts (Take notes for choosing Example):

- ***Change in state during the episode***
- ***General state*** (most general depiction of the patient's condition, combining clinical states together into an overall description / formulation, an overall conclusion)
- ***Clinical and personal states*** (mid-level judgements concerning clinical condition and the person)
- ***Domains***: Physiological (e.g., functioning of body systems), psychological (e.g., optimism, sad), family (e.g., family carer, lack of support), social (e.g., friends and neighbours)
- ***Risk / inferential judgements***
- ***Signs and symptoms*** (the cues / information available to you)

Take an **Example** of a empirically-based mid-level clinical judgement (e.g., general state: at risk of self harm, clinical state: depressed / poor family support / ok with independent living)

I'd like to take one example of a judgement, 'depressed', can you tell me what kinds of signs and symptoms would be associated with that judgement?

Take note of the **more specific labels** used to describe the general label, probe for which are the **most telling signs**.

3. At the time, what did you feel had caused this condition to occur?

Prompts:

- **Change** in explanations – during the course of the episode, with hindsight
 - Working hypothesis to **explain** the patient's state, and any alternative hypotheses
4. I'd like to ask about the strategies you used in this case, strategies based more on thinking and reasoning, and strategies based more on intuitive, quick routes to judge situations and make decisions
- Probe for **heuristic type strategies** (for example, familiarity heuristic, e.g., patient script, patient type; rule based decision making) and **reasoning type strategies** (use of analysis)

5. Describe the situation in which this event was taking place

Prompts:

- **Any influences to do with task conditions and task environment** (e.g., time pressure or stress, assistance from colleagues, standard work practices, working arrangements, inter-professional collaboration, management views)
- Any influences to do with **factors besides the clinical condition** (e.g., previous history, age, gender, etc., lifestyle, personality)

6. What decisions were you involved in with this case?

Prompts (Take notes for choosing Example):

- **Autonomous** decision making / group decision making
- **Clinical / coordination**
- Micro- and **macro-decisions** (minor decision / choosing between interventions)
- Why did the person that this decision would work?

Take an **Example** of an empirically-based macro decision (e.g., choosing between different approaches to care or interventions)

I'd like to take one example of a decision, 'choosing to do X', can you tell me about making that decision

Probe for **what the decision was intended to achieve**, decision **heuristics**, what was **attractive / unattractive**, whether **other options** were identified and ruled out, **autonomous** / group decision making

Appendix B
Case Outlines & Video Scripts

PILOT CASE: Damien Setting: DAY CENTRE

NB – For all case outlines the language of the original nursing notes from which they have been derived has been retained insofar (1) it preserves anonymity and (2) is understandable

Presentation

- Understands that he needs to take his medication and get his Lithium levels checked every few months
- Communicates very well with others.
- Appears to have problem ++ with constipation
- Understands that he occasionally needs to go for respite care to Hostel
- Is very aware of maintaining a safe environment both in unit and in everyday living.
- Sleep pattern fluctuates

History

- Has a mood disorder and several admissions to psychiatric hospital. Last admission in 1993.
- Periodic respite care
- Suffering from manic-depressive illness

Family

- His family appears to give him good support and have a reasonable understanding of his psychiatric illness

Lifestyle

- All seven children are married; five living abroad and two around town
- Lives at home with his wife
- Wife fully understands his illness.
- Enjoys the crack with fellow workers in unit.
- Smokes 20 cigarettes a day.
- Eats well, enjoys his food and does not consume alcohol

Other

- Weight: 8 stone

CASE 1: Karen SETTING: High Support Hostel

Presentation

- Level of communication would be considered fair, she does not mix very well socially.
- Tends to lie in bed especially at weekends if she does not go home
- Personal hygiene and dress is not great. Maintenance of her bedroom is very poor.
- Lacks motivation and has to be encouraged to work. She does not mix very well outside the hostel environment because she lacks confidence.

History

- Living in hostel since 1997. Ten admissions to acute inpatient care due to relapse since 1995.

Family

- Single
- Mother is a retired social worker
- Goes home some weekends, but does not see much of mother on those occasions
- Gets on well with sister, who looks after her at weekends

Lifestyle

- Lives on Disabled Persons' Maintenance Allowance
- Sometimes works in kitchen of hostel with domestic staff

Other

- Smokes

CASE 2: Noel SETTING: Acute Admission Unit

Presentation

- Self-referral
- Requesting admission
- “I can’t cope. I can’t sleep”
- Crying, poor eye contact, very reluctant to talk. Anxious.
- Low mood last two weeks
- Expressing death wish
- Poor appetite

History

- Re-admission after recent discharge
- Seen at clinic

Family

- He was back with his partner but she was unable to cope with him and threw him out.
- Parents and partner are aware that Noel is an inpatient.
- Has 1 child, 2 years old.

Lifestyle

- Shared flat with partner but thrown out of same.
- Smokes
- Unemployed – no past-times.

CASE 3: John SETTING: Admission Unit

Presentation

- Self-referral
- Poor sleep pattern.
- Feels hopeless and powerless to his situation at present.
- Feels thoughts racing, needs time to sort his thought out before he can deal with same.
- Has been drinking heavy up to admission, up to 10 pints and 6 shorts a day
- Admitted to low mood, suicide attempt and suicidal thoughts. He has OD on paracetamol 2 days ago and was disappointed that same did not work, “next time I take 60, not 26”. Expressed wish to die, but no suicidal thoughts at present.
- Has good insight
- Abnormal grief
- Feeling depressed since December.
- Poor appetite.

Family

- Widowed. Grieving for his wife who died some months ago (December 2005) of cancer
- Daughter lives abroad
- Family are aware of admission

Lifestyle

- smokes 60+ per day
- Became unemployed before Christmas as he lost his licence, worked as a truck driver.
- Needs time to sort things out before he can tackle his financial problems.
- Has been unable to meet mortgage repayments since September
- No social outlet since wife died, 3.5 months ago, finding life hard to bear since her death.

CASE 4: Patricia

SETTING: Out-Patient Clinic

Presentation

- Sleeps on and off from roughly 8.30pm to 5.30am daily
- Not currently psychotic

History

- Cyclical pattern over last 15 years of not attending clinic post-discharge and of voluntary and involuntary admissions to inpatient services.
- History of intentional self-poisoning. Last incident a few months back. Now glad she did not die as a result.
- History of disturbed sleep.
- Involved with Psych Services since she was 24

Family

- Patricia's father died when she was 11 and her mother when she was 47 (9 years ago).
- Patricia's mother lived with her up until her death. They were very close.
- Has 3 brothers
- She helped one of her brothers rear his children
- Gave up job after marrying, remains dependant on husband for income

Lifestyle

- Lives in bungalow with husband who is very supportive.
- Does not drink alcohol
- Enjoys playing music

Video Script for “Damien” (Pilot Case)

Cues in bold

Characters:

Damien – main case subject, 60yo man

Brenda – Damien’s daughter, in 40s

Brid – Damien’s daughter, in 40s

Receptionist

Scene 1

Car park outside health centre viewed through a window. Car pulls up and two women, Brenda (driver) and Brid (passenger) get out and assist back seat passenger (Damien) from car. Damien is **stooped over and appears stiffened in gait**. Both women **assist Damien to walk slowly** towards day centre entrance (off camera to right). Whilst doing this the women **address him affectionately as “Dad” and offer him reassurance**. He remains silent except for **quietly expressing assent**.

Scene 2 – is heard through an adjacent open door on which the camera is trained throughout.

Trio enter reception area. The women **help Damien to sit down**. When seated he **exclaims “Awww! Thank God!”**. Brenda approaches receptionist and has the following conversation:

B: Could I see the nurse please.

R: Ok, are they expecting you?

B: I don’t know, **we were sent here from the Admission Unit. I have a referral letter.**

R: Ok, I’ll check and see.

Scene 3

Camera goes through door and out to reception area. Nurse (camera) is addressed by Brid: “Hello, we’ve just brought my father here from the Admission Unit. They’ve discharged him and said to bring him here, that you’d look after him here as a day patient until his test results come back from the General Hospital. I gave the referral letter to the receptionist”

Damien interrupts loudly: “I want to go to the toilet!”

Brid: “**We’ll bring you in** now in a minute Dad”

Damien: “I have to go now! I need to go!”

Brid (to camera): “**We’d better take him in**, I’ll be back to you”

END

Script for Clip 1

Characters:

Karen – c.34yo woman with Schizophrenia - CAROLINE HAROLD

Carol – 1st Year Student Nurse NAOMI LINIHAN

Nurse #1 – DCU staff

Scene 1 – Karen’s Room

Karen is lying on bed in her room. Appears sullen and tearful. Carol has been asked to see if she can get Karen to clean her room with her.

Carol: “Hi Karen, how are you?”

Karen does not respond.

Carol: “Would you like me to help you with cleaning your room”

Karen does not respond

Carol: “Karen?”

Karen sits up in bed and shouts at Carol: “Will yis ever f&\$k off and leave me alone!!!” before turning over on her side facing wall.

Carol withdraws from room.

Scene 2 – Hotel kitchen

Carol addresses Nurse #1, who listens

“I went up to see if Karen wanted to clean her room, but she just swore at me to go away. She was like this yesterday as well when Marian was trying to get her into the shower. I thought she was going to hit someone, and Marian said we’d best leave her alone for the time being. There’s an awful smell of rotten fruit or something out of her room.”

Nurse #1 “Right, well...” film fades out

Video Script for “Noel” Case

Characters:

Noel – main case subject, c.25yo man dressed in night clothes, dishevelled and unwell – pale, coughing constantly

Briege – RPN

Joan – RPN

Briege (to Joan): “So everything’s okay really, Noel Cleary has been the only new admission. He came in himself late this am, he’s not long gone from here, but he says he couldn’t cope; girlfriend threw him out of the flat. She knows he’s here and so do the parents, so we’ll see now if she comes in to see him. He’s much the same as last time, crying, anxious, not eating, suicidal ideas but no plans. He has an awful cough as well; I think he was sleeping rough a couple of nights. The admitting Doctor started him on antibiotics for his cough and other than that he’s just on Xanax. He was fairly anxious when he came in, but I think the Xanax settled him because he’s a lot quieter now and even seems a bit drowsy, probably with the Xanax.”

Joan & Briege go over to Noel, who is lying curled up on his side in his bed. He is noticeably clammy, and drowsy. He moans now and again between chesty coughs and his breathing is rapid and shallow. He is rosy-cheeked with underlying pallor.

Joan: “Are you alright Noel?”

Noel continues coughing, moans and shakes his head.

Briege: “Well you’re only started on the antibiotics since lunchtime today, so it’s going to take a while for them to take effect.”

Noel nods and throws his bed covering back before coughing again. Briege and Joan return to office.

Camera lingers on Noel. He is lying on bed as before, coughing constantly.

Video Script for “John” Case

Characters:

Nurse

John – main case subject, 46 y.o. man

Mick – fellow inpatient, in his mid 40s

Gary – fellow inpatient, in his late 50s

Fred – fellow inpatient, in his mid 30s

It’s Thursday morning, around 11am. The nurse is engaged in unobtrusive participant observation a day room where patients are watching TV, reading, socialising etc. The nurse’s eye view is that of the camera.

Scene 1

John – seated adjacent from the nurse watching TV at a distance of about 15 feet his leg is tapping constantly

Mick – seated next to John, also watching TV

Gary – seated facing nurse, beyond John and Mick, reading book

Fred – pacing behind Mick and Gary to and fro nurses position counting on his fingers

Mick (turning to Fred): “Will you ever stop that pacin up and down, you’re getting on my nerves!”

Fred departs off camera hurriedly & muttering

Mick “I dunno, I couldn’t sleep last night with that fella pacin up and down in and out of the toilets”

John “Ah, you slept alright, from about 2 o’clock anyway”

Mick “Did I? Doesn’t feel like it!”

John “Ah yeah. I don’t sleep anyway. You were asleep at about quarter past two, and your man settled down at about 3.”

Gary “I do sleep alright, although I stay up reading as much as I can, it tires me out a bit. You should try that John”

John <a bit tetchily> “I don’t have the concentration for reading.”

Mick “Well I wouldn’t sleep without me Librium and me sleeper”

John <laughs lightly> “I could do with twice the amount I get” sighs deeply, gets up and leaves room

Scene 2 – just after lunch

Mick – seated next to John, also watching TV

Gary – seated facing nurse, beyond John and Mick, reading book

Fred – back pacing again, as before

John returns to seat, continues to move leg constantly

Mick “Goin home the weekend Gary?”

Gary “Ah yeah, myself and the wife are heading down to the daughter for the weekend”

Mick “Where is she?”

Gary “Below in Donegal, has a lovely place down there. If it goes well I’ll probably be out next weekend then for good”

John turns quickly to Fred and shouts “Will you ever stop that f*\$king pacing!!”

Fred scurries off muttering

Nurse *calmly* “Are you alright John?”

John “No, I’m not f&*king alright” storms off out of room

Scene 3 – around 7pm

John lying on bed staring despondently at ceiling with nurse sitting at bedside talking with him

Nurse “Is there anything you’d like to talk about John?”

John <after a few seconds and in a strained manner> “I’d like to get out tomorrow for the weekend. I think it would do me good”

Nurse “What would you do?”

John <pause> “I’d visit Anne’s [wife] grave.” <pauses, obviously withholding tears> I’d stop with Sean [son] <pauses, obviously withholding tears, looks directly at camera and says in a stilted, deliberate tone> It would do me good”

Nurse “Well your review meeting is in the morning, so we can talk to Dr Byrne and see what he thinks”

John remains silent, staring at ceiling

Nurse “I’ll let you relax for a while. Give me a shout if you want anything”

John: “Ok” and turns over onto his side, covering his face with his hand

Camera moves away from bed

Video Script for Patricia Case

Setting: Multidisciplinary team review meeting

Speaking Roles:

Consultant

Registrar

Community Psychiatric Nurse

Ward Nurse

Consultant: So moving on now to Patricia Wright. I think she's ready to go today, isn't she?

Registrar: Yes. She has shown improvement on Stelazine 5mg daily and no longer presents as having any persecutory ideas. I spoke with her husband at the clinic and he is happy to have her home again.

Consultant (to Ward Nurse): Do you think is she happy to go?

Ward Nurse: "She's keen to go, yes."

Community Nurse: "Em, will she be going to the day hospital"

Registrar: "I spoke with her and she has agreed to attend the clinic next week, but is not willing to attend the day hospital"

Community Nurse: "I doubt she'll attend the clinic either"

Consultant: "Well, we'll see how it goes" (to Registrar) "perhaps you might have another chat with her and underline the importance of attending the clinic next week."

Registrar: "Okay"

Consultant: "And continue her on the Stelazine, we'll review it at the clinic next week. Right then, who's next?"

Appendix C

Details of Sample

Sample Details

Participant No	Setting *	Years Registered.
1	Community	10 +
2	Community	0-5
3	Community	6-9
4	Community	Missing data
5	Community	0-5
6	Community	10 +
7	Community	Missing data
8	Community	6-9
9	Community	0-5
10	In-patient	10 +
11	In-patient	10 +
12	In-patient	0-5
13	In-patient	6-9
14	In-patient	0-5
15	In-patient	6-9
16	Community	0-5
17	In-patient	Missing data
18	Community	10 +
19	Community	10 +
20	Community	10 +
21	In-patient	0-5
22	In-patient	0-5
23	In-patient	10 +
24	In-patient	6-9
25	In-patient	0-5
26	Community	Missing data
27	In-patient	0-5
28	Community	Missing data
29	Community	10 +
30	In-patient	0-5
31	In-patient	10 +
32	In-patient	10 +
33	In-patient	10 +
34	In-patient	0-5
35	In-patient	0-5
36	Community	0-5
37	Community	10 +
38	Community	10 +
39	In-patient	6-9
40	In-patient	6-9

* - Denotes setting at time of data collection.
 Most participants are rotated between settings.

Appendix D

Information Sheet and Consent Form

Consent Form

Research Title:

Nursing Decision Making: Clinical Judgement and Decision Making Study

DCU School of Nursing Research Team

Professor P.A. Scott (Principal Investigator), Dr Pdraig MacNeela (NUI Galway), Mr Gerard Clinton, Ms Daniela Lehwaldt

I hereby confirm that having read the accompanying plain language statement I, _____ give my consent to be included in the study mentioned above. I understand clearly the information provided to me on this study and I am satisfied with the degree to which I have discussed my participation with the research team.

I understand that the purpose of this study is to investigate the process of judgement and decision-making among nurses working in mental health services in Ireland and that no evaluation or assessment will be made of my skills in making judgements or decisions, as the study's purpose is to describe what knowledge and thinking strategies I use. I understand that my participation is on a voluntary basis and that I may withdraw from the study at any time without being required to give an explanation. I understand that as part of my participation in this study my voice will be recorded and that if I choose to withdraw from the study that any such recording or other data concerning me will be destroyed.

I understand that the study may be published but that my name will not appear in any part of the study, nor will any information that could be used to identify me personally or the institution in which I work.

Name of participant in block capitals.....

Signature of the participant

Signature of the researcher

Signature of witness.....

Date: _____

Introduction

This study: “Nursing Decision Making: Clinical Judgement and Decision Making Study” is part of a Health Research Board funded research project. We aim to investigate the judgement and decision-making of mental health nurses working in Ireland. Nurses are continually required to make judgements and decisions in their practice.

What is required?

To help us better understand how nurses make judgements and decisions, we would like you to:

- Work through four clinical cases that we have prepared: This will help us understand more about how nurses approach judgement and decision-making.
- We are NOT concerned with labelling these judgements and decisions as “good” or “bad”.
- We will NOT be making value judgements about your judgement and decision-making.
- Participation is voluntary - you may withdraw from the study at any time without having to give an explanation.
- Each case will be presented to you using video clips and clinical documentation.
- In order that we might observe how you make judgements and decisions, we would like you to “think aloud” as you work through the case. We will also ask you to complete some ratings, and take part in a debriefing interview.
- It is anticipated that two hours will be required from you for this, which will be part of your normal working day.

Confidentiality & Anonymity

During this time we will record you using a voice recorder. This recording will be used solely for data analysis and will be heard by no-one other than members of the research team involved in analysis. After this analysis is complete the recording will be destroyed. This is to preserve confidentiality and protect your anonymity.

Potential Risks/Benefits

No evaluation is made of your skills in making judgements or decisions, as our purpose is to describe what knowledge and strategies nurses use. This is the first programme of nursing research funded in Ireland, so we would appreciate your involvement in increasing our understanding of the role that nurses have in delivering quality care in Irish mental health services.

Contact details:

Professor P. Anne Scott, Principal Investigator – 01 7008271

Dr. Padraig MacNeela, Grant Holder – 091 512699

Mr. Gerard Clinton, Researcher – 01 7008523

Ms. Daniela Lehwaldt, Researcher – 01 7008534

If participants have concerns about this study and wish to contact an independent person, please contact:

The Secretary, Dublin City University Research Ethics Committee, c/o Office of the Vice-President for Research, Dublin City University, Dublin 9. Tel: 01-7008000

Appendix E

Jefferson Notation System

Symbol	Indicates...
[text	Starting point of overlapping speech.
text]	Cut-off point of overlapping speech
=	Break and subsequent continuation of a single utterance.
(3)	Time in seconds of pause in speech.
(.)	A pause of less than .1 seconds.
↓	Falling pitch or intonation.
↑	Rising pitch or intonation.
> text <	Enclosed speech delivered more rapidly than usual for the speaker.
< text >	Enclosed speech delivered more slowly than usual for the speaker.
°	Whispering or quiet speech.
CAPS	Increased volume in speech.
<u>text</u>	Emphasis or stress on underlined parts.
::	Prolongation of sound of preceding letter.
Hhh	Audible exhalation.
.hhh	Audible inhalation.
(text)	Unclear speech.
<i>(italic text)</i>	Description of non-verbal activity.
\$ text \$	Words between dollar signs (\$) are in a "smile voice"

Adapted from Jefferson G. (2004) Glossary of transcript symbols with an introduction. In (Lerner G.H. Ed) *Conversation Analysis: Studies from the first generation*. John Benjamins, Amsterdam. 13-31.

Appendix F

Results of Comparative Keyword Analysis

Keywords in Order of Significance According to Log Likelihood

Keyword	observed frequency in Corpus 1 (dataset)	% of Corpus 1 represented by word use	observed frequency in Corpus 2 (BNC)	% of Corpus 2 represented by word use	Log Likelihood
"SHE"	8295	1.61	1485	.02	+34376.79
"HE"	9534	1.85	4412	.07	+32114.24
"HER"	5456	1.06	366	.01	+25258.39
"YOU"	12253	2.38	21796	.35	+21748.68
"KNOW"	5608	1.09	345	.07	+15996.51
"I"	9844	1.91	22356	.36	+14350.03
"HIM"	2918	.57	826	.01	+11120.96
"HIS"	2909	.56	1181	.02	+10166.93
"MAYBE"	1751	.34	345	.01	+7145.43
"JUST"	2869	.56	3273	.05	+6727.22
"SUPPOSE"	1432	.28	203	>.01	+6137.45
"IF"	2454	.48	4835	.08	+4029.47
"HOSPITAL"	906	.18	123	>.01	+3905.06
"MIGHT"	1265	.25	777	.01	+3888.45
"THEY"	3149	.61	8581	.14	+3855.91
"BECAUSE"	1846	.36	2601	.04	+3833.57
"THEN"	1842	.36	2997	.05	+3482.95
"THINK"	2078	.40	4145	.07	+3378.75
"DECISION"*	763	.15	152	>.01	+3107.90
"WE"	3287	.64	12212	.20	+2777.32
"COULD"	1265	.25	1967	.03	+2466.21
"OBVIOUSLY"	697	.14	389	.01	+2214.10
"EVEN"	647	.13	453	.01	+1894.84
"LOOKING"	563	.11	461	.01	+1547.21
"FELT"	395	.08	118	>.01	+1487.96
"CAN"	1390	.27	4332	.07	+1468.76
"WILL"/"LL"	1111	.22	4376	.07	+863.36
"MEAN"	701	.14	1960	.03	+835.60

* - used mainly by researcher

Appendix G

NS5001 Module Descriptor

Module Title	Engagement Assessment & Decision Making		
Module Code	NS5001		
School	Nursing		
Module Co-ordinator	Mr Gerard Clinton	Office Number	H272
Level	5	Credit Rating	10
Pre-requisite	None		
Co-requisite	None		

Module Aims

To enable students to critically explore the nature of clinical and managerial judgement and decision-making within the context of engagement and assessment in collaborative and autonomous practice.

Learning Outcomes

On completion of this module students will be able to:

- Critically reflect on the influence of individual, professional and organisational value systems, processes and approaches on how they engage with people's experiences of health, illness and health care provision when making judgements and decisions.
- Demonstrate and critically appraise assessment processes and their underpinning ideologies, philosophies and intended purposes in terms of their contribution to decision-making and outcomes in their defined area of practice.
- Critically discuss how theories of engagement, assessment (judgement) and decision-making inform and influence organisational activity, e.g. interaction with service-user's carrying a particular diagnosis.
- Critically analyse the processes of judgement and decision-making within clinical and organisational practice in terms of the notion of collaborative intra- and inter-professional teamwork.
- Critically explore ways of engaging with the values, goals and motivations of others in order to develop collaborative competence in judgement and decision-making.
- Utilise their understanding of judgement and decision-making to critically direct their approach to reflective and evidence-based practice.

Indicative Time Allowances

	Hours
Lectures	26
Tutorials	4
Independent Learning Time	120
Total	150

NOTE

Assume that a 10 credit module load represents approximately 150 hours' work, which

includes all teaching, in-course assignments, laboratory work or other specialised training and an estimated private learning time associated with the module.

Indicative Syllabus

- Models and methods of judgement and decision-making.
- Language, perception and communication in relation to predominant discourse and knowledge around engagement, assessment and decision-making, e.g. the influence of medical hegemony
- Organisational and environmental influences on engagement, judgement and decision-making.
- The role of classification of personal and clinical phenomena in engagement, assessment and decision-making.
- Use of information in the clinical setting to inform judgement and decision-making.
- Theories and practical application of reflection-in-practice and reflection-on-practice to issues around engagement, assessment and decision-making.
- Defining and making sense of evidence-based practice as it relates to engagement, assessment and decision-making.
- The intuitive-analytic spectrum/dichotomy in judgement & decision-making in healthcare
- Research approaches to judgement & decision-making in healthcare
- Experience, expertise and engagement, assessment and decision-making.
- Using a case study approach to understand engagement, assessment and decision-making
- Comparing the contribution of cognitive psychology, philosophy and sociological perspectives on engagement, assessment and decision-making.
- Judgement and decision-making in groups and by individuals

Assessment

Continuous Assessment	100% Examination Weight	0%
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Programme or List of Programmes

GDCAHP	<u>Grad Dip Child & Adol. Health Care Prac</u>
GDCANP	<u>Grad. Dip. Child & Adol. Nurs. Practice</u>
GDGHP	<u>Grad Dip in General Health Care Practice</u>
GDGNP	<u>Grad Dip in General Nursing Practice</u>
GDIDHP	<u>Grad Dip Intell. Dis. Health Care Prac.</u>
GDIDNP	<u>Grad Dip in Int. Dis. Nurs. Practice</u>
GDMHNP	<u>Grad Dip in Mental Health Nurs. Prac.</u>
GDMHP	<u>Grad Dip in Mental Health Care Prac.</u>