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Clinical Constructions by Nurses in Korea, Norway, and the United States

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Nursing practice involves engagement of nurses in clinical fields through deliberation and enactment. In the phase of deliberation, nurses observe, recognize, form ideas about and decide on clinical situations, and construct clinical pictures. Clinical pictures are critically connected to nursing enactments, thus it is important to discover how nurses arrive at clinical pictures. The purpose of this article is to describe how nurses construct meanings of clinical situations and arrive at specific clinical pictures. The results are from a clinical fieldwork study replicated in Korea, Norway, and the United States, with samples of nurses working in acute-care hospitals. Data were collected through participant observations and in-depth interviews. A general model of clinical construction was derived from the results, which specifies four dimensions (i.e., problem, progress, status, and particularism) as the bases for clinical picture evocations. Clinical pictures are constituted by nurses’ elicitations of meanings of clinical situations on these dimensions.

**Keywords:** clinical construction; clinical picture; nursing practice; nursing gaze

Nurses encounter clinical situations as they are involved in patient care. A clinical situation may be a simple one in which the client needs a change of body positioning or a rather complex one in which the client...
experiences multiple abnormal symptoms and requires various life-support measures. In clinical encounters, nurses formulate ideas regarding the meanings of the situations as humans do in their everyday encounters of situations. Clinical situations have specific meanings to nurses as they view them through what has been termed *nursing gaze* (Ellefsen, 2004). Such viewing and meaning making result in clinical constructions through which various sorts of nursing approaches get formulated, clinical decisions are made, and nursing actions are selected. This aspect of nursing practice has often been depicted from the perspective of a normative theory, such as the model of nursing process, in which an application of a nursing assessment framework based on a theory of client and health is viewed to result in identifying clinical problems and nursing diagnoses. This notion points to a process through which standardized clinical constructions are to be produced in an idealized fashion. This depiction, however, is somewhat misleading as described in the study of Norwegian nurses (Ellefsen & Kim, 2004). Clinical constructions cannot be viewed apart from other aspects of nursing practice, especially those involving nursing gaze and nursing enactments. Our understanding of nursing practice would be limited when relying solely on the development and application of normative theories that specify how nursing practice ought to be. It can be enriched by studying the nature of actual nursing practice and discovering descriptive theories of practice embedded in actual clinical experiences. We can detect shortcomings in nursing practice or identify models of exemplary practice through an understanding of nursing practice via descriptive theories. Our approach to discover and refine descriptive theories of practice in situ also addresses Draper’s (1991) concern that nurses tended to overemphasize the importance of idealistic theories without taking the realistic theories fully into consideration. In this article, we report on the findings from a cross-national study of nursing practice in acute-care settings in Korea, Norway, and the United States, focusing on the nature and content of clinical constructions nurses make in clinical situations with an aim to refine a descriptive theory of nursing practice.

**A Descriptive Theory of Nursing Practice**

The descriptive theory of nursing practice is an inductively developed theory based on a fieldwork study of nurses in practice. This is based on what Meleis (2004) terms *practice-theory development strategy*. Descriptive theory is here understood as describing a phenomenon, situation, or relationship (Riddlesperger, Beard, Flowers, Pfeifer, & Stiller, 1996), or as
Polit and Beck (2004) express it, “a broad characterization that thoroughly accounts for a single phenomenon” (p. 716). The general sketch presented is based on the data and analyses contained in three previously published articles regarding the practice of Norwegian nurses in an acute-care hospital. The phenomenon outlined here is nurses’ client-related practice in acute-care settings (Figure 1).

The nature of nursing practice is encompassed in three processes that nurses undertake in clinical practice: the nursing gaze, the construction of situation, and the clinical engagement. The nursing gaze is the starting point; it encompasses what nurses bring to the situation and what they are looking for and comprises the ontologies of client and practice. The nursing gaze is constituted by the frames, lens, or perspectives of nurses—that is, what and how to “see” clients (the ontology of client) and how they view their practice (the ontology of practice). Nurses view clinical situations through this gaze to move them to the next process—the construction of clinical situations. The nursing gaze, therefore, is oriented to the process of selective attention, whereas the clinical construction is oriented to the
process of meaning making by which a clinical situation is identified with a specific mental “picture.” Clinical constructions involve defining the clinical situations to have specific meanings in the context of nursing practice and patient care. These two sets of processes are then analytically connected to the last phase of practice (i.e., the clinical engagement), involving the processes of action. Clinical engagement involves actions undertaken to promote specific outcomes in a client, often involving the processes of knowing the client and enacting caring and therapeutic activities. The processes may seem linear, but they actually reflect a back-and-forth movement, culminating into the practice of patient care for specific clients. In this article, we focus on the dimension of clinical construction within this model.

Notion of Clinical Construction

Nursing practice involves the engagement of nurses in clinical fields as agents of deliberation and enactment (Kim, 2000). Clinical construction is a significant aspect of clinical deliberation in which various mental processes are involved. Nurses’ construction of their clinical cases has been explored in the nursing research literature in a variety of ways. Clinical construction has been viewed as comprising certain characteristics connected to nurse’s attitudes, types of knowledge used in practice, and cognitive strategies. May (1992) shows how nurses use both the more objectified medical knowledge about the client as having a problematic pathology and knowledge about the client as a participant with a social history. Curtis (2001) investigated nurses working with trauma clients and found that they used a systematic approach to prevent overlooking things. They told about three surveys: The first was a rapid assessment, performed immediately after arrival to identify problems and intervene in life-threatening injuries. The second survey was a complete head-to-toe examination. The third survey took place within 24 hours after admission and was a standardized clinical assessment for any injuries that might have been overlooked, but also to review all investigations so far. For these nurses, the overriding framework for their clinical constructions at this three-phase process of assessment was a trauma orientation.

Although the medical orientation emphasizing pathology, disease, and injury is often the most critical framework through which nurses’ clinical constructions are made, nurses’ clinical constructions and clinical understandings of clients’ situations are often viewed to be related to knowing individual clients and their specific responses. Radwin (1996) summarizes
her review of the literature on the concept of knowing the patient that it is important in two respects: for the nurses’ understanding of the patient and for the selection of individualized care. Jenny and Logan (1992) analyzed the concept of knowing the client through a qualitative study of expert nursing practice and found that it signified cognitive and relational processes associated with a particular client situation. Based on an interpretive phenomenological study of group interviews of 130 nurses and observations and in-depth interviews with 48 nurses from different units, Tanner, Benner, Chesla, and Gordon (1993) found that knowing the client means both knowing the client’s typical pattern of responses and knowing the client as a person. The importance of background data was evidenced in a quasiexperimental study of infant pain assessments by two groups of pediatric nurses where one group had background data and the other did not. The nurses who were given clinical background data about the patients assessed infants’ pain at higher mean levels, suggesting the importance of clinical data and background information in assessing infant pain (Fuller, Neu, & Smith, 1999). Another quasiexperimental study also revealed differences in pain management but, this time, based on attitudinal factors (Brockopp et al., 2004). Nurses’ preconceived notions regarding certain client groups influenced their management of pain, suggesting that knowing the patients is not only based specifically on the knowledge of specific clients but also on typological knowing of patients.

These studies provide some understanding regarding the contents of clinical constructions. Another issue regarding clinical construction, however, is how they set about constructing their cases. A description of nursing work outlined by Boblin-Cummings, Baumann, and Deber (1999) revealed complex nursing decisions made after selection of the intervention and prior to its implementation. Between these two occurrences, a complex network of interactions took place: enactment of the nursing role, collaboration, negotiation, delegation, allocation of resources, priority setting, and strategizing. Nursing practice consists of three distinct, and yet intertwined, processes: noticing, understanding and acting, (MacLeod, 1994), examining 10 excellent surgical ward sisters. Hedberg and Larsson (2003) also state that decision-making in practice was based on observation of the cues related to client situation, confirmation of the information gathered, and implementation of action strategies. According to Fowler (1997), clinical reasoning, as cognitive processing of multiple possibilities, is “the hallmark of a nursing expert” (p. 349). Based on interviews with five experienced home health nurses about 10 different chronically ill clients, Fowler revealed six cognitive strategies: cue logic (i.e., cognitive approach to
incoming cues), framing by using specific cues to direct the thinking, hypothesizing, reflexive comparison, prototypical case reasoning, and testing. The result also revealed that reasoning was context specific and varied according to whether it was previsit or postvisit. Lauri et al. (2001) identified both analytical and intuitive cognitive processes within nursing process, in which the analytic processes emphasized information collection, problem definition, and planning of care, whereas the intuitive processes emphasized planning, implementing, and evaluating care. These studies point to variations in clinical constructions formulated either systematically or intuitively by nurses based on their problem orientations, general understandings regarding specific groups of clients, and types of knowledge in use and ways of using it.

The major interest was what sorts of selective orientations regarding clinical situations lead nurses to have certain pictures of the situations—that is, what they focus on and what their areas of interest are when they come to an understanding of clients’ situations.

**Purpose**

The major aim of this article is to present the findings from our cross-national study of nursing practice in acute-care hospitals regarding formulations of clinical constructions examined within a descriptive theory of nursing practice initially derived from the study of Norwegian nurses reported earlier in three articles (Ellefsen, 2004; Ellefsen & Kim, 2004, 2005). By contrasting and comparing the findings from three countries, we aim to refine the theory’s depiction of clinical construction.

The specific research questions for this report were the following:

1. What are the frames that guide nurses’ clinical constructions?
2. What is the nature of nurses’ construction of clinical situations? That is, what do nurses see and recognize in, dialogue about (or tell), and describe regarding clinical situations?

**Design**

The research questions were addressed through a clinical fieldwork approach incorporating participant observation and in-depth interviews with experienced nurses in acute hospitals in Korea, Norway, and the United
States. Although we were primarily interested in investigating the nature of nursing practice in each of these countries, we were also interested in gaining understanding from a cross-national perspective. The cross-national perspective is applied in this study of replication in three countries.

The clinical fieldwork approach is a qualitative, naturalistic method carried out in an actual setting of practice, in which the major emphasis is on description, understanding, and/or explanation of ordinary occurrences (practice) as experienced by “usual” actors in the clinical field (Miller & Crabtree, 1994). The study was carried out at major acute hospitals (university-affiliated medical centers) in Seoul, Oslo, and a metropolitan city in a northeastern state in the United States. The data were collected at medical or surgical adults units of these hospitals.

**Sample**

A purposive sample of 4 to 6 registered nurses from each of the settings (6 nurses in Norway, 5 nurses in the United States, and 4 nurses in Korea) was selected among those nurses working at selected units at the respective hospitals. Because it was important to gain an understanding of nursing practice in a well-established mode in this study, these nurses were drawn from the more experienced staff (those who had more than 3 years of experience) working on the selected units in the hospitals. Their clinical experience ranged from 3 to 13 years, and their ages ranged from 26 to 42 years. Nurses qualifying for the study were asked to participate on a voluntary basis, after receiving an explanation of the research process.

**Methods**

Data were collected through observation and in-depth interviews. The researcher spent three shifts with each participating nurse during his or her usual days of practice, on shifts when the nurse had an assigned client-care load. Methods described by Schatzman and Strauss (1973) for participant observation and for data recording were used. Observations were made of the nurse participants not only when they were in direct contact with clients and their families but also when they interacted with other nurses, nursing assistants, and other health care professionals including physicians. For each country, there were between 126 to 144 hours of participant observations with the nurse participants.
At the end of each participant observation period (i.e., after each shift), the researcher asked the nurse participants questions relating to each client for whom they provided care during that shift and regarding various observations made during the shift. The interviews were audiotaped. The questions were the following: How would you describe this client as you saw him or her today? What are the specific things you noticed about this client today? What do these mean to you? What are the specific things you did today for this client? And why did you do them? What would you say if you were asked to write a detailed nursing note on this client at the end of your shift?

Analysis of Data

Data analysis was first carried out separately for each country, beginning with the first set of participant observations and continuing with the interviews examined to extract patterns and differences. The observational data and interview data were merged and transcribed to form a database for each nurse. The data were read line by line for categories and instances and also holistically to capture the narrative flow and order as described by Atkinson (1995). The analyses in the three countries were carried out with the data in the respective native languages (Norwegian, Korean, and English). Second, the analyzed data from each of the three countries were contrasted for a cross-national understanding. Although the findings from the Norwegian data were published earlier independently, this process of comparative analysis was a part of the original data analysis. For presentation of the data in this article, key excerpts from the Korean data were translated into English by the researchers who are fluent in both languages.

Ethical Considerations

The studies in the three countries obtained appropriate sets of approvals from various organizational entities as specified by the participating hospitals’ ethical boards and the universities’ institutional review boards. For the Norwegian study, an approval was obtained from the regional ethics board that was assured of no risk or harm to the participants, and a permission to study was granted by the hospital’s director. For the study in the United States, the institutional boards of the university and the hospital reviewed the consent forms and the procedures to protect the participants’ privacy and anonymity and granted an approval. For the Korean study, the director of nursing service reviewed the consent forms and granted a permission to carry
out the study. In all countries, nurses who met the inclusion criteria and working in the selected units were asked to participate on a voluntary base after the research process and procedures had been described to them. Written consent was obtained once they agreed to participate. The participants were informed that they would be shadowed by the researcher during three shifts of their usual duties in providing care and would be interviewed at the end of each shift. Data for patients receiving care from the participants were recorded using pseudonyms to ensure their confidentiality and privacy.

Findings

We first present the findings regarding clinical constructions from each country, and then these findings will be contrasted and compared across the three countries. The findings from the Norwegian study are summarized first as the details were reported in an earlier article.

Findings From the Norwegian Nurses

The Norwegian nurses’ clinical constructions guided by their nursing gaze were found to be constituted by four themes: (a) the patient’s disease and illness experiences, (b) the seriousness of the disease, (c) the functioning, and (d) the patient’s handling of the illness experiences as presented in an earlier report (Ellefsen & Kim, 2004). The patient’s disease and illness experience was a theme in clinical constructions with a bifocal emphasis on disease being the medical diagnosis and definition and illness being the patient’s experience of the disease. The seriousness of the disease was based on medical diagnoses, tests results and examinations, and observed signs and symptoms of the patient. Closely connected to this was the appraised progress with the disease. The nurses questioned whether the patient was in a normal recovery process or in a declining trajectory and whether or not the medication and medical treatment were effective in getting the patient on the road to recovery. Functioning as an aspect of the clinical construction addressed such aspects as how much assistance the patient needed and how much support is needed for the activities of daily living (ADL) with the disease. The last theme was related to how the patient managed or handled the illness experience, the treatments, and the disease trajectory. The question raised by the nurses on this regard had to do with how the patient faced the reality of the disease and medical treatment.

All four themes were incited by the nurses in arriving at the pictures of patients and the constructions of patient-care situations. Although the
central point of reference for these four themes of clinical constructions was medical diagnosis, the nurses’ clinical pictures were formulated integrating not only the seriousness of the disease conditions but also how patients responded to and managed with medical and health care processes that were on-going. This suggests that the nurses were oriented not only to the pathophysiological conditions but also to the experiential aspects that were present in the situations.

Findings From the Korean Nurses

There were four themes identified from the data regarding the types of clinical constructions made by the Korean nurses resulting in various clinical pictures of the situations:

1. Focus on patients’ conditions in terms of pathophysiology and causality (MC)—Picture of a patient’s condition in terms of pathophysiology was expressed by the nurses in relation to medical diagnoses; clinical data such as vital signs, respiratory distress, or edema; or medical instrumetations such as central lines, tracheostomy, and dialysis. Often, such constructions were based on inciting various causes for disease conditions and patient’s current problems.

2. Focus on patients’ progress in a comparative perspective (PR)—In the picture of a patient’s progress, the nurses interpreted and arrived at the construction in relation to how the patient progressed within the trajectory of illness or recovery course posed within what would be expected in a typical case or within the specific context of the patient.

3. Focus on comfort and patients’ general status (ST)—Clinical constructions with this focus showed the nurses’ viewing and reading of the patient in terms of whether or not they were comfortable in the situations or what their general status were like (e.g., in terms of strength, demeanor, or functioning). The nurses described their patients as to how comfortable they looked, whether they were suffering or having pain, or what they needed to be comfortable.

4. Focus on particularities of patients (PC)—Personal characteristics such as age, gender, body weight, biographical background, or social standing provided viewing of clients’ particularities as specific aspects of clinical situations.

Two quotes sampled from the nurses’ descriptions of their patients presented in the following section reveal these themes:

This patient had an MVP [sic] who had experienced a trial fibrillation postoperatively, had gone through several procedures, and still has C-tube (MC). Her
vitals [sic] are stable, but she is having much secretion (MC). This is an elderly woman who is rather passive and is very cautious and afraid about everything (PC). She is very uncomfortable and is not moving or coughing (ST). I don’t think she is having pain though (ST). She is progressing slowly (PR).

This is a 58 years old [sic] man with a long history of cardiac problems (PC), who had CABG 16 days ago (MC). He self-extubated and tried to manage respiratory care on his own on the 4th postop [sic] day, but had to be reintubated due to poor lung pathology after 4 days (MC). He has been unstable, up and down since (PR). He is experiencing a lot of cardiac complications which are controlled with meds (MC). He is being sedated in order to control vitals [sic] (MC). He is not doing as well as expected (PR), and is in a poor state (ST). He needs full support (ST).

Although not all descriptions by the nurses contain all four themes, the four themes are represented well in the nurses’ articulation of their patients’ situations. The first two of these themes were related to patients’ medical diagnoses and illness states, whereas the last two themes focused on constructing meanings of the clinical situations in relation to how the patients looked and what the patients brought to the situations.

**Findings From the U.S. Nurses**

The U.S. nurses formulated clinical constructions in relation to five themes: (a) nursing diagnosis or major nursing concerns (DX), (b) particularistic construction regarding problems (ST), (c) picture within the trajectory of recovery and illness progress (PR), (d) picture regarding comfort and mobility (CM), and (e) personal resources (RS). The first theme—nursing diagnosis or major nursing concerns—is oriented to medical diagnoses or clinical complications (DX), whereas the second theme focusing on clinical problems is oriented to patients’ experiences with disease conditions or those related to being patients such as bedsores, incontinence, poor eating, or sleeping problems (ST). The third theme focuses on nurses’ views of patients’ progress within the acute-care phase including judgments vis-à-vis the normal patterns (PR). The fourth theme is concerned with patients’ status in relation to comfort and mobility (CM); whereas the fifth theme focuses on the identification of patients’ personal resources related to their illness experiences (RS). The following three excerpts from the nurses’ descriptions of their patients show these areas of emphasis in constructing clinical cases by these nurses:

This patient had a total abdominal hysterectomy (DX), and is doing well but not progressing as expected (PR); not up and about as expected (CM). She was
out in chair, but not enough (CM). I would say her major nursing diagnoses are alteration in skin integrity and pain (DX). She is also complaining about heartburn and a loss of appetite (ST). She is not ready for discharge (PR).

A 90 years old [sic] medical patient, very confused, screaming, and agitated (ST). A very difficult patient to take care of (RS), scratches and rash from antibiotics (DX), excoriated peri [sic] with incontinence of urine, discontinued everything, no feeding tube and no access, on Posey restraints (ST). She is on DNI and DNR (PR), here for nursing home discharge (PR).

This patient has chronic renal failure and is on a full-run dialysis (DX), is self-sufficient (RS). She did not want to go for the dialysis because she was really tired (ST), but she knows herself well since she has had dialysis (RS). She has low blood sugars (DX), and I am not convinced that she will monitor her blood sugar well (RS)—she doesn’t strike me as a detailed person (RS). She can go home on ADL (PR).

These themes providing the areas of orientation for constructing clinical situations indicate that the U.S. nurses were interested in identifying problems at various levels (medical diagnoses, nursing diagnoses, and other immediate problems), identifying their progress within the expected trajectory, determining the patients’ status in relation to comfort and mobility, and specifying personal resources that may have impact on the patients’ management of their problems.

The Similarities and Differences Among the Three Countries

Table 1 shows the thematic areas embedded within clinical constructions in the three countries. There were more similarities than differences among the three countries. The patients’ medical diagnoses, pathophysiological status, and disease states constituted one major thematic area for all nurses. The Norwegian and Korean nurses identified more directly with the patients’ diseases and pathophysiology, whereas the U.S. nurses often inciting medical diagnoses interpreted medical problems into nursing diagnoses.

The nurses from all three countries incorporated the meanings of the patients’ situations in terms of progress and recovery-trajectory. The nurses often made estimations regarding how their patients are progressing in relation to what are expected in general with patients in similar medical conditions or situations. This means that the nurses used their knowledge of norms or expectations as the guidelines for judging patients’ status and progress.

On another dimension, the nurses were oriented to determining the conditions or status of their patients in relation to how the patients felt or functioned. Although the nurses from all three countries focused on this dimension,
the specific focus differed somewhat among three countries. The U.S. nurses and the Norwegian nurses focused on functional conditions: the U.S. nurses focusing specifically on mobility and comfort, whereas the Norwegian nurses emphasizing patients’ management of disease and level of functioning. The Korean nurses were more specifically oriented to identifying whether their patients were in comfortable states or not rather than focusing specifically on mobility or functioning.

A specific thematic orientation by the nurses in each of the countries focusing on individual differences was somewhat different—a theme of personal characteristics providing particularistic picture for the Korean nurses, a theme of patients’ illness experiences that focused on various experiences associated with illness for the Norwegian nurses, and a theme of personal resources used by the U.S. nurses to identify the inputs provided by clients into the situations. These are varying ways by which individual-specific factors get into the formulation of clinical constructions—the Korean nurses identifying personal background characteristics to characterize the individuality of patients, the Norwegian nurses illustrating what the illness experiences were like as persons, and the U.S. nurses focusing on specific resources or a lack of resources in patients that may be important in dealing with disease conditions and illness. These aspects seem to be closely aligned with the varied notions of knowing the patient as these refer to the dimension that was used to identify individuality of the clients.

<table>
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<th>Table 1</th>
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<tr>
<td><strong>Aspects of Clinical Construction By Nurses in Korea, Norway, and the United States</strong></td>
</tr>
<tr>
<td><strong>Country</strong></td>
</tr>
</tbody>
</table>
| Korea | • Patient’s conditions in terms of pathophysiology and causality  
       • Patient’s progress in a comparative perspective  
       • Comfort and general status  
       • Personal characteristics |
| Norway | • Patient’s disease and illness experiences  
       • Seriousness of the disease(s)  
       • Patient’s functioning  
       • Patient’s handling of illness experiences |
| United States | • Nursing diagnoses  
      • Patient’s particular problems  
      • Trajectory of recovery  
      • Comfort and mobility  
      • Personal resources |
Discussion: The Model of Clinical Construction

The findings of this study revealed an insight into the process and structure of clinical construction as depicted in Figure 2. Clinical construction resulting in a clinical picture is an interpretation of the clinical situation, which a nurse formulates through one’s nursing gaze. The general structure of nursing gaze that has emerged from our studies (reported elsewhere) encompasses three dimensions associated with two ontological orientations (the dimensions of normality and needs from the ontology of clients and the dimension of clinical expectations from the ontology of clinical practice). These orientations seem to have guided clinical constructions the nurses made as they encountered patient-care situations.

Because the nursing gaze is multidimensional, clinical constructions contained complex sets of meanings derived about the situations. Clinical constructions by these nurses in three countries contained four sets of information with which the clinical situations were depicted, although there were subtle differences within each dimension among the nurses from these countries as groups. We integrated the different aspects identified for each country presented in Table 1 into these four dimensions:

- What sorts and severity of problems the clients had (mostly related to the patients’ diagnoses, pathophysiology, types of surgery, or disease-related experiences)—Problem dimension
- How the clients were progressing in their courses of illnesses (or surgery) viewed within what are generally expected in similar situations—Progress dimension
- What sorts of statuses (conditions) the clients were in, specifically in relation to how they felt (comfort) or how they functioned (mobility or ADL)—Status dimension
- What the clients were like in terms of their characteristics, abilities, experiences, or resources—Particularism dimension

In arriving at clinical constructions constituted of these dimensions, the nurses seem to be using their frames of reference within the nursing gaze oriented to normality, needs, and clinical expectations to individualize patient care. Clinical constructions guided by the nursing gaze identified how deviant the patients are, what needs the patients had for attention, and what the individual contexts were like. Clinical constructions seem to contain information for the nurses to project (or orient them to) the kinds of nursing attention individual patients may require in their specific contexts as clinical constructions focus on the ways nurses understand and construct the clinical cases (Lauder, Anderson, & Barclay, 2002).
The four dimensions revealed for clinical constructions in this study are supported partly by other studies. The particularism dimension especially has received a great deal of attention in specifying the nature of nursing practice through the concept of knowing the patient—that is, what the patients bring into the situation of nursing care. A study of nurses by Tanner et al. (1993) revealed the importance of knowing the client as a person. Minick and Harvey (2003) emphasized the importance of knowing the client directly as a part of important knowledge for practice, whereas Fuller, Neu, and Smith (1999) underscored the importance of background data in nursing assessment of infant pain. In a study of nurses’ clinical decision making, Radwin (1995) found that the nurses used understanding of clients’ behaviors, experiences, and feelings to select individualized care. Tanner et al. (1993) also emphasized the importance of knowing the client’s typical pattern of responses. Gadow (1995) points to the importance of combining both general and particular knowledge in clinical assessment. Nurses from five different countries reported knowing the client directly, knowing the client through the family, knowing something is not as expected as three themes important in early recognition of client problems (Lauri et al., 2001). These suggest the critical nature of particularism as a dimension in the nurses’ constructions of patients’ situations within the idea
of individualized care. The degree with and type of which particularism is introduced into clinical constructions to individualize nursing care is, however, a critical issue, as some of the identified personal characteristics are superficial and may not be specific enough to personalize care.

Additionally, the differences of emphasis in the three countries on this dimension suggest a possible cultural difference in the nurses’ orientations regarding how patients are perceived as individuals. The Korean nurses seem to focus on personal characteristics to identify what their patients would be like, and the Norwegian nurses focused on how differently individuals experience their illness and illness situations. Whereas, the U.S. nurses focused on what sorts of resources or support the patients had to cope with in their situations. The Korean nurses’ focus on identity is in line with the cultural emphasis of affiliation in that society. The Norwegian nurses’ notion of individualizing care seem to be based on experiential differences that would mostly be circumscribed by patients’ personal histories and life situations. The U.S. nurses’ focus on personal resources suggests their orientation to patients’ needs in the context of what might be mobilized to deal with situations. These are subtle differences but indicate cultural specifications that are based either on the culture itself or on different emphases by which nurses are educated to view individuality in providing care.

Nurses’ focus on medical problems (pathophysiology, diagnoses, and severity) has been asserted by several authors as well (Curtis, 2001; Junnola, Eriksson, Salanterä, & Lauri, 2002; Liaschenko & Fisher, 1999). Junnola et al. (2002) found in a study in Finland that the metastases of cancer was one of four important foci for which nurses seek information for decision making in the care of cancer clients, whereas Curtis’s (2001) study showed how a rapid assessment was used in an attempt to determine the seriousness of the client’s situation. Although no report was found in the literature specifically regarding nurses’ focus on patients’ progress in constructing clinical pictures, a study of pain assessment showing nurses’ use of a strategy based on what to expect (Kim, Schwartz-Barcott, Tracey, Fortin, & Sjöström, 2005) suggests nurses’ orientation in patient assessment for a comparative evaluation regarding patients’ status and experiences. The progress dimension is an important one on two accounts, as it seems there are comparative frameworks held by nurses regarding disease or recovery progression used to compare patients’ conditions and that nurses view patients in the context of medical problems. The status dimension reveals the nurses’ orientation to what their patients are like at given situations, which may or may not be directly associated with the patients’ medical conditions. This suggests an orientation to the “present” and a
“nursing” orientation emphasizing comfort, functioning, ADL, mobility, mental and emotional status, and so forth.

In general, the similarities strengthen the results, and the differences, which are more in emphasis than in content, illustrate the variation and breadth of this aspect of nursing practice. These may be related to cultural differences or to different emphases integrated into nursing practice in the three countries.

The article has presented an overall model of a descriptive theory of nursing practice and outlined in detail the second part of the model: the nursing construction of clinical situation. Four dimensions delineated in this study have not been identified in other research and are refinements of the themes identified in the Norwegian data (Ellefsen & Kim, 2004). This theory suggests an insight that acute-care nurses are not oriented solely to medical problems, and the nursing perspective involves status, progression, and particularism. The acute-care nurses by specifying the characteristics of each patient on these four dimensions arrive at a clinical picture of the client.

The findings are important for understanding nursing practice, as the different dimensions will influence what is actually done (engagements) in providing nursing care. The problem dimension orients the nurse to address problems that have been identified, in most cases associated with patient’s medical diagnoses, surgery, or medical processes. This means that when nurses identify patients’ problems with a medical orientation, they may overlook other nonmedically oriented problems. Although the progress dimension seems to orient the nurses to focus on how patients are progressing in the care situations, the use of normative expectations as the comparative frameworks may distort the patients’ progress. The status and particularism dimensions should give considerations in nursing actions for individualization and particularistic approaches that fit with specific circumstances. Further results from this study will show the next link in the chain from nursing gaze and clinical construction to clinical engagement.

The major point revealed in this descriptive theory of clinical construction in contrast to a normative theory of nursing practice such as nursing process is the insight that the characteristics of a current, presenting situation are the bases for clinical constructions rather than any analytic or comprehensive framework. More specifically, if the concept of nursing diagnosis is to be applied as the basis for determining the nature of patients’ situations, there is a need to rethink its orientation to encompass not only problems but also progress, status, and particularism. There are also needs to investigate what sorts of nursing frameworks would actually work in clinical practice and to study how different clinical constructions influence
patient outcomes. In addition, it is critical to investigate further how
conscientious or insightful nurses are regarding the characteristics of their
clinical constructions in their practice.

Because this descriptive theory of nursing practice is a theory generation
from a qualitative study of few experienced nurses, it is necessary to exam-
ine the theory further in other groups of nurses and in different contexts.
More specifically, the nature of nursing gaze and the characteristics of clin-
ical constructions specified as constituting different dimensions illustrated
in this study may not be the same in different practice contexts such as com-
community health nursing, mental health nursing, or palliative care. We suppose
that although the overall relationships among nursing gaze, clinical con-
struction, and clinical engagement may be representative of how nursing is
practiced in general, the content and structure of these constructs may be
different in various practice contexts.

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