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4 **Professional autonomy in 21st century healthcare: nurses' accounts of clinical decision-**
5 **making**
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9 **ABSTRACT**

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11 Autonomy in decision-making has traditionally been described as a feature of professional work,
12 however the work of healthcare professionals has been seen as steadily encroached upon by State
13 and managerialist forces. Nursing has faced particular problems in establishing itself as a credible
14 profession for reasons including history, gender and a traditional subservience to medicine. This
15 paper reports on a focus group study of UK nurses participating in post-qualifying professional
16 development in a London university in 2008. Three groups of nurses in different specialist areas
17 comprised a total of 26 participants. The study uses accounts of decision-making to gain insight
18 into contemporary professional nursing. The study also aims to explore the usefulness of a theory
19 of professional work set out by Jamous and Peloille in 1970. The analysis draws on notions of
20 interpretive repertoires and elements of narrative analysis. We identified two interpretive
21 repertoires: 'clinical judgement' which was used to describe the different grounds for making
22 judgements; and 'decision-making' which was used to describe organisational circumstances
23 influencing decision-making. Jamous and Peloille's theory proved useful for interpreting instances
24 where the nurses collectively withdrew from the potential dangers of too extreme claims for
25 technicality or indeterminacy in their work. However, their theory did not explain the full range of
26 accounts of decision-making that were given. Taken at face value, the accounts from the
27 participants depict nurses as sometimes practising in indirect ways in order to have influence in the
28 clinical and bureaucratic setting. However, a focus on language use and in particular, interpretive
29 repertoires, has enabled us to suggest that despite an overall picture of severely limited autonomy,
30 nurses in the groups reproduced stories of the successful accomplishment of moral and influential
31 action.
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44 **INTRODUCTION**

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46 This paper reports on a focus group study of English nurses discussing their decision-making
47 processes. One of the defining characteristics of the professional is said to be autonomy in
48 decision-making (Carr-Saunders & Wilson, 1933). This, along with expert judgement, based on
49 access to a unique body of knowledge, coupled with an ethical commitment to their clients has
50 traditionally been seen as differentiating the professional's work from that of bureaucrats or others
51 with less occupational control (Freidson, 1970). However, since the 1970s such idealised
52 conceptions of professionalism and professional autonomy have been tempered and critiqued
53 (Atkinson, Reid, & Sheldrake, 1977; Kennedy, 1981; Larson, 1977). The medical profession has
54 been the subject of renewed attention since the 1990s when governments in many developed
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3 countries, notably the United Kingdom and United States, attempted to strengthen managerial and
4 bureaucratic control over doctors within state and insurance funded health systems (Alaszewski,
5 1995; Degeling, Maxwell, Kennedy, & Coyle, 2003; Harrison & Ahmad, 2000; Harrison & Pollitt,
6 1994). Further challenges to doctors' professional autonomy followed in wake of the rising
7 evidence based medicine movement that targeted the mystique and privacy of medical decision-
8 making (Greenhalgh, 1996; Horton, 1995; Smith, 1991), and new formalised systems of patient
9 management, such as care pathways, provided an increased clinical impetus for interprofessional
10 collaboration (Pinder, Petchey, Shaw, & Carter, 2005). So an examination of a profession's
11 response to governmental influences and challenges to control over its decision-making can give
12 us insight into the character of that profession.
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20 The other major health profession, nursing, has also been the subject of examination in terms of its
21 professional status and autonomy (Bixler & Bixler, 1945; Davies, 1995; Etzioni, 1969) including its
22 response to growing managerialism (Traynor, 1999) and to evidence based practice (Kitson, 1997;
23 Rolfe, 1999). One of the key issues concerns questions of how far the context for nursing work is
24 set by doctors leaving nurses with limited control over their decision-making. Although some of
25 these studies have concluded that nursing's professional status is not as assured as that of
26 medicine (Katz, 1969; Walby & Greenwell, 1994), more recent papers have focussed on local
27 strategies adopted by nurses to gain or maintain professional power in the face of medical
28 dominance. These have included the discovery of nurses' use of organisational 'guerrilla' tactics to
29 create a space for control over their work (Salhani & Coulter, 2009) and the employment of
30 subversive actions, such as humour or withholding information, to challenge the dominating
31 authority of doctors (Griffiths, 1998; Simpson, 2007). Such local struggles for professional
32 autonomy make the nurses' professional decision-making worthy of renewed study and this paper
33 reports on research into how nurses account for autonomy in their everyday decision-making. The
34 paper will contribute to a better understanding of the nursing profession's character and autonomy
35 in the present day context, which is influenced by dominating medical and managerial power-
36 relations, and under the influence of a rising impetus for interprofessional collaboration and
37 evidence-based practice.
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48 BACKGROUND

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50 The link between status and the decision-making processes of professionals has been the subject
51 of much investigation. One useful framework intended to distinguish the professions from other
52 occupations was developed by Jamous and Peloille (Jamous & Peloille, 1970). Examining the
53 French university hospital system in the 1960s, Jamous and Peloille proposed that the decision-
54 making of professionals differed to that of other occupations. Because professional work concerns
55 situations that are high in indeterminacy professionals employ higher degrees of tacit judgement
56 than those in non-professional occupations. They argued that the decision-making carried out by
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4 members of other occupational groups was based on relatively more easy to formalise, technical
5 factors. They predicted that a study of how these two types of decision-making affected work would
6 empirically identify 'genuinely' professional occupations because professional work would feature a
7 high proportion of indeterminacy relative to technicality – their so-called 'I/T ratio'. Their work has
8 been drawn on in recent studies of the medical and nursing professions though their ideas have
9 been applied more to studies of professional rhetoric than decision making in practice (Atkinson et
10 al., 1977; Traynor, 2009). Looking at professional rhetoric it is possible to argue that groups like
11 medicine or nursing face a dilemma. If they account for their practice too strongly in terms of its
12 technical complexity, explicit rules and procedures (that could be set out in a manual for example)
13 this risks the possibility of intervention and control by outside groups such as bureaucrats and
14 managers because of the predictability and visibility of the work. To avoid this, professions may call
15 attention to the indeterminacy of their work. Indeterminacy would call for professional judgement, or
16 the use of tacit or private knowledge. It therefore allows professions to emphasise the social
17 qualities and experiences of their members, which qualify them to make such judgements. The risk
18 of too heavy an emphasis on indeterminacy is that other groups can claim equal or superior skill
19 and the indeterminist loses control over their field and the ability to make rational decisions within
20 it. So the most effective professional claims would feature a particular combination of both.
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31 Though not researched as extensively as medicine, the character and status of the nursing
32 profession has also been studied. A number of tensions makes this large group worthy of
33 investigation. Within nursing, there is a particular risk related to emphasising the indeterminate
34 aspects of professional decision-making. The risk is associated with nursing's historical origins and
35 gendered character. Since the 19th century the profession's leaders have debated the issue of how
36 to understand and present the basic requirement for the nursing workforce, either in terms of the
37 indeterminate moral and gendered quality of nurses or in their technical and educational
38 preparedness. The indeterminate position, the 'moralists', argued that medicine was characterised
39 by science and rationality and 'by contrast, nursing was qualitatively different and 'good' nursing
40 could not be tested by examination' (Rafferty, 1993: 56; Rathbone, 1892). Generally speaking
41 those promoting the more technical position emerged as influential by the opening decades of the
42 20th century (Rafferty, 1996). Thus, a strong emphasis on the indeterminate features of decision-
43 making in current professional discourses could be seen as counteracting some of the work done
44 to position nursing within a technical, scientific basis for practice (Dingwall, Rafferty, & Webster,
45 1988).
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55 These tensions revolve around the following: first, despite a professional rhetoric, which strongly
56 emphasises its autonomy and separateness from medicine (Salvage, 1988; Tschudin, 1999),
57 nursing's close proximity to the medical profession raises the question of how far it exercises
58 control over its own practices (Walby & Greenwell, 1994). As a predominantly female occupation, it
59 has reflected, since its 19th century inception, the changing views and status of women, and part of
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3 its historical domination by medicine has been attributed to gender (Reverby, 1987). Second,
4 although the evidence based movement was embraced by the profession in the early 1990s,
5 alternative discourses of indeterminate expertise and intuition, set out for example by Benner et al.
6 who criticised an over reliance on rational models of clinical judgement (Benner, 1984; Benner,
7 Tanner, & Chesla, 1996) have continued to attract practitioners and educators. Third, in a similar
8 way to medicine, nursing has had to respond to the rise in managerialism seen in many health care
9 systems around the world. Nurses have reported finding themselves accountable to managers in
10 ways that many considered impinged on their professional autonomy (Traynor, 1999). Finally,
11 interprofessional collaboration is increasingly emphasised as a core feature of health care
12 organisations. Interprofessional collaboration has been promoted as replacing interdisciplinary
13 divisions and demarcations, but many professionals have found it difficult to hand over autonomy
14 and power to an interprofessional team (Øvretveit, Mathias, & Thompson, 1997).

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17 These four interrelated tensions provided the impetus for the present study of practising nurses. A
18 study of how nurses account for their decision-making can inform us about how dominating
19 discourses in the health care systems, such as managerialism, the evidence based movement and
20 the promotion of interprofessional work, influence UK professional nursing.

21 22 23 AIMS OF THE STUDY

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26 1. To gain insight into the character of the present day nursing profession by studying how groups
27 of UK nurses account for professional clinical decision-making processes, and 2. to determine the
28 usefulness of using Jamous and Peloille's 'I/T ratio' as a theoretical framework within which to
29 understand these accounts.

30 31 32 METHODS

33 34 35 **Procedure**

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38 Focus groups with qualified nurses working in three clinical specialities were held in 2008. The
39 sample was made up of nurses attending three post-qualifying study courses in a university in
40 London. The relevant University ethics committee approved the study and the course leaders gave
41 permission for the researchers to approach their classes. All the participants volunteered and gave
42 their signed consent to participate. The first two authors ran the focus groups in the lunch hours of
43 the courses being attended. The sessions were audio recorded and subsequently fully transcribed
44 by these authors. We initially used a modified conversation analysis (CA) transcription system
45 designed to capture the spoken interactions and the particular delivery of speech (Hutchby &
46 Wooffitt, 1998). However, we will present data extracts with a minimum of transcription symbols to
47 ensure a high level of readability. The groups contained between 8 and 10 participants. The
48 characteristics of the groups are provided in Table 1. Focus groups were chosen because our

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4 intention was to understand how groups of nurses described their decision-making in clinical
5 practice and negotiated the acceptability of these accounts in group discussions. As individuals
6 who were engaged with post-qualifying study, the participants might be considered as atypical of
7 the whole of the English nursing workforce, but their evident familiarity with policy and professional
8 issues meant that they were more able to articulate mainstream professional rhetoric, which was
9 the focus of this research.
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13 Every focus group started with the following exploratory question: What influences you when
14 making a clinical decision? This was followed up with prompts and requests for examples if
15 needed.
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18 19 **Analysing interpretative repertoires** 20

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22 This study is conceptualised within a constructionist perspective (Gergen, 1985). From this
23 perspective language mediates social reality and through language-use, individuals construct
24 socially situated versions of their worlds and their identity (Potter, 1997). We are thus interested in
25 the way the nurses use language in the conversational interactions during the focus groups and in
26 the way they draw on particular discursive resources to describe everyday decision-making
27 processes, professional autonomy and professional identity.
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32 We analysed the transcripts for conversational interactions and representations of professional
33 autonomy and decision-making. The analysis of conversational interaction included: the turn-taking
34 organization in the groups, the overall structural organization of the focus groups, turn-
35 constructions, topic-organisation, and the repair-organisation (Heritage, 1997; Sacks, Schegloff, &
36 Jefferson, 1974). The analysis of representations of autonomy and decision-making included: word
37 meaning, wording, narrative structures and plots (Brooks, 1984; Fairclough, 1992). We have
38 interpreted the findings from the analyses in terms of 'interpretative repertoires' (Wetherell & Potter,
39 1992) actively drawn on by the nurses during the focus group sessions.
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45 An interpretative repertoire is a pre-existing and relatively coherent set of terms, metaphors, and
46 stories that members of a community may draw on when they articulate themselves and their
47 worlds. The interpretative repertoires available for professionals will include elements of
48 mainstream professional rhetoric influenced by professional organisations, institutions, influential
49 journals and prominent individuals articulating representations of 'professional nurses', as well as
50 wider socio-cultural discourses concerning 'professionalism' or 'caring'.
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55 We would expect the nurses' conversational interactions to be limited by the particular conventions
56 for participating in focus groups as well as by the availability and character of discursive resources.
57 To a certain extent these discursive features will homogenize and position the nurses in pre-
58 configured 'subject-positions' (Fairclough, 1992). However, at the same time, the nurses are
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3 potentially capable of creatively challenging some aspects of conversational conventions and use
4 and combine discursive resources in unexpected ways.
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7 Most professional rhetoric tends to be positively loaded, such as that concerning the humanistic
8 healer or scientific expert, but there are also less positive discourses—of ‘victim’ in the face of a
9 dominant medical profession for example (Davies, 1995; Hart, 2004; Paley, 2002).
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12 **Findings**

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15 Twenty-six qualified nurses participated in the three focus groups. On average, the nurses had
16 been qualified for 10.4 years (SD = 10.8) (see Table 1). The participants from Group 3 had been
17 qualified for a shorter period of time compared to the other two groups and there was less variation
18 in the length of experience of the nurses in this group. Nurses practiced in both hospital and
19 primary care settings.
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23 TABLE 1 ABOUT HERE

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26 At first in the focus groups, the nurses were asked to reflect on what influenced their professional
27 decision-making. The nurses responded in a paradoxical way by depicting their decision-making as
28 problematic and their professional autonomy as subjugated, but also maintaining that decision-
29 making processes could be enacted with a high degree of autonomy. The nurses described their
30 experiences and attitudes by drawing on two interpretative repertoires, and in the following
31 sections, we will present their basic components. Although participants included practitioners from
32 primary care, the examples of data we have chosen are hospital based.
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38 **1. The ‘clinical judgement’-interpretative repertoire**

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41 When talking about decision-making in terms of making ‘clinical judgements’, the nurses
42 emphasised how they drew on different types of knowledge in making these judgements. This
43 interpretative repertoire included a wide range of terms and metaphors but was organised round a
44 sharp distinction between, on the one hand, rationally drawing on objective clinical knowledge and,
45 on the other, drawing on tacit ways of knowing. The nurses’ distinction had strong resemblance to
46 Jamous and Peloille’s distinction between technicality and indeterminacy.
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51 The nurses stated that in everyday clinical practice they would draw on technical knowledge as
52 well as indeterminate knowledge. The nurses drew on technical knowledge when they adhered to
53 standardized protocols or used evidence-based procedures and on indeterminate knowledge when
54 they spoke of intuitively grasping a clinical situation without always being able to articulate or
55 substantiate their understanding of the situation. In the following typical data extract a nurse (Nurse
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3 1) delivers a narrative describing how she adhered to a standardised protocol for actions to take in
4 case of an impending heart attack.
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7 Data extract 1:
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10 Nurse 1: One night I was doing night shift. We had two staff nurses working that night so they
11 called me to come and work with them. I went in and there was a patient in the ward
12 there. We went to her. She came in with breathing problems and I could see that
13 she's not well. What I did is to do her obs and then looking at the obs, you could see
14 that she's impending crash. So I went immediately and called the night practitioner,
15 because that is the guideline. It's very clear, call the night practitioner. She said, 'Ok,
16 increase the oxygen and watch'. I immediately called the night doctor on call
17 because I know this lady is about to crash. I bleeped the doctor and immediately
18 then I brought the crash trolley to the side because I know she is going to crash
19 because the fact is if the pulse is going down to forty-something, I know she is going
20 to crash. Fortunately the doctor came immediately and then asked me to go and
21 bleep the DMR. So I bleeped the DMR who came immediately and then. It was bad
22 that night. We did everything for the lady because she was... She crashed anyway.
23

24 Moderator You were saying you knew she was going to. How did you know that?
25

26 Nurse 1 Because when you look at her all the peripherals, you know that she's not diffusing
27 properly and then do the obs, you see the facts, you see the blood pressure, and
28 you see the pulse. Everything is abnormal.
29

30 Nurse 2 It's your knowledge, isn't it, it helps you make the decision.
31

32 (...)
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34 Nurse 3 I've actually had a sense that there's something wrong - more wrong - with a patient
35 than there is known at the time. And I've said it to my seniors and been right and I
36 don't know how I know. I can't say how but I just knew by looking at the patient. And
37 then speaking to other colleagues, they agreed, you know, they sensed that there
38 was definitely something more going on. But I don't know how. It's just. I don't know.
39 I'm not a witch.
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44 In this extract Nurse 1 tells the story of how she gathered observational data about an acutely ill
45 patient's condition and used them to act according to the standardised guideline. The narrative plot
46 is that the nurse's interpretation of the patient's condition was correct in spite of a night
47 practitioner's apparent reluctance to take appropriate action. Nurse 2 rearticulates the account by
48 affirming to the group that it is 'knowledge' that is the foundation for Nurse 1's correct action.
49 However, nurse 2's notion of 'knowledge' is ambiguous, as it could include not only a technical
50 assessment of the patient's status but experiential knowledge and the knowledge gained by
51 professional training. Nurse 3 continues by addressing the topic of knowing that a patient is more ill
52 than is officially recognised and being right about it. In this account, however, there is a refusal to
53 link this knowledge to any formal observations but to a 'look' at the patient. The figure of the witch
54 at the end of her passage, though apparently chosen casually, acts as a kind of gendered
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3 antithesis to the figure of the beneficent nurse, the potential danger behind too strong a call on
4 intuition.
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7 A second account of clinical judgement is striking because, as in the last section of data extract 1,
8 there is no mention of any formal measurable evidence to support the 'sense' that something is
9 wrong. This point is central to the narrative told by both nurses, along with the fact that each teller
10 turned out to be right. Nurse 4 conveys the narrative:
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14 Data Extract 2:
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19 Nurse 4 I wasn't long qualified when I had this patient. I went in in the morning and I kept
20 saying: 'He's not right. He's not right', but I couldn't put my finger on what was wrong
21 with him. I had no idea. I still can't remember. I remember saying to a senior house
22 officer who wouldn't listen to me and I was obsessing by this man now. I knew the
23 consultant quite well and I got the consultant to come and see him and the
24 consultant said to the senior house officer, I still remember, 'Because she can't tell
25 you what's wrong with the patient doesn't mean there is nothing wrong with the
26 patient. Always listen to a nurse'. That man ended up in ITU. I still say you may not
27 always be right but for some reason you just know when you see a patient. I
28 remember that and I wasn't long qualified. I can't remember what was wrong with
29 him. He ended up in ITU.
30

31 Nurse 5 Maybe you'd been monitoring him for a few days
32

33 Nurse 4 No he hadn't been in that long
34

35 Nurse 5 OK, whatever
36

37 Nurse 4 I remember the consultant that day saying: 'Always listen to the nurse. They'll never
38 be able to... might not be able to tell you what's wrong. You should listen to them'.
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41 Nurse 6 Because if you've nursed a patient for a few days you will know what the patient
42 looks like when they are not in that state and then when there is a change you will
43 notice that there is a change in that patient
44

45 Moderator2 Is that because we spend so much time as nurses with the patient so your time so
46 you know from hour to hour that there is a change?
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51 Nurse 4 delivers a narrative where she reacts to her indeterminate feeling that something is wrong.
52 The senior house officer does not listen to the nurse and instead she uses her personal
53 acquaintance with a more senior doctor to take action and circumvent the senior house officer's
54 decision not to listen. The narrative plot, 'you should always listen to a nurse even though she is
55 not able to articulate what is wrong', is emphasised both by the more senior doctor's rule about
56 listening and by the repetition that the patient 'ended up in ITU'. In response to Nurse 4's emphasis
57 on the unarticulated quality of her 'sense', where *not* knowing is emphasised rather than knowing,
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other members the group (and one of the moderators) interrupt and account for this in less indeterminate terms to bring the story within more comfortable professional boundaries.

In Jamous and Peloille's terms, the nurses drew on discursive resources from both the technical and indeterminate domain. However, the type of domain was not an important element in the nurses' narratives because the question of *how* they knew was subordinated to the narrative plot, that they were shown to be in the right. However, in professionalising terms, this legitimation is problematic. First it reinforces nursing's subordinate position to medicine in that it relies on the consultant's authority to sanction it. Second it reinforces a version of nursing as a place of inarticulate intuitions. This passage reminds us how problematic speaking about intuition can be in the context of a more rationally based professionalising discourse. Nevertheless, in these two contrasting accounts of decision-making, nurses tell stories of how they maintained decision-making power in the face of some opposition.

Through the discussions the nurses described how they relied on the two different types of knowledge in their descriptions of their clinical judgements. Furthermore, the interactional dynamics of the focus groups ensured that descriptions of unalloyed reliance either on indeterminate knowledge or on technical knowledge were modified to become more balanced. In professional terms, descriptions of both extremes were problematic, as predicted by Jamous and Peloille. Balancing meant that the nurses emphasised their professional experience as the basic *modus operandi* of using any type of knowledge. In this sense any decision, indeterminate or technical, was mediated by the nurses' individual agency, which supported an image of professionally autonomous practitioners.

2. The 'decision-making'-interpretative repertoire

The nurses drew on a 'decision-making'-interpretative repertoire when they described decision-making in terms of their opportunities for influencing patient care. This interpretative repertoire contained descriptions of organisational constraints that either impinged on the nurses' decision-making processes or, paradoxically, could be used as opportunities for influencing patient care. This is seen, for example in the hierarchical relationships depicted in the previous data extracts. The most fundamental obstacle to autonomous decision-making was stress caused by poor working conditions and high workloads. A further obstacle was related to teamwork and hierarchical decision-making. The successful management of both types of obstacle demanded varying levels of commitment from the nurses.

The nurses stated that stressful working conditions, a highly unpredictable work environment and high workloads decreased their ability to make decisions in a very practical sense: there was no time to make proper and safe professional decisions. On one hand, this condition made the nurses defensive, speaking of 'covering' themselves legally and professionally should any faults or accidents should occur. On the other hand, it was important for the nurses to actively prioritise their workload and, in the wider institutional context, to manage other staff members and allocate tasks to facilitate optimal conditions for direct clinical decision-making and care giving. In this sense, the

nurses understood the organisation of the ward as an intrinsic part of the decision-making process, which could be managed actively to improve the conditions for direct clinical decision-making.

Despite this, the nurses found it very difficult to practise in a way that they considered to be professionally acceptable.

The following data extract illustrates a common issue related to the nurses' difficulties in opening a clinical space where they can make informed clinical decisions. The nurses claim that they need legal cover in case of an adverse event. Nurse 7 talks about an experience where she was in charge of a hospital ward, which she claims had inadequate staffing.

Data extract 3:

Nurse 7: You know there are standards. Normally you got a standard number of nurses who are supposed to be working. They knew all day there was a patient coming out of ITU. They should have made adequate arrangements to get that patient extra staff, but they don't get it. They forget it or sometimes, the money situation these days, people talking about money. You're going way over your budget so sometimes people, in inverted commas, 'forget' to get extra staff. Because it means you are not getting money out at the same time. So you are ending with a situation where we've got extra load but if something goes wrong its going to come back to me because I'm the one who's covering that shift so that's why you need to cover yourself by putting your foot down. I don't want to work if it's unsafe.

Nurse 8: But if you take handover from staff and they [a manager] phone it means you've taken that shift and agreed to working. The best thing to do is not to take handover but in my ward, if staff works nights you have to take handover.

Nurse 7: We do get a lot of patients from ICU and then I have to go to site manager to solve the problem for me. She can take other from a ward that's less busy to come and cover me because, you know, you have to make those types of decisions. That's what we do. We have to.

Nurse 8: You have to take handover then you can ring the site manager and tell them you are short staffed if they have staff to send to you, but as far as you have taken the handover you can't say you can't work. You don't say we can't work because you've already taken handover. That's gone. You are left with the ward. What you do is fill in an incident form. That incident form will cover you.

Nurse 7 starts by referring to a technical decision-making feature, the formal standards for staffing levels. These standards are subverted by extra-clinical bureaucratic and financial factors. She argues that such a situation calls for a formal complaint. Nurse 8's response offers a legalistic solution (refusing to take charge of the shift) but simultaneously denies (twice) that such a solution is possible. This contradiction in her statement – you have to take action that you cannot take – intensifies the performance of powerlessness that this talk is enacting. Nurse 7 refers to a manager to solve the problem and ease the workload, and Nurse 8 suggests as a last resort to use bureaucratic methods to create judicial cover in critical situations.

The data extract illustrates how the nurses experience their work environment as disempowering and understand clinical decision-making as embedded in a prevailing institutional context that can, in effect, hamper direct clinical decision-making processes.

1 The nurses described teamwork and hierarchical decision-making as further constraints on their
2 professional autonomy. Teamwork was described as both empowering and disempowering. It
3 could be empowering because several professional groups had to work closely together and make
4 joint decisions, which would make the most powerful individual professionals less powerful, and the
5 less powerful groups more influential; It could be disempowering because the nurses themselves
6 would lose part of their professional autonomy through the inter-professional teamwork.
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8 The nurses often described themselves as overruled in hierarchical decision-making processes,
9 where they had to comply with decisions made by other, higher ranking nurses or by other
10 professional groups, notably medical doctors. This image of disempowered professionals was
11 continuously subverted in the focus groups by descriptions of nurses capable of circumventing
12 decisions made 'higher up' in the decision-making hierarchy. The nurses could use both technical
13 and indeterminate knowledge to substantiate their understanding of a clinical situation. For
14 example, in data extract 1, Nurse 1 refers to technical knowledge as the grounds of her actions and
15 uses the knowledge of the organisational hierarchy to subvert the 'wrong' decision made by the
16 night practitioner. However, nurses had to use their personal knowledge of both formal and
17 informal organisational structures to change decisions or push certain decisions forward. In this
18 sense, the nurses depicted themselves as victims caught up in bureaucratically constrained
19 situations, but paradoxically, also as autonomous agents capable of actively circumventing
20 decisions that they believed were wrong.
21

22 The nurses described their decision-making as ranging from concrete clinical decisions to
23 management of the whole organisational situation. They would draw on both technical knowledge
24 and indeterminate knowledge to support their clinical judgements and use both their clinical and
25 their organisational skills to circumvent 'wrong' decisions or to further 'right' decisions. The nurses
26 generally described their professional autonomy as limited. However, the bleak descriptions of
27 everyday work conditions were relieved by narratives of independent and successful action in the
28 interests of patients and which depicted the nurses as being in the right.
29

30 DISCUSSION

31 The findings of our study have brought up to date research into the professional status and
32 character of nursing in the contemporary UK National Health Service. The last major studies are
33 now between 10 and 20 years old (Davies, 1995; Strong & Robinson, 1990; Traynor, 1999; Walby
34 & Greenwell, 1994). Since these studies were completed the healthcare landscape has changed in
35 many industrialised economies. State and managerial power has increased in the face of
36 opposition from clinical groups (Hunter, 1994). Despite the size of the nursing workforce and its
37 increasing prominence in health policy in the UK it has been relatively neglected in sociological
38 studies of healthcare professions in favour of the attention given to medicine. Many of the same
39 issues, however, face both professions.
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41 The nurses in the focus groups drew on two different interpretative repertoires when they described
42 their clinical decision-making. One interpretative repertoire, 'clinical judgement', was used to
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1 describe the grounds for making judgements; another interpretative repertoire, 'decision-making',
2 was used to describe organisational circumstances influencing decision-making. The nurses in this
3 study paint a sometimes bleak picture of professional working in contemporary healthcare
4 bureaucracy. It is characterised by apparent managerial manoeuvrings and bureaucratic but largely
5 ineffective strategies on the part of the nurses to maintain some vestige of professional control.
6 The data from our study show nurses also talking about their professionalism as constrained by
7 powerful managerial and economic forces. Nevertheless, the stories that the nurses told
8 themselves about their own activities can feature nurses as successfully working around these
9 considerable constraints.
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13 One of our aims was to investigate the continuing usefulness of Jamous and Peloille's theory of
14 professional work. Though forty years old, Jamous and Peloille's theory has provided an insightful
15 framework for understanding the organising principles of what we named the "clinical judgement"
16 interpretative repertoire. In particular, it has proved useful for understanding instances where the
17 nurses collectively withdrew from the potential dangers of too extreme claims for technicality or
18 indeterminacy in their talk of clinical decision-making. However, their theory cannot explain the full
19 range of accounts of decision-making that were given in the focus groups, notably the "decision
20 making" repertoire where professional decision-making was articulated in terms of either
21 professional subjugation or successful nursing action. It seems that Jamous and Peloille, writing in
22 the 1960s, did not anticipate the situation of medical, and other professionals, working in the
23 bureaucratic and managerial culture that forms today's health service in many industrialised
24 countries. Their work has little conception of professional practice within a context of national
25 guidelines for detailed aspects of work and the heightened possibilities for surveillance and
26 recording of clinical activity, as well as performance management, that have been made possible
27 by new technology and new political ambition. Such changes in the organisation of health services
28 that feature surveillance, risk aversion and standardisation have made it impossible for
29 professionals to talk about their decision-making in ways that do not include some
30 acknowledgement of managerial and financial influences.
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42 Intuitive decision-making has been investigated and championed within nursing. Benner et al., e.g.
43 (Benner et al., 1996), are among the most influential authors criticising an over-reliance on rational
44 models of clinical judgement. They argue that intuition and practical wisdom gained from
45 experience play a significant part in everyday clinical decision-making. These kinds of argument
46 about the embodied and tacit knowledge that only comes with experience were prominent during
47 the 1980 and were marshalled by those wishing to enhance nursing's professional standing and
48 nurses' own self-confidence (Benner & Wrubel, 1989; Hagell, 1989; Tschudin, 1999). However, the
49 1990s saw the retreat of such talk in the face of more explicit economic challenges for nurses and
50 others to articulate their effect and value for money (Lightfoot, Baldwin, & Wright, 1992; Prentice,
51 1991; Royal College of Nursing, 1994). Later in the same decade the rise of evidence based
52 practice also made it harder for professionals to rely on indeterminate claims about their decision-
53 making and there was, perhaps, a backlash against this kind of talk. Lamond and Thompson, for
54 example, argued that intuitionists such as Benner overstate their case (Lamond & Thompson,
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2000). They argue that promotions of intuition often rely on the remembered stories of those nurses whose intuitions turned out to be correct. This is potentially misleading, they claim, because nurses are less likely to bring to mind occasions where they were wrong or where they failed to have intuitions. From our constructionist position we would argue that the production and repetition of such stories performs identity work in our study groups, enabling nurses to participate in an affirming an acceptable professional identity. This reservation is not evident in Benner et al.'s interpretations of their narrative data. As the healthcare context has changed since Benner and others first published their work, a more technically and rationally orientated climate prevails. Stories of intuition are likely to be tempered by technical explanations as we saw in our own groups.

Traditionally, professionalism has been associated with autonomous decision-making, access to a unique body of knowledge and an ethical obligation to the client. However, the nurses in the focus groups accounted for their professional autonomy rather differently. They articulated a strong moral commitment to their patients, but they did not describe or refer to a unique body of knowledge supporting their decision-making and described limited autonomy in their decision-making processes. In a focus group study, Stewart, et al. also identified a discrepancy between the traditional assumptions about professionals' and nurses' descriptions of professional autonomy in their clinic (Stewart, Stansfield, & Tapp, 2004). They found that the nurses linked their autonomy to 'how to get things done on behalf of patients' (p. 445) by using all available organisational possibilities. In this clinical nursing discourse, autonomous decision-making is legitimised by a moral obligation towards the patient rather than by drawing on a unique body of explicit professional knowledge.

We found clear evidence of Stewart, et al.'s clinical nursing discourse on professional autonomy in our dataset. In the focus groups, the nurses' commitment to the patients was bound up with 'seeing' or 'knowing' the patients' true need for healthcare intervention, in line with Benner's ideas about professionalism and indeterminacy. However, the descriptions of effective and autonomous nursing practices were almost exclusively limited to those parts of the dataset where the respondents used narratives to account for their practices. The respondents' narratives advanced descriptions of clinical autonomy by positioning the nurse as the narrative subject working heroically and successfully in the best interests of the patient. By means of this basic narrative plot, they constructed themselves as powerful, morally responsible and autonomous professionals promoting their legitimate observations. Furthermore, by means of these narratives the respondents reproduced an ideal of professional autonomy and were able to successfully downplay the contradictions and impossibilities inherent in their everyday work that were evident in other parts of the dataset. It is possible that collective storytelling strengthens the nurses' sense of being right and professionally autonomous and helps to legitimise decisions made out of a commitment to helping their patients.

Finally, by accentuating personal agency as the modus operandi of their clinical decision-making alongside a strong commitment to patients, the nurses were able to sustain a self-image as autonomous professionals. The emphasis on experience can be interpreted as an effective

discursive refutation of de-professionalising forces in present day health care organisations. In the same vein, the nurses described how their autonomy was limited by the 'proletarianisation' caused by managerialism and financial considerations, and their jointly produced 'success' narratives could also be interpreted as an opening of a rhetorical realm where they can experience a fantasy of clinical autonomy. Further field research into nurses' professional autonomy in everyday clinical settings is needed to determine how far the clinical nursing discourse reflects observable professional autonomy.

Limitations

Nurses engaging with professional development, as our sample was, are likely to be different to nurses who are not. They are possibly more familiar with professional discourses. There was only one group from each speciality therefore it would be hazardous to talk about differences between them and richer data may have been obtained with longer sessions. Although participants included practitioners from primary care settings, the examples of data we have chosen are hospital based. Focus groups with other professions would have enabled illuminating comparisons to be drawn and helped to identify characteristics of the discussions about decision-making that were unique to nursing. The quality of the sound recording was poor in some places making transcription occasionally uncertain. For all these reasons our conclusions should be read with some caution.

CONCLUSION

Our research, though small in scale, has given an insight into the complex forces acting upon this large group of clinical professionals and their nuanced response. With a theoretical approach informed by Jamous and Peloille's discussion of the dangers of too strong a reliance on indeterminacy or technicality in professional rhetoric, we have been able to understand nurses as collectively withdrawing from extreme accounts of either. Taken at face value, the accounts from the participants show nurses practising in sometimes indirect ways in order to have influence in the clinical and bureaucratic setting. This interpretation supports earlier findings by Salhani (2009), Griffiths (1998) and Simpson (2007). However, a focus on language use and in particular, interpretive repertoire, has enabled us to suggest that despite an overall picture of severely limited autonomy, nurses in the groups reproduced stories of the successful accomplishment of moral action. We can only speculate on the function of such stories for these groups. It could be that professional ideology is so influential that its presence is felt in the particular kinds of story that are repeated within the groups. Such stories offer the rewards of the (re)presentation of a stable, unified, and influential identity in the face of a disempowering and fragmenting context. Imaginatively experiencing such positive identities may help to give such groups a sense of solidarity and courage.

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TABLE 1 Basic characteristics of the groups and the participants

Group	1	2	3
Course and group size	Adult Acute (Cancer care) N = 8	Safeguarding children N = 8	Reproductive & sexual health N = 10
Mean years since qualification (SD)	12.5 (14.0)	12.1 (13.5)	7.5 (3.6)

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Response to reviewers

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2 Many thanks for such constructive and useful comments from all the reviewers and
3 editorial team. We have been able to respond to them all. In summary we have
4 worked to emphasise the contribution that the paper makes.
5

6 First we have changed the title to something that we think better signals the
7 significance of the paper.
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10 In the discussion (and elsewhere) we have contextualised our work within literature
11 that discusses the influence of managerialism on health care. We have made explicit
12 some of the arguments that previously were just implied. We have slightly expanded
13 how we worked with the data and acknowledge that the examples of text we have
14 analysed are taken from the hospital rather than community setting. Although some
15 of the participants worked in the community setting, the stories told about decision-
16 making were placed in hospital settings.
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18
19 We have changed the concluding sentence of the background section with a much
20 more sharply stated purpose of the research and of the area of literature that we
21 intend to contribute to. Our discussion section is significantly expanded. We make
22 the claim that the findings of our study have brought up to date research into the
23 professional status and character of nursing in the contemporary UK National Health
24 Service. We have emphasised the point that statements about professionalism in
25 healthcare cannot be made today without reference to the context of managerialism
26 and financial control. We have extended our discussion of the rise and fall of the
27 influence of the work of Benner and similar writers.
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30 We hope that the changes made have addressed the 'so what?' question that some
31 of the reviewers felt needed dealing with and made clear the contribution that this
32 research makes.
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