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Providing new insight into community nursing know-how through qualitative analysis of multiple sets of simulation data

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This paper describes how new insight into community nursing know-how or professional artistry was produced through qualitative analysis of 30 transcripts of audio-recorded simulation data. The data were generated by simulated patient assessments of two cases. These simulated assessments were undertaken by a heterogeneous sample of district nurses drawn from a large conurbation in central Scotland in 1995. The existence of multiple sets of rich, dynamic and interactive data about each case provided a sound basis for exploring important and poorly understood aspects of nursing knowledge which are generally regarded as implicit. These aspects of nursing knowledge are particularly challenging for empirical research. The findings described are believed to be of particular interest in their articulation of collaborative approaches to patient assessment. Illustrations from the data are provided, and it is argued that the validity of the findings is enhanced by the unusual nature of the database, as well as the analytical procedures described. The limitations and significance of the findings are also addressed. The empirical analysis is linked to a preliminary discussion of procedural knowledge in nursing practice. The findings are discussed with reference to certain aspects of Foucault's view of power.

Key words: collaboration; community nursing know-how; implicit knowledge; qualitative analysis; power

Introduction

This paper describes some of the findings of a study of community nursing practice undertaken in Scotland between 1994 and 1998. The study aimed to reveal the knowledge used by district nurses in their everyday practice when undertaking an initial patient assessment. There is a shortage of empirical work in this area. A wide-ranging review of relevant literature suggested that many aspects of knowledge may be involved, including know-how and ethical knowledge as well as formally taught components of nursing knowledge (Eraut, 1994; Sarvimäki, 1994). The findings presented here were generated through qualitative analysis of 30 simulation transcripts, and provide fresh insight into community nursing know-how or professional artistry.

A recent structured review of qualitative healthcare research papers concluded that failure to present sufficient and appropriately representative supporting evidence is a major weakness of such papers (Boulton *et al.*, 1996). However, it is notoriously difficult to report qualitative findings adequately within the constraints of an academic paper (Mays and Pope, 1995). Because of these constraints, both findings and associated theory can only be presented here in summary form, with selected illustrations from the data. The overview of analytical procedures which is provided goes some way towards demonstrating the rigour of the analysis as a whole. A more comprehensive

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account of both analysis and findings is available elsewhere (Bryans, 1998).

Background theory

The literature review which informed this study concludes that large areas on the map of professional nursing knowledge are currently either indistinct or completely invisible. Such grey areas include procedural, implicit or tacit aspects of nursing knowledge. Procedural knowledge pertains to actions and processes, and is predominantly practical in nature. It thus has affinities with 'professional artistry' and with 'practical knowledge', 'know-how' and 'artistry' as discussed in the nursing literature (Schön, 1983; Sarvimäki, 1994; McIntosh, 1996; Antrobus, 1997). Procedural knowledge is most commonly characterized by its tacit, implicit or unarticulated nature. Although this aspect of nursing knowledge appears to be widely recognized, there is a severe shortage of empirical nursing research in this area (McIntosh, 1996). An additional problem is that the related theoretical nursing literature is not always conceptually clear, with terms such as 'tacit knowledge' and 'unarticulated knowledge' being used interchangeably (Bryans, 1998). To add to the confusion, 'personal knowledge' is also sometimes used to describe a nurse's unarticulated, non-propositional-type knowledge (Smith, 1992).

The broad conceptualization of tacit knowledge which underpins this study resonates with that of Altheide and Johnson (1994: 487). According to their account, tacit knowledge may include propositional, socially and culturally absorbed aspects, *as well as* those practice-derived or experientially gained elements that are most commonly acknowledged in the nursing literature. Aspects of ethical knowledge which are expressed in action would also form a legitimate part of tacit knowledge.

With regard to ethical knowledge, the perceived power imbalance between health-care professionals and patients remains a major issue (Trnobranski, 1994). Lupton argues that the view that nurses should relinquish their 'power' over patients is somewhat ill-theorized. She draws upon Foucauldian theory to provide fresh insight into the positive potential of power within the nurse–patient relationship (Lupton, 1995).

If these elements of practical nursing knowledge are as central to expert practice as the literature suggests, it is crucial that we amass convincing evidence about them. With the drive towards evidence-based practice, and within the current climate of resource constraints and associated cost-cutting, it is becoming increasingly necessary to provide valid and useful information about qualitative aspects of expert nursing practice which enhance patient care (Bonell, 1999; Closs and Cheater, 1999).

Methods

Because procedural aspects of nursing knowledge are generally difficult to articulate, they may not be revealed by self-report methods. As these aspects of knowledge are essentially 'expressed in action' (Sarvimäki, 1994), it was deemed necessary to collect data which adequately captured nursing actions and processes. The innovative simulation method used was part of a multi-method research approach which has been described and defended elsewhere (Bryans, 1998). Two complex, typical and credible cases were created by an expert group of experienced practitioners who built in a wide range of physical, psychological and social needs to each case. A total of 30 district nurses, selected for their wide range of educational and experiential backgrounds, participated in the study. For logistical reasons, 12 nurses assessed one 'patient' ('MR') and 18 nurses assessed the other ('EM'). The 20-minute simulations were audio-recorded and generated rich and naturalistic interactive data. In addition, the actresses' performances were video-recorded to enable assessment of actress consistency (Bryans, 1998).

Reliability and appropriateness of the data

Data collection took place within the controlled and specially equipped setting of a simulation laboratory, and the quality of the recorded data was consequently excellent. Silverman has argued that the availability of transcriptions of recorded data satisfies proper demands for the documentation of procedures, and thus improves the reliability of qualitative research (Silverman, 1998).

This reliability also depends on the accuracy of

transcriptions. Data were transcribed from audiotapes by the author and a secretarial assistant. Each transcription was given a code number to protect participants' confidentiality. Utterances were numbered sequentially within each transcript and labelled with the speaker's coded initials. This enabled accurate identification of sections of dialogue, and rapid relocation of excerpted sections when required. All of the transcriptions were compared with original recordings by the author to ensure accuracy.

The size of the database and the scale and potential complexity of the analytical task highlighted the need for careful data management. Hyperqual, a qualitative data management system, was chosen because of its flexibility and its ability to accommodate the various types of data generated during the study (Padilla, 1993; Russell and Gregory, 1993). Hyperqual provided the facility for random selection, clear identification and future access to cross-checked data, thus improving the overall rigour of the analysis (Huberman and Miles, 1994).

The simulation transcripts were essentially social and interactive in nature. Thus while certain themes and topics of conversation arose frequently, each transcript represented a fresh dynamic entity. Repeated readings of the transcripts suggested considerable variation between the assessment approaches of participants assessing the same actress-patient. There were differences in pace and tone. Some assessments appeared to flow along effortlessly, while others seemed staccato and laborious. These initial impressions were powerful, but they were also tentative and imprecise. Complex processes appeared to be hidden 'between the lines' of transcripts. The challenge was to develop an analytical approach which would reveal these hidden processes.

Data analysis

The 30 simulation transcripts were analysed using two different methods. The first analysis was essentially content focused, and is described elsewhere (Bryans, 1998). An average of five observational visits were also undertaken with a theoretical sample of approximately one-third of the sample, in an attempt to establish validity. The final stage of analysis involved synthesis and further interpretation of the various findings through the use of illustrative case studies. It is hoped that these other findings will be published in due course (Bryans, 1998). The analysis and findings presented here relate specifically to procedural aspects of community nursing 'knowledge in use'. (Findings are referred to as 'knowledge in use' to indicate that knowledge revealed during a single simulated assessment is not claimed to represent a participant's knowledge base as a whole).

Analytical aims and approach

The broad aim of this phase of analysis was to discern and examine the processes inherent in the simulation transcripts. This involved describing practitioners' assessment approaches in detail, identifying differences between practitioners' overall approaches, and determining the functional implications of these different approaches to the simulated assessment.

Because of the essentially interactive nature of the data, conversation analysis (CA), with its prime interest in the organization of interaction, appeared to be an attractive analytical approach. However, because CA focuses on 'endogenously generated sequential opportunities and constraints . . . within conversations' for their intrinsic interest, without reference to the wider context, it was not entirely appropriate (Boden and Zimmerman, 1991). In order to reveal professional know-how or procedural knowledge, it was essential that the analytical approach encompassed functional and dysfunctional aspects of the assessment interactions as well as their constituent processes. That is, the professional context or purpose of the interactions could not be excluded. The author therefore developed a hybrid approach which falls somewhere between ethnographic, contextually oriented analysis and conversation analysis (Peräkylä and Silverman, 1991). Sequential explanations developed through detailed analysis of the transcripts were linked with 'contextual explanations of their functionality' (Peräkylä and Silverman, 1991: 627).

This approach enabled the author to describe and explain the simulation interactions systematically, precisely and meaningfully – that is, giving due attention to the context and purpose of the assessment interaction. Consistent with much qualitative work, the analytical approach was data-driven, evolving in direct response to emergent findings (Tesch, 1990).

Elements of – and differences between – participants' assessment approaches were discerned and

distinguished by the use of constant comparative method (Glaser and Strauss, 1967). Groups of indicators which characterized contrasting approaches to assessment and reflected different elements of knowledge in use gradually evolved. During this process, care was taken to avoid making unwarranted claims about patterns and regularities in the data, and the systematic analysis of deviant cases augmented and refined the findings of the analysis (Miles and Huberman, 1984; Silverman, 1993). A detailed description of this process is provided elsewhere (Bryans, 1998).

Conversation analysis and ethnographic approaches have both been used to some extent in nursing research (Hunt and Montgomery Robinson, 1987). However, to the author's knowledge the hybrid approach described here is new to this field. This approach proved effective, revealing previously unknown elements of the procedural knowledge or artistry inherent in expert assessment.

Findings

Summary of findings

Most simulation transcripts were categorized as either 'patient-focused and collaborative' (PF) or as 'nurse-agenda-led and less collaborative' (NAL). A few were categorized as 'mixed' in character (MIXED). As well as four nurse characteristics, there were two characteristic patient behaviours and responses linked to the two main approaches. These two approaches were clearly distinguishable across both simulated cases. A summary of the overall findings is presented in Table 1.

Table 1 Summary of nurses' assessment approaches by case

Approach	EM case	MR case
NAL	5	7
PF	11	4
Mixed	2	1

NAL, nurse-agenda-led; PF, patient-focused; EM case, Edith Morrison case; MR case, Mary Russell case.

Description of the two main approaches to assessment

The patient-focused or collaborative approach

This approach included four characteristics of the nurse's behaviour and two associated patient responses or behaviours. These are labelled PF (patient-focused) 1–6, respectively.

- **PF1** Patient-initiated topics, questions, statements, problems and needs are acknowledged by the nurse. There is thus a reciprocal and conversational style to the assessment visit, with both parties appearing to have some control over events.
- **PF2** Patient feelings (expressed both verbally and non-verbally) are acknowledged by the nurse through 'echoing' sequences, overlapping of speech, and encouraging remarks. Such acknowledgement may be explicit/verbalized or implicit. An implicit acknowledgement could be expressed by willingness on the part of the nurse to change topic to one which is of evident concern to the patient.
- **PF3** Advice and information given to the patient is patient-specific rather than generalized. That is, the nurse can be seen to be using information gained from the patient and/or the specific context of the visit to tailor information to that patient in particular.
- **PF4** The nurse explicitly checks out his or her judgements with the patient during the assessment.
- **PF5** The patient initiates topics, asks questions and freely volunteers information to the nurse.
- **PF6** The patient responds positively to the nurse's suggestions, advice and information-giving.

The nurse-agenda-led, less collaborative approach

This approach included four characteristics of the nurse's approach and two associated patient behaviours which are the obverse of those presented above. These are labelled NAL (nurse-agenda-led) 1–6, respectively.

- **NAL1** A 'nurse question–patient response' format dominates the assessment. Thus nurse-initiated topics predominate, with a consequent reduction in patient-initiated topics. The overall assessment has the character of a formal inter-

view, rather than a reciprocal conversation, and has a less collaborative tone.

- **NAL2** Patient feelings are not (explicitly or implicitly) acknowledged by the nurse. The nurse may even interrupt patient statements or responses in order to adhere rigidly to the nurse's agenda.
- **NAL3** Advice and information given to the patient by the nurse is impersonal and generalized, rather than patient or task-specific. That is, the information could have been given without any personal knowledge of the patient and his or her circumstances.
- **NAL4** The nurse alone decides on the nature of the patient's needs and the care to be offered.
- **NAL5** The patient stops freely offering cues and information and is less open, only answering the questions asked by the nurse.
- **NAL6** The patient responds negatively to advice and suggestions, either rejecting suggestions, asserting her own competence or giving neutral responses. This introduces a tone of dissonance, and the nurse is usually obliged to retreat from the topic.

Examples from the data of one characteristic of each approach

The contrasting data excerpts which follow are drawn from two different transcripts – one 'patient-focused' and the other 'nurse-agenda-led'. The excerpts are accompanied by an explanatory commentary in each case.

In the following example of PF1 (patient-focused characteristic 1), the nurse (DN06) initially asks whether the patient takes any medication and subsequently picks up and pursues two different problems identified by the patient (MR). A third problem raised by the patient, namely her son's asthma and associated night-waking, is explicitly acknowledged but is not pursued by the nurse until later in the visit (u202). Problems presented by the patient are shown in italics, and the nurse's pursuit of these is shown in bold text.

Excerpt from DN06 transcript, illustrating PF1:

88: DN06 Do you take any tablets, or anything?
89: MR I don't actually take anything, no, I was on stuff, but I don't take it now, I mean, the doctor knows I don't take it and that.
90: DN06 What was that for?
91: MR It was water tablets and something to help me sleep, eh, but *the problem was they were both working, so I had to stop taking them*. That sounds daft, doesn't it?
92: DN06 **I think, were you rushing to the toilet too much?**
93: MR Aye, yes I was.
94: DN06 **What time of the day were you taking the water tablets?**
95: MR I tended to take them about, eh, ten-ish, after I'd taken the wean [child] to school, I'd come back and take them then, but then if I had to go for the messages [shopping] or anything like that, you know, it would maybe catch you a wee bit sometimes. [6.36]
96: DN06 **And you didn't want to take them before taking . . .**
97: MR Obviously, aye.
98: DN06 **the wean to school, in case you needed the toilet then.**
99: MR Aye, that would have been a bit embarrassing for them, wouldn't it?
100: DN06 Is there any other time of the day when you're not going to be going out? Obviously if you took it before bedtime, you would be wanting to get up during the night.
101: MR Aye, uh-huh.
102: DN06 Could you take it maybe later on?
103: MR Mind you, *I'm no a great sleeper anyway*.

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104: DN06 **So you tend to waken up anyway.**
105: MR I tend to be up and down during the night, anyway. (7.05)
106: DN06 **On the other hand, you don't want to do without your sleep.**
107: MR Aye, well, that was it. *The other tablets was for sleeping, but they made me sleep too much.*
108: DN06 **So you were sleeping in in the morning?**
109: MR: Well, *my wee boy's got asthma*, you see, and sometimes I would be feart [afraid] that maybe he would be maybe looking for me during the night.
110: DN06 **And you'd want to be able to be awake.**
111: MR Aye, and you're kind of always alert at the back of your mind, you know. But I explained all that to the doctor, it's no as if, you know. Here, I never thought of that, actually taking the water tablets before I went to bed or round about, you know, later on.
112: DN06 Well, maybe even if you spoke to the doctor again . . .

This conversation has a reciprocal tone, with the patient's contribution being quickly apprehended and acknowledged by the nurse, and naturally incorporated into her responses. There is also a sense of flow or connectedness in the tone of the conversation. This example thus typifies the PF1 characteristic.

The next – contrasting – excerpt from a nurse-agenda-led transcript illustrates NAL1, the obverse of the PF1 nurse characteristic. The excerpt is a long question and answer sequence dominated by the nurse's agenda. Although pertaining to the same case, and sharing similar topics with the previous DN06 excerpt, the tone of this passage is markedly different. Frequent changes of topic by DN24 result in a series of short statements by each participant and a more abrupt, staccato phrasing. Problems presented by the patient (phrases shown in italics) are not pursued in any depth (if at all) because the nurse moves on to another topic. One exception is the pursuit of the patient's continence problem (u96-u120) in an impersonal and rather unsympathetic manner. The patient's statement about diuretic medication is briefly pursued, apparently to ascertain why this has been prescribed, rather than to explore MR's subsequent difficulties. MR's comment that she has stopped taking the diuretics (u115) is also briefly pursued in order to ascertain whether the GP knows of her non-compliance, rather than to explore why she has stopped taking the medication or whether there might be other options. Brief pursuits of patient cues by the nurse are shown in bold typeface in the excerpt below. However, the patient's contribution is generally more limited and the nurse does not seem to engage fully with the difficulties of the patient's situation. Consequently, the overall tone is neither collaborative nor reciprocal. The patient's negative response to the nurse's suggestion about incontinence garments within this excerpt (u115 and u117) is typical of such sequences.

Excerpt from DN24 transcript, illustrating NAL1:

92: DN24 Right do you sleep at night?
93: MR No *I don't sleep very well at night*. But I never have done you know, it's with the wee you know the wee yin [one] having asthma you know, it keeps me I like to always be listening oot [out] just in case he would maybe get up and be looking for me during the night.
94: DN24 Uhuh yeah. Bowels and bladder OK? (5.30)
95: MR Yes well *I have problems with my bladder*.
96: DN24 That's with the children or what?

97: MR Aye just with having the weans [children] really you know.
98: DN24 And do you get any help with that?
99: MR No I . . .
100: DN2 Have you been to . . .
101: MR No I haven't been to . . .
102: DN24 exercises or . . . you haven't been taught pelvic floor exercises to . . . Are you incontinent sometimes?
103: MR Well *if I'm oot [out] I would wet myself sometimes aye [yes]. See the doctor gave me these water tablets* and I found that really . . . I'd be oot at the shops or something and it would just come away.
104: DN24 **Right so why did he give you them then?**
105: MR I don't know actually why he gave me them. I think it was roon aboot the time I had what they said was a mild heart attack. It might have been round about that time he gave me them.
106: DN24 Okay I'll come to all that.
107: MR But eh *I don't know if that was what they were for* you know in particular.
108: DN24 O . . . kay. So you've never had . . . you've never been referred to physiotherapy or the hospital?
109: MR Oh no, nothing like that.
110: DN24 For any help with that? Do you have any pads or anything you use?
111: MR Oh no, I wouldnae [wouldn't] you know, nothing like that.
112: DN24 We have things like that to help you know . . . we have what they call you know inco . . . I know it sounds awf . . . you know you think of old ladies but . . .
113: MR Aye, sort of like they big nappy things . . .
114: DN24 No no no. There's modern small slim pads on the market that we can provide but I would give you a full assessment if if you wanted to try some of the garments and see what suited you? You know there's lots of . . .
115: MR You know *it's no so bad since I stopped taking the water tablets*.
116: DN24 Right.
117: MR I've still got it the way I've always had it.
118: DN24 And **does he know you've stopped taking them?**
119: MR Oh aye, I wouldnae stop . . .
120: DN24 Oh right, so that's fine. Any pain in your leg?
121: MR I wouldnae say . . . it's mair [more] like a nagging that I get wi' it you know kinna [kind of] you get that used to it that you know that it's usually kinna just the feeling of it.
122: DN24 Right, so otherwise your skin's . . . you just have the one ulcer there?
123: MR Just that yeah aye. (7.11)
124: DN24 So how long did you say that you've had that ulcer?
125: MR I would say aboot 3 years that was.
126:DN24 Hm. Any history in the family of having . . .. Did your mum or your dad or . . .?

127: MR Well, the heart attack my Da had you know.
128: DN24 Right, but not ulcers
129: MR Nothing like this, no . . .

Exemplars (and associated commentary) representing the complete range of findings, and drawing on material from across the database, are presented elsewhere (Bryans, 1998).

Categorizing the transcripts

In order to categorize a nurse's approach, detailed analytical notes were made about each transcript. These included quantification of PF and NAL characteristics and their exact locations within a transcript by utterance numbers. A summary statement then provided the rationale for placing that transcript within a category. Although many transcripts did not contain every feature of a category, most of them could reasonably be placed in either the collaborative or the nurse-agenda-led category. For example, some nurses seldom explicitly acknowledged patient feelings, but their performances included all the other features of a collaborative approach. Such transcripts were therefore categorized as collaborative. Decisions were thus based on the nature of nurses' overall performances and associated patient behaviours.

Developing and refining the categories

Miles and Huberman point out that people tend to 'habitually overweight facts they believe in, . . . forget data not going in the direction of their reasoning, and . . . "see" confirming instances far more easily than disconfirming instances' (Miles and Huberman, 1984: 216). Seeking disconfirming evidence is thus an important method of reducing bias in qualitative analysis. Systematic exploration of deviant cases improved the rigour and depth of this analysis, and proved useful in developing and extending the main categories.

It also led to an additional 'mixed' category, when it became apparent that neither patient-focused nor nurse-agenda-led characteristics clearly predominated in certain transcripts. For example, one such transcript initially appeared to be nurse-agenda-led, as the nurse consistently failed to acknowledge or pursue cues provided by the patient. This nurse also generally failed to acknowledge the patient's feelings or to provide patient-specific advice. Despite this, patient responses to this nurse's suggested input (almost all of which came towards the end of the simulation transcript) were positive. This therefore appeared to be a deviant case which did not conform to the analytical inferences drawn from the data, and the transcript was re-examined for possible explanations. It was noted that the nurse suddenly changed her approach 15 minutes into the 20-minute assessment, apparently in response to an incident in which the patient displayed emotional distress. From this point onwards, the nurse was highly supportive and patient-focused. Thus, although most of the interaction was noncollaborative in tone, the late change in approach appeared to increase the final acceptability of the nurse's suggestions to the patient. Through close examination, this apparently deviant case was thus shown to support the emerging picture of an association between nurse approach and patient response. It is of interest that this nurse clearly had the *capacity* to be patient-focused, although she did not demonstrate this during the first phase of the assessment. This point will be pursued further below.

Cross-checking the findings

When the categorization of transcripts was almost complete, the project supervisor was given one-third of the transcripts for inter-rater checking. These 10 transcripts were theoretically selected to represent the overall spread of categories – patient-focused, nurse-agenda-led and mixed. The project supervisor was given a written description of the characteristics of the two main categories, and categorized each transcript. There was 90% agreement. Another academic supervisor categorized two further transcripts in the same way as the author. The overall result of this cross-checking was thus 11/12 (92%), demonstrating a high level of agreement which improves the confirmability of the findings.

Discussion

The findings presented here are of particular interest with regard to procedural and implicit aspects of community nursing assessment knowledge. The main features of interest include the following:

- initiation and pursuit of assessment issues;

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- acknowledgement and use of patient cues and feedback;
- patient- and task-specific assessment approaches;
- structured and documentation-led assessment approaches;
- extent of reciprocity and collaboration;
- functional and dysfunctional aspects of different assessment approaches;
- potential relationships between assessment process, immediate and longer-term outcomes.

These findings are also of interest in relation to patient empowerment and the role of power in the nurse–patient relationship. These issues have been a focus of discussion in the nursing literature, little of which is research based. However, there is a substantial body of research on power within doctor–patient encounters. Some of this work (based on conversation analysis) suggests 'an asymmetry of interactional rights, based on a question–answer format', with the doctor's questions constraining the patient to answer on the same topic and the doctor consistently initiating new topics (Hughes, 1982). The current nursing literature tends to suggest that nurse–patient relationships are generally less repressive, and are characterized by greater equality (Lupton, 1995). However, the nurse-agenda-led approach described here, which was taken by a substantial proportion (*n*-12) of this study's 30 participants reflects the same question–answer pattern of behaviour as that discerned by Hughes in his study of medical encounters. This throws into question assumptions in some of the nursing literature that nurse–patient relationships are equal, and that they differ in this respect from doctor–patient relationships.

In a critical discussion of power in the nurse–patient relationship, Lupton describes the nature of such power from a Foucauldian perspective. According to Foucault, power:

> doesn't only weigh on us as a force that says no, but . . . traverses and produces things. . . . It needs to be considered as a productive network which runs through the whole social body, much more than as a negative instance whose function is repression.
>
> (Foucault, 1979: 94)

From this standpoint, power may be construed as potentially functional and productive, rather than as merely repressive. Although Foucault does not deny the existence of institutional power, he views it as one of the 'terminal forms that power takes', rather than as its source. He construes power 'in the first instance' as part of the process of interaction (Foucault, 1979: 92). In his succinct explanation of Foucault's conception of power, Porter states that 'for Foucault, the exercise of power always provokes resistance' and thus 'power and resistance are two sides of the same coin' (Porter, 1998: 218).

These aspects of Foucault's understanding of power are of special interest with regard to the activity or behaviour of the patient (as well as the nurse) within the assessment interaction. Patient disinclination to volunteer information, and the negative responses to suggested nursing input which characterize the nurse-agenda-led approach, might be described as two different methods by which the patient limits the nurse's power as an assessor. Thus a collaborative and patient-focused approach does not involve the patient being 'given' greater power with a corresponding reduction in the nurse's power within the assessment relationship. Rather, the notion of power as a functional flow of energy within the assessment interaction implies that an assessing nurse who uses her power or authority in a positive and constructive manner to guide and focus the assessment visit will evoke a similarly positive response from and use of personal power by the patient.

These findings suggest very practical reasons for collaborative, power-sharing behaviour by the nurse within the context of community nursing assessment. These reasons are related to the ultimate productivity of the nurse–patient relationship, rather than to power-sharing as an ethically desirable ideal. The findings also resonate with Jane Robinson's early theories of health-visiting practice as involving 'problem-oriented and relationship-centred' approaches (Robinson 1982). However, the patient-focused approach identified in this study appears to be more practically oriented and task-specific than 'relationship-centred'. It is thus perhaps more of a blend of Robinson's two modes of health-visiting practice. The nurse-agenda-led approach, like Robinson's 'problem-oriented approach', has affinities with a medical model, rather than with the more holistic and humanistic models of health now favoured in the nursing literature (Reed and Procter, 1993).

Lupton alludes to the fact that 'patient-centred discourse has . . . been absorbed into professional

thinking over the past 30 years' (Lupton, 1995). This point is of interest with regard to the relationship between 'traditional academic territory' and 'practice-based territory' (Eraut, 1994). A patient-focused approach may be the product of 'taught' knowledge which the participant has acquired during his or her nursing education. Thus although participants' assessment approaches may reasonably be described as reflecting procedural knowledge, this is not necessarily merely knowledge gained through community nursing experience. Furthermore, case-study analysis which involved the synthesis of the findings presented here with other findings of this study suggests a strong relationship between academically and experientially gained aspects of nursing knowledge (Bryans, 1998).

Validity, limitations and significance of findings

The issue of validity hinges upon whether a nurse's approach to the simulated patient accurately represents how that person would assess *this particular patient* within the context of actual practice. Observational visits undertaken with a selection of study participants were encouraging but not conclusive in this regard. Two further factors which enhance the overall validity of these findings are the spread and variation in approach between participants assessing the same simulated patient, and the fact that some assessment approaches were less than exemplary.

Although these findings suggest that a collaborative approach is generally more productive, it may also be particularly appropriate in certain assessment situations. A collaborative, patient-focused approach was prevalent with the more psychologically needy EM case, and additional data collected during observational visits suggest that some nurses may adapt their approach to suit a particular patient. A limitation of the 'one-shot' simulation method used is that it may not capture this potential flexibility. More evidence is required to identify whether community nurses possess a repertoire of assessment know-how and/or have the ability to select appropriately from this. Thus although the overall validity of these findings is defended, their significance would clearly be enhanced by further research.

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