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Insight and discovery in clinical nursing practice



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Summary Central to health care is clinical practice and its ongoing improvement is essential. Within clinical practice are embedded opportunities for nurses to engage and discover new ways to deliver care. Clinicians can position themselves at the forefront of professional practice development and through insight and discovery transform healthcare delivery. To date the position of clinical insight and discovery in nursing practice has been subtle and not strongly addressed. A greater understanding of insight and discovery by nurses has the potential to bring a new awareness to clinicians and thereby progress practice. This paper explores the current position of insight in nursing practice, perspectives on insight and past clinical contributions it has made to healthcare. Implications for nurses and organisations contemplating insight and discovery for improving practice include sensitising experienced clinical nurses to the process of reflection, insight and discovery; creating a clinical culture for practice advancement through insight and encouraging clinical nursing leaders to foster clinical discovery.

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1. Introduction

Clinical practice provides nurses with opportunities to progress practice through clinical insight and discovery. The value of insight is its capacity to trigger practice development through discovery by contesting existing clinical approaches. Insights are based in observations that attract attention, are often not the result of logic, are unplanned

and may be overlooked key observations (McWhinney, 2008). Observations that lead to clinical insight and discovery can only be made by clinicians grounded in the wisdom of knowing and caring for patients over time (McWhinney, 2008). It is the intersection of insight and unplanned discovery that nurses can use to progress their professional practice. To date the position of clinical insight and discovery in nursing practice has been subtle and not strongly addressed. Better understanding of insight and discovery is required by nurses as it has the potential to bring new awareness to clinicians and progress practice. This paper explores the current position of insight in nursing practice, perspectives on insight, clinical contributions insight has made in healthcare and

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how nurses and organisations can foster clinical insight and discovery in nursing.

2. Current position of insight in nursing practice

Insight is an outcome of reflective thinking (Forneris & Penden-McAlpine, 2007; Johns, 2004). Asselin's (2011a) study showed nurses practised reflection less than they thought and considered their peers were not reflective. Findings from a more recent study by Asselin, Schwartz-Barcott and Osterman (2013) showed experienced nurses were using a process of reflection that enabled them to gain insights and formulate intentions for changing nursing practice. However, this was being carried out unsystematically and not always in a timely manner. To date there is little evidence to show reflective thinking by nurses in clinical environments has led to actual changes in practice (Asselin, 2011a; Dube & Ducharme, 2015). Nonetheless reflection is the best tool that nursing has for advancing its practice and therefore should be integral to nursing (Jarvis, 1992; Kim, 1999). There is opportunity for fostering increased understanding of the insight process and focusing its use for discovery and change in nursing practice.

Nursing practice is influenced by factors in the clinical environment. The findings of Mantzoukas and Jasper (2004) showed the use of reflective techniques by clinical nurses was prevented by the nursing hierarchy and medical establishment (Mantzoukas & Jasper, 2004). Most of the nurses in Mantzoukas and Jasper's (2004) study were practising in a routine manner as a result of their own perceived powerlessness. Routine practice was normalised, that is embedded in the ward culture referred to as 'normal' practice, with nurses resigned to the safety of the routines. From this an inhospitable clinical culture was created that did not encourage formal reflective activity. Health care leaders' need to address the influence of organisational and social structures and shift the clinical culture to a nurturing environment for advancing clinical practice through reflection, insight and discovery.

3. Perspectives on insight

Understanding the concept of insight and its role in discovery is essential if it is to flourish in nursing practice. According to Kuhn (1962) discovery in science is a breakthrough that is unpredictable and not derived from normal scientific work, depending instead on a critical, unexpected insight that leads to a "better" way of understanding empirical relations. The experience of insight is described by Poincaré (1996) as an idea coming with "conciseness, suddenness, and immediate certainty" (p. 54). Discovery, according to Klein (2013), is arrived at through perception of new patterns that come without warning, with the mind doing the heavy lifting exclusive of awareness. The linkages formed in these new patterns are made without being certain why they make sense (McWhinney, 2008).

In the last decade neuro scientific evidence has shed light on insight and its antecedents. Jung-Beeman et al. (2004) found insight involves the right anterior temporal lobe of the brain acting to enable the integration of

information distantly related. A culmination of a series of brain states and processes, operating at different time scales, results in insight (Kounios & Beeman, 2009). This neural processing is more than that involved when working analytically or methodically on problems (Kounios & Beeman, 2009). Such moments of insight are preceded by alpha band brain activity, a precursor, to quiet relaxing resting positions (Kounios & Beeman, 2009). Recently Kounios and Beeman (2015) described the experience of the process of insightful thinking as being unaware, depending on freer thinking with looser associations in a broader context, having less regard for what is relevant and needing to change the context of the memories of their experiences.

The cognitive process of insight is not easily determined (McWhinney, 2008). An early account by Wallas (1926) describes the flash of insightful illumination as the result of a train of unconscious associations leading to a feeling of certainty that involves a four-stage process: preparation, incubation, illumination, and verification. Two contemporary theories of insight are representational change theory (e.g., Knoblich, Ohlsson, & Raney, 2001) and progress monitoring theory (e.g., MacGregor, Ormerod, & Chronicle, 2001). Representational change theory has been shown to be the more successful of the two at capturing insight performance (Jones, 2003). It proposes insight occurs through relaxing self-imposed constraints on a problem and by decomposing chunked items in the problem (e.g., Knoblich, Ohlsson, Haider, & Rhenius, 1999; Knoblich et al., 2001). Recently Klein's (2013) findings challenge these views of insight being restricted to a single path. Klein (2013) identified multiple strategies for gaining insights that is connections, coincidences, curiosities, contradictions, and creative desperation. By presenting an incident in which each of these strategies is used the nature of insight can be appreciated.

3.1. Connection strategy

Semmelweis, an obstetrician at the Vienna General Hospital in 1847, noted a 13.10% death rate from puerperal fever among women assisted at delivery by doctors and medical students. However births attended by midwives had a death rate of 2.03% (Carter & Carter, 2005). Investigating further, Semmelweis found medical students and physicians assisting labouring women were coming directly from performing autopsies (Hanninen, Farago, & Monos, 1983). The connection between examinations of delivering women by doctors and puerperal fever provided the insight that puerperal fever was contagious and matter from autopsies was implicated in its development. This is an example of Klein's (2013) connection strategy, the linking of two new pieces of information. Semmelweis introduced a procedure of hand-washing for medical students and physicians before assisting at deliveries, and the death rate dropped to 2.2% showing the occurrence of puerperal fever could be prevented (Carter & Carter, 2005; Hanninen et al., 1983).

3.2. Coincidence strategy

Kennell and Klaus (1984) and Klaus and Kennell (1982) were alerted by premature infants returning to hospital battered

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