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Mutual Intacting: Keeping the patient-practitioner relationship and patient treatment intact

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Abstract

The aim of this grounded theory study was to discover the main concerns of clinical practitioners when making clinical judgments in the community care context and to explain the processes they used to resolve practice problems. Interview data from twenty-one advanced practitioners working in various mental healthcare and accident and emergency settings in Ireland was collected. In this paper, the process of clinical judgment is conceptualised as 'Mutual Intacting'. It proposes that clinical judgment comprises three stages: *situated patterning*, *intacting therapeutic relationship*, and *intacting therapy*. 'Mutual Intacting' explains how clinical practitioners make clinical judgments through a process of adapting treatment so that the patient-practitioner relationship is maintained and treatment is delivered in a way that takes account of the patient's circumstances.

Background

The importance of understanding how clinical judgments are made is highlighted by the professional and policy literature about advanced practice in nursing (National Council, 2004; Royal College of Nursing, undated). The ability to make clinical judgments is an essential skill required for all areas of professional practice; however, it is the level of clinical judgment which involves initiating and delivering therapeutic interventions that differentiates advanced practitioners from other grades in nursing. From an international perspective, developments in nurse prescribing have resulted in a growing number of nurses who are responsible for prescribing medication and for making clinical judgments affecting direct patient care (International Council of Nurses, 2001). These developments place clinical judgment firmly on the research agenda with questions concerning the relevance of the knowledge base that currently informs clinical practice.

Current explanations of clinical judgment in nursing tend to be extrapolated from the knowledge gained from the hypothetico-deductive approach (Elstein, 1978) and the related information processing theory (Simon, 1978; Newell & Simon, 1972), and Benner's (1984) work on intuition. According to the hypothetico-deductive approach, practitioners work through a process of cue acquisition in order to generate potential hypotheses then further cue and data collection to confirm or negate each hypothesis so that eventually a single outcome or diagnosis is reached. The main contribution of this approach is that it provides a systematic analytical process for clinical practitioners when making a diagnosis. Assumptions within the hypothetico-deductive approach are based on normative cues; that is, the association of clusters of cues with a particular diagnosis is based on knowledge derived from generalisations. This excludes a small, but nevertheless, important part of the patient population. Patients who present with atypical symptoms when compared to the general population or patients who present with an individual set of symptoms unique to them are effectively outside of the 'norms' and this limits the usefulness of the hypothetico-deductive approach in clinical practice. Another limitation, noted by Buckingham and Adams (2000a), is that the majority of research studies focus on biomedical signs and symptoms and on how clinical practitioners process these cues. In contrast, there is a paucity of research considering the role of psychosocial factors as cues in clinical judgment. This is an important gap, particularly in view of the evidence on patient behaviour in chronic illness which demonstrates that significant cues may be unrelated to the illness or, alternatively, patients may have learnt to minimise or view persistent symptoms as being 'normal' (Paterson *et al.*, 2001).

An alternative explanation of clinical judgment, intuition, is said to involve the rapid and unconscious processing of data (Cader *et al.,* 2005; Buckingham & Adams, 2000b, Hammond, 2000). Contrary to the view that intuition does not involve analysis, intuition entails the use of heuristics or 'mental rules of thumb', which are short cuts to making clinical judgments (Hallett *et al.,* 2000; Cioffi, 1997). Whilst Tversky and Kahneman (1982) describe three different types of heuristics; namely, representativeness, availability and anchoring and

adjustment, a common cognitive activity throughout all heuristics involves pattern recognition. Pattern recognition is essential to intuition and clinical practitioners, through experience, learn how to recognise and act on appropriate patterns (Easen & Wilcockson, 1996). Opinions regarding the contribution of intuition to clinical judgment in nursing are divided. Some consider intuition important to nursing practice (McCutcheon & Pincombe, 2001; Cioffi, 1997); others point to a commonly cited criticism of intuition that links errors in human judgment with heuristics and bias (Thompson, 2002). This criticism, however, is now being challenged as further research in cognitive psychology regarding the use of heuristics demonstrates that simple rules, which yield quick decisions, can be highly accurate (Ayton, 2005).

Both approaches, hypothetico-deduction and intuition, provide some insight into the cognitive aspects of clinical judgment; however, they fail to consider other aspects including what is the clinical practitioners' main concern and what strategies are used to resolve practice problems. Given that advanced practitioners are often making clinical judgments in situations where patients are actively involved in their own care, this is an important gap in understanding the process of clinical judgment. Having broadly identified the research area from the literature, the problem, however, did not emerge until the researcher entered the clinical practice area and began the inductive process of grounded theory inquiry.

The Research Method

The aim of this study was to generate a substantive theory that explains how advanced practitioners make clinical judgments effecting direct patient care in community care settings. Grounded theory (Glaser, 1998; Glaser & Strauss, 1967) was selected as it provides for the systematic and inductive generation of theory from data and consequently, offers a viable means of developing theory that is relevant to everyday clinical practice. From an advanced practice perspective, the development of practice-based theory is important, so that practitioners can have access to useful and dependable knowledge. This has led practitioners and researchers to develop numerous middle-range theories that are considered highly relevant for specific aspects of clinical

practice (Brown, 2005).

Advanced practitioners working in community care settings in Ireland were invited to take part in the study. For the purpose of this study, an advanced practitioner was defined as an autonomous practitioner with nursing qualifications who was responsible for initiating and providing therapeutic interventions and for managing a patient caseload. Each participant was provided with information about the research and gave written consent prior to the interview. Theoretical sampling was used later in the research process to develop the key categories that were emerging from the initial data analysis. Theoretical sampling led to data collection in contrasting clinical judgment contexts: new and established patients; long-term mental health and acute accident and emergency (A&E). Comparative data were used throughout the process of data analysis. Importantly, it provided a means of exploring how clinical practitioners adapted their decision-making in these different clinical situations. At a point when theoretical saturation had been reached, a total of twenty-one clinical practitioners had been interviewed. The sample consisted of fifteen practitioners from mental healthcare and six from A&E. Fifteen were female and four were male. As part of negotiating access to clinical practitioners working in six healthcare organisations, institutional consent was obtained and, where required, from the appropriate research ethics committee.

Data collection took place directly in the clinical practitioner's clinical area immediately following patient treatment. Interviews were based on the clinical judgments made for actual patient care. An important grounded theory maxim is that researchers enter the research field with open questions to allow the participant's own story to unfold without the direction of pre-conceived questions. Therefore, the guiding questions used throughout the interviews focused on eliciting what were the clinical practitioners' main concerns and how they addressed or resolved such concerns when making clinical decisions. These open questions proved useful in facilitating clinical practitioners to tell their story. The use of such open interview questions also enabled multi-layered storytelling whereby during the same interview clinical practitioners could

revisit key issues/concerns and tell another 'mini-story' which provided yet further detailed information about their main concerns.

Once the first interview was completed the process of data analysis began. The systematic analysis started with open coding, whereby the interview transcript was analysed line-by-line. Glaser's (1998) key questions, namely, 'what category does this incident indicate?' and 'what property of what category does this incident indicate?' were asked constantly during the process of data analysis. The emergence of categories from the open coding and constant comparative analysis was the trigger for starting selective coding. Interview transcripts were analysed again; this time using the newly developed codes to test if they patterned out. The purpose of selective coding was to delimit coding to those categories relevant to the emerging conceptual framework (Glaser & Holton, 2004). Importantly, selective coding also provided verification that the emergent theory fitted the practice of clinical practitioners in the substantive area. Of the early substantive codes that emerged during the initial data analysis some (for example, 'Levelling') endured and became visible throughout subsequent data collection and analysis. Other early codes (for example, 'See-Saw Debating') were not substantiated during further data collection and analysis and were ultimately superseded by other codes. Memoing was used throughout data analysis to put down on paper any thoughts and ideas that came up. These memos became the powerhouse of the research process in the sense that they mapped out what was happening and provided the impetus and direction for subsequent data collection. Theoretical sampling was used to collect further data from specific areas; in this case, contrasting new with established patients and chronic with acute patient care situations.

In this study, the emergent categories were derived directly from the rich descriptions provided by the clinical practitioners and through the systematic analysis of data. One of the main categories, 'intacting therapeutic relationship', was developed as it became clear from the clinical practitioners' accounts that keeping the patient-practitioner relationship intact was an important part of the clinical judgment process. Comparative analysis of different incidents revealed that

avoiding break-upable moments was a strategy that clinical practitioner used to increase the likelihood of maintaining a therapeutic relationship. Comparative analysis of new versus established patients demonstrated that there was a relationship between avoiding break-upable moments and the stage of the patient-clinical practitioner relationship. With new patients, the clinical practitioner is more likely to avoid anything that jeopardises the relationship whereas she is more likely to take the risk of using interventions that challenge patients once she is sure that a clinical patient-practitioner relationship has been established.

The Emergent Theory

From data analysis of 33 in-depth interviews that explored practitioners' experiences and concerns in various clinical judgments, 'Mutual Intacting' emerged as a basic social process. It explains how clinical practitioners make clinical judgments through a process of adapting treatment so that the patient-practitioner relationship is maintained and treatment is delivered in a way that takes account of the patients' circumstances. The theory of 'Mutual Intacting' (see Figure 1) consists of three stages: 'situated patterning', 'intacting therapeutic relationship', and 'intacting therapy'. 'Situated patterning' describes how clinical practitioners use such strategies as selectively looking for evidence in order to identify patterns, gauging levels of priorities, situating clinical judgment in the context of the patient's circumstances and the clinical practitioner's professional and core value systems as part of patient assessment. 'Intacting therapeutic relationship' describes how clinical practitioners build up and then maintain their relationship with patients by getting alongside patients, building up the patient-practitioner relationship whilst maintaining professional boundaries, avoiding situations that interfere with the relationship and moderating patient treatment so that a therapeutic relationship is built-up and then maintained throughout the course of patient treatment. Finally, 'intacting therapy' describes how clinical practitioners use strategies such as providing information, guiding patients towards reaching therapeutic goals, working around problems that could interfere with treatment and avoiding situations that could block progress so that patient treatment is

maintained and ultimately completed.

Why 'Mutual Intacting'? How did this emerge as the core concept? As data collection and analysis progressed, it became clear that the clinical practitioners' main concerns were twofold: firstly, to maintain the patient treatment and, secondly, to maintain the therapeutic relationship. For example, the strategies that clinical practitioners used in order to get alongside patients to avoid break-upable moments during nurse-patient encounters and to de-limit boundaries indicated that they actively worked at developing and then maintaining the patient-practitioner relationship; that is, keeping it intact. 'Intacting' best summarised the complex strategies used in keeping the therapeutic relationship together, uninterrupted and undamaged. Itcaptured the essence of what had emerged from the data. Furthermore, the dynamic relationship between 'intacting therapeutic relationship' and 'intacting therapy' was evident from the ways in which clinical practitioners described moderating patient treatment in order to keep the therapeutic relationship intact and conversely, from the ways they described needing to establish the therapeutic relationship before starting patient treatment. The relationship between the two concepts, 'intacting therapeutic relationship' and 'intacting therapy', was based on their inter-dependence insofar as clinical practitioners actively and simultaneously worked at keeping both intact. 'Mutual Intacting' encapsulates this key process and conveys the sense of joint dependence, inter-connectedness, interaction and reciprocity which emerged from the data.

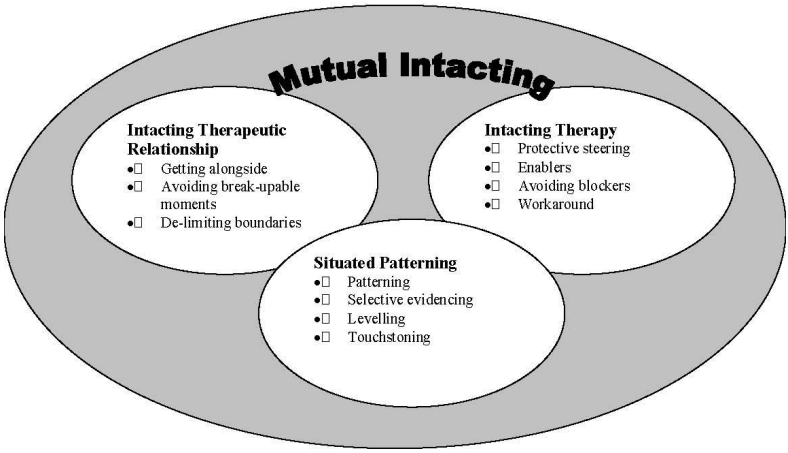

Figure 1: The Theory of Mutual Intacting

Situated Patterning

As part of the process of patient assessment, clinical practitioners are highly aware of the importance of reaching a diagnosis and of having a comprehensive understanding of the patient's problem. 'Situated patterning' is essential not only in deciding which clinical intervention to use at the start, but also in evaluating the effectiveness and on-going use of treatment. Practitioners are aware of the importance of making sense of the patients' problems before deciding which treatment is needed, and they work at achieving this by taking pieces of information during patient assessment and constructing them into patterns that they can recognise. Clinical experience is essential insofar as repeated exposure to similar types of problems or patient presentations enables practitioners to build up their own reference library of patterns; this forms the basis of their assessment of the patient's problem and diagnosis. Furthermore, practitioners also build up a reference library of treatments of which they have first-hand experience and have found to be effective in the past. Practitioners link the choice of treatment to ones that previously have worked and are considered to be 'tried and tested'. 'Situated patterning' not only involves matching patients with past experience of similar patients but also in putting the clinical judgment in context so that treatments can be moderated to suit the patient's specific needs. In order to complete 'situated patterning', practitioners

use a range of different strategies including 'selective evidencing', 'levelling' and 'touchstoning'.

Selective Evidencing

As part of the process of looking for patterns, practitioners search for evidence and use strategies such as looking for tell-tales, selective questioning and back-upping to collect the key information that is needed for making a clinical judgment. Selective evidencing is an important part of clinical judgment; however, practitioners use it differently depending on whether they are dealing with new or established patients. For new patients, practitioners use selective evidencing to develop recognisable patterns that support a diagnosis whereas for established patients, they focus more on establishing whether the treatment is effective.

During patient sessions, one of the key strategies is looking for tell-tales, whereby practitioners filter the dialogue and observe the patient's behaviour looking for indicators as to the nature of the problem or for positive/negative indicators as to how they are responding to treatment. In many situations, these tell-tales are subtle and practitioners are constantly alert to detecting indicators that are relevant to the patient's problem. As one practitioner explains:

> It may be the way they said it. It may be the amount of emphasis they put on. It may be the fact that he actually diverted from it in the first place. But there is usually something that alerts me… it's like you are able to separate the chaff from the wheat and you are able to go down the particular route that you are looking for.

Importantly, if there are any gaps in the information needed by the practitioners they use selective questioning to fill in these gaps. Selective questioning is used to: rule-out various factors; ascertain more fully the circumstances surrounding the problem; address specific concerns about the patient's situation, particularly about safety issues; and, assess how patients are responding to treatment. If sensitive issues such as domestic violence /abuse or sexual issues are involved or if the patient-practitioner relationship is not established, practitioners avoid direct questioning, which may have the effect of closing down the lines of communication and, consequently, be counter-

productive to obtaining necessary information. Instead, practitioners tend to wait until the patient-practitioner relationship is more established and then carefully collect the information needed to complete 'situated patterning'. Therefore, there is a link between selective evidencing, patterning, and maintaining the patient-practitioner relationship; namely, the practitioners work at completing the pattern whilst also keeping the patient relationship intact.

Practitioners also use back-upping particularly in situations where there is a high degree of uncertainty or risk associated with the clinical judgment. Common sources of back-upping include healthcare colleagues or tests such as X-rays, blood tests or psychological tests. In situations where the patient is not considered a reliable source of information, the patient's family or friends are a useful means of validating the patient's history. There are limitations to using family and friends as back-ups; namely, that the patient's confidentiality is maintained and some patients may not agree to having them present during history taking and assessment.

Levelling

'Situated patterning' also involves levelling whereby practitioners calculate what treatment priorities, risk of consequences and level of organisational support. Importantly, as part of the initial assessment, practitioners gauge the patient's comprehension level because it is perceived to be linked to the patient's ability to understand and follow healthcare advice. It is for this reason that practitioners note the patient's ability to understand language, the patient's age, gender, occupation and level of education so that they can moderate the vocabulary or indeed the information given to patients.

Touchstoning

Finally, 'situated patterning' involves touchstoning whereby practitioners refer to the guiding principles underpinning their actions. For example, practitioners sometimes refer to theoretical principles they have learned about in their professional training courses that are considered relevant to the particular patient problem. In situations where the healthcare institution has clinical guidelines developed

specifically for the practitioner's scope of practice, they ensure that clinical judgments meet these guidelines. As this practitioner explains:

> …our approach to patients would be quite similar you know, again I think it is because it is a safe and well outcome for the patient but, the guidelines have to be there for safe practice, but you can adapt them…not going outside of our scope of practice either.

Although clinical guidelines are used as part of everyday clinical judgment, they are not used as a rigid framework perceived as restricting clinical judgment but rather as a set of flexible guidelines that can be adapted to the specific situation. In touchstoning, practitioners also refer to ethical principles drawn from their professional code of practice especially in relation to protecting the patient, doing no harm and maintaining confidentiality. This includes recognising the importance of the patient's right to choice in deciding whether or not to accept treatment. The degree to which touchstoning occurs varies across the different clinical situations. In most situations, the level of touchstoning is low insofar as practitioners just briefly refer to the guiding principles and are aware that they set the parameters for their scope of clinical practice. In contrast, the level of touchstoning becomes high in situations where a difficult conflict needs to be resolved.

Intacting – Therapeutic Relationship

For clinical practitioners, 'intacting- therapeutic relationship' is considered critical to effective treatment insofar as the quality of clinical diagnosis or assessment is conditional on the patient's willingness to provide the necessary information for 'situated patterning'. The therapeutic relationship needs to be established before treatment can begin and furthermore, the patient's willingness to follow the practitioner's treatment advice or to continue with treatment is conditional on the therapeutic relationship. Clinical practitioners, therefore, are highly aware of the importance of firstly establishing and then maintaining therapeutic relationships with their patients.

Getting alongside

'Intacting-therapeutic relationship' involves getting alongside whereby practitioners work at engaging their patients. In situations where practitioners work in busy clinics with a lot of different people around, they actively work at creating an atmosphere where patients can feel that they are getting individual attention. In order to build up a one-to-one relationship, practitioners organise to see their patients in a quiet area or private room away from interruptions. Practitioners also use other strategies such as positioning the patient alongside them as opposed to sitting behind a table, avoiding using an interrogation or interview approach and mimicking a friendly, homely situation in which the patient can feel at ease.

Avoiding break-upable moments

Keeping the therapeutic relationship intact involves avoiding break-upable moments, which includes avoiding anything that can interfere with the patient's level of trust in the practitioner or which distresses/angers patients so that they want to end treatment before it is completed. Practitioners continuously monitor patients for indicators that the relationship is deteriorating.

De-limiting boundaries

Although the practitioners' main concern is to maintain a therapeutic relationship, it can also involve the use of de-limiting boundaries. Particularly with first appointments, practitioners avoid situations that cause embarrassment and instead work at helping patients feel at ease. Although strategies are used to get alongside and to befriend the patient, boundaries are also laid down to limit the level of friendship. Practitioners are aware of the importance of being friendly and supportive to patients; however, they are equally aware of the need to maintain a balance between being friendly and maintaining a professional boundary.

Intacting Therapy

An important feature of clinical judgment is the strategies that practitioners use to maintain treatment and keep it progressing towards the stated goal. 'Intacting therapy'

explains that practitioners are also concerned about maintaining treatment and achieving the treatment objectives. Whilst treatment is considered important, practitioners do not carry it out if it risks jeopardising the patient-practitioner relationship. It is for this reason that practitioners moderate treatment. Under conditions where treatments are carried out over a prolonged period of time, it is moderated for the purpose of bringing patients back for further treatment sessions. If patients do not attend their appointments, they cannot be treated and consequently this can delay recovery. Under conditions in which treatments are completed in once-off sessions, practitioners moderate treatment for the purpose of using treatments that are acceptable to patients. This increases the likelihood that patients will follow the healthcare advice and make the best possible recovery. The extent to which practitioners can moderate treatment, however, is limited and they work within the boundaries of accepted practice. 'Intacting therapy' involves a variety of different strategies; namely, protective steering, enablers, avoiding blockers and workarounds that help maintain treatment and keep it progressing towards a completion.

Protective steering

Protective steering is one strategy used by practitioners in guiding patients towards reaching their therapeutic goals and shielding them from setbacks during the process of making a recovery. It involves leading patients rather than telling them to do something. Practitioners provide information in the form of verbal advice or written leaflets that support patients in making the 'right' decisions. In some situations, specific advice sheets have been developed and are used in combination with verbal advice for the reason that it increases the likelihood that patients would understand and follow the advice.

In situations in which a patient's ability to understand information is considered limited, practitioners avoid giving complex information and use alternative strategies whereby patients can have their information needs met. Therefore, decisions regarding what information to give the patient are based on the practitioner's judgment of whether it is helpful to patients. For some practitioners, protective steering not only concerns *what* information is given but *how* it is communicated.

Different styles of communication are used for the purpose of emphasising important elements. Whilst practitioners actively guide patients in taking a particular line of action, on the other hand, they are aware of the importance of not forcing advice on patients. Protective steering also involves supporting patients as they navigate their way through a complex or unfamiliar healthcare system. The main reason for this aspect of protective steering is to facilitate the smooth movement of the patient through the healthcare system so that patients get what they need to facilitate recovery yet do not become overly dependent on the services.

Workarounds

'Intacting therapy' is also characterised by workarounds whereby practitioners work at resolving actual problems that interfere with treatment. Problems can be classified into three main types; namely, problems relating to patient characteristics, ineffective treatment, and organisational arrangements. For problems relating to patient characteristics such as the patient's intellectual level or ability to cope with illness/ treatment, practitioners moderate and adapt treatments to suit the patient's individual circumstances. For problems relating to a mismatch between the individual patient needs and the facilities available within the organisation, practitioners work within the system so that patients can continue with treatment. An important pre-requisite to workarounds, therefore, is the practitioners' knowledge of the healthcare system insofar as knowing what treatments are available and how to access them. As this practitioner explains:

> knowing what is available…you are in the system for a while, so you know. I have been there for about 12 years, so I know the wards well. I know all that, so to actually leave this job is kind of very difficult starting another job cause you are in the system…knowing the ground level running some of these programmes helps.

This kind of knowledge results from years of working in the service during which time practitioners have direct experience of what treatments are effective and for which type of patient problems. In contrast, practitioners are more cautious about

using services they have not used before. Consequently, the degree to which practitioners use workaround is dependent not only on their knowledge of what services are available but also on whether they have first-hand knowledge of their effectiveness.

Enablers and avoiding blockers

In addition to protective steering, practitioners use a combination of enablers and avoiding blockers to maintain patient treatment. As one practitioner explains:

> …you work on it in different ways, you find what we call an in-road, and it does feel sometimes that you are going up these roads and you are getting somewhere and it's a cul-de-sac. There is a block. You have to come back down and try again, some other route in and usually you find it.

Many of the techniques, for example keeping a diary, are specific to a particular type of treatment. Nevertheless, they serve the function of keeping patients actively involved with their treatment until the next appointment. Practitioners use avoiding blockers for the reason that it prevents disruptions to therapy. Avoiding blockers could be considered as a parallel to the practitioner's use of avoiding break-upable moments in maintaining the therapeutic relationship. Avoiding blockers involves avoiding any treatments that are considered counter-productive to patient progress.

Discussion

When compared to existing clinical judgment theory, there are several notable differences in how clinical judgment is explained in 'Mutual Intacting'. One difference is found between the approach used by clinical practitioners, conceptualised here as 'situated patterning', and that described by heuristics. In heuristics, the clinical practitioner's reasoning is said to involve a process of associating current patient presentation with prior experiences of similar situations (Cioffi, 2000; 1997). Likewise, clinical practitioners in this study actively looked for patterns which not only matched the patient with previous experience of similar patients but also identified a 'fit' within the patient's own usual behaviour or usual state of

health. An important difference in 'situated patterning', however, is that the process also includes the application of rule-based systems either in the form of verification by external sources, application of theoretical principles of treatment or ethical principles concerning patient rights to choice and self-determination. Previous clinical judgment research in nursing has tended to juxtapose the two forms of reasoning as either information processing (Corcoran-Perry *et al.*, 1999; Lajoie *et al.,* 1998; Fowler, 1997; Narayan & Corcoran-Perry, 1997; Greenwood & King, 1995; Grobe *et al.,* 1991; Corcoran, 1986) or intuition (Cioffi, 2000; 1997; Benner 1984,). By contrast, 'situated patterning' suggests that in everyday clinical practice, practitioners use a mixture of different forms of reasoning.

Another difference is found between 'situated patterning' and that described by the hypothetico-deductive approach. In the hypothetico-deductive approach, assessment is dominated by the identification of signs and symptoms as cues, and matching these against pre-set, normatively defined cues; together, these processes comprise a diagnosis. By contrast, in 'situated patterning' the emphasis is on assessing a wider range of cues that takes into account the patient's subjective experience of illness, including the ability to cope with illness or treatment. Thus, patient assessment and diagnosis involves understanding the patient's problem, is not limited to finding a diagnostic label but instead positions the problem within the patient context. Previous research supports the finding that nurses take into account the context in which a patient's problem exists (Rydon, 2005; Clark, 2004; Haworth & Dluhy, 2001; Offredy, 1998). Similarly, the way that clinical practitioners in this study 'knew' the patient in terms of family circumstances, social/ work life, previous experiences of treatment, issues causing concern/ anxiety, lifestyle habits and preferences, suggests that clinical practitioners are able to interpret the problem differently for each patient. Although the type of presenting problems differ across mental health and A&E areas, clinical practitioners take into account the particular set of conditions surrounding the problem, so that each problem is situated within the patient context.

A key feature of 'Mutual Intacting' is that it identifies the main concerns of clinical practitioners when making clinical

judgments and the strategies used to resolve these concerns. Data suggests that the clinical practitioners' concerns are twofold; firstly, in maintaining treatment by ensuring the delivery of care to the patient, thereby facilitating patient recovery and, secondly, in maintaining a therapeutic relationship with patients. The main strategy used by clinical practitioners to resolve these concerns involves moderating the treatment to take account of the patient's needs. Clinical practitioners continuously adjust treatment and make subtle adaptations so that treatment is presented in a form that is acceptable to patients. Importantly, 'Mutual Intacting' highlights the dynamic relationship between maintaining treatment and maintaining a patient-practitioner relationship.

Other research on clinical judgment reports that nurse practitioners often negotiate treatment plans with patients. This may be a compromise initially, leading to compliance at a later stage (Offredy, 1998). Similarly, the strategies of protective steering, workaround, enablers and avoiding blockers identified in this study suggest that clinical practitioners actively reason throughout assessment and treatment to work out the 'best' way forward for the individual patient. In the context of midwifery, Levy (1999) conceptualised the processes by which midwives facilitate informed choices for pregnant women as *Protective Steering*. Levy's study, which portrayed midwives as 'walking a tightrope' between meeting the wishes of pregnant women and acknowledging their own concerns about ensuring a safe delivery, is now considered dated and a product of a medically dominated maternity service (Maimbolwa, 2006; Mander, 2006). In this study, protective steering refers to a process of information giving in the context of navigating a way through the healthcare services and of enabling the patient to recover from chronic mental health problems or acute minor injuries. It is, however, one strategy that fits within a more complex explanation of clinical judgment.

Another key feature of Mutual Intacting is the way in which it conceptualises clinical judgment as a social encounter. In contrast to the traditional approaches of hypothetico-deduction or intuition that view clinical judgment as cognitive reasoning by the individual, Mutual Intacting highlights the

patient-practitioner interaction as an integral part of clinical judgment. In the mental health literature, it is well established that a therapeutic relationship between clinical practitioner and patient is of central importance to mental healthcare (Clark, 2004; McGuire *et al.,* 2001). In this study, clinical practitioners in mental health contexts used a number of strategies to develop and maintain a therapeutic relationship for the reason that bringing patients back was essential to continuing treatment. An unexpected finding, given that clinical practitioners in A&E see patients on a once-off basis, was the extent to which 'intacting-therapeutic relationship' was also used in the acute care setting. The reasons for developing a therapeutic relationship by A&E clinical practitioners differed from those in mental health contexts. In A&E, establishing a relationship with patients was fundamental to patient consent for procedures such as physical examination, suturing of wounds, immobilising fractures and application of Plaster of Paris. Furthermore, establishing a therapeutic relationship was important, firstly, for the purposes of diagnosis in that it influenced the patient's willingness to disclose relevant information and, secondly, in terms of compliance in that it influenced the patient's level of trust and willingness to accept the healthcare advice.

Empirical support from other studies identifies the links between the patient-practitioner relationship and treatment. For example, partnership and involvement in clinical judgment are identified as key determinants of patient satisfaction and acceptance of healthcare advice (Winefield *et al.,* 1995). Taylor (2006) also identifies knowing the patient and gaining their trust as key factors for the reason that it enables nurses to 'get' patients to work with them. For Morse (1991), it is critical that both the nurse and the patient are involved in negotiating healthcare. If either is unwilling to be committed to resolving the healthcare problem, then a unilateral relationship will develop where one side tries to manipulate the other, including patient withdrawal from the health service. The patient-practitioner relationship, therefore, is inextricably linked to the effectiveness of patient treatment.

Limitations

Although clinical practitioners from all areas of healthcare

practice who met the inclusion criteria could have participated, only those working in mental healthcare and A&E were involved in this study. It is recognised that other concepts may have emerged if the study had been extended to include other areas of clinical practice. Further research to determine if the emergent theory holds in other areas of clinical practice and in other areas of professional practice is necessary.

Conclusion

The theory of 'Mutual Intacting' provides an expanded understanding of clinical judgment that challenges traditional approaches of reasoning; namely, hypothetico-deduction and intuition, to consider issues relating to the patient context and the integration of association and rule-based forms of reasoning. Importantly, 'Mutual Intacting' conceptualises clinical judgment as a social encounter in which the establishment and maintenance of a patient-practitioner relationship is central. It sensitises advanced practitioners to consider clinical judgment as a social interaction and how these issues influence the process of clinical judgment in community care contexts. 'Mutual Intacting' is an emergent concept and is one perspective that is premised on the clinical practitioners' understanding of clinical judgment. As a conceptual explanation of clinical judgment, however, 'Mutual Intacting' is limited to the context from which it is derived. Further theoretical development is needed so that the concept is modified through a process of further theoretical sampling drawing from other areas of clinical practice within nursing and indeed, from other healthcare professions.

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