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MODES OF RATIONALITY IN NURSING DOCUMENTATION – BIOLOGY, BIOGRAPHY, AND THE 'VOICE OF NURSING'.

ABSTRACT

This article is based on a discourse analysis of the complete nursing records of 45 patients and concerns the modes of rationality that mediated text-based accounts relating to patient care that nurses recorded. The analysis draws on the work of the critical theorist, Jürgen Habermas, who conceptualised rationality in the context of modernity according to two types: purposive rationality based on an instrumental logic and value rationality based on ethical considerations and moral reasoning. Our analysis revealed that purposive rationality dominated the content of nursing documentation, as evidenced by a particularly biocentric and modernist construction of the workings of the body within the texts. There was little reference in the documentation to central themes of contemporary nursing discourses, such as notions of partnership, autonomy, and self-determination which are associated with value rationality. Drawing on Habermas, we argue that this nursing documentation

depicted the colonisation of the socio-cultural lifeworld by the bio-technocratic system. Where nurses recorded disagreements that patients had with medical regimes, the central struggle inherent in the project of modernity became transparent – the tension between the rational and instrumental control of people through scientific regulation and the autonomy of the subject. The article concludes by problematising communicative action within the context of nursing practice.

Key words: Nursing documentation; Critical theory; Discourse analysis; Ireland.

Introduction

Conflicting perspectives on the workings of the human body have been a central though not exclusive theme in distinguishing nursing from medicine. A crude categorisation is that medicine confers fundamental importance to the body structure (anatomy) and systems (physiology) and assumes that all causes of disease, including mental disorders, can be understood in biological terms, hence the term '*biomedicine*.' Nursing, by contrast, has been linked to a construction of the body not merely as a collection of biological systems, but also as an entity that is influenced by a person's biographical narrative, and there is an appreciation of the embeddedness of the illness experience in psychosocial contexts (Edwards 2001). This distinction between the philosophies of nursing and medicine is far from flawless, since biomedical practices have been subjected to criticism on the one hand for being reductionist (explaining bodily functions solely with reference to biology), and on the other for their social control function in extending their role into psychological and social realms (Zola 1972, Skrabanek 1994, Armstrong 1995). Nonetheless, however imprecise this delineation, it has been useful in exploring the kinds of reason that are believed to mediate the occupational practices of each of the disciplines. Drawing on the work of the critical theorist Jürgen Habermas (1984, 1987, 1987, 2001), biomedicine has been linked to an 'instrumental rationality' (detached and success-orientated) (Mishler 1984, Barry et al 2001,

Scambler 2002), while nursing has been identified with a 'communicative rationality' (reflexive and value-oriented) (Porter 1998). For Habermas, the struggle between instrumental rationality and communicative rationality represents the most fundamental crisis in modernity (Delanty 1999).

This paper presents an analysis of nursing records aimed at identifying what nurses document about their practice, with a view to understanding what nursing practice actually entails. A prominent theme to emerge in the analysis was the manner in which the issues that nurses record relate to the central tensions of modernity, and this theorisation is the focus of the paper. Although analytical links to modernity were derived inductively, the paper begins by presenting a background to the emergence of biomedicine in the context of modernity. We present a brief overview of Habermas' theory of communicative action, which offers insights into how the repressive effects of modernity may be moderated through a particular type of rationality. This is linked to the aspirations of nursing theorists to move away from a biocentric approach to the workings of the body towards a more person-centred, biographical approach. The methodology used for the study is then outlined, and followed by the data, which are presented around two broad themes: 'instrumental technocratic rationality and the 'voice of medicine'', and 'the eclipsing of the autonomous subject'. The analysis links modes of rationality that underpin text-based material relating to patient care that the nurses recorded with Habermas' work and the central predicament of modernity.

The emergence of biomedicine and the project of modernity

A dominant belief prevalent until the 17th century was that the elements moved 'naturally' and the natural world was regulated only by the laws of nature rather than the laws of humans. Thereafter, a major revision in this worldview was to occur, as the objective became the control of the natural world by understanding its patterns and regularities, with concomitant revisions in notions about the workings of the human body. Changing beliefs about body functioning that have occurred over the past 200 years are

related to rapid economic and political changes in society and what is referred to as the project of modernity. Modernity concerns rapid capitalist expansion and a series of historical transformations arising from the Renaissance, Reformation, the American and French revolutions and the Scottish Enlightenment. Modernity was related to the notion of progress and the emancipatory potential of human reason (Lyon 1999) through liberating humanity from what were deemed to be the brutal forces of nature and traditional religious codes of conduct based on 'natural law'. Cognitive rationality in the form of scientific knowledge was believed to be the means to achieve this (Delanty 1999).

The mechanistic view of the world was advanced by the 17th century philosopher Rene Descartes who asserted that there was no essential relationship between the physical world and the sensory experience of it. This way of thinking was applied to the human body, resulting in the body being likened to a 'machine' and bodily functions deemed to be separate from the workings of the mind (the Cartesian mind-body dualism). Thus the physical body came to be viewed as a 'piece of technical equipment to be maintained, serviced and finely tuned for maximum performance' (Marsh et al, 2000:439). Any 'breakdowns' in the body would be 'cured' with 'a pill for every ill'.

Almost from its inception, the aspirations of modernity became questionable as social reality as experienced by social actors did not match modernity's liberating ambitions. A capitalist mode of production that required the rational and instrumental control of people subverted the autonomy of the subject. Modernity was underpinned by the notion that social order would be regulated by a political realm based on secular democratic principles. However, the predicament of modernity is how to accommodate different sites of autonomy without them imploding on one another (see Delanty 1999). On the one hand, the human subject became free from the manacles of medieval religious worldviews, and on the other, scientific 'truths' were developed to explain and regulate the workings of the body and the wider world. As scientific 'truth' claims began to replace religion as a regulating force in society, human autonomy was undermined, with 'science' replacing nature and religion as the controlling force.

Weber referred to the technocratic instrumental rationality of modernity as an 'iron cage' with an associated loss of spiritual and cultural values (Weber 2002 [1930]). Weber's notion of bureaucracy as a modernist way of organising human activities through rationalisation, and specialised, depersonalised knowledge, has been applied to the workings of the modern hospital (Davies 1995).

Restraining instrumental rationality

In contrast to many postmodern thinkers who cast aside modernity as an obsolete project, Habermas (1984, 1987, 2001) viewed it to be an unfinished, albeit problematic, venture that held promise and potential. A central feature of his optimism is that a particular type of human reason, that based on the presentation of valid arguments through verbal communication, can mitigate against Weber's notion of 'the iron cage'. Indeed, Habermas' work is an advancement of a second kind of rationality identified by Weber, value-rational action, based on ethical values and moral reasoning rather than being success oriented (Weber 1947). A brief review of Habermas' work is necessary in order to clarify his theoretical position as it relates to the present analysis. (For a comprehensive analysis of critical theory as it relates to health and medicine, see Scambler 2002.)

Habermas (1984, 1987, 2001) conceptualises contemporary society in relation to two spheres, the *system* and the *lifeworld*. The system represents the component of society concerned with technical-scientific rationality, and is mediated by power and economic matters. The mode of rationality demanded in the operation of the system is strategic rationality (Habermas 1984). The motives of the social actor are self-serving insofar as the objective is to maximise the individual pursuit of utility or economic profit. Dialogue, communicative reflection, evaluation of relationships and mutual understanding are not aspirations within the system (Andersen 2000). Habermas theoretically developed the contrasting realm, the *lifeworld*, from the works of Edmund Husserl, and Alfred Schutz (Andersen 2000). For Habermas, the *lifeworld* comprises the symbolic space where meaning, solidarity and personal identity are linguistically

communicated. It is characterised by reflexive discourse, human rights and relationships, and aims at consensus through reasoned dialogue (Habermas 1984).

Habermas (1984) differentiates two action orientations, namely, non-social and social. Non-social action situations are orientated to success, and are regulated by instrumental purposive-rational action. Social action situations are of two types, according to their orientation; those orientated to success are mediated by strategic action, while those orientated to reaching understanding are mediated by communicative action. Habermas (1984:285-6) distinguishes these action orientations as follows:

We call an action orientated to success *instrumental* when we consider it under the aspect of following technical rules of action and assess the efficiency of an intervention into a complex of circumstances and events. We call an action orientated to success *strategic* when we consider it under the aspect of following rules of rational choice and assess the efficacy of influencing the decisions of a rational opponent. Instrumental actions can be connected with and subordinated to social actions of a different type – for example, as the ‘task elements’ of social roles; strategic actions are social actions by themselves. By contrast, I shall speak of *communicative* action whenever the actions of the agents involved are coordinated not through egocentric calculations of success but through acts of reaching understanding.

Habermas identified the central concern in modernity as the ‘colonization of the lifeworld’, a situation whereupon where the system, with its dysfunctional tendencies, is disposed to continually extend its purposive rationality to the detriment of the communicative rationality of the lifeworld (Andersen 2000).

Drawing on Habermas’ theorisation, Mishler (1984) identified purposive technocratic rationality which he coins ‘the voice of medicine’ as the mode of rationality that dominates medical encounters with patients. More recent research on the balance between system and lifeworld in medical encounters suggests that the lifeworld may not be as repressed in medical interactions as Mishler had found (Barry et al 2001). Nonetheless, a sizeable proportion of interactions in Barry et al’s study indicated that the lifeworld component was either absent, or dealt with it in an unsatisfactory manner.

Relating nursing to the lifeworld and system

Although nursing theorists are divided on the relationship between the mind and the body, with some nursing theorists retaining the Cartesian mind-body dualism (Watson 1988), there appears to be a widespread consensus that the mind and body are fundamentally related. This has been theorised around the notion of holism (Edwards 2001), a highly problematic and as yet theoretically underdeveloped notion in nursing (Mulholland 1997). Holism is an attempt to conceptualise people in relation to their physical, psychological, social and spiritual dimensions, and is often perceived in opposition to the biological determinism of biomedicine. In nursing worldviews, the meaning and significance of illness in a person's life are considered to be important - illness is linked to a person's self-project (Edwards 2001). These notions are bound up with theoretical debates about the meaning of caring in relation to nursing (von Dietze and Orb 2000). Illness is viewed in terms of narrative - the context of the chronology of a person's past present and future (Edwards 2001). As Edwards notes, '...it is the *significance* of the biological data for a particular patient which is crucial to the proper care of that person [our italics].' This suggests that it is important for the nurse to consider the context of the illness, and the meaning and interpretation that the person places on her symptoms. Among the characteristics of the contemporary nurse, Davies (1995:150) proposes that he or she is a '*creator of an active community* [original italics] in which a solution can be negotiated.' Embedded in contemporary nursing discourses is evidence of the more general democratic impulse (Bury 2001) towards patient empowerment, patient participation and collaborative care (Allen 2002). It must be acknowledged, however, that theoretical developments in nursing have been problematised by some commentators who view nursing's increasing interest in the psycho-social realm through a critical and sceptical lens (see Armstrong, 1983; May, 1992; Porter, 1997; and for a wider discussion on the elitism inherent in therapeutic relationships, see Furedi, 2003). Such theoretical developments have been linked with the self-serving motives of nursing elites whose mission is to professionalise nursing, or as a means of extending nurses' power over patients and of privileging the nurse as 'expert'. For now, though, we will link the *ideals* of nursing theory to Habermas' notion of lifeworld, since these represent the 'official' line of nursing (internal diversity among nursing theorists notwithstanding).

When these (ideal) contemporary perspectives advanced by nurse theorists are considered in relation to Habermas' notion of lifeworld (as outlined above), it is clear that nursing is centrally concerned with contextualising illness within the social nexus of everyday interactions of a person's cultural realm, that is, his or her lifeworld. Habermas explored the mutual interdependence of the symbolic reproduction of the lifeworld and the material reproduction of the system (Habermas 1987). Indeed, in theory at least, nursing work draws upon both instrumental rationality in the execution of physical tasks, and value-orientated rationality aimed at mutual understanding through dialogue (Porter 1994). If the 'voice of medicine' is dominated by an instrumental technocratic rationality (Mishler 1984, Bradley et al 2001), then, based on contemporary nursing theories, what we will term the 'voice of nursing' ought to be distinguished by an appreciation of the interdependence between technocratic and value-orientated rationalities.

Porter (1994, 1998) has linked contemporary nursing practice with Habermas' notion of communicative action. In interviews with nurses about their relationships with patients, Porter found that relations between nurses and patients were more relaxed and friendly than had been the case in previous generations when a fear culture dominated. Porter (1998:149) proposes that the introduction of primary nursing has also facilitated better communication between nurses and patients.

. . . rather than having one-way interaction whereby the nursing expert colonised the lifeworld of the passive patient, there was now the possibility of dialogue, in which patients felt enabled to voice their concerns.

More widely, Habermas' notion on the systemic colonization of the lifeworld has been applied to the practice of obstetrics (Scambler 1987) and to the manner in which the role of the midwife is impeded (Hyde & Roche-Reid 2004()).

In the analysis that follows, we explore the types of rationality that are revealed in nursing documentation, and consider the extent to which contemporary nursing theory finds expression in nurses' recordings about their practice.

Methodology

This analysis of nursing documentation is part of a wider five-year study, the aim of which is to identify nursing activities and to develop a Nursing Minimum Data Set¹ within the context nursing in of the Republic of Ireland. In addition, the cognitive processes involved in nurses' clinical decision-making will be explored within the broader remit of the study. This extended research involves the collaborative work of two research teams, one focusing on general nursing (Treacy et al 2003) and the other on psychiatric nursing (Scott et al 2003). This paper concentrates on one data set from the broader project – documentation within general adult nursing settings – and is concerned with what nurses document about their practice.

Permission to gain access to nursing records was obtained from the ethics committees at each of four hospitals in the Republic of Ireland, and by the ethics committee at the university with which the research team is associated. Three of the four hospitals were located in urban areas (in data excerpts below, these hospitals are referred to as A, B, and C), and the fourth in a rural location (identified in data presentation as D). Four specialisms were represented across these four hospitals; oncology nursing, cardiac nursing, general medical nursing and general surgical nursing. Ward Managers were approached to determine the average length of stay for patients in each specific unit, so that the nursing notes of patients who most typically represented patients on a unit could be selected. Long-stay patients whose protracted hospitalisation was for social reasons, or those with diagnoses that did not reflect the ward specialism were excluded. Collectively, the complete nursing records of 45 patients were included in the study; a complete set of records encompassed all of the text-based material that the nurses wrote in relation to a patient's care. The length of each patient's stay at the time that the records were gleaned varied from 3 days to 21 days. Each set of records was copied verbatim in the ward location, so that a completely

accurate account of the documentation would be acquired. To maintain ethical standards and ensure anonymity, all identifying indicators in documentation, such as the patient's name, ward name, and all health care workers' names, were not included in these notes. Access to the complete records were restricted solely to the research team.

Data were analysed using discourse analysis. Discourse analysis acknowledges that language constitutes meaning with a particular social and historical context (Cheek and Rudge 1994). Texts reflect particular versions of reality, and also influence how reality is maintained and reproduced. Thus, while nursing records provide insights into selective dimensions of nursing practice, they simultaneously exclude others. In the process of analysis, each document was read and re-read with the purpose of exploring how the language used was linked to wider cultural structures. Documents were interrogated to gain an understanding of the structural and social processes that permeated the text, and to problematise elements of dominance and power embedded in text (Lupton 1992). The discourse analysis employed in this study endeavoured to render transparent the powerful discursive frameworks that both mediated and framed the texts.

Instrumental technocratic rationality and the voice of medicine

The most striking feature of documentation at all four hospitals was the voluminous amount of medico-technical details written in nursing records. This documentation primarily related to the physiological status of the patient, and included vital signs (temperature, pulse, respirations, and blood pressure), tests 'ordered' and completed, test results, procedures, and prognosis. Interspersed with this type of data were references to patients' functional capacity, that is, their competence at Activities of Daily Living (ADLs). In

¹ A Nursing Minimum Data Set is a tool validated in the clinical realm that is used to classify patient problems and nursing phenomena, nursing activities and interventions, and related patient outcomes, with the objective of identifying

most cases, nursing actions that were recorded related to the physical component of care. The 'voice of medicine' emerged strongly from this nursing documentation. The example below typifies the way in which an instrumental rationality dominated the textually-based version of nursing work. The patient was an 88 year old female, admitted for shortness of breath and tachycardia; she had a previous history of heart failure, depression, and hypertension:

A2 Plan is to r/v echo/antacids. To await u+e [urea and electrolytes] today. MIOC [Medical Intern On Call] to retake as u+e haemolysed. Anti-emetic charted by Dr. Frumil changed to Lasix 40mg. Od po, to start tomorrow. And to await HRCT. To stop Ca Resonium tomorrow also. Pt. C/o nausea++ this pm. Emesis bowl given. Anti-emetic also given as charted.

In some hospitals, 'core' or predetermined plans were in operation, and there was an implicit notion of the whole person in the layout of these templates. Notes written freely on the continuation sheets of core plans tended to focus on the patient's functional abilities specific to the particular ADL, but they too afforded primacy to physical and physiological factors.

As indicated earlier, in contemporary nursing discourses humans are conceptualised in relation to the notion of holism; in nursing documentation, however, there was clearly a mechanistic construction of the body in evidence. The body tended to be reduced to its parts, and symptoms treated through pharmacological means as they arose. This modernist perspective of the body seemed to be driven by the intense biomedical overlay in the context of the nurse's work. It has been noted that in the biomedical construction of the body, there is a 'pill for every ill'. However, recent nursing theory has moved towards non-pharmacological practices to enable the body to sooth and heal itself through mind-body symbiosis, such as massage therapy for pain and anxiety, pressure-point therapy for nausea and insomnia and therapeutic communication for psychosocial difficulties. Nonetheless, the following extracts suggest biochemical responses to pain, soreness and nausea.

B3 Complained of back pain at her back. DF118 and oxycontin given with good effect
...

what nurses do and to what effect.

A3 Slight ooze to wound dressing. Same re-padded. Complained of soreness. Zydol 100mgs given IM.

B4. Fair day today. Feeling quite nauseated today. Stemetil 12.5 mgs IM given as charted with some effect.

What appeared to be fairly minor symptoms were also responded to with a pharmacological intervention.

B4. Complained of heartburn early nocte, gaviscon given with good effect.

B1. Pt sneezing . . . may need hayfever treatment.

Problems relating to the environment that affected the patient's daily functioning were also treated bio-chemically.

C11 . Pt slept very little overnight due to noise in ward → query to increase Normacin (*drug*)

C6 19:00 Pt finds nebulisers can make patient nauseated at times. Charted for slemetil PO/IM if required.

Data suggest that complaints of a psycho-social nature were also handled in a technocratic fashion, and biochemical interventions were the norm for these.

C6 . S/B [seen by] MIOC 2mgs valium given. Pt reported feeling nervous.

B1 mood very low, remained in bed, refused to sit out . . . seen by team, for psychosocial referral, commenced on oromorph, IV dose first. . . seen by psych team to commence citalopram mane.

There was a sense from the documentation that nurses actively encouraged patients to take medication for symptoms of pain and nausea.

C11 On Durogesic patch 25mg. Same due down Friday. Required Sevredol x 1 overnight → needs encouragement to ask for same.

Nurses also suggested in their reporting that they actively requisitioned junior doctors to prescribe certain medications to control symptoms.

A2 Have requested medical intern on call to chart anti-emetic as she sites nausea as the reason for not taking meds.

Even in situations where patients were apparently not experiencing pain according to their own self-reports, their behaviour was recorded as having 'refused' medication.

A 3 Vital signs stable c/o soreness but no pain analgesia refused.

D5. No complaints of soreness or pain. Declines analgesia.

There was a subtle sense in which symptoms that were disruptive to the peace and routine of the ward were linked to pathologies that were amenable to control by pharmacological interventions.

C2 Unsettled night, calling out at times. Denies any C/O pain, headaches.

Non-interventions also came to be recorded, where the medical personnel had been informed about a symptom, but had not prescribed medication in response.

B4 Pt observed to be flushing in the face. Team is aware nil order.

C2 Reviewed by Dr X this a/m. BP ↑ 90-95mmHg diastolic. No intervention for same.

From these records, the nurse's role appeared to be one of observing and recording symptoms, reporting them to the medical staff and administering the prescribed medication. This amounted to a quick and pragmatic way of responding to patients' needs.

There were some examples of alternative, non-pharmacological interventions by nurses, but these were rather exceptional in the context of the overall data.

C1 Pt anxious +++ this am and breathless. Encouraged to use deep breathing, relaxation exercises. Same subsided.

A2 Requested a commode, opened her bowels x1 this evening with large amount of hard stool. Prune juice provided and patient settled to sleep.

In addition to containing patients' symptoms with 'a pill for every ill', there was evidence that nurses were working in the wider context of fragmentation of the human body. Specialists with expertise in systems of the body were consulted about the 'broken down' parts that related to a particular specialism, so that a single patient might be reviewed by several consultants simultaneously, each dealing with a system or bit of the body. There was also evidence of the mind-body split in the following extract, where a patient with heart failure was reviewed by a cardiologist.

A2 S/B HF Dr. Informed him of K+ level, pt.'s decreasing mood and refusing meds yesterday. Was informed that from a heart failure point of view she is fine.

Nursing notes also revealed the way in which particular 'problems' are divided among a range of personnel. Patients were referred to medical social workers for social problems, physiotherapists for physical problems, and dieticians for nutritional problems.

The eclipsing of the autonomous subject

Recordings of episodes and incidents where patients displayed a degree of autonomy or involvement in decision-making about their illnesses were very sparse indeed. There was little evidence of communicative action recorded in documentation; however, there were some examples of strategic communication. In one example, a patient who apparently had been making frequent visits to the smoking room to smoke cigarettes against the advice of the nurses, eventually agreed to stop smoking. The chronology of events leading to the patient's decision are as follows:

A1 18:00 patient once went to smoking room without telling nursing staff, advised not to smoke and ill effects of it, continues to smoke. Non-compliant with O2 therapy . . .
[next day] Mobilised to smoking room and c/o feeling very weak, wheeled back to bed . . . rested for a few minutes and returned to the smoking room against all advice.
[next day] smoked by 3 up to now, refused to let nurses to remove nicotin patch as had been instructed by the team, restless and walking up and down at times or sitting on the bed, states that he has issues to sort out in the morning.
[next day] . . . Seen by health compliance officer – patient agreed to try to quit smoking, continue on nicotin [patches].

The scenario appears to suggest that the patient's decision was arrived at by a gradual 'wearing down' into compliance rather than by a process reasoned argument, understanding and dialogue.

In another example, when a patient decided not to take her medication, in spite of encouragement from the nurses, the latter colluded with her family in order to influence her action.

A2 Pt. eating scones for family member, so asked them to encourage her to take her tablets. Took frumil but not anti-biotic.

There was also a situation in which a 72 year old female patient, admitted with a suspicious mass on the left helium of her lung, appears to have expressed her intentions on admission not to have any treatment.

C8 Pt may decide to leave without having further treatment and will not want to be told 'bad news'.

This patient appeared to have expressed a wish not to have specific tests performed, not to be told the test results if they were unfavourable, and not to undergo treatment.

19:00 Pt voicing to nursing staff this pm, on being told of CT thorax and CT brain procedures morning, that Pt not keen on having procedures done. Also not wanting to be told results of examination, does not want further interventions or tests or surgery. Team to talk to Pt morning regarding same.

Although details of the discussions are sketchy in the records, this patient's wishes were recorded and she appears to have been successful to some degree in having her wishes respected. The extract that follows suggests that, although the woman did not want any tests to be performed, she appears to have successfully evaded one of the tests at least:

. . . for CT thorax and CT brain today. . . .
Pt not keen for having any procedures to be done and Pt doesn't want to know any results of examinations and doesn't want any further interventions or surgery.
S/B Dr X. For cardiology review, holter, ECG 3, CT brain/thorax – tests ordered. Pt voiced to Dr X of not wanting CT brain performed. Request heard, therefore Pt only for CT thorax.

It seems to be the case that she conceded some ground because later records suggest that the staff did manage to attain her consent to undergo further tests:

ECG done,. . .
[few days later] To fast from 12 midnight tonight for broncoscopy morning. IV bung 3, consent 3. A/w CT thorax and holter result. A/w echo at 10:00 . . . Seen by Dr X's team, awaiting holter review, for cardiology consult re: arrhythmias.
12:30 Attended for broncoscopy

This patient was found to have a fungating carcinogenic mass on the left lung. From these records, it seems that the patient made a decision not to engage in communicative action about the course of treatment with the hospital staff. Since the patient apparently stated that she did not want to know the outcome of tests, it appears that any attempts at dialogue and the presentation of information and reasoned arguments by staff were immediately forestalled. This suggests that successful communicative action between nurses and patients requires co-operation between both parties. Since there was no update in the records as to whether surgery would be performed or not, and the patient was due to be

discharged on the day following data collection, the researcher asked the Head Nurse what the position was regarding this woman. The Head Nurse stated that the woman was in denial about her condition, and that she was due to be discharged on the following day without treatment. However, a member of the medical team would speak to her (present a medical 'validity claim') in one final attempt to ask her to consider surgery.

Parallel to the records above was a separate set of documents about this patient relating specifically to 'communicating' as an activity of daily living. In it, the following was recorded:

21/1/03 pt appears very tearful this afternoon regarding broncoscopy tomorrow. Pt very anxious re: what the broncoscopy may show. Reassurance provided and Pt appeared more settled.
22/1/03 Reassurance given re: broncoscopy morning.
10:30 Continues to be anxious regarding broncoscopy. Reassurance given.
23:00 Appeared settled and comfortable on the chair. No anxieties expressed.
23/1/03 10:00 No anxieties expressed.

While this documentation conveys the patient's distressed state, the nature and substance of the nursing intervention that apparently had the positive impact of 'settling' her remains locked and invisible under the vague category of 'reassurance'. The extent to which 'reassurance' encompasses communication action rather than strategic action is impossible to determine from these records. It is also interesting to note that these specific recordings ended three days before other parallel records as though the nurses had 'given up', and had accepted the patient's wish not to engage in communication about her illness.

Patient resistance

Nursing documentation was littered with examples where patients resisted medical regimes and expectations about activities of daily living. These related mainly to the taking of medications and attending to hygiene.

A4. . . vomited x 2. Small amounts, refused antiemetics.

A2 Refusing assistance with hygiene.

In this sense, the autonomy of the individual was exercised and the agency of individuals displayed.

According to the records, some patients chose not to take medications because of their probable side-effects. At times, where it appeared that patients disagreed over their treatment, no indication as to why the patient's choice was at variance with that of the medical regime was given.

C11 Lips remain cracked and dry but refusing acyclovire cream, using only cold sore lotion (cymex).

In another case of a 75 year old with a diagnosis of congestive cardiac failure, nursing notes contained details about physiotherapists' discussions with the nurses. In the almost antithesis of a patient-centred approach to care, physiotherapists allegedly advised nurses to adopt 'a more strict approach' with the patient.

C1 S/B physio who spoke with nursing staff and feels a more strict approach needs to be used when trying to get Pt to do things for himself.

Although details of the nurses' responses to this are recorded in a perfunctory manner, it appears as though the recommendations of the physiotherapists were endorsed.

C1 Pt sat out in chair for an hour this pm with use of Zimmer frame. Encouraged to mobilise more but with little effect.

While there was little evidence in documentation of nurses directly advocating on behalf of this patient, there is some sense in a later record of an implicit acknowledgement of the patient's difficulties in endorsing the physiotherapists instructions, by referring to his dysnoea (shortness of breath):

C1 Pt requires much encouragement to do things for himself. However was dyspnoeic on minimal exertion overnight.

This might, at best, be described as a weak and informal type of advocacy. In general, records suggested that nurses co-operated with others in the health care team rather than defended the patient's position.

Discussion

The foregoing data, drawn from nursing records, suggest that an instrumental logic using purposive-rational action dominated the content of nursing documentation, and expositions displaying the autonomy of the reflexive subject were restrained. Representations of the aspirations of nursing theory that promote notions of partnership, autonomy, and self-determination that would be facilitated using value-rational action were notably sparse in data. There was little evidence of a clear or dominant 'voice of nursing' that might represent the interrelationship of both the lifeworld and system. There is no suggestion in the overall argument being presented here that nursing documentation is a valid representation of what these nurses actually did. Rather, it is proposed here that if the nurses involved engaged with patients by reflexive discourse where the rights of the autonomous subject were facilitated, and where consensus about care or treatment was arrived through reasoned dialogue, then this was not rendered transparent in documentation. The social world, cultural milieu, and biographies of patients that nursing theorists canvass as legitimate jurisdiction for nursing work were a marginal feature of nurses' text-based accounts of the nurse's role. The manner in which disagreements that patients had with medical interventions were recorded suggests that nursing practice is at the centre of the fundamental predicament of modernity – the hegemony of instrumental rationality based on 'scientific' evidence undermining the capacity of the social actor (Delanty 1999). Drawing on Habermas, nursing documentation depicts the colonisation of the socio-cultural lifeworld by the bio-technocratic system.

Instrumental modes of rationality were in evidence in the weighting that nurses afforded to documenting medical-technical details relative to psychosocial dimensions of illness. While the present qualitative analysis is concerned primarily with the understanding data and offering theoretical insights based on data, the sheer empirical scope of medico-technical details is highly revealing in terms of the dominant frames that mediated these documents. In keeping with a biomedical construction of disease and illness, these tended to be presented in relation to specific or multiple aetiology (theory of cause), and the cause and course of disease were predominantly identified as they affected parts of the body. It was rarely recorded that pharmacological interventions did not 'work', thus reinforcing the legitimacy of biomedicine; however, numerous side-effects were documented. In these records, the experience of

illness was overshadowed by technocratic control of symptoms to the detriment of other components of illness. Every little problem, including psychosocial ones, had a pharmacological or technological remedy. Crossley (2003) argues that there is a propensity in contemporary society to treat psychologically-induced distress with biochemical solutions, even where socio-structural factors are acknowledged as the causation. Irving (2002) noted that nurses in her Australian study used biochemical medicines to treat agitation which was in fact precipitated by unmet daily needs. Crossley attributes the continued rise in bio-chemical treatments for illnesses such as (even mild) depression precisely to their ability to reduce symptoms, and the speed and ease of their administration:

‘. . . they may be the only practical solution that may be administered in a brief consultation, sandwiched between many others. . . This affords the bio-medical model practical dominance. Whatever ‘new age’ maps of the soul we are attracted to in our moments of reflection, we are increasingly drawn to bio-medicine in our moments of need. And our moments of need . . . are increasing (249-50)’.

This practical dominance of biomedicine is attractive to busy nurses in their efforts to relieve the pain and suffering of ill people, superceding, it seems, ‘new age’ maps developed within nursing theory.

In spite of the emphasis in nursing theory on the patient’s biography, that is, features of a person’s life that impact upon the experience of illness, nursing documentation depicted an almost complete absence of emotions, feelings and experiences relating to the illness. The emotional labour involved in nursing (James 1992), such as spending time with patient, listening to them, and advocating on their behalf did not tend to feature in the documentation. Where ‘nursing’ work was represented in text, it tended to refer to task-orientated, physical aspects of the nurse’s work, also underpinned by a purposive instrumental rationality. The outcome is that the manner in which nurses documented their work rendered central aspects of nursing invisible, as other studies have also indicated (Heartfield 1996). The invisibility of emotional labour in nursing has been conceptually linked to the way in which the nurturing role has been undervalued and invisible at a broad societal level (Oakley 1993).

The central tension of modernity arising from the imposition of technical-scientific knowledge, namely the subjugation of the autonomous subject, was transparent in data. In terms of what the nurses wrote about their practice, there was a tendency to prioritise the patient's physical health above all other domains of health (psychological, social and spiritual). In some cases, patient autonomy appeared to be undermined in order to augment physical health. Biological well-being was therefore at the top of the nurses' hierarchy of importance in selecting what to document about their work, reflecting the bio-medical context of their work and the impact of medical dominance. Records suggested that restoring the bio-physical status of the patient to within 'normal' limits meant that nurses directed patients' behaviour towards a range of activities: keeping on uncomfortable face masks to regulate oxygen levels, taking medications to stabilise vital signs and 'abnormal' symptoms, 'pushing' fluids to regulate urea and electrolyte levels, and 'encouraging' mobilisation to promote independence. In short, biology took precedence over biography.

There were examples in data which suggest that nurses used strategic rather than communicative action to achieve particular ends. Habermas (2001:35) refers to strategic communication in terms of one of the party's presenting a partial perspective whilst failing to recognise the 'validity claims' of the other.

For self-interested actors, all situational features are transformed into facts they evaluate in the light of their own preferences, whereas actors orientated towards reaching understanding rely on a jointly negotiated understanding of the situation and interpret the relevant facts in the light of intersubjectively recognised validity claims.'

Other research on nursing documentation has interpreted the tone of nursing records as authoritarian with evidence of a discourse that shapes and restrains patients' activities (Cheek and Rudge 1994). Similarly, the defensive language used in the nursing records in the present study appeared to suggest that the treatment 'ordered' constituted the 'proper' course of action. The word 'refused' was frequently used in relation to patient behaviour, suggesting that patients were rejecting the most logical course of action. There was no sense in the language used to suggest that patients were making choices that best suited their experience of illness at that particular juncture in the illness trajectory.

However, an alternative explanation that must be considered is that the nurses were unproblematically respecting the autonomy of the patient, without burdening patients with alternative validity claims to support the biomedical position. The defensive tone of the documentation, with language such as 'refused' being documented, may simply be used by nurses to 'cover' themselves by demonstrating that they had at least presented the biomedical options. Nonetheless, whichever explanation is offered, the biographical dimension remains marginalised within the documentation. Challenging commentators may also legitimately raise questions about the place and necessity of communication action by nurses in the context of a patient's poor physical health. We outline some of these challenges in order to appraise possible counter-arguments that problematise communicative action within health care.

The first point relates to people's ability to engage in communicative action in the context of immediate suffering and disability. It may be argued that people experiencing fairly severe physical illness or disability, because of their engrossment in the immediate pain and suffering, need to be encouraged and persuaded in a direction that will restore their physical health. Arguably, without physical health, they will not be able to re-engage in the lifeworld. In this case, a paternalistic position might seem justified, whereupon the nursing and other health care staff prioritise physical well-being, and 'push' reluctant patients towards a state of physical health. The priority of regaining physical health may arguably overrule notions of attempting to engage in the lifeworld at a point in their illness trajectory when people are solely preoccupied with the short-term. However, the prioritising of physical health becomes difficult to defend in cases of very poor prognosis, where the person's quality of life is diminished by bio-technological interventions.

A further issue concerns the capacity of lay people to make rational decisions about health. Over the past couple of decades, there has been an emphasis in sociological scholarship on lay people's experiences in relation to their own health (Lawton 2003). The growing trend has been to take into account lay people's perspectives on the management of their health. However, in a recent provocative paper drawing on empirical examples, Lindsay Prior (2003) argues that lay people are often misinformed about their illness,

and are not sufficiently skilled to diagnose and manage it. Prior notes that Habermas (1987) perceived expert culture to be essentially anti-democratic; Prior's challenge to the validity of lay perspectives and his defense of expert knowledge problematises the notion of communicative action in health care. His argument is that when health experts present scientific knowledge based on research (their rational perspective), lay people sometimes choose to act upon their own version of events which may be 'wrong'. The implicit argument is that one party in the dialogue (the lay person) does not always possess the knowledge and skills to present valid claims to enable him or her to engage in dialogue based on reason. Prior's argument raises wider issues about claims to 'truth' in the context of the postmodern deconstruction of science; arguably, expert knowledge is not always 'valid' either. Miers (1999:189) explores the notion that expert knowledge is based only on the uncertain probability of treatment outcomes, and people are offered a choice only 'when the 'best' course of action is not clear'.

An additional consideration that may have escaped many nurse theorists moving apace with the wave of the democratic impulse (Bury 2001) is that patients may not be as enthusiastic about participating in their care as is widely assumed. Allen (2002) cites several studies where this was the case. There is some evidence from research into doctor-patient interactions to suggest that patients are not necessarily dissatisfied with encounters where the 'voice of medicine' is the only style used in the course of the dialogue (Barry et al 2001). As far as the present documentary data are concerned, however, disagreements over treatment appeared to arise where patients *did* take a stance about aspects of their care.

The burning question that remains is whether communicative action was actually a feature of patient-nurse interactions in the hospitals from where the records were located. Porter (1995) found that nursing documentation did not accurately reflect what nurses did; rather it was used for legal reasons. Actual empirical evidence based on observation from a British study found that the extent to which nurses engaged in participatory care with patients depended on structural conditions, resources and workload of different wards (Allen 2002). In later writings, Porter (1998) was more guarded about his earlier optimism

(Porter 1994) regarding the practice of communicative action in view of the material and structural barriers that needed to be surmounted to facilitate it. It is widely acknowledged that nurses in the Irish health services are stretched to capacity in a climate of staff shortages, a situation that does not bode well for value-rational action. It may be the case that even if nursing ideals are being practised, the 'voice of nursing' may be impossible to capture in nursing documentation. Davies (1995) identified the difficulty of articulating the caring dimension of nursing within organisational settings because it cannot be properly manifested in a minute breakdown of tasks.

More broadly, critical theory's defense of private autonomy against regulating structures in the public realm has not been without criticism. Theorists such as Zygmunt Bauman (2000:34) root many of society's current problems (unhappiness, depression and so forth) with the move towards a society of individuals whose quest for individual autonomy has led to 'chronically . . . disembedded individuals'.

Irrespective of these reservations about communicative action in nursing practice, it does, nonetheless, appear to be central to nursing, since its tenets are already evident with dominant models of nursing that incorporate mutual goal setting, empowerment, democracy and so forth. Arguably, the outcome of *not* documenting this aspect of the nurse's role is that, if it is being practised, 'the voice of nursing' is not articulated, and an important dimension of nurses' work is concealed.

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