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Reflexivity in nursing: Where is the patient? Where is the nurse?

Introduction

We are two registered nurses with around forty years of nursing experience between us, with a higher degree in both social sciences and public health. We have also previously worked as clinicians, tertiary educators, health researchers, administrators and policy analysts in a variety of public health settings. Our initial formal nursing education occurred in hospitals (Australia and England). At the time of writing, we had recently returned to working in clinical and academic settings. Our recent active engagement in clinical practice has provided us with an opportunity for reflexivity.

Upon reflexivity of our collective experiences, we have often asked ourselves the following questions: Why is there a greater emphasis on technology in health care than on human beings? Why are nurses progressively focusing more on being technicians rather than as human beings providing holistic care to other human beings? What is a 'critical pathway' of care, and how does it impact upon patients and nurses? What is 'evidence-based nursing'? What are the implications for nursing practice?

In this paper, the sociological concept of reflexivity serves as a framework for discussion. We consider four inter-related issues arising from the above questions and how they present a problematic situation for both patients and nurses: i) technological solutions to health and ill-health; ii) the patient-healer relationship; iii) critical pathways; and, iv) evidence-based nursing. Our reflexivity is grounded in our collective nursing clinical practices; asking questions and generating debate.

ABSTRACT

Drawing upon forty years of nursing experience, in this paper we are reflective about four issues relative to nursing clinical practices: seeking technological solutions to health and ill-health; moving from the nurse-patient relationship to the patient-healer relationship; utilising critical pathways; and, supporting evidence-based nursing. We examine current nursing practices and ask probing questions to generate debate. Most of all, we encourage nurses to engage in reflexivity and not to lose sight of their selves (knowledge, expertise and skills), and their patients' voices and subjectivity, in their contribution to health care.

Keywords:
Patients, Nurses, Reflexivity, Technology, Patient-Healer Relationship, Critical Pathways, Evidence-Based Nursing
Reflexivity

Reflexivity is 'a turning back on oneself, a process of self-reference' (Davies 1999:4). It is like having 'an ongoing conversation about experience while simultaneously living in the moment' (Hertz 1997: viii).

Several authors make commentary upon 'reflexivity', the necessity for it and its usefulness for biomedicine and social sciences (Beck, Giddens, Lash 1994). Giddens (1984:3) defines reflexivity as 'the monitored character of the ongoing flow of social life'. Williams and Calnan (1996:1612) refer to reflexivity as:

the susceptibility of most aspects of social activity, and material relations with nature, to chronic revision in light of new information and knowledge; a situation in which the social sciences themselves play no small part.

Furthermore, 'there is a need to develop a much more reflexive understanding of the ways in which expertise—whether professional or lay—is structured' (Popay & Williams 1996:766).

The sociological concept of reflexivity has been viewed as an important process for monitoring, changing and improving social life. Reflexivity provides an opportunity for self-critique and self-appraisal within a social context (Beck et al. 1994; Hertz 1997). The social context may be, for example, nursing management of an asthmatic patient in an accident and emergency department of a rural hospital. Hence reflexivity in a sociological sense (or usage) mirrors the more commonly used terms 'reflection' or 'reflective practice' within the nursing profession. For example, Cash, Broker, Penney, Reinold and Strangio (1997) assert that reflective practice through journaling provides nurses with an opportunity to gain insights into their practices and improve patient care. Reflective journaling also increases awareness of oneself as a person and how one practises as a health professional in the social world of nursing. Taylor (2000) discusses technical, practical and emancipatory types of reflection, in addition to strategies for reflective practice by nurses and midwives. Cotton (2001) critiques definitions and the value of reflection and reflective practice as being 'good' for nurses, when private thoughts enter the public sphere. Northway (2000), and Freshwater and Rolfe (2001) use reflexivity specifically as a tool for nursing research.

It is not the place of this paper to debate the definitions or merits of reflection, reflective practice or reflexivity. In this paper and our practices, we consider reflexivity as the ability to reflect upon and articulate our experiences of being in the world. Language then becomes the means to express our consciousness, thoughts, observations, positions and interests. We use reflexivity to view nursing with a sociological lens, by examining current approaches to nursing care in Australia. In terms of the nursing profession, we argue that it is vital for nurses to be reflexive about their own clinical practices, now and in the future. Reflexivity enables an examination of the biases, assumptions and values underpinning nursing practice, and encourages lateral thinking, flexibility, innovation and resourcefulness. The desired outcomes of reflexivity are nurses becoming more critical about their practice, acknowledging patients' subjectivity and selfhood, maintaining a crucial human-centred approach to nursing care, reducing the promotion of a technically oriented practice and utilising evidence to enhance patient health outcomes.

As part of a multi-disciplinary health care workforce, nurses are daily contributing to patient care alongside their colleagues. Nurses are also making clinical decisions that influence patient outcomes, for example, pain relief and the use of psychotropic medications with the aged (Cheek 1999; Pillars, Chang, Cioffi 1999). As nurses' ability to make sound clinical judgments depends not only on the different levels of knowledge they individually possess (Liaschenko & Fisher 1999), we assert that nurses' reflexivity about their relations with patients as unique human beings located in a fragmented health care system, is also crucial.

As an important aspect of promoting reflexivity in nursing, we wish to illuminate the 'cage' that nurses' practices help to make. We also suggest reasons—based on our clinical experiences and review of the literature—on why nurses may be
complicit in the absence of the invisibility of their relations with patients and with other members of the multidisciplinary health care workforce.

1: Technological Solutions to Health and Ill-health

Since the late 1960s, the high technological revolution in biomedicine has enabled nurses, doctors and other health professionals to 'gaze' at the internal workings of the body and diagnose maladies by 'looking' at computer printouts (Atkinson 1995). Peerson (1998:59) comments on the changing role of technology to manage human bodies:

The body has gained increasing prominence in social science literature in the last two decades, in recognition of the shifting boundaries between Nature and technology (for example, developments in organ transplants, IVF, genetic engineering, and the impact of bionic body parts on the ageing process).

Entering the 21st century, biomedical health professionals (including nurses) are dependent upon technology to resolve episodes of acute illness and minimise ageing, whilst being limited in their ability to treat chronic illness and disability.

The public intellectual, Neil Postman (1999) raises some concerns about the value of technology in everyday life. He asks the following questions: 1) What is the problem to which this technology is a solution?; 2) Whose problem is it?; 3) What new problems might be created because we have solved the problem?; 4) Which people and which institutions might be most seriously harmed by a technological solution?; 5) What changes in language are being enforced by the technologies, and what is being gained and lost by such changes?; and, 6) What sort of people and institutions acquire special economic and political power because of technological change? Postman's questions apply equally well to the spectrum of technology and our dependency upon it as nurses in the clinical setting. High technology presents both solutions to treating disease as well as creating a problematic situation (Williams & Calnan 1996; Barnard & Sandelowski 2001).

As part of their clinical practices, nurses are constantly using and relying upon technology in addition to performing technical tasks. The complexity of technology used by nurses ranges from the mercury thermometer and intravenous fluid pumps to ventilators and surgical instruments. The technical tasks related to these forms of technology consist of taking a patient's temperature, administering intravenous fluids, assisting respiration and participating in surgical procedures. Nurses require knowledge and skills to perform these technical tasks which are important for patient care. Barnard (1991a, 1991b, 1997; Barnard & Sandelowski 2001) has written extensively on the nursing-technology relationship and he questions nurses' control and uncritical acceptance of technology, and its presumed neutrality and ideal of progress.

Barnard and Oerber (1999) report on a phenomenographic study of 20 surgical nurses' use and perceptions of technology. They argue that in contemporary surgical nursing, technology is experienced both pessimistically and optimistically as changes to skills; increasing knowledge; respect and autonomy; gaining control of clinical practices; clinical resources of the practice environment must meet the needs of technology; the need to include the patients' experience and clinical presentation; and, alteration of the free will of nurses. More recently, Barnard and Sandelowski (2001) discuss the place of technology in nursing and the ability of nurses to provide humanistic care. Drawing upon the insights of previous studies on reproductive technology and usage of resuscitation technology in emergency departments, they highlight the shifts in use and meanings of technology, and techniques, as human/dehumanising, that are specific to the use context.

Reflexivity provides a means to question the place of technology in nursing by shaping clinical practice and influencing patient health outcomes. We ask: how can a shift occur from a focus of technological interventions to one that includes viewing patients as human beings? When examining the benefits and risks that technology pose, we must also consider the value of removing human elements from the planning, provision and delivery of health services. Essentially, we suggest a reconsideration (and consequent reformation) of how technologies currently construct...
the nurse-patient relationship and nursing practice.

2: Moving from the Nurse-Patient Relationship to Patient-Healer Relationship

How can the nurse-patient relationship be better understood within the provision of care by a multi-disciplinary team of healers? According to Armstrong (1983) the nurse-patient relationship is fabricated upon subjectivity. It is oriented more towards care that is humanistic and holistic (Lowenburg 1989; Watson 1985). Parker (1995) writes of the multi-faceted character of the nurse-patient relationship and the importance of the nursing 'look' as part of patient care:

The 'looking' of the experienced nurse involves highly skilled clinical judgments that incorporate not only an understanding of the physical and pathological bodily processes, of drug regimens and interactions, of infections and wounds and healing processes, but also at the same time include a responsive understanding and knowledge of the person and their manner of dealing with what is happening.

Croft (2000) claims more attention is given to the instrumental/visible caring provided by nurses, than expressive/invisible caring, which is rarely accounted for in health outcomes in terms of effectiveness and efficacy of health care delivery.

Instrumental/visible caring refers to meeting patients' needs and desires, the resources required to meet them, the physical environment and the observable physical (and often technological) care that is provided. Expressive/invisible caring refers to the positive relationship between the patient and nurse, and addresses issues of anxiety, frustration, changes to self-identity and despair that are often expressed by patients 'consequential to their treatment. It requires an approach based on 'knowledge' (social, cultural, psychological) of the patient's needs/desires. Nurses are challenged to articulate expressive/invisible caring as part of patient care, to each other and to other members of the multi-disciplinary health care team, conveyed verbally in 'handover' and documented in patients' medical records. Croft concludes there is a need to observe and measure the visibility and invisibility of nursing practice by using inductive approaches to make the entire scope of nursing care visible to demonstrate nursing judgments and the value of expressive/invisible caring in nursing and other health care resources allocation. Such a change in approaches to nursing will also have implications for the nurse-patient relationship and patient health outcomes (Cheek 1999).

Medical sociologists have discussed at length the problematic nature of the doctor-patient relationship (Willis 1989). It is understood to refer to the unequal 'power-knowledge relationship' (Foucault 1979) existing between two persons of dissimilar social class, gender, age, occupational category and education. In keeping with the 'sick role' (Parsons 1975) the patient has little or no agency, but is passive and dependent on the doctor (usually male) to make decisions on her/his behalf and to initiate diagnostic and therapeutic procedures whereby informed consent is assumed. The patient is obliged to actively seek assistance for alleviation of their ailment. They are also absolved from blame for their sickness and relieved of their work obligations (Gerhardt 1987). The relationship characterises the medical dominance paradigm whereby the health care system consists largely of biomedical health professionals (including nurses) and health care services. Biomedical knowledge and practices are privileged, valued, regarded as legitimate and, socially and legally sanctioned. Within the medical dominance framework, healing takes place in a formal public setting of the hospital or the clinic. In this sense it differs markedly from a model of the health care system as 'medical pluralism', which comprises various healing options (lay, complementary therapies, folk healing in addition to biomedicine) in a multitude of settings (households,
community, social networks, institutions). Thus, it is possible for patients to have relationships with healers other than nurses and doctors (Frohock 1992; Kleinman 1980).

While Budd and Sharma (1994) use the term 'patient-practitioner relationship', other writers following a market model of health care, prefer to describe patients as 'clients', 'consumers', 'customers' or 'service users' (Sitzia & Wood 1997). Peerson (1998) contends the term 'doctor-patient relationship' is narrow and outdated, arguing that it is far better to consider the health care system comprising of many healing modalities in which all knowledge, practices, efficacy, and power to heal are of equal status. This does not assert that one is better than the other, but rather that they all have the potential to heal. Peerson proposes a new term - patient-healer relationship - and provides four reasons for her use of this term.

First, anybody can be a patient-illness and injury are inevitable and unpredictable, are features of the human condition, and cross 'marked identities' of gender, ethnicity, social class, sexuality and age (Kleinman 1998). Many biomedical health professionals and social scientists have written of their experiences of illness, injury and disability (Frank 1991; Moore 1992; Murphy 1987; Toombs 1987; Zola 1982). For example, Sacks (1984) relates how his convalescence from a serious leg injury led to his experiencing feelings of being in limbo, dependent upon others and their kindness and assistance. He was not immune to being expected to conform to the sick role nor to being treated like a patient by his medical colleagues, although he is an eminent neurologist.

Second, anyone can be a healer and provide healing for someone else, according to his or her knowledge, confidence and abilities. For example, many lay people are working in an informal, unpaid capacity as caregivers of persons with advanced cancer. They provide a health care service similar to that of biomedical health professionals although this lay healing role is commonly taken for granted by health professionals. They provide a health care service similar to that of biomedical health professionals although this lay healing role is commonly taken for granted by health professionals.

Third, this term extends the generally accepted construction of who is a patient and who is a healer. The patient is the sick person who requires healing, whilst the healer is one who heals another person of their ailment that may be of a physical, mental or spiritual nature. Fourth, the term patient-healer relationship also questions the power differential nature of that relationship. Here, decision-making for diagnosis and treatment of illness/injury has a greater chance of being jointly informed or shared with patients having primacy in the therapeutic relationship with their healer(s). They also have greater potential to exercise agency and being primary decision-makers (Charles, Gafni, Whelan 1997; 1999; Wood 1996). In this relationship, nurses (as healers) provide patients with information about diagnosis and treatment to enable them to make informed decisions that will influence their well-being and quality of life.

We suggest nurses' awareness of the patient-healer relationship either does not exist or is simply invisible and that this is to the detriment of patients who seek more from healers (including nurses) than technological solutions to ill-health; for examples, opportunities to express their spiritual needs (Halm, Myers, Bennetts 2000).

3: Utilising Critical Pathways

Although the patient-healer relationship is arguably a preferred model of care, in the acute care setting decisions about patient care are determined by economic rationalism (Barnes 2000). In the late 1990s, critical pathways (CP) (also referred to as 'clinical pathways, 'care pathways', 'critical paths' or 'patient progress plans') were implemented in various Australian public and private hospitals as an efficient and cost-effective way of managing patient care (Barnes 2000; Gibb & Banfield 1996; Price, Bernard, Drew, Foss, Wheeleger 1998). Critical pathways incorporate management strategies in an attempt to standardise practice and predict outcomes that are patient, health professional, treatment and organisation related. They are used in specialty areas of nursing such as intensive care units and orthopaedic wards, as well as for specific illnesses, and diagnostic and surgical procedures. A positive clinical outcome is equated with 'cure'
and a prompt patient discharge following a recovery period that is 'complication free' and which occurs at a pre-determined rate.

Critical pathways rely on a range of technologies and tasks for their implementation. We suggest that CP have become a technology to socially control patient care (Foucault 1973), and restrain nursing practice and inquiry. In a similar vein, Barnes (2000) argues that critical pathways are employed by health care services as regulatory mechanisms that act indirectly on clinicians and patients to link their conduct with broader aims and objectives of economic efficiency and effectiveness. Nurses' professional identity and practices are constrained by using CP which cement a corporate business interest and not the interests of the nursing profession. Furthermore, CP is not a value-neutral tool used to manage the process of health care delivery—in engaging CP nurses can only practice clinically within rigid and limited boundaries (Barnes 2000).

Our clinical exposure to clinical pathways has presented us with opportunities for reflexivity about their value to nursing and to patients' well-being. Consultations with nursing colleagues inform us that CP development should of necessity occur over four years, and be subsequently evaluated for their usefulness and appropriateness on an annual basis. However, in a similar fashion to the prolific 'McDonaldization' of fast food outlets in wider society (Ritzer 1996) each CP has been computer written and 'standardised' following a 'textbook' approach to the norms of disease and expected patient responses to treatment (Canguilhem 1989). In some private hospitals, clinical nurses have been actively involved in the design of CP. However, many of these are usually employed on a short-term or part-time basis as 'project officers', and many do not have pre-existing research qualifications and skills to adequately prepare them for this role. Therefore, it is unlikely that the same person will undertake regular evaluation of the CP implemented in specific areas of nursing.

Similar to Gibb and Banfield (1996), Chou and Boldy (1999) and de Luc (2000), we suggest there has been little evaluation of the benefits and outcomes of implementing CP. However, authors such as Pestian, Derkay, Ritter (1998), Ling and Cheah (1999), Choo and Cheah (2000) and Johnson, Blaisdell, Walker and Eggleston (2000) have evaluated their CP for (paediatric) asthma management, tonsillectomy, adenoidectomy, cardiac surgery and (adult) acute myocardial infarction and laparoscopic cholecystectomy. The adoption of the CP requires some reflexivity. We have often wondered: where is the presence of the patient and the nurse? Are their voices being heard? What are the implications of this model for the nursing profession? Is this model the answer to quality patient care in the current climate of cost containment? Whose interests are being served by using this model? While the medical and technical needs of the patient are abundantly evident in the CP, the patient's selfhood and subjectivity is clearly absent.

The CP assumes a multidisciplinary approach to patient care during hospitalisation consisting of a team of nurses, social workers, doctors, pharmacists and other allied health professionals, and reflects an increasingly technical and costly approach to patient care (Price et al. 1998). The CP consists of tasks and expected patient health outcomes listed under a broad range of headings: nutrition/hydration; skin integrity; sleep; pain management; wound/drain; elimination; consultation/physiotherapy; investigations; treatment; and discharge planning. Each chart consists of a series of text with boxes similar to a questionnaire format, with little room for nurses to be reflexive in the form of comments. In many Australian hospitals, it is policy for nurses to document patient care only in the CP and not in the patients' medical records and practice shared by other health professionals of the multidisciplinary team. Consequently, nurses' decision-making processes and caring actions are...
An outcome as standardised in the CP constitutes a deviance from the norm or a pathological entity recorded as a 'variance' (Canguilhem 1989). Nurses are required to place a sticker stating 'variance' on the CP chart, and then write on a separate chart what the variance is, when it occurred, what action(s) was taken and the outcomes. It is only here that the nurse's reflexivity and presence is evident, and assumes, of course, that the variance has been documented.

From using this model of care during our recent clinical practices in Australian hospitals (public and private), we make the following observations. First, what nurses do well (reassurance, education) is not reflected in the CP, and thus, nurses' contributions are undervalued and muted. The presence and ability of nurses to provide quality care to patients are hidden (Parker & Gardner 1992). Therefore, we ask: where is the nurse in the CP? Since the CP only require the nurse during each shift to 'tick the box', there is little room for reflexivity about care provided in that time frame, or about nursing practice in general.

Informal discussions with nursing colleagues inform us that they like the CPs because 'I don't have to think.' We ask ourselves, what then is the point of nursing becoming a profession and nurses obtaining a tertiary education, including honours, masters and doctoral degrees, if they are not to use their reflexivity and critical analysis skills in their daily nursing practice? We are also concerned that holistic care comprising psychological, spiritual, socio-economic and cultural factors crucial to patient care are not catered for and may be overlooked by nurses since they are not explicit in the CP. This situation is at odds with nurses consistently being told they are required to provide 'holistic' care to patients.

Nurses are expected to perform technical tasks to ensure the surgical patient follows the prescribed critical course during the pre-, peri- and post-operative phases. For instance, the patient who has had cardiac surgery (triple bypass) is expected to be extubated when stable and able to spontaneously breathe by themselves. They will have their inter-costal catheter (ICC) removed one to two days following surgery. Variances to their post-operative condition could include unforeseen complications that are iatrogenically induced (e.g. phrenic nerve damage, infection, wound breakdown, fluid overload, haemorrhage, respiratory distress) or due to comorbidities associated with pre-existing conditions such as renal impairment, hypertension and diabetes. We suggest these occurrences may also explain why a hospital admission is longer than prescribed in the CP.

Nevertheless, nurses do more than follow the prescribed tasks as outlined in the CP. Nurses make sound clinical judgments regarding patient care using their intuition, emotional intelligence and experiential knowledge (Goleman 1995; King & Appleton 1997; Peerson 1998). Nurses also respond to invisible to others. This is a clear statement by management to nurses of limiting their professional presence and voice within the multi-disciplinary health care team.

A biomedical model of cure dominates in the CP rather than an approach that prioritises nursing care or a multi-disciplinary input into patient care. Doctors pre-determine patients' outcomes during an acute episode of illness, valuing cure (Wicks 1995). It is the doctor who decides which stage and at what time a certain outcome is expected, so that simultaneously, the patient's voice is increasingly peripheral and silent. The patient is reduced to a biological system that is malfunctioning and in need of repair, with the expectation that it recover within a specified time-frame predetermined by the medical profession. Patients have minimal input into their health care which revolves around physical, pathological, radiological and biomedical parameters to restore homeostasis. These parameters often depend on high technology to facilitate and fine-tune medical diagnosis and treatment (Atkinson 1995). In turn, since high technology is costly, the quicker the patient adheres to and moves along the critical pathway, the more likely their care will be cost-effective for the hospital, who can then maintain their budgets.

Impediments to following the CP may occur during the patient's hospital admission, such as hypertension, respiratory distress or wound breakdown. Failure to achieve
the patient's illness experience with sensitivity, empathy, trust and caring (Aranda & Kelso 1997; Wick 1995). Nurses' presence in providing care 24 hours a day, seven days a week, in addition to their 'intimate' and succinct knowledge of the patient enables them to make clinical decisions (Parker 1995). Nurses also contribute to positive patient health outcomes such as: no complications, discharge when well, patient satisfied with care. May (1992), MacLeod (1993) and Radwin (1996) comment on the importance of nurses and doctors 'knowing the patient' to aid healing (Peerson 1998). This aspect of care is under-valued and not reflected in the CP, but, we suggest, is more likely to be evident in oral communication of the nursing handover (Parker & Wiltshire 1995), and in the patient's medical records, in which the observations, decisions and actions of other health professionals contributing to patient care are documented. Similarly, nurses' myriad roles and responsibilities are 'muted' in the CP. Rather, the nurse is portrayed as a taskmaster performing a series of tasks and monitoring the patient's progress in a high technological environment. This appears to be a regressive return to the task-oriented practices of nurses during the 1950s, discussed at length by Menzies Lyth (1959).

Conversely, we have observed over time that if the presence and voice of nurses are absent in CPs, so too are that of the patient (and their family). They are not consulted or involved in the development and evaluation of CP, and their individuality, subjectivity and selfhood are not acknowledged. Nor are the many socioeconomic, cultural, emotional and spiritual factors influencing their health status or care. While patients who are unique individuals are given the same diagnosis, their illness experience can be different. Within CPs, diversity and uniqueness of self and the illness experience are de-emphasised while standardisation of patients and their clinical conditions are prioritised. The patient has lost subjectivity and their bodies have become 'reified' (Taussig 1980). We advocate a return to humanistic and holistic care which patients seek from nurses when in ill-health (Lowenburg 1989; Pearson, Vaughn, Fitzgerald 1996; Watson 1985).

We observe that many biomedical health professionals, including nurses, tend to ignore the patient's subjectivity and hence the associated factors of identity, personality, beliefs and culture. Furthermore, patients' perception of illness, diagnosis and treatment may conflict with that of the professional providing health care (Peerson 1995). It is curative rather than preventive medicine that has pre-eminence. And within the biomedical model, the mind and body are considered separate entities, while the spirit is absent (Peerson 1998). This is reflected in the treatment of physical and psychological ailments by clinical medicine and psychiatry respectively, with increasing specialisation (Capra 1988) and little or no attention to the lay spiritual practices of patients. Whereas health professionals are considered experts, alternative forms of knowledge are not deemed real or legitimate (Frohock 1992).

The biological aspects of medical problems are the "real ones", while the psycho-social and cultural aspects are seen 'as second order phenomena and are thus [rendered] less "real" and important (Kleinman 1980:57). 'Illness as experience' becomes decoded to 'disease as biological pathology' (Kleinman 1980:2, emphasis in original), that leads to a negation of the sick person's suffering. Conversely, as discussed by Peerson (1998), some individual biomedical health professionals may adopt a more pluralistic approach to healing. For instance, in recent years nurses have extended their scope of practice by using complementary therapies as part of patient care, supported by policies developed by hospitals and nursing organisations (McCabe 1996; 2001).

A further concern about CP is whether they follow the current trend in biomedicine towards evidence based practice. The underlying outcomes or goals of a CP do not appear to rely on evidence. Our experience suggests that the norm is to
create CP based upon tradition, habit, routine and the time-honoured adage of 'we’ve always done it this way'. However, some health professionals do rely on evidence to inform development and implementation of CP (Bergman 1999; Currie & Harvey 2000; Dykes & Wheeler 1999). In the following section we are reflexive about the trend towards evidence-based nursing and the implications for nurses in the clinical setting.

4: Supporting Evidence-Based Nursing

Healers of all modalities may admit to uncertainty, and when knowledge is imperfect must sometimes take a 'risk' to reach a diagnosis and implement treatment that achieves healing. Medicine, and increasingly nursing, is practised on the basis of clinical evidence (Felch 1996; Lomas 1997; Pearson, Borbasi, Fitzgerald, Kowanko 1997). Clinical evidence is defined by Sackett, Rosenberg, Gray, Haynes, Richardson (1996:71) as:

the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients. The practice of clinical evidence based medicine means integrating individual expertise with the best available external evidence from systematic research.

The strength of evidence is evaluated from quantitative data resulting from epidemiological studies and randomised clinical trials as the gold standard of research investigating the efficacy of clinical interventions (i.e. medications, procedures, information provision) with a control group and an experimental group over time. These trials are frequently purported to be scientific and value-free (Latour 1987; Oakley 1992). Generalisations are drawn from data about specific population groups recruited to these studies as a basis for delivering best practice to an individual patient. The evidence to date is used in conjunction with the clinician's subjective judgment, intuition and experiential knowledge to reach a decision about an individual patient's care. Closs and Chester (1999) claim the patient's viewpoint is included as part of the decision-making process. This is an ideal situation. Frequently, patients and their families are presented with *ipsa facto* information about their health status, diagnosis, healing options and prognosis with little discussion or explanation. It is, therefore, difficult for them to make an informed decision about health care (Wood 1996).

Online bibliographic databases such as Medline and CINAHL, and the Internet (email and World Wide Web) enable nursing and medical practitioners of all specialties (particularly in well-resourced industrialised countries) to rapidly access the latest clinical evidence from their colleagues in other clinical and research settings around the world. Other sources of evidence for use in health care are systematic reviews, surveys, census, cohort studies and case-control studies (Glassiou & Longbottom 1999). Lupton (1998) and Williams (1997:1042) contend these strategies support medicine as 'a modernist enterprise, steeped in a scientific tradition in which truth, order and progress are seen as paramount virtues'. There is a need for diverse healers, including nurses and doctors, to consider the insights gained from evidence in social and behavioural sciences perspectives on health and illness. Additionally, it is important to retain a focus on lay knowledge and the 'personal significance' of health and illness for patients (Popay, Rogers, Williams 1998; Sweeney, MacAuley, Pereira Gray 1998), and to take seriously their 'illness narratives' (Kleinman 1988). To do so would reduce the likelihood of patients being dissatisfied with diagnosis, treatment and therapeutic outcomes (Annandale & Hunt 1998; Sittia & Wood 1997). However, Popay et al. (1998:342) assert that 'little attention has been paid to outlining a rationale or developing standards for the systematic review of qualitative research'. Evaluation of the rigour and validity of qualitative studies should demonstrate an epistemological and ontological framework for the research question(s), as well as indicate their relevance for health policy and practice. Good qualitative research should manifest evidence of responsiveness to social context, flexibility of design, theoretical or purposeful sampling, adequate description, data quality, theoretical and conceptual adequacy, and potential for assessing typicality.

The current trend of evidence-based nursing (EBN) is following evidence-based medicine in its discourses and practice. Closs and Chester
(1999:11) note that the underlying assumption of evidence-based nursing is: that science-based evidence tells us what the most successful and cost-effective approaches to nursing care are. We will then be in a position to provide best possible care at least possible cost in an environment of limited resources. Australia’s health care system is focused on economic rationalism and an increasing reliance on evidence to achieve the following outcomes: increased throughputs, shorter hospital length of stay, task-oriented behaviours, greater efficiency and cost-effectiveness (Bloom 2000). An emphasis on resourcing health professionals to deliver quality of care is less apparent. This is true for nurses whose workloads have dramatically increased with a higher staff:patient ratio (from 1:1 to 1:8 or 1:10) as a consequence of understaffing (Considine & Buchanan 1999), and clearly evident in Victoria prior to the ruling by Commissioner Blair in August 2000 (Australian Industrial Relations Commission 2000). An emphasis on resourcing health professionals to deliver quality of care is less apparent. This is true for nurses whose workloads have dramatically increased with a higher staff:patient ratio (from 1:1 to 1:8 or 1:10) as a consequence of understaffing (Considine & Buchanan 1999), and clearly evident in Victoria prior to the ruling by Commissioner Blair in August 2000 (Australian Industrial Relations Commission 2000). In some public and private hospitals, nurses are being assigned care of six to eight patients for the afternoon shift, with the potential to compromise quality of care while attempting to meet performance indicators based on economic rationalism. This appears to be ‘standard practice’ but does not take into account the acuity of patients’ conditions, nor the potential for complications to arise. There is little time for nurses to address patients’ spiritual, emotional, educational or discharge planning needs as a result of inadequate nurse:patient ratios. The emphasis is upon the physical technical tasks in the clinical setting. In the area of stomal therapy nursing, for example, nurses relate they have to justify their positions within their employing institutions (public and private hospitals, community health services). Many are no longer just doing stomal therapy nursing; they are also undertaking a combination of other tasks: wound care, breast care, continence management, and intravenous antibiotics. Much of their work cannot be readily quantified (Parker, Wright, Pearson 2000).

We agree with Closs and Chester (1999:16) that nursing, ‘in comparison with medicine, has not yet generated enough research to provide the extensive scientific body of knowledge to underpin it.’ Evidence-based nursing remains largely restricted to discourse and quantitative data only, and the strength of the evidence to date is variable. Furthermore, ‘there is currently insufficient good trial evidence to inform many aspects of nursing. In the absence of RCTs (randomized-controlled trials), the use of the best evidence available is advocated (Closs & Chester 1999:14).

A wide range of methods emanating from both qualitative and quantitative methodologies is therefore needed for a research base to support nursing practice. As we know, nursing is very much a human science (Watson 1985). The phenomenon of nursing lends itself to qualitative study to provide a better understanding of the unique and myriad dimensions of nursing practice.

Despite the recent establishment of the Joanna Briggs Institute for Evidence Based Nursing and Midwifery (Adelaide) and the Victorian Centre for Evidence-based Practice (Melbourne), and other centres interstate and overseas (Pearson 2000), there is still little evidence of nursing research being used in clinical practice (Hundley, Milne, Leighton-Beck, Graham, Fitzmaurice 2000; Kajermo, Nordström, Krusebrant, Björvell 2000; Parahoo 2000; Retsas 2000). The recent establishment of clinical chairs in (acute and specialty areas of) nursing in some public and private hospitals in Australia, in collaboration with university nursing departments, however, would ensure nursing research translates into practice (Dunn & Yates 2000). Roberts (1995:231) stipulates that:

A professoriate with expertise in clinical practice will concentrate on the development of clinical nursing knowledge and this will foster the development of nursing scholarship. In the next generation, the chairs will be held by scholars with doctoral degrees based on nursing practice research.

The clinical chairs in nursing
serve as crucial 'bridges' to overcome the traditional gulf between research and practice, build a body of clinical evidence, and implement evidence based practice in clinical settings. The impact of these joint appointments will not be known for a few years. In some instances, senior nurses are being appointed as researchers on a clinical-only basis in hospitals to provide in-house staff development and research direction for nursing and other staff. This is perceived as a positive direction for the nursing profession. Nevertheless, the outcome of this new role cannot be determined until a few years after the role becomes established. But, are clinical chairs value for money? And do they pursue their own research interests or contribute to advancing the nursing profession, or, just endeavour to survive the partnership? They have two 'bosses' to please: a university and hospital. Dunn and Yates (2000) interviewed 20 Australian clinical chairs of nursing during 1996-97 and observed that the role addresses leadership in research, education and the politics of the nursing profession, and is perpetually evolving in accordance with the sometimes conflicting priorities of both universities and hospitals.

From our participant-observation in various clinical areas over the years, we believe few Australian nurses working in the clinical setting have an interest, understanding, experience or qualifications in research that includes proposal design, implementation, data analysis and report writing, as well as submissions to ethics committees and funding bodies. Increasingly, nurses are expected by their heads of department to undertake research as part of their job description. It is reasonable to presume that nurses with a Diploma or Certificate level of education do not have research skills. However, the current composition of the national nursing workforce reveals many nurses have graduated with a Diploma and/or Bachelor of Nursing degree (AIHW 1999).

In undergraduate nursing courses, nursing research is a core unit. These nurses have basic research skills, which are further developed in the postgraduate courses, although these are not often sustained in the clinical settings. There are few mechanisms in the clinical setting to encourage nurses and support them in their endeavours to apply their research skills (eg. appraising the merit of a published study before applying the findings to clinical practice). Since the work of Funk, Champagne, Weiss and Tornquist (1991a, b) the most frequently cited barriers to nurses' utilisation of research are related to four factors: setting, presentation, nursing and research.

Parahoo (2000), for example, encountered the following factors with the highest percentage as a great or moderate barrier (61-75.4%) to utilisation of nursing research in Northern Ireland.

- The nurse does not feel they have enough authority to change patient care procedures;
- Statistical analyses are not understandable;
- There is insufficient time on the job to implement new ideas;
- Management will not allow implementation;
- The nurse feels results are not generalisable to their own setting; and,
- The nurse does not feel capable of analysing the research.

Retras (2000) identifies barriers as: accessibility of research findings, anticipated outcomes of using research, and most significantly, limited support from the organisation and other nurses to use research. Various nurses, however, collect data for other health professionals - principally doctors. Most frequently, they are employed as data managers, research nurses or clinical coordinators to work on a specific project. Additionally, recognition of nurses' research skills is lacking and requires urgent redress so that nurses themselves may undertake evidence-based nursing in their own right, or as part of a multi-disciplinary research team. Factors that facilitate nursing research are (paid) time, management support, funding and resources to undertake research projects, mentors, collegial support, and professional development to advance their research knowledge, skills and experience (Gillett, Peerson, Wilson 2001; Parahoo 2000; Peerson, Gillet, Wilson 2002).

Whilst we are aware that not all nurses wish to engage in
research, those few nurses with research skills are often undervalued by their colleagues and other health professionals. A common negative attitude is reflected in the following comment. "Why do you want to do a masters or doctorate degree?" The devaluing of research skills gained through completing higher degree by research courses is often soul destroying to those students who endeavour to apply their research to improve quality of nursing care. Some clinical nurses also perceive research as an academic exercise to fulfill a course requirement, and irrelevant to the reality of clinical practice. Evidence-based nursing will only be an illusion or viewed as paying lip service to the nursing (and other multi-disciplinary) literature unless there are marked changes of attitudes within the nursing profession. Implementation of a positive research culture within health care institutions will support and encourage nurses to utilise and apply their research skills and utilise evidence for the benefit of patients (Parahoo 2000; Peerson, Gillet, Wilson 2002).

We are cautious about jumping on the bandwagon of pursuing evidence-based nursing without considering the quality, rigour and validity of data and methodology exposed by both quantitative and qualitative research. The conduct of research requires an understanding of both ontological and epistemological issues. The answers to questions do not arise from nowhere, but rather, are founded within the context of daily clinical practices.

**Conclusion**

To conclude from our discussion, we maintain the importance of nurses being reflexive about the use of technology to redress ill-health, the patient-healer relationship, the trend of critical pathways and evidence-based nursing. Where are patients' subjectivity and nursing care in these issues? We make the following recommendations about nursing practice

"...increase nurses' confidence in themselves as individuals and as a profession..."

- Provide praise and positive feedback to nurses for their creativity, intuition, common sense and experiential knowledge, critical analysis, and use of research in clinical practice (guided by clinical chairs of nursing and nursing heads of departments).
- Adopt a more reflexive approach to nurses' utilisation of technology and performance of technical tasks in health care services.
- Endeavour to make the voices and presence of patients and nurses more evident in the CP and in the medical records.
- Raise an awareness of nurses' diverse knowledge, skills and expertise in providing patient care.
- Encourage and support nurses to develop research skills and undertake their own research projects that they perceive to have direct relevance to their clinical practice and improve patient health outcomes.
- Foster nurses to widely disseminate their project findings to their colleagues and other health professionals, through seminars and workshops in the workplace, as well as presenting conference papers and publishing in journals.
- Boost nurses' skills by providing education and research resources, funding and personnel to assist them. These measures will increase nurses' confidence in themselves as individuals and as a profession, plus promote reflexivity of clinical practice. We agree with Parker (1995:342) that nurses 'become empowered through recognising, strengthening and articulating their unique knowledge and skills.' In addition, these measures will ideally contribute to reform and improvement of the Australian health care system and result in better outcomes: enhanced patient well-being and quality of care, reduced barriers to the utilisation of research and greater implementation of evidence based practice.

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The 12th International Conference of the Nursing Network on Violence Against Women

Violence Against Women: Evidence of Difference?
Rethinking current paradigms and exploring innovative approaches to ending violence.
20 - 22 June 2003, Stamford Grand Hotel, Glenelg, South Australia

Hosted By
The School of Nursing & Midwifery, Flinders University
In collaboration with the Nursing Network on Violence Against Women International

Conference Aims and Objectives:
This conference aims to provide a forum for all those who work in human services to come together and discuss the work that is occurring to end violence against women and children and promote their safety. In particular this conference aims to promote collaborative efforts throughout the community and across sectors with an emphasis on the responsibility of the health system to respond to violence against women and provide options for safety.

Who should attend
It is anticipated that the conference shall attract professionals who have a special interest, or work in, the following areas:

Abuse/Neglect
Children's Health & Safety
Emergency Departments
Indigenous Domestic Violence
Research & Evaluation
Women's Health

Advocacy Services
Dentistry
Forensic
Mental Health
Sexual Assault
Women's Services

Aged Care
Domestic Violence
General Practice
Midwifery
Veterinary Practice
Trauma/Criminal Injuries

Alcohol & Other Drugs
Education
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Migrant & Refugee Health
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