Advocates or Corporates: Constructions of Clinical Nursing Practice in Australia with regards to the idealisation of Advocacy and Autonomy

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This thesis is submitted in total fulfilment
of the requirements for the degree of
Doctor of Philosophy

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Abstract

Although the idealisation of nurses as advocates is popularised in nursing literature and supported within nursing frameworks, codes and standards, there has been little critical examination of these ideas within contemporary Australian healthcare settings and nursing practice. The Australian Healthcare system is a complicated system of interacting service providers and consumers. Institutions that regulate healthcare professionals and organisations normalise understandings of nursing and nursing practice, including conceptualisations of the importance of autonomy and advocacy and how each is to be supported and/or practised. This study used the perceptions of practising Registered Nurses (RNs) to examine the actualities of advocacy and support for autonomy as they are carried out within clinical practice, and to highlight, problematise and then analyse differences between the rhetoric and realities of practice.

Firstly, a phenomenological lens, including an ethnographic model of observation, was used to thematically map and examine the RNs' lived experience of their practice, paying particular attention to their conceptions of and responsibilities toward advocacy and autonomy. This thematic analysis brought to the fore a range of assumptions that, although clearly normative within nursing practice, are in evident tension with one other. These were then re-examined using a range of Michel Foucault's concepts concerning the construction and maintenance of regimes of truth. Designed to unpack the operations of power and knowledge, and to make visible the techniques of disciplinarity and governmentality that inform and support them, an engagement of these concepts has allowed this thesis to critically examine the normative constructions and enactments of nursing practice with regards to ideas and practices concerning advocacy and autonomy. What this thesis provides is a detailed examination of the contrasting constructions of power and knowledge within nursing practice in relation to advocacy and autonomy, how and why these concepts have been operationalised within nursing practice, and how they could be re-visioned into the future.

Statement of authorship

Except where explicit reference is made in the text of this thesis, this thesis contains no material published elsewhere or extracted in whole or in part from a thesis by which I have qualified for or been awarded another degree or diploma. No other person's work has been relied upon or used without due acknowledgement in the main text and bibliography of the thesis

Signed:	Signed:
Dated: 16/09/2019	Dated: 16/09/2019
Mrs. Clare A. Cole Candidate	Dr. Jane Mummery Principal Supervisor

Statement of ethics approval

Approval

Human Research Ethics Committee

University of Ballarat
Learn to succeed

Principal Researcher:	Sally Wellard
Other/Student Researcher/s:	Jane Mummery Clare Cole
School/Section:	SHS
Project Number:	A12-153
Project Title:	Unpacking advocacy in contemporary nursing
For the period:	22/01/2013 **to** 31/12/2014

NB: Before the research begins, please submit letters of approval from any external organisations involved in the project.

Please quote the Project No. in all correspondence regarding this application.

REPORTS TO HREC:

A final report for this project must be submitted to the Ethics Officer on:
31 January 2014

These report forms can be found at:
http://www.ballarat.edu.au/research/research-services/forms/ethics-forms

Acting Ethics Officer
22 January 2013

Please see attached 'Conditions of Approval'.

CONDITIONS OF APPROVAL

1. The project must be conducted in accordance with the approved application, including any conditions and amendments that have been approved. You must comply with all of the conditions imposed by the HREC, and any subsequent conditions that the HREC may require.

2. You must report immediately anything which might affect ethical acceptance of your project, including:

    - Adverse effects on participants;
    - Significant unforeseen events;
    - Other matters that might affect continued ethical acceptability of the project.

3. Where approval has been given subject to the submission of copies of documents such as letters of support or approvals from third parties, these must be provided to the Ethics Office before the research may commence at each relevant location.

4. Proposed changes or amendments to the research must be applied for, using a 'Request for Amendments' form, and approved by the HREC before these may be implemented.

5. If an extension is required beyond the approved end date of the project, a 'Request for Extension' should be submitted, allowing sufficient time for its consideration by the committee. Extensions cannot be granted retrospectively.

6. If changes are to be made to the project's personnel, a 'Changes to Personnel' form should be submitted for approval.

7. An 'Annual Report' must be provided by the due date specified each year for the project to have continuing approval.

8. A 'Final Report' must be provided at the conclusion of the project.

9. If, for any reason, the project does not proceed or is discontinued, you must advise the committee in writing, using a 'Final Report' form.

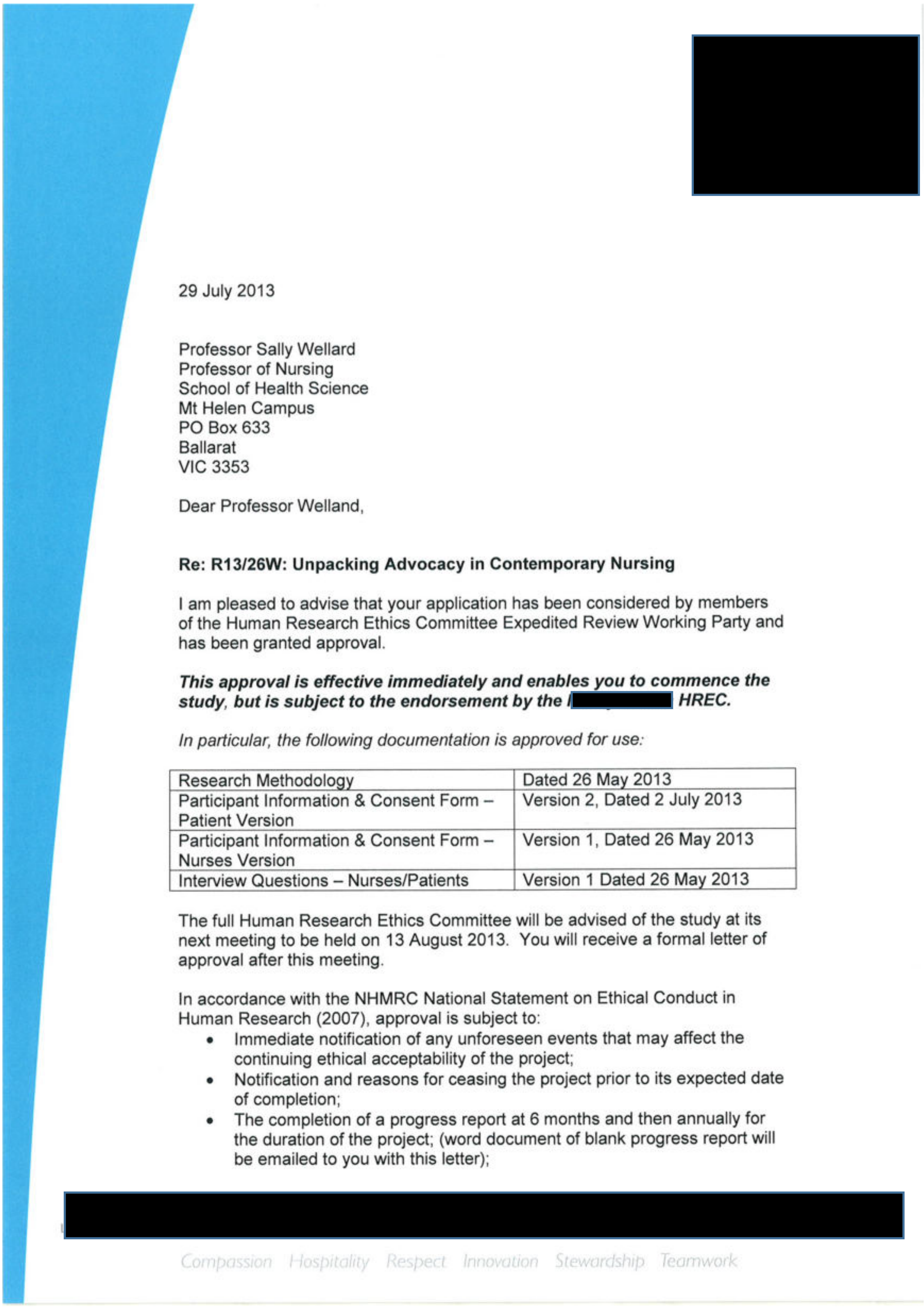
10. You must advise the HREC immediately, in writing, if any complaint is made about the conduct of the project.

11. You must notify the Ethics Office of any changes in contact details including address, phone number and email address.

12. The HREC may conduct random audits and / or require additional reports concerning the research project.

Failure to comply with the *National Statement on Ethical Conduct in Human*

***Research* (2007) and with the conditions of approval will result in suspension or withdrawal of approval.**



[redacted]

29 July 2013

Professor Sally Wellard
Professor of Nursing
School of Health Science
Mt Helen Campus
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Ballarat
VIC 3353

Dear Professor Welland,

Re: R13/26W: Unpacking Advocacy in Contemporary Nursing

I am pleased to advise that your application has been considered by members of the Human Research Ethics Committee Expedited Review Working Party and has been granted approval.

This approval is effective immediately and enables you to commence the study, but is subject to the endorsement by the [redacted] HREC.

In particular, the following documentation is approved for use:

Research Methodology	Dated 26 May 2013
Participant Information & Consent Form – Patient Version	Version 2, Dated 2 July 2013
Participant Information & Consent Form – Nurses Version	Version 1, Dated 26 May 2013
Interview Questions – Nurses/Patients	Version 1 Dated 26 May 2013

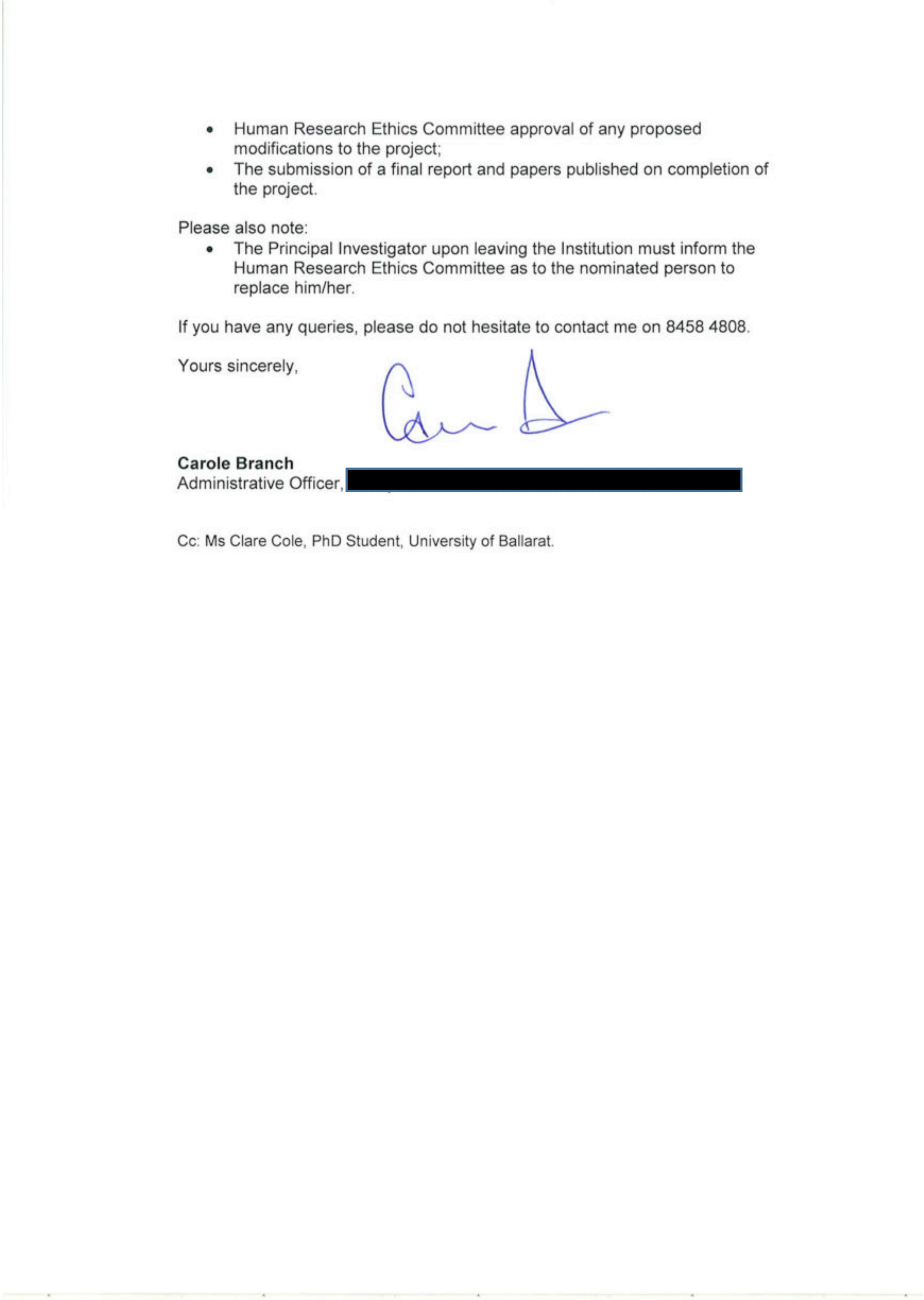
The full Human Research Ethics Committee will be advised of the study at its next meeting to be held on 13 August 2013. You will receive a formal letter of approval after this meeting.

In accordance with the NHMRC National Statement on Ethical Conduct in Human Research (2007), approval is subject to:

- Immediate notification of any unforeseen events that may affect the continuing ethical acceptability of the project;
- Notification and reasons for ceasing the project prior to its expected date of completion;
- The completion of a progress report at 6 months and then annually for the duration of the project; (word document of blank progress report will be emailed to you with this letter);

[redacted]

Compassion Hospitality Respect Innovation Stewardship Teamwork



- Human Research Ethics Committee approval of any proposed modifications to the project;
- The submission of a final report and papers published on completion of the project.

Please also note:

- The Principal Investigator upon leaving the Institution must inform the Human Research Ethics Committee as to the nominated person to replace him/her.

If you have any queries, please do not hesitate to contact me on 8458 4808.

Yours sincerely,

Carole Branch
Administrative Officer, [redacted]

Cc: Ms Clare Cole, PhD Student, University of Ballarat.

Acknowledgements

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A special thanks to Terry Finn who read this beast from start to finish without complaint.

I would like to acknowledge the amazing nurses that I met while completing this study and without their support and involvement, this would have not been possible.

Friends who have been there to listen, have coffee, and save me from myself. You kept me grounded. Family, who have had my children while I went to meetings (no matter how badly behaved they were) and for the encouragement and pep talks when I needed them.

Finally, my husband Corey and our four beautiful children Thomas, Charlotte, Niamh and Millie. They all came on this journey, for better and worse, and in the challenging times their unwavering support and the hugs, kisses and giggles have been nothing short of inspiring. This journey shows my children that anything is possible with hard work and determination.

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24/7 – 24 hours a day/ 7 days a week
ACN – Australian College of Nursing
ACSQH – Australian Commission on Safety and Quality in Healthcare
AHPRA – Australian Health Practitioner Regulation Agency
ANMAC – Australian Nursing and Midwifery Accreditation Council
ANMF – Australian Nursing and Midwifery Foundation
ANUM – Associate Nursing Unit Manager
BIBA – Brought in by Ambulance
BiPAP – Bilevel Positive Airway Pressure
BSL – Blood Sugar Levels
COPD – Chronic Obstructive Pulmonary Disease
CPD – Continuing Professional Development
DE – Diabetic Educator
DKA – Diabetic Ketoacidosis
DON – Director of Nursing
EBP – Evidence Based Practice
ECG – Electrocardiogram
EFT – effective full time
EN – Enrolled Nurse
GEM – Geriatric Evaluation and Management
I/C – In Charge
ICN – International Council of Nurses
ID – Identification
IQ – Intelligence Quotient
IV – Intravenous
KPI – Key performance indicators
MET – Medical Emergency Team
Morph – Morphine
NMBA – Nursing and Midwifery Board of Australia
NICE – National Institute for Health and Care Excellence
NSQHS – National Safety and Quality Health Service Standards
NWB – Non-weight bearing
Obs – observations
OT – Occupational Therapist
OT – operating theatre
PAC – Pressure Area Care
PCC – Patient Centered Care
Physio – Physiotherapist
PLIS – Plain Language Information Statement
PM – afternoon
Pt. – patient
R) – right
RDNS – Royal District Nursing Service
Rehab – Rehabilitation
RN – Registered Nurse
RTW – return to ward
S/C – subcutaneous
SCP – Standardised Care plan
SES – Socio-economic Status

Chapter 1- Significance and Organisation

Situating Autonomy and Advocacy

The nursing profession is a practice-based discipline that has a unique body of knowledge that has developed and expanded to establish nursing as a profession from its humble religious beginnings. As a profession, nursing is multifaceted and has come to incorporate not only practices of caring, but also, as I will discuss in detail, ideas around advocacy and supporting and protecting the autonomy of patients, more recently framed as consumers[1] of healthcare.

Key nursing theorists (such as Lawler, 2006) have described the partnership of nurses with patients with regards to issues of autonomy and advocacy as being informed by a framework of holistic practice. Here the idea of holism stresses the importance of encompassing, along with the standardised biomedical focus, the social and cultural contexts that have the potential to influence an individual's healthcare choices and journey, therefore influencing the support and care that they may require.[2] It is this holistic practice framework that has allowed nursing to differentiate itself from and contest the reductionism typical of the biomedical model and some other parts of the medical profession. In particular it has led to the development of broader understandings of what it should mean to respect autonomy – a cardinal value of healthcare and nursing – which also shape new understandings of what it means to be an advocate.

When I started this journey, as a currently practising Registered Nurse and an educator within the tertiary education sector, if you had asked me if I was an advocate for patients and always acted with respect for their autonomy then I would without hesitation have said yes. However, as my journey has progressed, I have realised that the conceptualisation and actualisation of advocacy in nursing practice, along with its work in protecting and supporting specific ideas and practices of autonomy, are more complex

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[1] The term consumer is very complex in the frameworks of healthcare. In patient centered care frameworks, it has come to replace traditional biomedical references of the 'patient'. I will be examining the shifts in such terms such as patients to consumers in details in later chapters in this thesis. At this stage, however, I will use both of these terms as appropriate.

[2] These key ideas will be introduced and examined in detail in the next chapter and considered throughout the thesis.

and contested processes than they are conventionally presented as being. In fact, I question whether nurses are able in practice to behave as advocates in the way it has been assumed that they can do so, or whether the broader contexts that inform and shape nursing practice make this an ideal only. It is these issues and associated questions that drive this project to uncover the possible roles and functions of ideals of advocacy and autonomy within the nursing profession and to examine how these ideals are actualised within clinical nursing practice.

Background to the Study

In recent years, the face of Australian nursing practice and registration has undergone significant changes. July 1st, 2010 saw the commencement of the National Registration and Accreditation Scheme with the overarching regulatory body Australian Health Practitioner Regulation Agency (AHPRA)[3] responsible for overseeing the regulatory requirements of nursing practice and the registration of individuals. More recently, June 2016 saw the implementation of revised standards for practice which function to regulate and monitor the practice of both student and Registered Nurses in Australia. This shift in the political control of nursing practice has challenged some of the ideals, assumptions and values of nursing practice and warrants further investigation. For instance, the development and adoption of concepts of patient-centered care within healthcare settings and the ensuing focus on the empowerment of consumers in a changing healthcare environment presents the need to re-analyse the ideals and practices of nursing – and its assumptions concerning advocacy and autonomy – in the context of contemporary healthcare in Australia. Of particular interest, as noted above, are questions around advocacy as being integral to good nursing practice, and the possible effects that such ideals of advocacy may have on the positions of consumers within the system of healthcare.

Some of the possible complexities here concern, for example, the impacts of healthcare terminology, with terms such as patients, clients, residents, carers, relatives and community advocates all in use and used interchangeably to refer to consumers of healthcare. All of these terms are also reflected in key documents regulating nursing

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[3] The Australian Health Practitioner Regulation Agency works to support the 14 national boards that are responsible for the regulation of the health professions. The primary role of the National boards is to protect the public and they do this by setting the practice standards and policies that are met by all registered health practitioners (Australian Health Practitioner Regulation Agency [AHPRA], n.d.).

practice in Australia such as the Registered Nurse Standards for Practice (NMBA, 2016); the Code of Professional Conduct (NMBA, 2008b); the Code of Ethics for Nurses (NMBA, 2008a); and, more recently, the Australian Commission on Safety and Quality in HealthCare (NSQHS) and the National Safety and Quality Health Service Standards (2017).

As a recent blog post by Bastian Seidel (2016) entitled *'I specialise in patients, not consumers, clients or users'* makes visible, such changes in rhetoric have occurred at the political level of healthcare, and, enforced top down, have operated to regulate and control healthcare. This top down mechanism, Seidel argues, places nursing focus on the fiscal management of healthcare, with key performance indicators (KPIs) becoming the bottom line, rather than the health and wellbeing of the individual receiving treatment and care. At the same time, Seidel (2016) notes that such rhetoric has also been presented as a mechanism to encourage the empowerment of healthcare consumers. Tomlinson (2012) recognises that this change in terminology has been an attempt to challenge the traditional subject position of the patient so as to modify their relationships with illness, society and healthcare professionals. Nevertheless, such changes are problematic in relation to standard views of the roles and significance of advocacy and autonomy insofar as constructions of illness and of what it means to receive care are, as Tomlinson (2012) also points out, historically and socially embedded. It is suggested that no matter what terms are currently popular, there is an underlying and connected context that implies a power struggle between the regulation of consumers and providers of healthcare (Tomlinson, 2012).

This complexity leads me to argue that to fully understand the modern constructions of nursing practice and healthcare, and their relations to and contestations of long-held nursing ideas around advocacy and the need to protect and support autonomy, there is a need to explore these ideals and relationships in detail. To put this another way, there is a need to unearth the force and play of relations that inform the particular values, assumptions and practices framed as significant for nursing practice and the nursing profession, and their historical developments, as well as to map these relations as they interconnect in surprising ways. This is, of course, an examination of practices of power, knowledge – power/knowledge, to borrow from Michel Foucault – and truth, where truth, after Foucault (1980/1972a), is always remembered to be a construction which is

> produced only by virtue of multiple forms of constraint. And it induces regular effects of power. Each society has its régime of truth, its "general politics" of truth: that is, the types of discourse which it accepts and makes function as true; the mechanisms and instances which enable one to distinguish true and false statements, the means by which each is sanctioned; the techniques and procedures accorded value in the acquisition of truth; the status of those who are charged with saying what counts as true. (p. 131)

Such techniques, in turn, point to what might be called, after Foucault, the governmentality of nursing and healthcare, where government is understood as referring to "the way in which the conduct of individuals or of groups might be directed" (Foucault, 2002/1994a, p. 326).[4]

Foucault thus provides for this thesis what Powell and Gilbert (2010) refer to as a 'conceptual toolkit' that will help me identify and interrogate the various relationships that have been constructed between healthcare professionals and consumers of healthcare, and around the various ideals played out through nursing practice. Indeed, Foucault (1977) has himself argued that when professions such as nursing are considered within the contexts of contemporary healthcare, they clearly operate as instruments of governmentality. That is, the agent (in this case, the nurse) carries out the reproduction and maintenance of a 'régime of truth' that regulates not only healthcare professionals and consumers or patients, but socially constructed Western notions of health and illness – and ideas of autonomy and advocacy. Regimes of truth are maintained via the repetition and circulation of what Foucault has called discursive practices, meaning "words, materialities and practices [that] hang together in a specific, historically and culturally situated way" (Mol, 2008, p. 9) so as to shore up and legitimate the constructs of identity, subjectivity and truth that, in this case, inform healthcare and the nursing profession.

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[4] Also important for this thesis is Foucault's insight that even this power of governmentality – and what he has also called disciplinary power (1977) – is not purely repressive but productive. That is, power runs throughout the social body, and is always exercised rather than possessed (Bradbury-Jones, Sambrook & Irvine, 2008; Foucault, 1977; Gallagher, 2008; Henneman, 1995; McGowen, 1994; McHoul & Grace, 1993; Rabinow, 1984). Foucault indeed theorises that in order for power to be recognised, resistance has to exist (Foucault, 1990/1978).

Aims, Structure, and Approach

Aims

The aim of the study is to explore the various constructions/ideals of advocacy and autonomy that are seen as fundamental for both nursing and being a nurse and examine how well they cohere with the actuality of nursing practice, as well as to examine the impacts and implications of any tensions between them. This aim unpacks into two objectives. The first objective of this study is thus to investigate how ideals of autonomy and advocacy are constructed both within nursing literature and policy and by nursing practitioners in and through their nursing practice. A second objective is to analyse how these constructions support and maintain specific ideals, subject positions and practices which, themselves, work to either maintain or disrupt these constructions.

Structure and Approach

There are two main sections to the thesis with regards to both its structure and my approach. The first section, addressing the first objective, consists of a phenomenological study using methods of both one-on-one interviews and microethnographic observation of practising nurses in a clinical ward, and a subsequent thematic identification and analysis of their views regarding the ideals of advocacy and autonomy in their practice. This study is further framed by analysis of the roles of concepts of advocacy and autonomy within both nursing literature and policy, paying specific attention to the way these concepts have been situated in Australian nursing policy documents. Thus, this part of the thesis, comprising the next three chapters, allows for the identification and articulation of normative views of the nursing ideals and practice – as expressed both within the literature and by the participants – that frame contemporary nursing practice.

The second section of the thesis – from Chapter Five onward – examines these views in more detail, critically considering both the ways they construct and support certain subject positions and practices as normative whilst undermining others, and the implications of such constructions for both nursing practice and policy more broadly. These various points will be exemplified throughout these later chapters with reference back to insights from both the interviews and the observational data, and from the policies as considered in the first part of the thesis. As noted, what these earlier chapters make clear are the prevailing assumptions around nursing practice and its valuation of ideals of autonomy and advocacy in the Australian context. What they also make visible, however, are a range of points of contestation with regards to attempts to actualise these ideals through nursing practice. As such, this second section of the thesis draws on a range of Foucault's concepts to re-examine the thematic findings from the first part of the thesis. This analysis will explore in more detail both the dynamics of normative practices of nursing with regards to issues of power/knowledge and governmentality, and how ideals of autonomy and advocacy are differentially engaged across conflicting discursive practices and regimes of truth. In other words, a Foucaultian lens will allow for the identification and examination as to where seemingly normative discursive practices of nursing dissolve into contestation and paradox, and consideration of other frameworks within which roles for advocacy and autonomy for nursing practice can also be seen. My examination of the relationships of different practices has also been enhanced by my recognition of what I am calling an insider/outsider framework. Such a framework has allowed me to, for example, make visible the tensions between the insider views of my nurse participants and the outsider view of nursing practice foregrounded through Foucaultian conceptualisations of governmentality.

My engagement with Foucault's ideas in the second section of the thesis thus allows me to challenge taken-for-granted truths – as identified in the first section of the thesis through both nursing literature and policy and the voices and observations of nursing in their everyday practice with patients – and to explore how and why these truths might be problematic and might need to be re-theorised. It is also prudent here to stress the importance of engaging these two modes of analysis: phenomenological and ethnographic on the one hand, and Foucaultian on the second. Although these two modes of analysis – phenomenological and Foucaultian – have sometimes been seen as being in tension (Lawlor, 2004), with Foucault himself noting his turn away from a particular understanding of phenomenology (1994/1970), at the same time Foucault does note the importance of an empirical context for his own discussions of the practices of knowledge/power and governmentality (Ferreira-Neto, 2018; Foucault, 1989/1984). In the context of this study, then, I have used the thematic analysis, as a deep study of advocacy and autonomy, as the empirical beginning point and context for my later Foucaultian analysis.

These analyses together bring me to my final argument, which is that there needs to be a repositioning of how advocacy and autonomy are currently perceived and enacted in nursing practice. Overall, then, this study uses multiple methods to examine the ideals of nursing practice, the role of the nurse as an advocate, to explore the place of the concept of autonomy within healthcare, and to offer a range of insights for further consideration and debate. It is anticipated that my findings may lead to deeper understandings of the strengths and difficulties associated with nursing practice and the patient experience, and how these may be enhanced or addressed to facilitate care, particularly with regards to advocacy work and the support of patient autonomy. How these understandings and insights are developed is outlined in the next section which presents a summation of what each chapter contains.

Study Outline

Overall, this study analyses the complexity of the various discursive practices that construct contemporary nursing practice and nurses in relation to ideals of advocacy and autonomy. As will become clear, the concepts of advocacy and autonomy ascribed to nursing practice are complex and multifaceted for both patients and nurses – and further complicated when considered in practice – with points of contestation having substantial implications for nursing practice and its constructions of value and subjectivity.

Chapter 2

Chapter Two, the literature review, explores the historical, social and cultural contexts within which nursing practice and ideals of advocacy and autonomy have been articulated. This chapter demonstrates that the historical conceptions of autonomy and advocacy come from a bioethical perspective and are constructed within dominant bioethical frameworks designed to protect individuals and their rights when engaging with healthcare. The chapter then outlines the more contemporary idealisations of autonomy and advocacy through the work of Beauchamp and Childress (2013). Comparing this historical basis and Beauchamp and Childress' (2013) construction of bioethics and associated understandings of autonomy and advocacy allows me to begin to problematise the definitions and conceptualisations of autonomy and advocacy within healthcare. Of particular note are the issues around liberal autonomy and advocacy within healthcare that lead to discussions of biomedically constructed ideas of capacity, competency and autonomy. This chapter thus outlines the focus and dominance of what can be called the biomedical model within contemporary healthcare. This is done through an initial interrogation of the contemporary codes and standards of nursing practice that influence the enactment and understanding of autonomy and advocacy by practising nurses, and then through exploration of the biomedically sanctioned ideas of the sick role (Parsons, 1951), paternalism and vulnerability.

Chapter 3

Chapter Three is an explanation of the research methodologies and methods used for the thematic analysis setting out the views of practising Registered Nurses (RNs). Given my aim of understanding the workings of assumptions and ideas of advocacy and autonomy within nursing practice – to understand the insider view – the first step needs to be to identify and give voice to those assumptions as they play out in practice. This makes investigating the views of practising nurses essential. This process of gaining insight into the experiences and views of nurses thus involves a hermeneutic phenomenological methodology underpinned by ethnographic methods. More specifically, it involves a research study of five nurses who agreed to be observed in their work for a period of 12 weeks and to participate in multiple one-on-one interviews. This process saw the researcher becoming immersed into the ward culture and shadowing the nurses throughout their nursing interactions with patients and other healthcare professionals. Ethnographic methods relevant to this study include the way in which data is collected through moderate participant observation maintaining a balance between being an 'insider' and being an 'outsider'. From a hermeneutic phenomenological perspective, as noted above, multiple one-on-one semi-structured interviews were also conducted with each participant. The ethical framework and considerations of this study are also explored in this chapter, along with a detailed outline of the process of sampling of participants. This is followed by an explanation and justification of how and why data was collected through microethnographic observational fieldwork practices and phenomenological interviews. In this section, the processes of recording and transcribing the ethnographic interviews and some of the limitations of using ethnographic interviews as a data collection technique are discussed. As part of this discussion, I also introduce what I am calling the insider/outsider framework, addressing some of the complexities of the role of the researcher as an insider/outsider. As I make visible, these points add to the challenges associated with this type of data gathering. It is also important in this chapter to identify and discuss the concepts of validity within qualitative research, as this is often referred to as a weakness of qualitative research design methods. To conclude this chapter, I outline the process of the initial stage analysis of the study, using Colaizzi's method of analysis to produce a thematic analysis that works to make links to help to establish validity within the study.

Chapter 4

In Chapter Four, the thematic analysis of the interview transcripts identifies three main overarching themes with regards to nurse participant understandings of the roles of ideas of advocacy and autonomy in their practice: Supporting Patient Autonomy; Advocacy in the Context of Duty of Care; and The Contextualisation of Care. As will be seen these themes are further illustrated and supported through reference to relevant observational data and extensive field notes. Each of these three themes also include several sub-themes. Although this thematic analysis focuses primarily on what is said by the participants and strives to represent their voices as fully as possible, what also becomes visible through this chapter are some of the connections between participant views and perspectives normalised in existing literature and policy, as well as some of the tensions and paradoxes that will drive my investigations and analysis in later chapters.

Chapter 5

As is well known, Foucault has an interest in exploring practices – including those of healthcare – through an examination of their dynamics of relationality and power/knowledge. This section of the thesis and the following chapters offer critical considerations of the normative dimensions of advocacy and autonomy that have been conceptualised and enacted within healthcare and which have been made visible through my consideration of nursing literature, policy and practice. This chapter and the following chapters thus draw attention to the points where there is conflict, or tensions between the ideals and the actuality of practice concerning autonomy and advocacy. Outlining the key concepts of Foucault's philosophical work which will be important to this thesis – the focus of this chapter – in turn allows for a deeper exploration of not only some of the assumptions and practices concerning autonomy and advocacy that influence healthcare, but further consideration of how these assumptions and practices have been made visible through the thematic analysis of the interviews and field observations. These discussions will finally lead to a comprehensive analysis of the relations of power and knowledge currently at play within the clinical healthcare framework. As this and the next analysis chapters make clear, these differing relations of power and knowledge visible within healthcare comprise what Foucault would call differing regimes of truth.

Chapter 6

Chapter Six begins by recapping the significance of the insider/outsider roles and relationship within this thesis. Within this chapter I recap how insider views have been shaped and influenced by the specific ideals that are influential and are embedded within the governmentality of contemporary nursing practice. Following a Foucaultian style of analysis – the focus of both this and the next two chapters – Chapter Six is an examination of the cross-cutting operations of power and knowledge that inform one of the dominant discourses in nursing practice, the biomedical regime of truth. By doing this I will be examining the hierarchical structures of healthcare when it is conceived under the biomedical model of healthcare. This chapter will briefly provide the reader a reminder regarding the basics of the biomedical model before bringing to the fore certain issues for consideration that will include the biomedical structures of health management, and biomedical conceptions of professional expertise and the way they are maintained through disciplinary techniques of power. Also examined in this chapter is the use of medicalising language or jargon, and the hierarchical framing and normalising of individuals into limited subject positions, particularly those of the patient as being a passive, submissive and obedient subject as well as an object that can be measured and examined. Finally, I consider key points where the biomedical regime of truth starts to fail in its own maintenance, where it appears no longer able to sustain its own normative models regarding the operation and professionalisation of the healthcare domain. It is at these points, after all, that it becomes possible to see the biomedical regime of truth being interrupted by, for example, the contrasting ideals of Patient Centered Care (PCC) (this being the focus for Chapter Seven). These various points will be illustrated through the use of examples from the interview data and the observational data.

Chapter 7

Chapter Seven presents a second dominant discourse, Patient Centered Care (PCC). This regime of truth is a counterpoint to the biomedical regime of truth that has been discussed in Chapter Six. It is also a point of debate supported within the interview data and observational fieldwork used as exemplars throughout this chapter. Initially this chapter functions to define PCC and to trace how it works in contemporary clinical practice. The chapter goes on to establish PCC as a regime of truth and outlines the importance of mapping how it is operationalised through the kinds of subject positions, relationships and practices that its principles construct and normalise. The second part of this chapter thus looks at how PCC facilitates the construction of certain kinds of relationships and subject positions – often outlined by my participants and noted in the thematic analysis set out in Chapter Three – in order to present and normalise an alternative model of nursing and healthcare for patients. The final section of this chapter examines some of the main factors that can act as barriers to PCC including fragmentation of the healthcare system and confusion around terminology. Also considered is the potential discrepancy between PCC's promotion of empowerment and the institutionalised nature of healthcare, with its routines and inflexibility. These issues will then be further addressed in the next chapter.

Chapter 8

The previous two chapters both highlight ways in which these two respective regimes of truth operate in the everyday practices of the contemporary healthcare systems. Indeed, the ongoing pertinence of these regimes of truth in Australian healthcare practice has been well supported through the interview data and observational fieldwork. Regimes of truth are, however, dynamic and can become more or less dominant depending on the clinical context. Indeed, as the previous chapter demonstrated, constructions and operations of PCC cannot be understood independently of the biomedical regimes of truth; they are inextricably entangled and therefore informed by each other in complex ways. It is this entanglement that becomes the focus of this chapter. More specifically, the aim in this chapter is to identify and examine the values and disciplinary techniques – drawing again on the work of Foucault and utilising the fieldwork observational data and interview data – underpinning both the biomedical regime of truth and PCC that not only allow healthcare practitioners and consumers to move between and variously engage these two frameworks, but which govern them as they do so. These values and techniques, I suggest, comprise what Foucault might call the governmentality of nursing. While it is important to explore the ways in which the enactment of a regime of truth is contextualised, it is also important to consider how the values and technologies that drive the governance of nursing, shape, guide and affect the conduct of people within the healthcare profession, regardless of which regime of truth is considered to be in operation.

With this focus, this chapter comprises two main sections. Care has been identified as a core value of nursing practice, regardless of which regime of truth is considered to be dominant. As the first section of this chapter shows, this value of care, has been interconnected in the literature and by my participants with a range of other values including kindness, compassion, and empathy. This outline is followed by a discussion of how this value has been embedded within technologies of government. These technologies of government work at both the individual and institutionalised levels of nursing practice and inform the operationalisation of both the frameworks of biomedical models and PCC. These technologies can be summed up in the professionalised concept of duty of care. Although these technologies are framed with reference to this value of care, as I show in the second section, they are also technologies of professionalisation which are themselves driven by sets of external and internal pressures and, as such, do not always operate in accordance with care. It is the impact of these tensions that in turn drives what will be my aim in the following and last chapter – to finally consider what the operations of both these regimes of truth and these technologies of professionalisation mean for the other key values of nursing: advocacy and autonomy.

Chapter 9

Chapter Nine is the final chapter of the thesis and looks once again at the conceptualisation and operationalisation of advocacy and the ideals of autonomy. This chapter will firstly identify and discuss some of the challenges that were faced during the collection of data and how this may have influenced the results presented within this thesis, along with considering the ways Foucault's ideas have helped me come to critically reconsider the ideals and work of nursing care. Through engaging with the model of a hermeneutic circle, this chapter also marks my circle back to consider where I have reached with regards to my research aims. These were to explore the various constructions/ideals of advocacy and autonomy that are seen as fundamental for both nursing and being a nurse and examine how well they cohered with the actuality of nursing practice, as well as to examine the impacts and implications of any tensions between them. As has been noted, this will involve both investigating how ideals of autonomy and advocacy are constructed within nursing literature and policy and by nursing practitioners in and through their nursing practice, as well as analysing how these constructions support and maintain specific ideals, subject positions and practices which, themselves, work to either maintain or disrupt these constructions. As such, the next part of this chapter circles explicitly back to my thesis aims, paying attention to the conceptualisations and operationalisations of autonomy and advocacy that have become evident throughout the preceding chapters. The final part of this chapter, and indeed this thesis, will be my recommendations for contemporary nursing practice in relation to my findings concerning the roles and importance of autonomy and advocacy in Australian healthcare, thus leading ultimately to a suggested reconfiguration of the expectations of the nurse in relation to these concepts within contemporary nursing practice. When I began this journey, I thought it was going to be a relatively straightforward critical analysis using both a phenomenological framework and a Foucaultian lens to look at the ideals, assumptions, practices and relationships that inform contemporary healthcare. Instead, my often tortuous journey to understanding and acceptance of myself as a person, a nurse, an academic, a researcher and as a novice Foucaultian user is presented in this thesis as I unpack and interrogate the constructions, practices and subjectivities that influence contemporary nursing practice and the practices of advocacy and autonomy within healthcare.

In this introductory chapter, then, I have presented the topic of my study and background to its choice. I have posed the main research aim and objectives related to the topic and described the theoretical frameworks and research methods I have used in order to best answer these questions. The content of each chapter in the study has been outlined, and the main findings are discussed together with the potential implications of these findings. In the following chapter, as noted above, I situate the concepts of autonomy and advocacy within contemporary nursing literature and provide the historical contexts of these concepts within healthcare and within nursing practice.

Chapter 2- Literature Review

Introduction

The previous chapter outlined the overall structure of the thesis. This chapter outlines the various models for understanding autonomy and advocacy that are prevalent within nursing practice. As this chapter shows, one of the major models includes the range of principles established to inform the field of bioethics which were then refined by Beauchamp and Childress (2013). The bioethical framework and principles provide an important initial road for understanding how autonomy and advocacy have been conceptualised and operationalised within healthcare broadly and nursing practice specifically. These are thus outlined in some detail throughout this chapter, including with regards to how they inform – and are attempted to be actualised through – the array of Australian nursing codes and professional standards. Although these principles (and standards) provide the foundation for the widely accepted assumption that advocacy – and the support of autonomy – is essential to good nursing practice, interrogation of the codes and professional standards guiding nursing practice in Australia also shows that there is conflict about what this actually entails within clinical settings. As will be shown, this begins to problematise the taken for granted assumption that nurses should be advocates for patients (and for patient autonomy). In summation, this chapter unpacks a range of the influential ideas behind understandings of advocacy and autonomy within healthcare, a process which will allow for examination of the predominant assumptions that surround these concepts.

Autonomy

Ideas of autonomy have roots in the legal profession with autonomy commonly defined as the ability for an individual to self-rule, self-govern, or self-determine (Breier-Mackie, 2001; Beauchamp & Childress, 2013; Friedman, 2000; Goering, 2009; Mackenzie, McDowell, & Pittaway, 2007; MacKenzie & Stoljar, 2000; Tsai, 1999). So understood, autonomy is both a personal ideal and a competency/skill for the making of choices and the acting out of these choices (Abrams, 1999; Anderson, 2003). Importantly, the individual has to have a sense of volition and an engagement in their own behaviour (LaGuardia & Ryan, 2007). Dudzinski and Shannon (2006) refers to this as self-determination. Kukla (2005), Rendtorff and Kemp (2000) and Stoljar (2011) recognise that this self-determination is the kind of autonomy said to matter in a healthcare context.

This definition of autonomy is also typically drawn from the liberal ideal of individual autonomy which assumes that each individual should be independent and not influenced by outside and competing factors (Beauchamp & Childress, 2013; Christman, 2004; Friedman, 2003; MacKenzie & Stoljar, 2000). As such, the definitions of autonomy that are emphasised in medical literature, and the various codes and standards of practice used to regulate healthcare practice, are always linked back to the ability of the individual to choose their own actions and to then act on their choices without constraint (Dworkin, 1993; Stiggelbout, Molewijk, Otten, Timmermans, van Bockel & Kievit, 2004). Indeed, as will become clear through my subsequent discussions, the frameworks of governance that are in place within the Australian context of nursing practice are aligned within liberal conceptualisations of autonomy (Atkins, 2006). This is because of the influence of these conceptualisations on bioethics – where the bioethical principles themselves inform healthcare regulation and governance.

Historical Bioethical Context

The movement of bioethics started in the 1970s, with the Belmont report (1979). This report outlined the first ethical principles and guidelines for use of human subjects within research. That is, the Belmont report functioned to protect human subjects of research and, as noted, was originally created as a reaction to previous human subject violations. The basis of the Belmont report was the principles of respect for persons, beneficence and justice. Respect for persons identifies that each individual should be treated as autonomous[5] and that persons with diminished autonomy, either real or perceived, are entitled to protection (National Commission for the Protection of Human Subjects of Biomedical and Behavioural Research, 1979).[6] The basis for the conceptualisation of autonomy in the Belmont report comes from the work of Immanuel Kant.[7] Kant believed that because rational beings display the capacity to act in a consistent and self-directed moral manner, they should be allowed to do so (Tai & Lin, 2001). For Kant, the ability of an individual to act autonomously through individual free choice was what needed to be

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[5] The Belmont Report defines an autonomous person as being capable of deliberation about personal goals and acting under the direction of such deliberation (National Commission for the Protection of Human Subjects of Biomedical and Behavioural Research, 1979).

[6] Specifically the report refers to vulnerable populations such as children, prisoners and the elderly (National Commission for the Protection of Human Subjects of Biomedical and Behavioural Research, 1979).

[7] Immanuel Kant's conceptualisation of autonomy was based on ideas of the autonomy of will within a framework of deontological ethics (Kant, 2010/1785; Komrad, 1983). Kant opposed this idea of autonomy with what he called heteronomy, the situation where someone's will and resultant choices are made with reference to and/or under the dictates of others (Gillon, 1997; Kant, 2010/1785).

protected (Donnelly, 2010). Therefore, Kant aligned morality with both the exercise of and protection of autonomy.[8] Based on these moral conceptualisations of autonomy, respect for autonomy becomes a cardinal moral value where the individual should have the right to live their life at their own volition (MacKenzie, 2008).

At the same time, not all people are capable of acting autonomously and any person's ability to be autonomous may also be compromised at specific times during their lifespan. It is widely acknowledged, for example, that children lack fundamental skills in terms of autonomous decision making, and that such skills are only developed over a period of time (Haylett, 2009; Shore, 2006). In other instances, the ability to act autonomously can be compromised with illness or restricted through environmental contexts (in the instance of prisoners, for example). Such loss of autonomy may be permanent or transient in nature. Under the value given to autonomy and given the associated principles of respect for persons and justice, also as defined by the Belmont Report, there is always an obligation to protect vulnerable individuals during any periods when they are unable to act autonomously.

The second principle, beneficence, refers to the imperative *'do no harm'*. The idea behind beneficence was that, as a result of participation within research,[9] subjects should experience a maximisation of benefits and a minimisation of risk (National Commission for the Protection of Human Subjects of Biomedical and Behavioural Research, 1979). This is often referred to as a concrete obligation, although it is also worth noting that the Belmont Report did not intend for researchers to obtain the standard of "above all, do no harm" (*primum non nocere*).

Offering protection for vulnerable individuals is a major emphasis of the third principle of the Belmont Report, justice. Through this principle, clearly closely linked to the previous one of beneficence, the vulnerable are recognised as needing to be protected through the

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[8] If we accept the framework proposed via a Kantian lens then those patients who are determined to be non-autonomous come under the auspices of what he calls heteronomy (Gillon, 1997; Kant, 2010/1785). Darwall (2006) refers to heteronomy as interference with an individual's self-determination. LaGuardia and Ryan (2007) and Ryan and Deci (2006) then expand on this definition to include feeling compelled, pressured, or forced to behave in particular ways.

[9] The idea of beneficence 'do no harm' also has links to medicine and the Hippocratic oath.

distribution of the benefits/burden[10] of participating in human research (National Commission for the Protection of Human Subjects of Biomedical and Behavioural Research, 1979). Interestingly, this principle of justice considers an array of power relationships that can also challenge how this principle is enacted. That is, within the Belmont report, questions can be raised with regards to the equal distribution of benefits and risk based on subjects being considered to be equal or unequal (National Commission for the Protection of Human Subjects of Biomedical and Behavioural Research, 1979). As will be shown, this is potentially a pivotal point in relation to the conceptualisation and enactment of these ethical principles in healthcare.

When we look at the proposed application of these principles, we can start to see similarities with normative assumptions that are currently pivotal in contemporary healthcare structures. According to the Belmont Report, for example, and also a fundamental precept in contemporary healthcare, respect for persons and beneficence are best derived and upheld through the processes of informed consent[11] (Lysaught, 2004). That is, the principle of beneficence requires that participants always be fully informed about inherent risks, potential benefits and have their confidentiality upheld (National Commission for the Protection of Human Subjects of Biomedical and Behavioural Research, 1979).

Perhaps the principle whose enactment in contemporary healthcare is the most varied from its outline in the Belmont report, is the principle of justice. Justice specifically refers to the equitable selection of participants and avoidance of exploitation of vulnerable populations (National Commission for the Protection of Human Subjects of Biomedical and Behavioural Research, 1979). Within contemporary healthcare, based on the work of Beauchamp and Childress (2013) and to be discussed below, justice refers to the equal

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[10] This is based on five formulations: everyone gets an equal share; distribution occurs according to need; according to individual effort; according to societal contribution; and according to merit (National Commission for the Protection of Human Subjects of Biomedical and Behavioural Research, 1979).

[11] Informed consent requires that a person has appropriate information and that the decision made is voluntary in nature (Cole, Wellard & Mummery, 2014). It also relies on the competency and capacity of the individual to be able to make a decision, understanding the risks and benefits (Cole et al., 2014). Although informed consent is considered to be the gold standard in protection of autonomy within a healthcare context (Cole, 2012), there is debate about the use of informed consent in nursing practice. Cole (2012) identified that nurses in practice routinely use implied consent rather than informed consent. Cole et al., (2014) also criticize the understanding of autonomy solely in the realm of informed consent as being unsophisticated and due largely to legal protection for healthcare professionals.

distribution and access to services based on a system of fairness. Nevertheless, what is important to note is that a key outcome of the Belmont report has been that these three principles – respect for persons, beneficence and justice – have been accepted as the minimum standards for ethical conduct that involves human subjects. It was these three principles, then, that were redeveloped into the contemporary bioethical principles (Beauchamp & Childress, 2013) that underpin healthcare practices.

Contemporary Bioethics

As should be evident, the Belmont report engages what has become a dominant framework for bioethics: principlism (Shore, 2006). Principlism is based on the idea of obligation (DeGrazia, 1992). More specifically, the idea of principlism was to move ethical decision making from the context of abstract moral theory to a concrete principle-based system (Iltis, 2000; Petersen, 2013). Under this framework moral principles – such as those foregrounded in the Belmont Report – should be considered norms of conduct that in turn describe particular obligations based on the common morality assumed to be shared by reasonable persons (Beauchamp, 1994; Childress, 2009; McCarthy, 2003). This principlism framework is shared by the contemporary bioethical frameworks currently used in healthcare, as set forward by Beauchamp and Childress. Beauchamp and Childress (2013) furthermore assume that the principles comprising these frameworks should be *prima facie* (Beauchamp, 2007; McCarthy, 2003), by which they mean that every principle should be fulfilled unless there is conflict with an equal or stronger principle, whereupon contextual influences have to be considered (Ebbesen & Pedersen, 2007).

Beauchamp and Childress (2013) refine the principles of the Belmont report (1979) into four: justice,[12] beneficence, non-maleficence ('do no harm'),[13] and respect for autonomy.

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[12] There are three categories of justice recognised within the bioethics literature informed by Beauchamp and Childress: distributive justice, rights-based justice, and legal justice (Gillon, 1996). Distributive justice refers to fair, equitable, and appropriate distribution of both benefits and burdens (Beauchamp & Childress, 2013). Overall the function of the principle of justice is to ensure that individuals are provided with fair, equitable, and appropriate treatment (Tsai, 1999).

[13] Non-maleficence translates into to do no harm (*primum non nocere)* (Gillon, 1997). In the healthcare environment, this principle is upheld through the educational preparation and competency of the healthcare professionals (Tsai, 1999). This principle is more relevant than that of autonomy and beneficence when there is recognised potential harm to patients (Beauchamp, 2007). Some of the familiar moral rules associated with this principle are 'do not kill' and 'do not cause pain (Clouser & Gert, 1994). Within a healthcare environment, the principle of non-maleficence is framed under the pretence of due care (standards of care), accountability and therefore the legal consequence of negligence.

Along with these four guiding principles there are also rules, such as truth telling, privacy, confidentiality, and informed consent, that help to guide the use of these principles in concrete situations (McCarthy, 2003). These rules are specific and offer useful guidelines when applied to ethical dilemmas within nursing practice (Macklin, 1999). Indeed de Almeida and Schramm (1999) have identified that the principle scheme has been attractive for healthcare precisely because it provides specific orientation for clinical practice, provides a framework for resolving ethical problems, and allows for a direct approach to clinical problems often seen as problematic in nature.

As Beauchamp and Childress (2013; also see Ebbesen & Pedersen, 2007) stress, the context of the situation should determine which principle is given priority. As such, Beauchamp and Childress (2013) argue that there is not one dominant principle and that all the principles should be examined on an individual basis. What this means, however, is that these principles not only always require interpretation by the individual to implement them effectively in practice (Arras, 1994), but that such interpretation can be influenced by cultural and individual perceptions. Such issues have meant that the principles approach has been criticised for not consistently or necessarily considering contextual influences, and for having the potential of being ethnocentric and reductionistic when put into practice (Gerrits, Reis, Braat, Kremer & Hardon, 2013; Rajtar, 2013). Shore (2006) further argues that this principlist approach can tend to oversimplify ethical considerations, insofar as it does not clearly recognise operations of power, oppression and domination which are also important for ethical practice (Sherwin, 1992).

Despite these points, it is important to recognise that the principles approach of bioethics has been extremely influential for healthcare, and that the four principles from Beauchamp and Childress (2013) have been instrumental in the development of the modern healthcare framework. It is also important to note their inter-relatedness. Not only is the idea of professional obligation based primarily on the principles of non-maleficence and beneficence (Beauchamp, 1994), but both the Belmont report (1979) and contemporary bioethics (Beauchamp & Childress, 2013) identify that respect for persons is best understood and actualised through the process of informed consent (Lysaught, 2004; Sims, 2010;Vollmer & Howard, 2010). Indeed, informed consent has become a legal concept in healthcare that is itself reliant on three main factors: disclosure of information, autonomy, and competence of the patient (Humphreys & Smallwood, 2004). Respecting the autonomy of patients is in turn linked to the respect of persons, further implying that the person has the capacity and availability to make choices in accordance with their chosen pre-determined life plan (Humphreys & Smallwood, 2004). The assumption of informed consent is that it works to protect the rights of the individual (Corrigan, 2003).

Although, as shown, these principles are inter-related in practice, it is also clear that the principle of autonomy dominates healthcare practice. With autonomy referring to self-rule or self-governance (Gillon, 1996; MacDonald, 2002a), the assumption is that the person must be liberated (free from controlling influences) and display a capacity for agency (intentional action) (Beauchamp, 2005; Beauchamp & Childress, 2013; Whitehead, 1999).[14] Healthcare, then, must be carried out in ways that respect autonomous choice and self-determination[15] (Agledahl, Forde & Wifstad, 2011; Fagan, 2004; Goering, 2009; Harnett & Greaney, 2008), making clear again the emphasis placed on ideas of informed consent. Indeed, if respecting self-determination marks a negative obligation of autonomy (Ebbesen & Pedersen, 2007; Beauchamp, 2007), then its positive, *prima facie* obligations (Beauchamp, 2007; Fan, 1997; Harnett & Greaney, 2008) include informed consent, truth telling and information disclosure, and confidentiality (Gillon, 1996).

Autonomy, Competency and Capacity

One of the criticisms of Beauchamp and Childress' (2013) interpretation of autonomy – and indeed of liberal constructions of autonomy more broadly – is that for autonomy to be upheld, the person involved has to already be deemed autonomous and competent.[16] More specifically, within healthcare, autonomy is recognised as a basic legal and human right for those adults who are deemed competent (McIlwraith & Madden, 2006). To put this

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[14] This idea of liberal autonomy will be challenged and further explored later in this chapter.

[15] As well as being informed by the theoretical work of Immanuel Kant, the conceptualisation of autonomy within healthcare is also informed by the framework of utilitarian liberalism developed by John Stuart Mill (Komrad, 1983). Mill interpreted autonomy as the individual having the right to decide and make active choices (Rajtar, 2013). From this interpretation there is clear alignment with the ideology that a person should always be able to be autonomous unless such action is perceived to be harmful to another; if this is the case then the principles of beneficence and non-maleficence should supersede that of autonomy (Donnelly, 2010; Gillon, 1997; Mill 2010/1859). In healthcare ethics, the dominant view of autonomy is derived from the views of Mill rather than those of Kant (Donnelly, 2010) and is linked with the concept of informed consent within the healthcare paradigm (Dworkin, 1993; MacDonald, 2002a; McIlwraith & Madden, 2006).

[16] This is from the work of Mill (2010/1859) who also recognises that this doctrine can only apply to those who possess maturity in their faculties.

another way, competent individuals are attributed with possessing the moral and legal rights to make autonomous decisions (Brier-Mackie, 2001). Indeed, there is a presumption that all adult patients – unless demonstrating otherwise – are competent to make medical decisions (Emmett, Poole, Bond & Hughes, 2013; Geist & Opler, 2010; Giordano & Duffy, 2010; Naik, Teal, Pavlik, Dyer & Mc Cullough, 2008). This is to say that the competent adult has to be capable of understanding and weighing up the risks and benefits of a choice of action, and then accepting the consequences (McIlwraith & Madden, 2006).

Competence, within healthcare, tends thus to be defined as the capacity to understand general information given in relation to a specific cause of action/treatment (Braun, Skene & Merry, 2010). This is highlighted by Craigie (2011) who mentions criteria for competence as including: understanding relevant medical facts, appreciating the personal relevance of these facts, showing the ability to reason, and being able to express the decision made. However, the idea of competency is also highly contested in healthcare. First those who are deemed to be incompetent, or to have reduced autonomous capabilities, are seen as requiring assistance in navigating the healthcare system. Complicating this, Gillon (1997) identifies that disease and illness can themselves undermine autonomy and competency due to their specific effects on the person, the constraints present in the healthcare environment, institutional processes, and a patient's lack of or inexperience in professional and medical knowledge. That is, in the healthcare setting, illness and treatments can all effectively influence a person's ability to consent and be recognised as competent (Braun et al., 2010).

Arguably, then, to be fully autonomous and competent within the healthcare setting, given that the options open to patients are already confined and constricted, is unattainable. This is a point made by Agledahl et al., (2011) who state that because patient choice is always limited, decisions can never be wholly autonomous. This view is also supported by Anderson (2003) and Dennehy and White (2012) who state that individuals are never able to be fully autonomous due to the vulnerability associated with both the constraints of the healthcare environment and the illness itself. Dennehy and White (2012) further call autonomy illusionary in relation to decision-making and choice in healthcare. In total, there is acknowledgment that autonomy can only be partial in nature due to the relationships and interdependence of any individual with others (Abrams, 1999; Anderson, 2003).[17]

This recognition of the impossibility of full autonomy may be one of the reasons much discussion around such issues has come to be framed in the language of capacity. Capacity is based within the legal profession and is based on specific legal standards: understanding, appreciation, reasoning and expressing a choice (Braun, Gurrera, Kavel, Armesta & Moye 2009; Geist & Opler, 2010; Simpson, 2010). Emmett et al. (2013) also include the necessity of being able to retain information and to communicate. These standards tend to focus on the cognitive abilities of the individual because of the relationship that exists between cognitive abilities and the capacity for decision making (Braun et al., 2009). Capacity, however, is not a static attribute and a person's capacity for consent can be permanently or temporarily affected due to factors such as illness, urgency of treatment, and family and religious influences (Emmett et al., 2013; Moye, Gurrera, Karel, Edelstein & O'Connell, 2006; White & Seery, 2008). This means that capacity is usually determined only in relation to a specific matter (Emmett et al., 2013). Understood broadly in the context of healthcare, capacity is thus about being able to express a choice, understand the choice that has been made, appreciate the consequences of this choice, and being able to show reasons why this choice is appropriate for the individual (Karel, Gurrera, Hicken & Moye, 2010).[18] As should be evident, assessments of capacity, alongside judgements of competence, have become seen as significant for the processes of informed consent. Indeed, the major goals of frameworks of both competence and capacity in relation to healthcare decisions are to determine whether or not a patient is able to comprehend, appreciate and then able to use reasoning with reference to treatment options (Giordano & Duffy, 2010).

Such a definition of capacity can, however, sit uneasily with the requirement of healthcare professionals to uphold the autonomy of the patient. That is, if a patient has reduced

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[17] Although these issues are certainly problematic and have a range of ramifications for healthcare practice, the assessment required determining competence of a person still cannot be understated as a way to ensure and protect autonomy (Geist & Opler, 2010; Simpson, 2010).

[18] In the context of medical procedures and being able to give consent, competence and capacity have very similar meanings (Braun et al., (2010). It is also important to note that these definitions of competence and capacity are based on a bioethics perspective. If we consider competence from a patient perspective, the difference in definitions is startling. From a patient's perspective, competence refers to feeling effective in individual actions and meeting the challenges of everyday life (LaGuardia & Ryan, 2007).

capacity, this has clear implications in relation to the healthcare professional being able to uphold and support a patient's autonomous decision making. Certainly, patients should be given every chance to prove their capacity, a process which should also be open to the use of means such as interpreters and non-verbal communication aids (White & Seery, 2008). Unfortunately, however, although Scanlan and Kerridge (2009) highlight that it is important to acknowledge the impact of the illness of the individual and how this may influence their behavioural and decisional choices, the bioethical conceptualisation of autonomy predominant in healthcare is not always reflective of the idea of capacity as a fluctuating identity. Furthermore, standard definitions and assessments of capacity are still problematic insofar as they can fail to identify and take account of the personal and social values, cultural norms and environmental factors that influence the decisions and capacity of the individual (Simpson, 2010; Braun et al., 2009). Assessment of capacity and competence should be considered in relation to the patient's experience of these concepts – for instance, Giordano and Duffy (2010) identify that the patient's family should be involved in this process both as emotional support and potentially in relation to communication issues. Giordano and Duffy (2010) suggest that the patient's family is important as they can assist the patient in arriving at a decision. This suggests that a broader understanding of these concepts needs to be implemented rather than the narrow focus that currently exists (Scanlan & Kerridge, 2009). These issues are going to become increasingly important for my later discussions.

Further issues arise with regards to those individuals who are considered unable to make decisions (Dworkin, 1993). If, as outlined both in liberal constructions of autonomy and in its conceptualisation by Beauchamp and Childress (2013), only an autonomous and competent person has the right to autonomy, and if a person is not deemed competent, then the autonomy model will not be upheld and what might be called the paternalistic beneficence model will take its place (Ebbesen & Pedersen, 2007). This is because such patients are seen as not having the capacity to make informed decisions. These issues were first highlighted in the difference between the understandings of autonomy as constructed by both the Belmont report (1979) and then through Beauchamp and Childress (2013).

Within the beneficence model of the Belmont Report (1979), there is an understanding that persons with diminished autonomy are considered to require protection (Lysaught, 2004). For beneficence to work, then, there has to be both protection of and respect for patient autonomy (Gillon, 1996). Within a beneficence model, the protection of autonomy is operationalised through the concept of 'doing good'. However, viewing contemporary bioethical understandings of autonomy (see Beauchamp & Childress, 2013), autonomy now becomes the *'prime facie'* principle and is prioritised over beneficence (Lysaught, 2004). To accommodate this there has been a shift from a model of beneficence to one of autonomy (Beauchamp, 2007).

It is here that we begin to see the first conflict in the interpretation of autonomy within the healthcare context. It could be suggested that if a patient is autonomous, then the principle of beneficence ('to do good') will automatically follow because of the autonomy of the individual. However, in practice, we often see paternalistic behaviour towards patients that functions to limit their autonomy, and which swings the power back towards the healthcare professionals, and therefore back to a beneficence model of healthcare. In addition, Beauchamp and Childress (2013) arguably contradict themselves in relation to their conceptualisation of autonomy as the protection of individuals with diminished autonomy is discarded and instead becomes an issue related to non-maleficence and beneficence (Lysaught, 2004). This begins to demonstrate the problems that are associated with conceptualisation of liberal autonomy that I will discuss further in the following sections.

Problematising Liberal Bioethical Constructions of Autonomy within Healthcare

Along with these issues of an easy slide from autonomy to paternalism, other issues also problematise some of the constructions of autonomy within healthcare. First, although the processes of informed consent have been identified as protecting the autonomy of vulnerable patients and protecting against paternalism (White & Seery, 2008), it is a very narrow focus. Indeed, informed consent is arguably still paternalistic in the conceptualisation of the process, and in relation to determining capacity and competency. Vollmer and Howard (2010) also contend that autonomy is highly contested through the process of informed consent. They describe this process as being limited due to the legalities of the forms for informed consent and the way that these are produced. This is in relation to the process of informed consent being normalised through the medical profession and primarily functioning for the legal protection of the healthcare professionals rather than being truly patient orientated. Similarly, Naik et al. (2008)

conceptualise the framing of the patient in terms of autonomy and informed consent as merely authorizing the clinical interventions that healthcare professionals are performing. While it seems clear that ideas of autonomy and informed consent, have centered on the ability of the patient to make decisions, understand information and to make voluntary decisions (Naik et al., 2008), Devisch (2010) further identifies that the concept of informed consent is also idealistic in that it is based on the view that medical treatment is chosen voluntarily by an autonomous and rational patient who has been informed.

Another key criticism of central ideas of autonomy, briefly mentioned earlier with regards to issues of capacity, concerns its underpinning by liberal assumptions concerning human modes of being according to which the individual is said to be shaped before social interaction and is considered capable of making autonomous choices independently (Abrams, 1999). More specifically, traditional liberal views of autonomy have been critiqued for neglecting to take into consideration humanistic characteristics such as emotions and our social inter-relationality with others (Abrams, 1999; Christman & Anderson, 2005). Liberal conceptions of autonomy are thus more broadly criticised as being atomistic, asocial, ahistorical, emotionally detached and failing to recognise the role of the social context of identity (Christman, 2004; Friedman, 2003; MacDonald, 2002b; MacKenzie & Stoljar, 2000; May, 2005; Nedelsky, 1989; Saharso, 2003). In other words, such a definition of a liberal autonomous self ignores the power inequalities and the diverse social circumstances, histories, and obligations and commitments that influence not only construction of the self but self's decision-making (Abrams, 1999; La Guardia & Ryan, 2007; MacDonald, 2002b).

As multiple commentators have pointed out, individuals are simply not unencumbered or disengaged from their social connections (Ikonomidis & Singer, 1999; Mill, 2010/1859). Christman (2004) thus argues that looking at autonomy without considering social influences is to ignore and misunderstand the fluidity and relationality of individuals and the social contexts of autonomy. Abrams (1999) and Anderson (2003) argue that a viable conceptualisation of autonomy must acknowledge the relational aspects of being human. MacLean (2006) states that autonomy is meaningless unless the social context is considered. Furthermore, as Dworkin (1993) notes, liberal individualism is incapable of dealing well with those patients who are deemed to have decreased capacity.

What these points suggest, then, is that the narrow understanding of liberal individualism and autonomy is problematic. Indeed, the process of informed consent demonstrates the confined and restrictive definition of autonomy that conventionally operates within the healthcare context. Information and consent do not alone lead to autonomy, especially when some of the environmental and social constraints that exist within the healthcare environment are considered (some of these will be discussed later in this chapter). The stigma and persona of the patient, the impacts of illness and hospitalisation, and the power inequalities between patients and healthcare professionals, all suggest that autonomy will remain elusive to many patients. Furthermore, if a person is seen as incompetent, then the process of informed consent is unable to be upheld and, therefore, the person's autonomy is seen not to exist. This, again, is a very narrow view of how autonomy can or should be understood to be enacted and upheld in clinical practice.

Contemporary Codes and Standards

Despite these points, the liberal bioethical understanding of autonomy has been influential in the development of nursing codes and standards, and for guiding what is considered to be ethical nursing practice. That is, not only have the concepts of bioethics become fundamental in healthcare settings, they have also become readily adopted as the gold standards for ethical conduct by healthcare practitioners. The standards and codes outline standards of behaviour and the moral responsibility and duty of care that healthcare practitioners are expected to have towards their patients. Fisher (2011) identifies that these codes and standards are utilised in providing what are assumed to be general norms within the field of nursing. These norms work to provide delineation in relation to scope of practice, professional roles and professional obligations (Fisher, 2011).[19]

The Nursing and Midwifery Board of Australia (NMBA)[20] has, for example, developed four influential codes and standards for nursing practice. These include the Registered Nurse Standards for Practice (2016), which replaced the National Competency Standards from 2006; A Nurses' Guide to Professional Boundaries (2010); the Code of Professional

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[19] These are issues that will be returned to in various ways throughout this thesis, particularly with regards to the kinds of relations and interactions between ideals of autonomy and advocacy and professionalised codes of conduct.

[20] The Nursing and Midwifery Board of Australia functions to register nursing and midwifery practitioners and students develop standards, codes and guidelines for the nursing and midwifery profession; handle notifications, complaints, investigations and disciplinary hearings; assess overseas trained practitioners who want to practice in Australia; and function in approving accreditation standards and accredited courses of study (Nursing & Midwifery Board of Australia [NMBA], n.d.).

Conduct (2008b); and the Code of Ethics (2008a). These standards and codes are designed to work in conjunction with each other and not in isolation. The nursing professional is inherently responsible for adopting these guidelines into their practice and, therefore, their interpretation of the said guidelines.

Before the implementation in June 2016 of the revised Registered Nurse Standards for Practice, the National Competency Standards for the Registered Nurse (2006)[21] were the dominant and guiding standards for nursing practice. With the introduction of the revised Registered Nurse Standards for Practice in June 2016, some clear differences should be noted. One of the major changes in this document is the replacement of four domains of practice – professional practice, critical thinking and analysis, provision and coordination of care, and collaborative and therapeutic practice – by the seven standards for practice set out below.

1.Thinks critically and analyses nursing practice.
2. Engages in therapeutic and professional relationships.
3. Maintains the capability for practice.
4. Comprehensively conducts assessments.
5. Develops a plan for nursing practice.
6.Provides safe, appropriate and responsive quality nursing practice.
7. Evaluates outcomes to inform nursing practice.

These standards function in interconnected ways with each other. For example, Standards 1 to 3 are interrelated and further function in conjunction with the dimensions of practice in Standards 4 to 7, as Figure 1 below makes evident.

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[21] The National Competency Standards for Registered Nurses (2006) were first adopted for nursing practice in the early 1990s in an attempt to adopt a national standard and regulatory framework for nursing practice (Nursing and Midwifery Board of Australia, 2006). Within the National Competency Standards there were four domains: professional practice, critical thinking and analysis, provision and coordination of care, and collaborative and therapeutic practice. The domain of professional practice is aligned with the professional, legal, and ethical responsibilities of nurses.

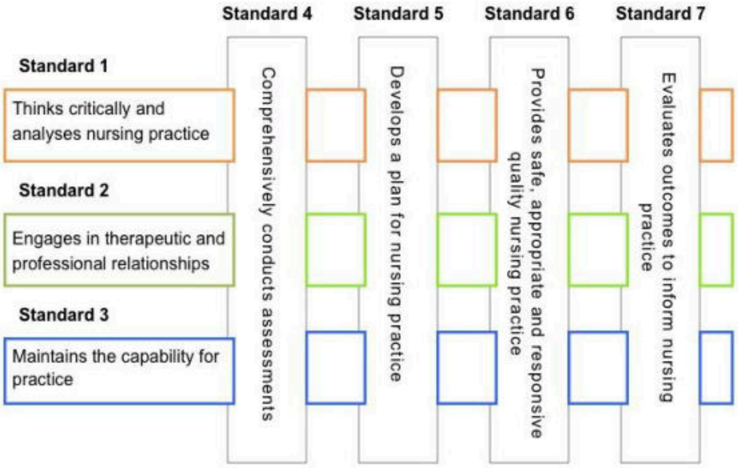

Figure 1: The Registered Nurse Standards (NMBA, 2016)

There are specific criteria that demonstrate the functionality of each standard within nursing practice. Like the previous version of the practice standards from 2006, these standards are designed to be read and enacted in conjunction with the Codes of Practice. In its turn, this document provides guidelines about the expected education standards for the Registered Nurse (RN) and determines the nurse's capabilities for practice and guides consumers, employers and various stakeholders in relation to the expectations of the nursing profession within Australia.

Autonomy within Nursing Codes and Professional Standards

We cannot dismiss the importance of these standards and codes with regards to how support for autonomy is considered able to be enacted within nursing practice. Within the 2016 Registered Nurse Standards for Practice, unlike the National Competency Standards for the Registered Nurse (2006), there is direct reference to respecting and supporting patient autonomy. This occurs under Standard 2, *Engages in therapeutic and professional relationships*, specifically in point 2.5, *Advocates on behalf of people in a manner that respects the person's autonomy and legal capacity.* Further implicit recognition of autonomy can be framed through the informed consent process. Standard 3, *maintains the capability for practice*, under point 3.2, *provides the information and education required to enhance people's control over health*, is clear recognition that appropriate information and education is required for people to be able to have control over their own health. This notion of supporting autonomy through the process of informed consent is further supported within the Code of Ethics (2008a) and the Guide to Professional Boundaries (2010).

Support for autonomy within the Code of Ethics (2008a) is contained within Value Statement 5, *Nurses value informed decision-making*. Nurses have a legal obligation and moral right to promote the decision-making capabilities of individuals. Another way that the Code of Ethics (2008a) and Professional Boundaries (2010) recognise the concept of autonomy within healthcare is the role of confidentiality. This is in Value Statement 7, *Nurses value ethical management of information*, which states that there is a need for the nurse to protect and respect an individual's privacy and confidentiality, clearly identified within the Code of Ethics (NMBA, 2008a).

Nurse Advocacy

Related to the stringencies of practices to do with informed consent, and the broader requirements of the bioethical principles with regards to protecting autonomy, many of the regulatory codes that govern nursing practice use ideas of advocacy as a fundamental ethical and moral obligation for nurse conduct (MacDonald, 2007; Negarandeh, Oskouie, Ahmadi, Nikravesh & Hallberg, 2006; Negarandeh, Oskouie, Ahmadi & Nikravesh, 2008). This is drawn from the idea that a key flow-on effect from practices of advocacy is the support of patient autonomy (Devisch, 2010), a view prevalent in the literature. Indeed, in nursing literature, nurses are hailed as patient advocates (Bird, 1994; Schwartz, 2002) and advocacy is portrayed as being a trait essential to good nursing practice (Bird, 1994; Bu & Jezewski, 2007; Hanks, 2010; Hewitt, 2002; Simmonds, 2008). There is, however, no consistent definition of advocacy or of the nurses' role as an advocate which leads to confusion around role description and has implications for patient care. Most broadly, however, nurses and health care professionals define patient advocacy as the process of informing and supporting patients with their health care choices (Bu & Jezewski, 2006). A further common theme presents advocacy as the process in which one person is able to plead the cause of another (Breeding & Turner, 2002; Bu & Jezewski, 2007; Jugessur & Iles, 2009). This definition of advocacy is based within the legal profession, but also recognised in nursing literature (Bird, 1994; Hyland, 2002; Jugessur & Iles, 2009).

Three core attributes are identified as necessary to fulfil an advocacy role: the ability to act on behalf of patients, to safeguard patients' autonomy, and to be a champion of social justice within a health care environment (Bu & Jezewski, 2007). When acting on behalf of a patient, an advocate acts as a representative, protector, surrogate, and a delegate (Bu & Jezewski, 2007). Safeguarding patient autonomy occurs, as discussed previously in the context of issues of informed consent, by promoting and encouraging self-determination (Bu & Jezewski, 2006; Hanks, 2007). Being a champion of social justice highlights the need to recognise and protect a patient's legal rights and best interests within this system (Bu & Jezewski, 2007). Broadly, then, the notion of being an advocate for patients arises from the fiduciary nature of the nurse/patient relationship in which it is expected that nurses will always act with the best interests of the patients in mind (Benner, 2003; Gaylord & Grace, 1995).

Unpacking these points in more detail, there are several advocacy models that have been developed and that are influential in healthcare settings. These include, first and second, Curtin's (1979) human advocacy model and Gadow's (1980) theory of existential advocacy. According to Breeding and Turner (2002), Curtin's and Gadow's models of advocacy are thought to be embedded in the foundational philosophy of the nursing profession. This is supported by Murphy and Aquino-Russell (2008), who contend that most practising nurses would utilise the concepts of existential advocacy (Gadow, 1980) and human advocacy (Curtin, 1979) in relation to their understanding of nursing values and practices. Curtin's human advocacy model (1979) is based on the explicit recognition of nurses' common humanity with patients as derived from the theory of human rights (Bu & Jezewski, 2007; Jugessur & Iles, 2009). It frames individuals as distinct and unique, with individual needs, and details the role of the nurse as being one of providing a supportive environment for decision-making (Hanks, 2005).

Curtin's (1979) model thus represents the nurse as establishing a working relationship with the patient which identifies and protects the patient's humanity and uniqueness. The model is thus not so much focused on the legal aspects of patient rights, but rather on the ability of the nurse to protect and support patient's values. Gadow's theory of Existential Advocacy (1980) is also built on a humanistic philosophy of nursing and relies on notions of freedom and self-determination being fundamental human rights (Bishop & Scudder, 2003; Bu & Jezewski, 2007; Gaylord & Grace, 1995; Hanks, 2005; Hewitt, 2002;

Jugessur & Iles, 2009). Under this model, nurses focus on the patient as a total person, recognising and incorporating a wide range of patient values into their practice. It is thus believed in this model that patients should be able to reach decisions that are in alignment with their personal values (Bu & Jezewski, 2007). Through advocacy, under this model, nurses should consequently assist patients to find clarity about their health care and life choices while remaining steadfast in their own (patients') values. Nurses should work with patients to help them to establish their unique understanding of health, illness, and suffering (Bishop & Scudder, 2003; Gaylord & Grace, 1995). Gadow believed that advocacy was an integral role for nurses (Hewitt, 2002).

Both of these models thus prioritise patient-centeredness and ideals of humanism in relation to both nursing practice and advocacy. The purpose of advocacy within these models is to help the person facilitate and determine their own personal journey through the healthcare system (Murphy & Aquino-Russell, 2008). Kohnke and Gadow further discuss this as enabling the individual to develop strength and confidence within themselves through the recognition of there being a common humanity and vulnerability shared between the nurse and the patient (McSteen & Peden-McAlpine, 2006; Murphy & Aquino-Russell, 2008).

Another influential model of advocacy is Kohnke's (1982) functional model of advocacy where the role of the nurse is to inform the patient of their options and then support them in relation to their decisions (McSteen & Peden-McAlpine, 2006). Under this model, then, advocacy is tightly linked with the concept of self-determination. Mallik (1997a) believes, however, that the advocacy model supported by Kohnke is not a natural role for nurses to undertake and that upholding a functional model of advocacy would require considerable skills and knowledge. This model of advocacy also connects with ideas of informed consent. What these models make clear is that there are several different conceptions of advocacy in play within nursing and that the decision about which model should be used becomes one of individual interpretation.

Advocacy within Nursing Codes and Professional Standards

There are multiple regulatory and governing bodies that dictate the nurse advocate as an essential professional role (Bu & Jezewski, 2007; Breeding & Turner, 2002; Hanks, 2010; Hyland, 2002; Jugessur & Iles, 2009). In particular, there are two areas where advocacy is specifically referred to in the National Competency Standards (2006). The first reference comes under point 2.3, *Practises in a way that acknowledges the dignity, culture, values, beliefs and rights of individuals/groups* (NMBA, 2006). Here the NMBA defines advocacy as being when the rights of individuals are overlooked or compromised (NMBA, 2006). Point 2.4, *Advocates for individuals/groups and their rights for nursing and health care within organisational and management structures* (NMBA, 2006), clarifies how nurses are expected to affect organisational and management changes through factors such as identification of insufficient resources, skills mix, facilitating informed decisions, and explaining, clarifying and recommending changes to policies, practices and guidelines (NMBA, 2006).

Within the recently adopted Standards for Practice (2016), Standard 2, *Engages in therapeutic and professional relationships*, makes explicit reference to advocacy. This is within point 2.5 which reads: *advocates on behalf of people in a manner that respects the person's autonomy and legal capacity*. However, what we also need to recognise is that advocacy does not have to be explicitly mentioned to have functionality within these guiding documents. For example, point 2.3 reads: *recognises that people are the experts in the experience of their life*, and 2.2 states: *communicates effectively, and is respectful of a person's dignity, culture, values, beliefs and rights*. These clearly show some of the values that are typically used to underpin the significance of advocacy for nursing practice.

The Code of Professional Conduct for Nurses (2008b) also specifically refers to advocacy, with Conduct Statement 7 making direct reference to it: *Nurses support the health, wellbeing and informed decision making of people requiring or receiving care*. In this statement the nurse is specifically named as the person who endeavours to ensure that the patient's perspective is represented (NMBA, 2008b). However, this does not require that the nurse is the person who should advocate for the patient, rather it suggests that the role of the nurse is to find an appropriate advocate for the patient.[22]

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[22] This refers commonly to a public advocate who works in conjunction with persons with a disability to promote and facilitate access and coordination of services to promote individual independence and protection from abuse and exploitation (Office of the public advocate, n.d.).

Leading international nursing bodies, such as the *International Council of Nurses* (ICN), also promote advocacy as a key role for nurses to undertake in practice (Jugessur & Iles, 2009; McGrath, Holewa & McGrath, 2006). However, when the ICN Code of Ethics for Nurses (2012) is reviewed, what becomes clear is that again the only reference specifically to advocacy is in relation to nurses being champions of social justice and providing equity. Reading the document there is, however, common language throughout that relates to some of the key concepts found in the advocacy literature. These include ideas of accountability and responsibility, human rights and informed decision making. From the language used throughout the document, a close alignment with ideas of autonomy is also apparent.

Although the term advocate is only mentioned within the Code of Professional Conduct (2008b), National Competency Standards (2006), and the Standards for Practice (2016), other standards and codes also play a role in promoting the nurse as an advocate. In the Code of Ethics (NMBA, 2008a), for instance, there is acknowledgement that there is a need for nurses to promote and safeguard the rights of all people. This is important as definitions of advocacy also stress the significance of protecting human rights within nursing practice. This is aligned with what we see in the Standards for Practice (2016). Thus, we read in 2.2, *communicates effectively, and is respectful of a person's dignity, culture, values, beliefs and rights*, Standard 3*, Maintains the capability for practice*, and point 3.2, *provides the information and education required to enhance people's control over health*.

The first Value Statement, *Nurses value quality nursing care for all people*, draws attention to the importance of the quality of nursing care provided to people (NMBA, 2008a). The idea of advocacy within this Value Statement is that nurses are accountable and responsible for their own decisions that have the potential to influence nursing care for patients. Within this framework, nurses are specifically referred to as needing to be a champion of social justice and influence social policies, institutions and legislation (NMBA, 2008a). Value Statement 2 of the Code of Ethics (2008a), *Nurses value respect and kindness for self and others*, highlights the need for nurses to value respect and kindness and prioritises the preservation of dignity while the patient is potentially vulnerable and powerless. Value Statement 3, *Nurses value the diversity of people*, gives recognition to the diversity of individuals and foregrounds the importance of the provision of individualised care that would supports diverse patients' rights. This is also noted in the Standards for Practice (2016) in Standard 2, *Engages in therapeutic and professional relationships*, under 2.3, *recognises that people are the experts in the experience of their life*, and 2.4, *provides support and directs people to resources to optimise health-related decisions*. Again these points stress the idea of the nurse being a champion of social justice as one of the key ideals of an advocate. Hanks (2010) refers to this as an ability to communicate, inform, protect, speak out for patients, and to build relationships.

Within the Guide to Professional Boundaries (2010), we can again see familiar language used to describe advocacy within healthcare. Specifically noted are the therapeutic relationships that are essential in protecting patient rights and nurse abilities to act on behalf of the patient. It is assumed that the nurse will act within the best interests of the patient within the boundaries of a professional relationship that takes into consideration the individual needs of the patient (NMBA, 2010). The other side of this position is, of course, that the role of the nurse as an advocate is problematic. MacDonald (2007) thus debates whether advocacy is a role that needs to be fulfilled by the nurse. Bernal (1992) recognises that by too closely tying ideas of advocacy to those of autonomy, nurses risk having a distorted and impoverished view of illness and suffering and, therefore, of the professional obligations of being an advocate. Breeding and Turner (2002) suggest that the role of the nurse as an advocate is always limited by the power and relationship inequalities that are inherent between the nurse and the patient. Breeding and Turner (2002) also note that there is a need to be able to better define the role of the nurse as an advocate, as well as to wonder if, indeed, nurses should take on this responsibility within their practice.

Questioning the Role of the Nurse as an Advocate

Questions that require further clarification concern why nurses continue to hold to this advocacy role, and whether this role is still valid in the consumer driven healthcare system that now exists. Is the role of the nurse as an advocate really about protecting patients' rights and values in the healthcare setting, or an attempt by the nursing profession to distinguish themselves from other healthcare providers?

Nurses argue that they have more contact with patients than any other healthcare professional, making them ideally placed to observe and also support firsthand patients' abilities to make and carry out autonomous decisions (Hanks, 2010; Hyland, 2002; Mahlin, 2010). Bird (1994), Hanks (2007) and Morra (2000) also argue that nurses are seen as ideal advocates because of their attendance on patients in their most distressing times, often for sustained periods, providing intimate physical and emotional support and care which facilitates the development of a therapeutic relationship built on mutual trust and rapport. Davis, Konishi and Tashiro (2003) concur and add that the role of the nurse as an advocate is also an ethical obligation. This is reiterated by Blackmore (2001) and Bu and Jezewski (2007) who state that it is not only the contact with patients, but also the underlying philosophy of nursing, and the educational preparation of nurses, that make them ideal to facilitate an advocacy role in the healthcare setting.

Conversely there are claims, for example, that nurses adopted the advocacy role purely as a professionalization strategy for occupational advancement (Blackmore, 2001; Breeding & Tuner, 2002; Hyland, 2002; Jugessur & Iles, 2009; Mahlin, 2010; Mallik, 1997a; 1998). There are also arguments that recognise that, regardless of their self-perceived position, nurses may not be best placed to act as advocates (Gaylord & Grace, 1995). Here it has been argued that the role of the nurse as an advocate for patients is always distorted by the institutional and hierarchical constraints in which nurses operate (Bernal, 1992). Bernal (1992) notes that because the social relationships that are dominant within hospitals and healthcare contexts tend to be adversarial and manipulative in nature, this threatens the rights of the patient. This would mean that advocacy work is nothing more than assisting the patient through a clinical event (Schwartz, 2002; Sellin, 1995). Counter arguments once again situate the idea of advocacy as being deeply embedded in the philosophy of nursing but argue that, unlike the profession, the articulation of the role of the nurse as advocate has not developed with the changing healthcare system and new conceptualisations of patients. In this vein it has been suggested that rather than the focus on speaking for, or on behalf, of a patient, or even of supporting the patient, advocacy should be more explicitly reconceived around issues of empowerment, independence, and autonomy (McGrath et al., 2006).

What these points make clear, then, is that without a single clear definition of advocacy as it is enacted within clinical practice, the role of an advocate for nurses seems to remain at the whim of the individual. The background experience (both professional and personal), the educational preparation of each individual nurse, and even the context of practice (both institutionally and with regards to individual patients) will then influence how advocacy as a role is enacted in practice.

Further Complexities

These questions and issues show again the intricate interconnections between ideas of advocacy and autonomy, as well as making clear that neither idea is particularly clear-cut in its framing within nursing and healthcare. There are, in addition, a set of further factors that have implications for the understandings of autonomy and advocacy that inform nursing and healthcare practices that also need mention. These include the continuing influence of the biomedical assumptions concerning health and sickness, associated concerns regarding paternalism, ideas of the sick role (as developed by Parsons in 1951), and issues to do with vulnerability and power inequalities. These are briefly introduced in turn below but will be re-examined in multiple ways throughout this thesis.

The biomedical model and Autonomy

The biomedical model, which has been dominant in the frameworks of healthcare for well over a century, functions to reduce the individual to their biological mechanisms (Borrett, 2013). That is to say, it focuses on the biological or physical aspects of disease and illness to the point that it separates the biological mechanisms of disease from the social behaviours of illness (Engel, 1977). It thus works on a model of diagnosing and treating diseases once symptoms become present. Whilst in some ways it follows the framework of the self as assumed in definitions of liberal autonomy, with its focus on biological processes the biomedical model works to reduce the patients into passive objects – whose systems need diagnosis and treatment – within the healthcare relationship. Under the biomedical model, then, the healthcare professional is afforded a paternalistic type of power and the patients are seen and treated as biological objects (Borrell-Carrio, Suchman & Epstein, 2004). Mallik (1997b) refers to this as entailing a privation of patient autonomy.

Engel (1977) notes that despite its continued influence, the biomedical model is not able to adequately explain health and illness within the societal context. This is due not only to the framing of the biomedical model around the expertise of the healthcare professionals but because of its continued lack of consideration for the social, cultural, and psychological factors that are now known to influence health and illness (Engel, 1977; Fee & Krieger, 1993). As such the biomedical model is often criticised as being reductionistic in nature (Engel,1977), and as tending in practice to show a disregard of patient autonomy.

Paternalism

Another argument in the literature that warrants consideration concerns the idea that in some cases a framework of advocacy as held and practised by nurses (and other healthcare professionals) may entail paternalistic behaviour and consequent interferences in patient autonomy and self-determination (Bird, 1994; Hewitt, 2002; Spenceley, Reutter & Allen, 2006; Wilson-Barnett, 1994). Paternalistic care is where an authority figure determines what is in the best interests of the patient (Bramlett, Gueldner & Sowell, 1990; Elliott, 2001; Holroyd, 2009), entailing thereby not only a possible interference in the patient's ability to make autonomous decisions, but justification of that interference (Holroyd, 2009; Komrad, 1983). Although Harnett and Greaney (2008) do note that paternalism can clearly be justified within healthcare due to the relationship of expertise that exists between healthcare professionals and patients,[23] Darwell (2006) describes paternalism as a failing to value and respect a person as an equal, and Veatch and Spicer (1994) outline it as marking interference with an individual's autonomy. To put this another way, paternalism – even when carried out in the best interests of the patient – marks a taking away of power from the patient (Bird, 1994), and paternalistic practice can diminish the capacity for negotiation and reciprocity between the patient and healthcare professionals (Dudzinski & Shannon, 2006). This is particularly problematic because patients are always already at a disadvantage in healthcare contexts, with nurses and other healthcare professionals having the benefit of an intimate understanding of both health conditions and the environment in which care occurs (Mallik, 1997a). In addition, tendencies towards paternalism are in tension with contemporary healthcare systems according to which greater focus is being given to the patient needing to become responsible and accountable for his or her own healthcare.

The Sick Role

Because the attributes of capacity are changeable according, at least partially, to the health or otherwise of an individual, it is clear that there are periods of time when a patient will have diminished autonomy (Komrad, 1983) and may enter what has been

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[23] This is the idea that healthcare professionals do indeed possess the expertise needed for patient recovery, meaning that such professionals can make a clear case for acting, medically at least, in the patient's best interests, but that those with diminished capacity require a paternalist response (Komrad, 1983).

called the ‘sick role’ (Parsons, 1951). The sick role is a patterned social role that is understood to be adopted by individuals and which functions to permit an individual exemption from routine responsibilities and normal societal expectations (Berk et al., 2013; Faulkner & Aveyard, 2002; Pearce & Pickard, 2010; Willard, 1996). More specifically, the sick role legitimises sickness when it has been sanctioned by those with expertise (Christopoulos, 2001; Prior & Bond, 2008). It is, to put this otherwise, a method of social control (Gabe, Bury & Elston, 2004). Interlinking with the previous section, Hyland (2002) and Willard (1996) argue that when patients adopt the sick role, patient autonomy is reduced – even, arguably, given up – and a paternalistic response of the healthcare professional becomes appropriate. Part of the complexity of the sick role in relation to healthcare environments is that when a patient adopts the sick role, healthcare professionals are required to take on the responsibilities that the patient would normally have (Faulkner & Aveyard, 2002). This incorporates the necessity for healthcare professionals to make decisions on the behalf of patients and, therefore, to advocate for patients (Faulkner & Aveyard, 2002). Komrad (1983) links increased vulnerability and diminished autonomy to the sick role (Parsons, 1951). However, invoking the sick role is itself an autonomous decision that is made by the patient often in agreement with the healthcare professional (Chrisp, Tabberer & Thomas, 2012). In addition, while patients within the sick role are perceived as dependant and passive, potentially requiring the assistance of an advocate (Faulkner & Aveyard, 2002; Pearce & Pickard, 2010), the current model of healthcare insists that patients are active participants in their own healthcare needs (Faulkner & Aveyard, 2002).

Alongside these tensions, Burnham (2014) recognises that because much of the sick role relationship between patients and healthcare professionals takes place within an institutionalised social system, the sick role itself functions as an institutionalised role. Indeed, if the sick role is examined in terms of autonomy and advocacy within nursing practice, what becomes clear is perhaps why nurses have taken on roles as advocates in the past. Within the sick role, after all, there is a series of obligations that an ill person must fulfil in order to obtain the rights associated with being sick (Berk et al., 2013; Gabe et al., 2004; Perry, 2011). These obligations include seeking appropriate medical advice, cooperating with medical experts and therapists for the duration of the illness, and displaying and acting in accordance with a want to get better (Faulkner & Aveyard, 2002; Glenton, 2003; Prior & Bond, 2008). These obligations clearly make a role for the healthcare professional as advocate. However, there is also a counter argument to suggest that the hospital environment disrupts the natural transition of patients into and out of the sick role (Faulkner & Aveyard, 2002). This may be due to healthcare professionals being gatekeepers who work to legitimise illness and therefore the sick role (Glenton, 2003). However, these cultural and societal expectations of illness are continually being redefined and changed (Chiong, 2001; Christopoulos, 2001). As well as the societal expectations of illness, there are also the personal constructs of illness of the patient that have to be considered (Magid, 2001).

Vulnerability

One of the points the sick role makes evident is that although patients are encouraged – in contemporary models of healthcare, at least – to be responsible for their own health, there are many barriers that prevent this from occurring, such as a lack of knowledge and a reduced capacity due to disease (Benner, 2003). These barriers have the potential to leave patients vulnerable and perceived to be powerless by healthcare professionals and institutions (Benner, 2003; Bu & Jezewski, 2007), thus permitting uptake of paternalistic and/or advocacy work. Churchill, Fanning and Schenck (2013) indeed contend that becoming a patient is intrinsically linked to being vulnerable. Vulnerability caused by disease or illness, the healthcare environment, or sociological factors such as culture, gender, race, or religion, thus all impact on patient autonomy (Jugessur & Iles, 2009; Negarandeh et al., 2008; NMBA, 2008a). Generally, within the literature, the concept of vulnerability is understood to imply that many patients are incapable of being autonomous due to a lack of knowledge, ill health, and temporarily reduced capacities (Benner, 2003; Bu & Jezewski, 2007; Jugessur & Iles 2009; Kubsch, Sternard, Hovarter & Matzke, 2004; Mallik 1997a, 1997b, 1998; Negarandeh et al., 2008; O'Connor & Kelly 2005; Spenceley et al., 2006).

As noted above, then, vulnerability is often associated with both the effects of health and illness and the healthcare environment itself (Scanlon & Lee, 2007). That is, the process of hospitalisation itself can be very confronting for individuals and can involve a loss of role or identity, or a perceived lack of autonomy from the patient's perspective (Scanlon & Lee, 2007). Added to this, one of the major issues around the hospitalisation process in relation to the perceived autonomy of patients, is that through the current accepted definitions of disease and infirmity there is already an assumption that a person's capacity for self-determination is impaired, leaving the individual perceived to be vulnerable and dependent (Davies & Elwyn, 2008; Hendriks, 2009).[24] Shirley (2009) also explores the idea of vulnerability within the healthcare environment and states that the position of being autonomous is usually taken up by what can be seen as a privileged few, and in fact works to exacerbate the challenges already experienced by the vulnerable many. Jugessur and Iles (2009), Schwartz (2002) and Thacker (2008) all argue that it is this vulnerability that makes the advocacy role in practice so important.

At the same time, as already noted, it has also been argued that no person is ever fully autonomous, insofar as all individuals show a reliance, to a degree, on social networks and interpersonal relationships (Tauber, 2003). Indeed the changing relationships that an individual participates in during different stages of their healthcare experience all have the potential to affect their capacities for autonomy (MacDonald, 2006).[25] Certainly illness can impair an individual's autonomy either temporarily or more permanently, but individuals may also be autonomous in some situations but not others (Mackenzie, 2008). Other factors that may also influence the relationship between the patient and their ability to be autonomous include life experiences, cultural and religious values and beliefs, previous experiences, both as patients and as caregivers, and their overall life experience (Moye et al., 2006). Moye et al. (2006) also highlight that generational differences can be important in relation to a person's socialisation and capacity for autonomy in medical environments. These points all stress the fact that autonomy and its enactment in healthcare by patients is not an all or nothing capacity. There are times that patients will display autonomous decision-making skills and abilities, but there will also be times when this may be viewed by the patient themselves as counterproductive and they may choose to delegate their autonomous decision-making to a third party. Nurses thus need to understand what makes each individual patient vulnerable and what might be impacting on their capacities for autonomous decision-making, meaning, therefore, that there can be no single adequate definition for the role of nurses as advocates.

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[24] Dudzinski and Shannon (2006), and Scanlan and Kerridge (2009) have further argued that the conceptions of autonomy prevalent in the healthcare setting can themselves fail to fully take into consideration patient vulnerability in relation to serious illness and disease and, therefore, their ensuing dependency on healthcare.

[25] Relevant different interpersonal relationships may be between the nurse and patient, the patient and the doctor, or the patient and their personal support networks.

Power

Finally, the Professional Boundary Guidelines as set out by the NMBA (2010) highlight that the relationship between nurses and patients is inherently unequal. As has been shown above, the vulnerability of the recipient of care places them in a perceived powerless position within the healthcare environment. Conversely the healthcare professional is in a powerful position, with power arising from both professional and educational preparation, and the access that the healthcare professional has to private information about the patient (NMBA, 2010). As Mallik (1997b) puts this, it is due to the endemic nature of nursing that there is inevitably a power relationship that exists between the nurse and the patient. This vulnerability and powerlessness are also identified in the Code of Professional Conduct (2008b) and the Code of Ethics (2008a).

Importantly, the idea of advocacy itself highlights situations where there is power inequality, where the power distribution between two people is unequally divided and there is a need for a stronger or more influential person to speak on behalf of a weaker person (Bramlett et al., 1990; Brashers, Haas & Neidig, 1999; Breeding & Tuner, 2002; Jugessur & Iles, 2009). Usually the person in the relationship with the stronger position is the healthcare professional, whereas the patient, usually due to disease or illness, is in the weaker, vulnerable position. This, of course, is argued by Bird (1994) as one of the main reasons that nurses can and should undertake the role of patient advocate (also see Mallik, 1998; Mahlin 2010; O’Connor & Kelly, 2005). Jugessur and Iles (2009) conversely note that because nurses are always in a powerful position compared to patients, the only advocacy role that a nurse can undertake is paternalistic in nature. Hyland (2002) also recognises that the assumption of an advocacy role by the nurse contributes to disempowering patients. Blackmore (2001) adds that because the patient is allocated a nurse and is not able to choose who represents them as an advocate, this is a paternalistic influence in the relationship. Mallik (1998) also recognises that other professionals and individuals are able to advocate for patients, and the thought that nurses are the only ones who are able to advocate is naïve and arrogant.

Conclusion

This chapter has set out to examine the major historical bioethical influences that shape the contemporary understandings of autonomy and advocacy that inform healthcare and that ultimately, I am looking to critically examine within this thesis. Within this chapter I start to lay the foundations of some of the fracture points that occur within conventional conceptualisations of autonomy and how these are not able to be easily operationalised within contemporary healthcare settings. To understand why the operationalisation of autonomy remains contested, there is also a discussion of this concept within the guidelines, standards and frameworks that situate nursing practice in Australia. This chapter has further allowed for some initial consideration of the conventional role of the nurse as an advocate, showing how it has been complicated by conceptualisations of traditional Biomedical models of care, paternalism, the sick role, and the concepts of vulnerability.

What these discussions have made clear is that there are multiple ways of thinking about and responding to issues concerning patient autonomy and the role of the nurse as advocate that are apparent within both nursing and healthcare literature and the policies and standards that guide nursing practice. Not only are there diverse perspectives on what it means to uphold patient autonomy – as well as what upholding it should entail – and to be an advocate, but there are a range of different tensions that undercut many of these ideas and associated practices. These are tensions too in the relation commonly set out to hold between ideas of autonomy and advocacy. Given these complexities, a question arises as to how they are played out or covered over within nursing practice itself. The next two chapters examine this issue in further detail.

The following chapter will serve to outline, for the reader, a concise description of the contexts and methods of this thesis demonstrating more of the complexities that surround the ideas of examining such a complex phenomenon. Specifically, what will be discussed are the intricacies of conducting the research within the healthcare environment and the underlying methodology that supports this thesis.

Chapter 3 - Context and Methods

Introduction

Given that in the previous chapter I began to show some of the points of tension that arise within the conceptualisations of advocacy and autonomy within current literature, it is reasonable then to ask ‘how do we go about beginning to understand the ways in which nurses understand advocacy and autonomy within clinical practice?’. One beginning point for addressing this challenge is to clarify why nurses themselves have so strongly adopted the role of advocacy within the clinical practice setting, and to explore how this focus plays out in their clinical practice. The consideration of these issues will be unravelled in the following chapters where the experiences, perceptions and attitudes of nurses with regards to advocating for and supporting patient autonomy within their everyday clinical roles will be uncovered and examined. While the previous chapter outlined and contextualised the conventionally accepted versions of advocacy and autonomy that currently influence nursing practice, and the next chapter sets out how these ideas are understood and put into practice in one clinical practice setting, this chapter examines the methodologies and methods that inform how data has been initially gathered and thematically analysed with the aim of identifying nurses’ own understandings of the significance of both autonomy and advocacy in their practice. This data and the findings from the thematic analysis (which will be set out in chapter four) will in turn provide the base for my later explorations of some of the ways nurse understandings of advocacy and autonomy are informed by a variety of regimes of truth. Conflicts between these regimes of truth and associated practices help make visible some of the inconsistencies in conventional assumptions and understandings – in both the literature and from nurse participants – regarding the importance of advocacy and autonomy for nursing practice.

To outline my processes of data collection and subsequent thematic analysis, this chapter is divided into four main sections. These sections 1) explore the links between the aims of the thesis and the theoretical tenets of qualitative research; 2) outline an understanding of and respective roles for phenomenological, hermeneutic and ethnographic methods; 3) set out the ethical details of the study; and 4) detail the methods of data analysis that will be used and which are consistent with the theoretical models informing this first part of the thesis. These sections are further detailed below.

Section one of this chapter begins with an exploration of the links between the stated aims of the thesis and the theoretical tenets of qualitative research (including its broad acceptance of social constructivism). A closer consideration of the qualitative research paradigm leads into the second section – a discussion about the links between experience and research practices associated with the phenomenological, hermeneutic and ethnographic traditions. As a qualitative research tradition that provides a foundation for engagement with the experiences of participants, phenomenology allows for examination of how ideals and assumptions of advocacy and autonomy are being understood and operationalised in practice. A phenomenological orientation also foregrounds the need to situate my own historicity and to recognise my own experiential embeddedness within the project as both an insider and outsider researcher, and to consider the challenges and advantages that this positioning affords. Ethnographic methods and how they are used within this study in conjunction with a phenomenological orientation to further illuminate the phenomena under question are also outlined and further discussed. Consideration also needs to be given to how rigour is maintained within the research process. The third section of this chapter includes an outline of the ethical considerations of the study, sampling and inclusion criteria, as well as the recruitment process. It also includes brief descriptions of the participants who shared their stories with me. The phenomenological and ethnographic methods engaged in this part of the study are also further elaborated upon in this section, including a description of how the data was collected from participants, the types of ethnographic data collected through both observational fieldwork data, and the one-on-one semi-structured participant interviews. Finally, the fourth section of this chapter outlines an approach to data analysis that is consistent with the theoretical models outlined here and which will allow me to examine my participants' experiences regarding their deep-seated assumptions and practices concerning the significance of autonomy and advocacy in clinical healthcare settings. As will be detailed, this approach is based upon a thematic analysis of the participants experiences using a modified approach informed by the work of Colaizzi (1978).

Locating Qualitative Research

Qualitative research represents a particular world view or paradigm that informs a series of normative assumptions about knowledge, experience and the location of the individual within it. Qualitative research is defined by Denzin and Lincoln (2017) in terms of a complex set of interconnected terms, concepts, assumptions and practices that recognises the place of the observer in the world. Qualitative research is thus an interpretive, naturalistic approach[1] through which the researcher attempts to study phenomena in their natural settings and attempts to make sense of, or interpret, phenomena from the meanings that people bring to them (Denzin & Lincoln, 2017). This naturalistic approach assumes that there are multiple, socially constructed realities. It also assumes that there is an inherent relationship between the inquirer and the object of inquiry with each always interacting with and influencing the other (Lincoln & Guba, 1985).

This assumes a social connectedness which is thought to yield an influence upon our understanding of ourselves, others and the world. This position is recognised as *Social Constructivism*[2] and contains the argument that in order to make meaning of and understand phenomena – as well as the meanings that people attribute to them – one always engages in practices that are dependent on processes of both construction and interpretation (Schwandt, 1998; Walker, 2015). In a constructivist approach, there is hence a recognition that knowledge and truth are created and, therefore, should be considered to be both pluralistic and plastic. This means that reality is expressed within symbolic and language systems, but at the same time is also stretched and shaped to fit the circumstances and needs of the individual (Andrews, 2012; Kukla, 2000; Schwandt, 1998). Under such a framework, reality is understood as a dynamic and ongoing process of co-creation which is further reproduced by individuals acting on their co-constituted interpretations and knowledge. It follows, therefore, that the capacity of the qualitative research paradigm is always to examine reality as socially constructed, which in turn forms the basis for explaining what is considered by individuals (and groups) to be important, legitimate and reasonable (Cody, 2006; Denzin & Lincoln, 2017; Patton, 2002). Within a social constructivist paradigm, individuals and their contexts are at the centre of meaningful experiences, placing focus on the individual and their interactions within social contexts (Thomas et al., 2014). Knowledge therefore needs to be understood as being constructed by the ways in which each individual makes sense of their experiences in the world.

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[1] Naturalistic inquiry is an approach to understanding the social world in which the researcher observes, describes and then interprets both the experiences and actions of people and groups.

[2] Social constructivism is a sociological theory of knowledge that focuses on how individuals come to construct and apply knowledge within socially mediated contexts (Thomas, Menon, Boruff, Rodriguez & Ahmed, 2014).

The world view of the social constructivist position is particularly relevant to nursing practice where it is palpably evident that each individual experiences health in fundamentally different ways. This understanding allows for the exploration and understanding of phenomena based on sets of world view assumptions and/or beliefs (Denscombe, 2008; Lincoln & Guba, 1985). Also important to social constructivism is the idea of dissonance, defined as "the uncomfortable tension that comes from holding two conflicting thoughts at the same time" (Thomas et al., 2014, p. 56). More specifically, dissonance is understood as a stimulus for learning and for developing revised understandings. In the instance of this project, the tensions that can exist when nurses interpret normalised expectations and then try to implement them into a clinical setting, can serve as a driving force that can facilitate nurses (in this case) acquiring new thoughts or modifying existing beliefs (Thomas et al., 2014). The importance of this idea should not be overlooked and operates to support the fact that each of us can at different times hold different ideas or understandings about the same topic of situation. As such, the reflexivity of this central idea makes social constructivism a suitable approach for the everyday realities of nursing practice. The central ideas that inform the theoretical foundations of social constructivism for use as a qualitative approach are consistent with the aims of examining nurses' own understandings regarding their practices around autonomy and advocacy. These are issues that will become increasingly significant for this thesis. To look at nurses' understandings we are going to be initially using a phenomenological approach. As will be shown, phenomenology allows for an examination of the phenomena under consideration through the viewpoints and the lived experience of the nurses who participated in the study.

Phenomenology

Phenomenology revolves around the acknowledgement of the role of subjectivity and consciousness in the development of knowledge and its inherent influence upon experience (Moran, 2000). There are two main schools of philosophical thought within phenomenology – the transcendental phenomenology of Edmund Husserl (1913) and the hermeneutic phenomenology founded by Martin Heidegger (1927). Founded on the belief that consciousness is both the condition of all experience and a way of thinking and knowing about experiences, Husserlian phenomenology called for a science of pure consciousness (Moran, 2000). A pure transcendental subjectivity could only be obtained, however, through what Husserl described as the suspension or bracketing (out) of both the subject's and researcher's empirically inflected viewpoints (Moran, 2000). Only through this process of bracketing, it was argued, could scientific, philosophical, cultural, and everyday assumptions be put aside, allowing access to pure consciousness (Moran, 2000). Actively engaging in the process of bracketing requires setting aside the impacts of historical and contextual factors that influence individual experience, a process that Heidegger – a student of Husserl – came to challenge.

Heidegger (1962) rejected the Husserlian requirement of bracketing on the basis of what he came to term *Dasein* or 'being-in-the-world'. Heidegger (1962) argued that a person's history is not something that can simply be put aside in such a way as to then reveal understanding. Instead, he argued, it is only through one's being in the world that we develop an initial understanding – our history – from which we then make meaning or develop better or different understandings in the present. Importantly, the understanding in the present always has its beginning from our history and for this reason Heidegger (1962) suggests that we cannot genuinely transcend history in the Husserlian sense. Instead, one's history provides the very condition of our understanding anything at all.

For Heidegger (1962), then, any description of experience is always solidly derived from understandings and interpretations informed by an individual's 'being' within the world (Moran, 2000). Heidegger (1962) indeed asserted that humans are always embedded in their world such that subjective, lived experiences are always interlinked with social, cultural, and political contexts. Under this framework, experience must include the events and circumstances of direct involvement that an individual has in relation to a specific phenomenon (Paley, 2014). That is, the idea of lived experience embodies the idea that it is possible to understand and describe the world or phenomenon as it is lived by the individual, including their taken for granted and common-sense ideas (Laverty, 2003). Such a focus leads attention to hermeneutics and to language. That is, meanings are embedded in common life practices and experiences based on individual interpretation, transformation and understanding, all of which have their origins in language (Annells, 1996; Ferraris, 1996; Grbich, 2007; Heidegger, 1972; Jardine, 1992; Kafle, 2011; Lopez & Willis, 2004; Patton, 2002; Rundell, 1995; Walters, 1995; Welford, Murphy & Casey, 2012). Understood in a hermeneutic sense, language is recognised as the means of sharing the complexities of the human experience, and of how reality and meanings are constructed and interpreted (Gadamer, 2004/1976; Patton, 2002; Regan, 2012). Indeed, Heidegger argued that the essence of being human[3] and *'what it is to be'* human could only begin to be discovered when we live and engage in the world through language. When hermeneutics is discussed in the terms of phenomenology, there is consequently always a focus on the role of language in the development of understanding. *Dasein* is therefore a mode of being that requires that one make sense of and to understand the world, all the while being situated within and conditioned by language (Heidegger, 1962).

Thus, one's preconceptions and pre-understandings come to present and provide meaning to the world and the self. Here language is the medium within which *Dasein* has its function. Thus, in the current study, the researcher recognises that her historicity as a nurse is not something that can be overcome, but instead it is the very foundation from which understanding begins. Equally, those nurses engaged as participants are also shaped by their historicity and are only able to share their stories through language. Importantly, the language that they use to share their experience with the researcher is not different from that language that conditions their very experience itself. Here the work of Gadamer (2004/1976) helps further identify the inextricable links between language and experience.

Gadamer (2004/1976) identifies that language is a universal medium within which understanding occurs. In the culmination of his argument, Gadamer (2004/1976) suggests that although language is the medium within which we have understanding at all, all language is in fact speculative and as such it carries meaning that goes on well beyond simply that which is said. He argues that each of us brings with us our understandings 'thus far' which are the culmination of our historicity. We apply these in bringing the world to understanding, and they can be termed a 'horizon'. Gadamer uses the imagery of the horizon to symbolise all that can be seen from a particular vantage point, and thus helps us recognise that we can always change the position from which we come to understand the world. In so doing, Gadamer (2004/1976) argues that understanding – between people and for one's self – always takes the form of a dialogue.

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[3] For Heidegger the essence of being human is referred to as *Dasein* which means life or existence. *Dasein* is the potentiality for being and therefore existence represents the phenomenon of the future; however, it is also historically conditioned and represents the phenomenon of the past as having been; and finally, it also exists in the present (Heidegger, 1972).

The dialogical nature of understanding means that understandings are always in constant flux and undergoing a process of formation or fusion (Weinsheimer, 1985), and that meanings and interpretations are always tied to particular contexts, times and places. This constant flux of understanding is neatly articulated in the idea referred to as the hermeneutic circle (Boell & Cecez-Kecmanovic, 2010; Heidegger, 1962). Outlining the process of understanding, the hermeneutic circle shows that interpretation can emerge only based on already existing understanding (Heidegger, 1962). Therefore, when we look at a hermeneutic circle, understanding of a phenomenon as a whole is established by its reference to is unique parts and the understandings of these parts as they come together to form the whole. Hermeneutic phenomenology – which informs the first half of this thesis – thus focuses on how subjective or lived experiences are understood and expressed within their contexts (Kafle, 2011; Welford et al., 2012).

Heidegger also reminds us that consciousness cannot be separated from our understanding of the world (Heidegger, 1962; Laverty, 2003). The idea of historicity is that we are always embedded within the context of where we work and where we live. This means that nurses, for example, are embedded within the professional identity of the nurse. Nurses are also embedded within the organisational identity of where they are employed. Nurses are also individuals who come with their own experiences and contexts of healthcare. All of these versions of the nurse come together to allow the individual to interpret their context and, therefore, come to understanding (Laverty, 2003).

In the context of being used as a research methodology to present participants' own understandings and interpretations of being-in-the-world (Walters, 1995), hermeneutic phenomenology thus requires that, rather than the researchers' points of view being imposed on the participants, there is emphasis placed on the researcher and participants identifying and exploring meanings together in relation to the phenomenon of interest through a movement of a dialogue (Smith & Osborn, 2007; Wojnar & Swanson, 2007). One key way to achieve this is of course through the phenomenologically oriented interview process. This will be outlined later in the chapter.

It is important to note, however, that phenomenology only provides one part of what is needed to present the phenomena under scrutiny. Nursing is a practice-based profession;

therefore, I also needed methods that would allow me to examine and observe nursing practice in action, allowing me to note how the phenomena under scrutiny plays out in the setting of clinical practice. This is to consider the steps that are needed for a phenomenology of practice (Van Manen, 2007). In practice based professions such as nursing, medicine and allied health such as physiotherapy and occupational therapy, the learning environment is often a clinical setting (e.g. hospital or a community setting) and learning usually occurs on the job or during discrete periods of time referred to as clinical placements that can be integrated, longitudinal or short in nature (Thistlethwaite, 2013). Such professions show a framework of moving from a novice to expert in relation to competency in practice (Benner, 1982). Most importantly, as a practice-based profession, nursing and nurses need to be able to be considered in the terms of their day to day routine practice. That is, the theoretical and conceptual beliefs and principles of nursing are played out in practice. If we take for example, nursing, nurses do things with, to and for patients. This doing involves the integration of psychomotor skills and theoretical knowledge all the while using a multitude of psychosocial skills to communicate with the patient. Ethnographic methods thus offer one way in which to examine the practice-based nature of nursing because they allow for the capture of what occurs in the real-world clinical setting in which nurses, my participants, operate. Additionally, the time spent observing in an ethnographic sense will ultimately allow for points of reflection in the phenomenological approach later in the study.

An Ethnographic Lens

At its essence, ethnography is the study of culture and can be described as the art and science of describing groups or cultures (Bryman, 2001; Francis, 2013). Focused on learning about people through immersion in real-world contexts, ethnography is important as it allows for the examination of culture and the ways culture can work to create an identity for a particular group. As identified by Crawford (2019), ethnography focuses on a single setting or a group where the actions of those individuals can be analysed and interpreted. First introduced by the work of Malinowski in his deep study of the Melanesian culture, his ethnographic methods were popularised by the work of the Chicago school and the work of Park (Bryman, 2001). With its basis in both anthropological and sociological traditions, ethnography has evolved into four major school of thought/approaches: 1) classical; 2) systematic; 3) interpretative or hermeneutic; and 4) critical (Francis 2013). Classical ethnography relies on extensive fieldwork where the researcher aims to describe culture through descriptive observation (Bryman, 2001; Francis, 2013; Singer, 2009). Systematic ethnography looks specifically at the organisation of culture and how this affects the structure and operationalisation of culture. This can be compared to the third tradition of interpretative or hermeneutic ethnography[4] where the focus is on understanding the meanings of the interactions and behaviours occurring within a given culture or group of people (Francis, 2013; Singer, 2009). The fourth and final type of ethnography is critical and focuses on the power relationships that influence the way individuals behave within the group (Francis, 2013; Singer, 2009). Regardless of the type, it is their immersion in real-world contexts that allows researchers to discover and describe the complexities, shared cultural meanings and nuances which can be used to interpret the meaning of the phenomenon that is being investigated (Jones & Smith, 2017).

Designed as such to primarily examine and explore different cultures (Crawford, 2019; Lambert, Glacken & McCarron, 2011), ethnography provides the means for uncovering hidden, taken-for-granted assumptions that may be inherent with an environment (Crawford, 2019). An ethnographic approach thus allows for examination not only of the practice-based nature of nursing but its culturally based elements. Standard ethnographic methods include using in-depth observations, complemented with interviews and detailed data analysis (Jones & Smith, 2017). In the context of my examination of nursing practice with regards to nurse beliefs concerning autonomy and advocacy, my role as a researcher was to engage a participant-as-observer model through which I could become a part of the ethnographic fabric of the ward. Using a participant-as-observer approach also allows for a natural engagement between the researcher and participants' real-world context. This form of participant observation involves immersion in the setting under investigation so as to observe the language, behaviours and culture of the setting. This was important given that the practice-based nature of nursing requires observation and examination of the world in which nursing takes place.

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[4] This can be seen as the first instance where there is a direct link between the ideas of phenomenology and ethnography. As with the hermeneutic traditions of phenomenology, meaning is consistently tied to concepts such as context, time and place. Thus, it is the cultural influences and understandings that can be influential in the ability to be able to interpret and assign meaning. Thus, if we link this back to the ethnography it is clear that phenomenology and ethnography are linked through hermeneutics where we are trying to make and understanding meaning through our cultural and societal connections.

This study specifically engages the aims of the interpretive / hermeneutic ethnographic tradition to examine the interactions and behaviours that occurred within a specified setting. This approach saw me interacting with nurses and collecting data during the provision of direct care, allowing me to observe the therapeutic interactions between nurses and patients. This type of observation style is referred to by Spradley (1980) as moderate participation in which the researcher maintains a balance between 'insider' and 'outsider' roles. The in-depth interviews that were held after the completion of my observational fieldwork also gave nurses the ability to be able to elaborate further and explain their nursing care, adding further depth to the observed data. In this instance, my focus on examining the everyday interactions and culture of a discrete community with a limited number of participants (Alvehus & Crevani, 2018; Bikker et al., 2017) also fits with a microethnographic approach. Microethnography was first adopted by Strodtbeck, Smith and Geoffrey who used the technique to examine the practices of the urban classroom (Streeck & Mehus, 2005). Microethnography not only examines the cultural influences but also looks at organisational contextual factors that may be influential in the environment under study (Streeck & Mehus, 2005). Within the context of this study a microethnography refers to the focus being that of a singular ward. It is important however to acknowledge that while ethnographic principles informed the close examination of the practice based elements of the nurse-patient interaction, it is the deepening of understanding the meaning and practices that nurses apply to autonomy and advocacy that is of central interest to this study. As such the data derived from ethnographic methods will be used to refine my phenomenological understanding of advocacy and autonomy.

Rigour

Cypress (2017) defines qualitative research as a journey of explanation and discovery. Any research journey informed by the tenets of the naturalistic paradigm, consistent with a recognition of multiple realities, must however demonstrate that it is rigorous in nature.[5] Indeed, the recognition of the basic tenets of social constructivism that support the existence of multiple realities dependent upon the mental activities of the independent observer, is often considered to leave qualitative research open to the charge of relativism

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[5] Rigour is thought of in general terms as the quality of the research and how trustworthy the findings are.

and, subsequently, leading to research findings that are of limited value. In seeking to address this assumption, ideas of rigour in qualitative research have been related to the strength of the research design and the appropriateness of methods to answer research questions. Rigour is thus used to establish consistency in relation to methods and to then ensure that the research process has been carried out correctly (Cypress, 2017). Despite these calls for qualitative research to establish its rigour, the literature contains a tension between attempted regulation by the application of criteria on the one hand and the development of other more creative approaches on the other (Cypress, 2017). For this thesis, to assess the rigour, I have used Lincoln and Guba's (1985) ideas around: credibility (truth-value); transferability (applicability); dependability (consistency); and confirmability (neutrality).

Credibility can be described simply as the need for accurate and truthful depictions of the participant's experience (Cypress, 2017). Lincoln and Guba (1985) describe credibility as being parallel to the decidedly quantitatively oriented concept of internal validity.[6] In establishing this criterion, a researcher seeks to reflect the ethnographically constructed realities of respondents and the reality that is represented by the researcher. Transferability is described by Lincoln and Guba (1989) as being parallel to the quantitative researcher's stress on external validity or generalisability. [7] Dependability finds parallels with reliability and is concerned with the stability of the data over time (Lincoln & Guba, 1989) and is described as providing an audit trail on how the study was conducted (Thomas & Magilvy, 2011). Finally, from a phenomenological perspective, confirmability relies on the reflexivity of the researcher in relation to what occurred in the study and how one's biases may have influenced the research process (Thomas & Magilvy, 2011). Lincoln and Guba (1985) identify that confirmability is the ability to demonstrate that the data, its interpretation and the outcome of inquiry are rooted in both the contexts and the persons' that are represented.

The ways that I maintained connection and ensured credibility within this thesis was through an ethnographic technique of prolonged engagement and ethnographic

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[6] Internal validity in quantitative research refers specifically to the extent in which it is possible for an inference to be made that the independent variable is causing the variation in the dependent variable.

[7] External validity in quantitative research is concerned with the extent to which it can be inferred that the relationships that are being observed within the study can hold true over variations.

observation within the research field. This works to immerse the researcher into the context of the phenomenon under investigation.[8] Credibility was further ensured by comparing transcripts to assess and identify any similarities that are occurring between the participants. Credibility was also ensured through the process of data analysis by ensuring that the words of the participants were used to reflect common themes and ideas (Thomas and Magilvy, 2011). Using the words of the participants allows conveyance to the reader of the thoughts and feelings that the participants may have in relation to advocacy and autonomy in nursing practice, and that might affect the way that they behave. Transferability was enhanced using the sampling method chosen which was purposive in nature, and through the provision of phenomenological thick descriptions within the thematic analysis wherever appropriate.[9] Dependability was encouraged through the thesis through a code-recode strategy using a stepwise replication and peer examination or inter-rater comparisons. [10] And, finally, confirmability is in relation to the ideas of neutrality where the interpretation of data has to be demonstrated to be grounded within the data and not from the potential biases of the researcher. [11]

In practice this assumes that every participant's 'being-in the-world' is integral to the interpretation and meaning ascribed to the experience being examined (Crist & Tanner, 2003; Flood, 2010). This allows for deeper insights and co-creation of meaning between the researcher and participants (Benner, 2004; Crist & Tanner, 2003). Repeated interactions between myself, as the researcher, and the nurses, as the participants, occurred through the data collection process of both observational fieldwork and one-on-one interviews – a process that took place over twelve weeks. My approach to this research was to have an open dialogue with participants that allowed both the participants

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[8] In this instance, more specifically, the researcher spent three months with the Registered Nurses, working with them on the ward and becoming orientated to the clinical setting and building rapport and trust with the participants. Throughout this time, the researcher was socialised with the participants and other nurses on the ward.

[9] Examples of such descriptions include those of the individual participants (included later in this chapter). The analysis of the data can be inherently time consuming and special care and attention was given to this important stage of the thesis to ensure that the phenomenon was captured from the perspective of the participants.

[10] Dependability was achieved in this thesis by having the supervisory team review the transcribed material and the thematic analysis to validate the themes identified. Consensus about the final themes for presentation in the thesis was eventually reached through this crosschecking process.

[11] Confirmability is achieved in this thesis as the researcher kept notes and ideas within a journal that would be beneficial to the process of reflexivity. In addition, through the process of the thematic analysis, an audit trail took place that examined how data was collected and analysed and therefore how interpretations related to themes were eventually made.

and myself to explore our historicity as a condition of our understanding of the phenomena of advocacy and autonomy. Recognising that both myself, as a researcher, and the participants bring our own historicity – and that this is not something that can be ignored nor dismissed – helps to form the basis of understanding and shapes our interactions and the language that is used to describe advocacy and autonomy within clinical nursing practice.

This also brings about the discussion in relation to data saturation. Data saturation in simple terms refers to a criterion for identifying when data collection and / or analysis is as complete as it will get (Saunders et al., 2018). This is the point of recognition that more data will not necessarily lead to more information or indeed a better quality of information (Mason, 2010). Although data saturation is a key concept for quantitative research, it has a more problematic status in qualitative research (O'Reilly & Parker, 2012). For instance, it has been argued by numerous authors (e.g. Strauss & Corbin, 1998 [1990]; Dey, 1999) that the concept of saturation is inappropriate as there is always the potential for the new to emerge. Of importance for the approach to data collection and saturation taken in this thesis, Cresswell in his work from 1998 argued that for a phenomenological study, sample sizes of 5 were more than adequate to examine the phenomenon under investigation. O'Reilly and Parker (2012) further identify that in accordance with this kind of research approach, the idea of saturation should be measured by the depth of data, and that participants should be selected from those with the closest ties with the research topic in question. Such an approach also recognises that because each life is individual and each experience unique, data can never truly be saturated and there is always different ways of viewing things and new things to discover (O'Reilly & Parker, 2012). Low (2019) also agrees with this stating that analysis is never complete and there is always something new to discover and some new insights to be made, making data saturation realistically a matter of degree.

More specifically, this study aligns with the theoretical tenets of Charmaz (2006), according to which the focus should be on exploring the phenomena in question with regards to what it means to each of the participants. Participants are chosen for their close ties with the phenomenon in question. This is a reminder that the purpose of qualitative research is to tell the stories of the people themselves at quite a personal level. Under this framework, what matters is the depth to which ethnographic interactions have occurred with participants (Burmeister & Aitken, 2012; Fusch & Ness, 2015; O'Reilly & Parker, 2012). In the instance of this research, each participant was observed intensely by the researcher for an extended period of time – over the course of twelve weeks – thus allowing for the development of a depth of understanding of the phenomenon from the participants' viewpoints. During this time, participants also participated in multiple one-on-one in-depth interviews with the researcher. These research processes will be outlined in more detail later in this chapter.

Insider/Outsider

My historicity – in particular my experience as both a nurse and as a researcher – means that I am both an insider and an outsider in this research. Being an insider can have varied meanings depending on the context of the environment and the context of the researcher. Therefore, it is important that, preceding a discussion about the complexities of being an insider/outsider, I define my perspective as an insider. The definition presented by Kanuha (2000) and Asselin (2003) states that insider research is conducted within a population of which the researcher is a member, giving a shared identity, language and experiential base. For the purposes of this study, this is the definition of insider research that will be referred to. The duality of being a nurse, but also a researcher, has meant that I was an insider through my role and identity as a nurse, trying to defamiliarise myself in a way that would allow me to become immersed as an outsider researcher able to consider issues from a different 'outsider' perspective. At the same time, as Heidegger's and Gadamer's arguments concerning language and understanding suggest, it is simply not possible to become a total outsider. The historicity of an individual makes this impossible, although strategies that will be discussed in the following sections identify how processes of defamiliarisation can be facilitated so as to not obstruct the research findings as voiced by the participants.

It is much easier to repeat established norms and to uphold the status quo of the insider rather than trying to actively dissociate and take a position as an outsider. Aside from the impossibility of taking a completely outsider position as mentioned above, the difficulty with taking an outsider position was also due to my being immersed in the literature and being heavily embedded in my own normalised experiences. To become an outsider, I would need to defamiliarise my normative expertise and knowledge so that insider assumptions could become more pronounced. At times during the study I found it easy to slip into the role of insider clinician rather than researcher. This occurred when nurses asked for my clinical opinion on patients and their treatments. While for me it was easy to slip back into the clinical nurse role, and my need to help with formulating ideas around patient care was a strong pulling force, I had to also keep in mind that my role was as an outside researcher.

Although at times I did offer suggestions, especially in higher acuity situations, this was usually at the beginning of a relationship with the nurses when development of rapport was a focus.[12] Part of the challenge for me as a researcher was to be able to identify this occurrence and then put into place strategies to remain aware of the effect of this on the study being conducted. To achieve this, I had to develop and promote reflexivity in the study. In terms of participant observations, I decided that it would be more productive and beneficial to the study to participate in the mundane aspects of clinical practice, such as making beds. I found this was a good way to start conversations with nurses about various issues as well as lighten their loads clinically so that they felt they had more time to be able to assist me in terms of conducting interviews with participants.

Reflexivity

As noted above, before entering the field to conduct the study, one of the challenges that I had as a researcher was to identify my own preconceived ‘insider’ ideas concerning autonomy and advocacy. Allen (2004), Dwyer and Buckle (2009) and Mercer (2007) acknowledge this as being a challenge for the insider researcher. This, however, is part of being reflexive. Reflexivity as defined by Baumbusch (2011) is the ability of the researcher to reflect, explore and examine the social processes and contextual factors that influence the relationships of research and the participants themselves. The purpose of being reflexive is to provide insight into the relationships formed and to enable the participants to be co-producers of the research rather than just informants or participants (Burns, Fenwick, Schmied & Sheehan, 2012). As part of being reflexive, I had to focus on my belief systems and challenge the thoughts and assumptions that I had as a professional insider but an organisational outsider.

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[12] Van Maanen (2011) refers to this as whistling native tunes and describes it as a way for the researcher to present the perspectives and voice the words of the participants rather than of the researcher.

Hewitt (2007) and West, Stewart, Foster and Usher (2013) identify that reflexivity enables the researcher to develop a deeper level of meaning and promotes self-awareness throughout the study. Hewitt (2007) talks about the emotions, beliefs, and values of the researcher being integrated and centrally involved in the research process. West et al. (2013) identify this as being able to potentially limit the knowledge distortion and blurring of boundaries that may occur. As part of the process of being reflexive, the researcher has to consider their professional identity as being influential in the development of research. As identified by Burns et al. (2012), this can lead to role confusion and an over-identification with participants. This may cloud the results of the study resulting in over-rapport and leading by the researcher and increasing bias within the findings. This over-rapport can lead to what Ballinger (2008) refers to as a loss of the researcher's capacity to see and note social processes and interactions with the perspective of an outsider. There are many debates in the literature (see for example Thwaites, 2017) about the role of the insider/outsider in relation to this building of rapport and having to be reflexive in interview situations and how it impacts the research findings. It remains challenging for individuals who perceive themselves to have a duality of roles to be reflexive and understand how both insider and outsider roles may influence the research process. Inherently there are both disadvantages and advantages to the dualities of these roles which I will explore further in the coming sections.

Advantages of the Insider/Outsider Role

The idea that the researcher adopts or fulfils multiple identities when conducting research is considered to be unavoidable and in some cases a resource in entering the research field in relation to forming and maintaining relationships with participants (Coffey, 1999; Lavis, 2010; Murray, 2003; Reinharz, 1997). Allen (2004) and Shah (2004) argue that being an insider better positions the researcher to look for patterns of interaction and to be able to provide an authentic account, which is important for phenomenologically aligned analysis. Mercer (2007) further argues that being familiar with the social context enables a greater depth of understanding about subtle social cues that may be missed by an outsider. Allen (2004); Brannick and Coghlan (2007); Burns et al. (2012) and Taylor (2011) identified that subtle cues such as body language, the use of jargon and the ease with which the researcher is able to 'blend in' is also an advantage of being an insider. Labaree (2000) also notes that the hidden meanings that may not be identified by the outsider researcher are often clearly visible and useful to the insider researcher. Allen

(2004) further identifies that this prior knowledge allows the researcher to be able to judge and identify changes in normal clinical behaviour.

Ergun and Erdemir (2012) acknowledge that the identity of the researcher is in constant flux and negotiated with the participants of the research being studied. This is true of the current study where, at times, I was considered an insider, but also at times, the role of outsider was more appropriate. An example of this dichotomy of roles would be as an insider helping the nurses to make a bed while having a general conversation, whereas as an outsider when I participated in the grand round with the nurse in charge and the other unit managers. Disclosing that I was a Registered Nurse to participants facilitated acceptance, trust, and rapport with the participants much faster than if I had been perceived as a complete outsider. At times, the blurring of the boundaries was even more apparent with the participants asking for my opinion or advice when dealing with patients. Ethically and legally, there were limitations placed on me due to my outsider status that limited my clinician's role in the setting, but it was my insider perspective that enabled me to integrate into the setting.

Being an insider allows for an intimate understanding of the values, beliefs and social norms of the group and the profession which allowed a greater emphasis on the observational data and a more focused collection of observational data than would be possible if the researcher has been an outsider (Johnson, Rogers, Van der Lunden & Bianchi-Berthouze, 2012). Laurier (2010) believes that it is essential for the participant-observer to have been involved in and have tried to be a part of the phenomenon they are observing. Laurier (2010) identifies that part of the benefit of being an insider is that the researcher already has an advantage in understanding why things are done, but also there is a distinct disadvantage where the mundane and routine become unseen. As part of identifying as a professional insider, my knowledge level and comfort with the study setting can be both a benefit and a hindrance. This insider knowledge is highlighted by Mercer (2007) as being privileged and allows the insider to have a lived familiarity with the group. However, it must also be noted that populations are not considered homogeneous in nature, so there were individual differences regarding the context of the study that had to be taken into consideration (Dwyer & Buckle, 2009).

Disadvantages of the Insider/Outsider Role

One of the disadvantages of being an insider/outsider in this type of research is in relation to the data collection. While the observational data and its collection can benefit from having a dual identity, when it comes to conducting interviews with participants the insider role can drastically affect the data collection process. Over-familiarisation as an insider can lead to subtleties in interviews being overlooked or missed. This is particularly the case if the insider is still immersed within the field when the interviews are taking place. As a strategy to avoid this from occurring it is suggested that the researcher undergoes a process of defamiliarisation and deidentification (Ybema and Kamsteeg, 2009).[13] These two processes allow the insider to take on the position of the outsider, and, therefore, as Ybema and Kamsteeg (2009) refer to it, 'resurface' and engage with a distanced analysis and observation that allows for examination of the emic rules and routines that become normalised and accepted.

It must be recognised that where researchers may identify as an insider, this also does not necessarily mean that the research participants accept the researcher as an insider, or that they trust, identify, or want to be studied (Crean, 2018). Brown (2012) goes further to state that without reflexivity and understanding of the concept of your own personal identity in the context of research, the insider/outsider is complex and influential in relation to research outcomes. Naples (1996) referred to an outsider phenomenon as the shifting power relations that are existent in the research field. Both Brown (2012) and Naples (1996) identify that the insider/outsider dichotomy exists and is influenced heavily through the political and social contexts of research and that one has to identify that there are multiple identities.

Crean (2018) also suggests that no matter how hard one might want to align and position oneself as an insider, they may never achieve this coveted position due to positionality and subjectivity influencing the research process itself. For example, the positionality of myself as a nurse and as the researcher, created the ability of having a shared history of nursing which allowed for access to the participants and also assisted, to a degree, with data collection, but then also created problems in relation to the analysis of data.

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[13] Under the framework of Hermeneutic Phenomenology, we know that it is difficult for a researcher to reach a point of defamiliarisation and deidentification. This is because as we have discussed individuals enter the hermeneutic circle with history and this influences their interpretations and meanings.

However, Savvides, Al-Youssef, Colin and Garrido (2014) talk in their research about whether or not it is possible for an outsider to remain objective due to the level of intimacy that is required between the researcher and the participants in qualitative research. It is this intimacy traditionally, that does not allow for the concept of true outsiderness to develop and, therefore, this duality of insider/outsider has to exist.

Savvides et al. (2014) further argue that the insider/outsider duality has to exist in order to develop rapport and trust that is required to increase the credibility of the study. However, as an outsider, there can be construed power imbalances in the relationships regardless of the insider connections that exist and, therefore, participants can at times begin to feel threatened, exploited and misrepresented (Savvides et al., 2014). This is due to the fact that insider/outsider issues are not avoidable due to the historicity that facilitates the embedding of norms within nursing practice. It is due to these reasons that the use of phenomenology as a research methodology has been used to explore the experiences of the participants and will help to explore and examine further the phenomenon under scrutiny. Nursing is a practical profession, based on actions and outcomes of actions. Part of this thesis was observing the outcomes of actions of nurses as they practised their nursing care in an everyday nursing context. Van Manen (2007) refers to this as the phenomenology of practice.

The preceding sections have outlined the use of qualitative research within this thesis and, more specifically, the functionality of phenomenology as a means of examining the experience of the participants to uncover encultured – insider – norms of advocacy and autonomy within contemporary nursing practice. Using phenomenology to uncover lived experience also provided an opportunity for me, as both an insider and an outsider, to explore and eventually challenge the conventional conceptualisations of advocacy and autonomy foregrounded throughout the literature, and to better allow the voices of the participants to be heard in their ‘lived’ versions of advocacy and autonomy. Gaining a deeper understanding of the cultural embeddedness of advocacy and autonomy within contemporary nursing practice, by exploring not only the historicity of nursing practice, but also by exploring the historicity of the participants (and myself), allows for a much deeper engagement and critical reflection of these concepts. Phenomenology and hermeneutics provide the theoretical foundation that supports and recognises the importance of identifying not only my historicity as a researcher, but also the participants' historicity within their stories.

Within the next sections of the thesis, ethical considerations regarding the study will be outlined, and the historicity of the participants will be demonstrated by giving the reader an insight into their backgrounds by way of brief biographies. The reader will also be introduced to the key methodological aspects of data collection. The final section details how the participants' experiences will be presented to the reader through a thematic analysis.

Ethical Considerations

The ethical conduct of the study was paramount in order to ensure no harm to participants and other stakeholders. Harm in this study is primarily considered in terms of breaches of privacy, anonymity, and confidentiality, but also considers issues concerning the safety of patients. To address such issues, the confidentiality of the participants was maintained at all times with pseudonyms used in the field notes and interview transcripts. All identifiable information was stored separately on a computer and password protected. Only the research team had access to the information collected. In an effort to maintain confidentiality it was also decided that the organisation would remain unidentified to protect the confidentiality of the participants.

Approval was given from the both the health care organisation where the study was being conducted and the University of Ballarat (now Federation University Australia) Human Research Ethics Committee (A12-153) before entering the field. Each participant was provided with a plain language information statement (PLIS) which provided a brief summary of the study and explained the role of the participant and what was expected from the participants. Once the participant was satisfied with the expectations of the study and had been provided an opportunity to ask questions, each participant was asked to sign a consent form. Participants were informed that they had the right to withdraw at any time and that there was no obligation to participate in the study being conducted.

As I have noted, one of the complexities of undertaking this study is my dual role. At times I am foregrounded as a researcher – an outsider – while at other times as a Registered Nurse – an insider. These are not trivial labels and, as I have noted, are important considerations. While it is valuable to have deep insights into being a nurse and nursing for engaging with clinicians and for informing the development of meaning and understanding through the processes of research, the dual role does also have the potential to establish power inequalities between other clinicians and myself, and affect the quality of the data provided. In seeking to address any influence my dual role might have it was important that the nurses understood that they were not obligated to participate in the study and that there would be no consequences if they chose not to. It was also important for the nurses to understand the implications of my role as a researcher in terms of judging practice and observing their nursing care.

Before entering the field, it was decided, through consultation with my supervisors, that if I directly observed questionable nursing behaviour that directly endangered patients' safety, then, as an obligation of my professional registration, I would intervene and seek assistance from other staff members. This would also mean that data collection would cease. In the case of this study, and after discussion with my supervisors, attention to patient safety was understood as meaning the work of minimising the incidence and impact of adverse events for patients and of maximising patient recovery from any adverse event (Emanuel, Berwick, Conway, Combes, Hattie, Leape, Reason, Schyve, Vincent & Walton, 2008). Although the concept of patient safety can be considered across a variety of fields ranging from physical, psychological to cultural, the decision was made to keep attention on the issue of physical safety. Fortunately, there were no incidents threatening patient safety within this context, and I was able to witness and observe everyday nursing practice.

An additional ethical issue that also needed consideration was the role of the patient in the ethnographic observational fieldwork. Although this study was focused on the experience of nurses rather than patients, it can also be seen that the ethnographic observational fieldwork carried out observed not simply nurses but the patients they were interacting with. This was a very intimate form of observation, as mostly what happens between a patient and a health provider is held in confidence and considered to be very private. As such, several steps were taken to ensure patient wellbeing in this research context. First, as noted above, patient safety was set as the condition for observation practice. Secondly, it was recognised that patient anonymity and privacy would need to be maintained along with the anonymity of nurses themselves. Given this need, it was decided that patients would be referred to by their conditions only, and that any additional personal attributes that would make them distinguishable and identifiable would be excluded. Finally, it should be noted that in accordance with my ethnographic approach I was genuinely trying to observe nurse and patient interactions by trying to be invisible. As mentioned previously, the role of myself as a moderate participant in observational fieldwork allowed me to maintain a balance between my ‘insider’ and ‘outsider’ roles. This allowed for a good combination of involvement but also the necessary detachment that is required to be able to remain objective (Spradley, 1980). From an ethical point of view, if asked by patients I always gave an explanation about myself and my role, but other than this I maintained a professional distance and role and simply observed interactions between healthcare providers and patients. A further pertinent point here is that this hospital is a teaching hospital and therefore patients and staff are already encultured towards having additional people at any time on the ward.

Sample

In this study, the approach to sampling used was purposive sampling (Holloway & Wheeler, 1996; Patton, 2002; Ritchie, Lewis & Elam, 2003; Robson, 2002). The participants in purposive sampling were all chosen against a series of inclusion criteria that were developed in order to provide what was considered to be a sound foundation for providing detailed understanding of the phenomenon being studied (Mays and Pope, 1995a). As part of the eligibility criteria for inclusion into this study all participants needed to be:

1. Over the age of 18
2. Able to fluently converse in and understand English
3. Registered as a Division 1 Registered Nurse with AHPRA
4. Currently employed at a 0.5 effective full time (EFT)
5. Providing direct clinical care to patients

Aside from these eligibility criteria, the decision was made to focus sampling within a single ward. There were a number of reasons for this decision. The first reason with regards to so confining sampling was in order to limit the influence of culture on the findings. Each ward in a hospital provides specialist care for a different subset of patients and each ward tends to establish a set of normative practices that in combination with the personalities of the nursing staff seem to establish a culture within a clinical setting.

Given that each is so very different and the perceived likelihood that the ward culture influences the way in which patient autonomy and advocacy are enacted (DiCuccio, Colbert, Triolo, Schreiber & Dean, 2020), the decision was made to limit the study to one single setting. At the same time, although nurses' experiences of autonomy and advocacy as a phenomenon may be shaped by the ward and the culture of that ward in which they are working, we can also assume that this influence will be moderated by the shared educational preparation and professional understandings that come with being a nurse. The second reason for choosing to sample from a single ward concerned this ward's orientation as an acute medical ward. Patients were typically inpatients for a longer period of time due to their complex illnesses and comorbidities and this allowed for extended periods of time of interaction between nurses and patient. Such a ward situation thus potentially offered greater opportunities for observation of practices of advocacy and therefore the support of patient autonomy.

Recruitment

Initially, recruitment of participants was achieved through structured information sessions held on the ward during clinical handover. This gave potential participants time to ask questions and for me to introduce myself. Information fliers were also displayed in the handover room inclusive of my contact details so that potential participants were able to contact the researcher directly. Through this process, seven nurses identified as interested in participating in the study. Over the duration of the study, this number was reduced to five participants as two of the nurses decided not to participate.[14] Due to the qualitative nature of the proposed project, a small number of participants were considered acceptable as it was more important to gain deeply rich descriptions of experience over increased participant numbers. By using a descriptive/interpretive method, the sample size was small and purposeful to the study (Connelly, 2010).[15]

Participants

The nurses who consented to be interviewed in this project are considered to be co-researchers rather than subjects. Sharing their personal views and nursing experiences has

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[14] The two nurses who decided not to participate cited that they felt they did not have the time to devote to the study.

[15] The sample size was considered to be relatively homogeneous in nature because the participants are classified as insiders as they are all Registered Nurses, they all hold Division 1 registration with AHPRA, and they were all female. However, this homogeneity is contextually based and there are factors that make the sample less homogeneous in nature. Things such as some of the participants' cultural background, the fact that some of the participants did their original nurse training outside of an Australian context, and also the varying ages of the participants all contribute to the diversity of the seemingly homogenous sample.

helped to develop and expand the understanding surrounding the important concept of advocacy and autonomy for nursing practice. I am indebted to these nurses for letting me shadow them while they worked tirelessly to provide quality patient care and give me an insight into the often taken for granted assumptions that surround nursing care. This section gives a brief overview of the nurses to provide the reader with further context of the nuances of the individual participants. All the names used in this analysis have been changed to pseudonyms to protect the confidentiality of the participants.

Natasha

Natasha was a new graduate on her first rotation after finishing her Bachelor of Nursing at a large metropolitan university in Melbourne. As the youngest participant, only being 19,[16] Natasha was single and living out of home with housemates who were also nurses. Natasha was recruited by the researcher after an in-service information session. Although her clinical experience was limited due to her graduate status, her insights into the perceived differences between the older nurses and herself in terms of her nursing practice were important.

Linda

Linda was a 43-year old, married female, originally from New Zealand. Linda completed her general nursing training in a major university in New Zealand. At the time of the interview, Linda had been a practicing nurse in Australia for 20 years with a varied clinical background in mental health, palliative care and medical nursing. Rapport was easily developed with Linda and our shifts together, and the interview conducted, were times of mutual storytelling and comparing experiences. Linda worked as the nurse in charge on some shifts which provided an added dimension to the information and her perspective in relation to advocacy in nursing practice.

Kylie

Kylie was the oldest of the nurses interviewed being 52. Culturally, Kylie was from India originally, although she had been in Australia practising as a nurse for 25 years. Her training was in India where the cultural expectations and care provided is very different from that in Australia. Kylie had been married as a young woman and had two grown children and one grandchild. Kylie was often placed in charge of the ward during shifts and was expected to attend departmental meetings. This provided an added complexity to her nursing role and, therefore, the research perspective. Kylie had the benefit of experience in practising nursing in different cultural contexts.

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[16] This participant had completed an accelerated pathway Nursing degree, explaining her young age.

Rose

Rose was a 46-year-old Filipino nurse who had trained and worked in the Philippines for the first half of her nursing career. Rose was married but had no children and had immigrated to Australia in the 1990s. Rose explained things in very concise terms as she was worried that I would not understand what she meant. I had to assure her that I had no trouble understanding or conversing with her. Her insights into the differences in the cultural expectations of healthcare, and specifically with regards to the roles of autonomy and advocacy within nursing practice, have been invaluable in understanding some of the prevailing conceptualisations of these ideas in contemporary healthcare. Rose can only be described as energetic. When shadowing her there was little time for sitting and reflecting as she was always on the move.

Rebecca

Rebecca was a 42-year-old mother of three who lived locally and had completed her training at a University in Melbourne. Rebecca was considered a senior staff member and was often placed in the high dependency unit to work. The high dependency unit was for critically ill patients who required high levels of nursing intervention and monitoring. The fact that for many of the shifts where I shadowed Rebecca, she was placed in this clinical area is testament to her seniority and clinical experience. Rebecca was placed in several high stress situations while I was observing her nursing practice which allowed a unique insight into how the acuity of patients can influence nursing practice.

All the nurses were initially shadowed so that I could observe their nursing practice within context. Data was collected in this study through ethnographic observational fieldwork and one-on-one interviews with the nurses who participated in the study. Observational data collection techniques as well as the interview techniques themselves will be explored in more detail below.

Interpretative Microethnographic Fieldwork

In ethnographic observational research it is important that the researcher clearly identifies what type of observer role is to be assumed. Even though my study is microethnographic because it only looks at a small pocket of a population, the principles that inform ethnography in general are the same and therefore will be discussed in more detail below. In seeking to remain neutral while at the same time situated in such a way as to obtain accurate descriptions of all participants' experiences, the researcher assumed the role of observer-as-participant. An observer-as-participant is theoretically consistent with the idea of the role of the insider within this project. It was decided that this would be the most beneficial role for the researcher to undertake while ethnographically in the field for a number of reasons. DeWalt and DeWalt (2011) recognise that participating in the field ethnographically has the potential to increase the quality of the data obtained, further acting to enhance the quality of the interpretation of the data. This is because, as DeWalt and DeWalt (2011) describe, it allows the ethnographic observer to come to 'know' and therefore understand what they are observing in a unique way because as a participant observer they are becoming a participant in what is being observed. It is this insider knowledge and relationship as a participant observer that serves to work as a quality control mechanism in relation to the quality of the interpretation of the data where the vignettes and the observational examples used are provided and reflected upon within the context in which they occurred and supported with the voices of the participants themselves. Capitalising on the researcher being a Registered Nurse and therefore feeling confident and competent in the environment within which observation was being undertaken, it was decided that taking an active role and participating with the participants of the study in the environment of care itself would provide the deepest level of engagement through opportunities for rapport building and open up opportunities for the collection for rich data.

DeWalt and DeWalt (2011) recognise the ethnographic participant as being a native within the setting, and that they will as such take part in daily activities, rituals, interactions and events. As also discussed above, participating in these activities also helps the participant understand the social contexts and interaction common to that setting (Andriessen, Kluin, van Gulijk & Ale, 2013; Duncan & Diamond, 2011). Participant observation has the benefit of providing a platform for gaining insight about a phenomenon from the emic (insider) and etic (outsider) perspectives (Burns et al., 2012). This is a way of learning the explicit and tacit aspects of the culture under study (DeWalt & DeWalt, 2011). This process is referred to as enculturation and works to develop the tacit knowledge that is often of interest (DeWalt & DeWalt, 2011). Through the exploration of tacit knowledge, what is left unsaid and responses to actions are able to be understood and explored, and this type of knowledge shapes what is observed (DeWalt & DeWalt, 2011). As an 'insider' Registered Nurse the researcher is able to understand deeply the nature and meaning of the nursing rituals within the clinical space and to capitalise on them as opportunities for understanding.

Ethnographically, the observer-as-participant has two main functions: (1) to engage in the activities that are appropriate to the given setting and (2) to observe the interactions between participants (nurses and patients) and the environment (Spradley, 1980). If we look at point (1) above, the researcher was able to facilitate this by engaging with the participants through processes such as making patients' beds and engaging with clinical communication and dialogues. This was only made possible by the 'insider' perspective that the researcher possessed through her previous experience and knowledge as a Registered Nurse. The purpose here is to interact but also to observe the social situation as it unfolds (Spradley, 1980). Engaging with participants while they were undertaking care for patients meant that it was then not as obtrusive for the participants when the researcher was observing direct patient care and seen to be taking notes. This facilitated acceptance of the researcher into the clinical environment. The challenge, then, for the participant observer is to become explicitly aware of the social contexts of the environment rather than subconsciously aware (Spradley, 1980). The researcher needs to increase their awareness of the environment and one way to do this, as has been discussed, by the insider/outsider experience. At any time during ethnographic observational fieldwork the researcher is considered to be both an insider and an outsider simultaneously (Duncan & Diamond, 2011). Therefore, it was up to the researcher to set boundaries between the participants and herself in relation to what she was able to participate in and what was considered to be inappropriate. There were also times when the researcher would leave the clinical venue to make notes and give time away from the clinical field work to gain clarity.

The Process of Ethnographic Participant Observation

In total, the researcher spent 12-16 hours per week in the field over a period of 12 weeks. The first 3-4 weeks were used to develop rapport with participants. This is referred to as descriptive observation and is used solely for orientation into the field and provides unspecific descriptions of the clinical environment (Flick, 2008). It was here that physical elements of the ward space were mapped out thus giving an understanding of the physical elements of the ward space. Crawford (2019) refers to this understanding the cultural patterning of the participants and as an ethnographic method it is a valuable tool to help to understand the cultural functionality of the ward. The second phase of the observational fieldwork was to be focused observation through which the researcher would be able to narrow the perspective of the observation to the area of interest – an acute medical ward in a public metropolitan hospital (Flick, 2008).

During this phase of the observational fieldwork, field notes were taken that were very descriptive in nature. These handwritten notes were considered to contain all the details that were observed and took nothing for granted, ensuring that every detail was recorded to be later reviewed or clarified with the nurse either via a question later in the observational session or during the one on one interviews. These observations were important for helping me to start to see some of rituals and patterns that were emerging in relation to patient advocacy and nursing practice.

To conduct the ethnographic observational fieldwork over the set period of 12 weeks, I attended the ward three days a week to observe the nurses in clinical practice. I was aware that to achieve the data collection desired I would have to be flexible in fitting in with the flow of the ward. At times, when I arrived, it was apparent that it was not going to be possible to conduct observational data. This was in part due to several reasons – either the nurse that I was working with was sick; the ward was physically too busy, and my presence would have been a hindrance to patient care and safety; or at the request of the participants themselves. I attended important ward events, such as handover, so that I had a little idea about what the nurses were dealing with on the shift in terms of patient acuity. I also attended organisational 'bed meetings' which were conducted by the Director of Nursing (DON) and Associate Nurse Unit Managers (ANUMs). These meetings were attended by myself because of the participants that I was shadowing on that shift. I also ensured that I worked alongside the same nurse for more than one consecutive shift, which facilitated with the development of rapport and trust that is necessary for this type of data collection. I was also welcomed by the participants to join staff for morning and afternoon tea, which I did on several occasions. These events enabled me to become less of an outsider for other staff on the ward who were interested in what I was doing but weren't involved in the study directly. This transparency across the staffing group, not just those who were involved in the study, was an important aspect of developing rapport and trust.

Patton (2002) describes observational data as being able to accurately describe the setting – including the activities that were being undertaken; the people participating, and the meanings of the interactions as perceived by the participants themselves. The second purpose of observation is that it allows the observer to have direct personal contact with the setting, enabling better engagement and understanding of the context of the environment (Patton, 2002). This also works to reduce the preconceptions of the observer in relation to the environment (Patton, 2002). The observer, being new to the setting, may also be able to observe the 'taken for granted' routines and practices that influence the contextual setting (Patton, 2002). This was true for myself when I attended the handovers, team meetings and engaged with routine nursing care with the nurses.

Critiques of Observational Ethnographic Fieldwork

It was important for the researcher to recognise that field notes constitute both data collection and data analysis (DeWalt & DeWalt, 2011). Although they are a direct representation of what occurred during the observational period, they are also the outcomes of construction by the researcher and therefore may often be associated with subjectivity (Atkinson & Coffey, 2003; Baker, 2006; Cassell & Symon, 1994; DeWalt & DeWalt, 2011; Duncan & Diamond, 2011; Mays & Pope, 1995a;1995b; Watts, 2008; 2010). Referred to by Baker (2006) as researcher bias,[17] the process of self-reflection (reflexivity) is considered to be a useful means of offsetting this (Giacomini & Cook, 2000). In this study, the researcher used a personal journal to make note of key points to follow-up with research participants, the timing of incidents that were significant, and also thoughts and feelings of myself as a researcher that may have been significant or impacted on the researcher at that particular point in time.

A further criticism of ethnographic observational fieldwork is noted by Mays and Pope (1995b) and Spradley (1980) who identify that by virtue of the subjective nature, using only one observer has the tendency of limiting the data collected and may mean the data is overly open to the critique of subjectivity. To overcome this, I kept very precise observational field notes and coupled these with a personal reflective journal that allowed me to go back and, if required, clarify points with nurses the next time I observed them in clinical practice. It is also noted that participants can have a tendency to modify and change their behaviour when being observed (Giacomini & Cook, 2000; Mays & Pope,

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[17] It is important to remember, however, that accepting that it is our historicity that allows us to have experience and understanding of the world, it follows that we are never free from bias. Instead, the historicity of each individual will inform their interpretation of each situation.

1995b; Watts, 2010). In this study, engaging with participants and interacting in with them while performing simple tasks, such as bed making, worked to limit the modification of behaviour as the participants become more at ease with the researcher (Mays & Pope, 1995a).

Interviews

Interviews are considered one of the main methods of data collection for many qualitative research methodologies (Edwards & Holland, 2013), including for phenomenological approaches. It is noted that the interview process is aimed at providing an authentic access to experiences and the meanings that participants attribute to these experiences (Fossey, Harvey, McDermott & Davidson, 2002; Hewitt, 2007; Moyle, 2002; Roulston, 2010). Interviews provide an opportunity to clarify and explore events through the eyes of the participants. Each participant will see and interpret the world around them in very different ways and bring that experience and understanding to the interview (Galletta, 2013). Therefore, interviews allow the researcher to illustrate and explore the conceptualisation of the phenomenon and how this varies between the individuals (Brayboy & Deyhle, 2000). Edwards and Holland (2013) describe interviews as being able to elicit understanding which remains consistent with the context from which it originates and is in fact co-produced by the researcher and participant. It is in this sense that interviews involve the reconstruction of knowledge.

In accordance with a phenomenological lens, the aim is to have an open-ended conversational interview which allows and encourages digression and exploration of potentially important concepts and topics (Edwards & Holland, 2013). Interviews are typically considered to be in-depth which allows for probing of meaning and to explore and capture the areas of concern that may be missed in the observational data collection (Edwards & Holland, 2013). Many interviews are classified as either semi-structured or unstructured in qualitative methodologies, especially phenomenology (Edwards & Holland, 2013). The interviews conducted in this study are defined as semi-structured in nature, which gives the researcher an interview guide to prompt participants about possible topics and questions (Edwards & Holland, 2013). The use of an interview guide is identified by McGrath, Palmgren and Liljedahl (2018) as facilitating a more focused exploration of the topic and allows for follow-up from the ethnographic observational phase of data collection. The ethnographic observational data can also be used as a basis for the questions asked and to give clarification about what was observed from the participants themselves.

Challenges of Interviewing

One of the challenges of interviewing participants is the asymmetry of power that has the potential to exist in the encounter. Kvale (1996) and Edwards and Holland (2013) both recognise that it is the interviewer who initially has power over the participants as they set the context for the interview and what will be asked of the participant. However, there is recognition by these authors that due to the fluid nature of interviewing there is the potential for this power to shift between the participants and the researcher at any given moment (Kvale, 1996; Edwards & Holland, 2013). It has to be remembered that participants give accounts that are subjective in nature and influenced by numerous contexts – such as past experience, socialisation and professionalisation, and various other variables – and as such their perceptions and accounts can change over time (Roulston, 2010).

Another difficulty highlighted in current literature is the potential for bias on the part of the researcher (Galletta, 2013). The nature of interviewing is unpredictable and the idea that researchers come into a research project without bias or pre-conceived ideas is naïve (Galletta, 2013). Interference, as recognised by Galletta (2013), has the potential to alter the data collected and influence the analysis. However, an orientation from hermeneutic phenomenology challenges this because it recognises, as I have discussed earlier, that as individuals we begin from our historicity, so it therefore always conditions our understanding. Being reflexive, however, does allow for scrutinisation of those factors that influence data collection and analysis (Banner, 2010). Therefore, it is important to highlight that the context of the interviews undertaken is identified and explored. In the current study, interviews were conducted in a quiet meeting room on the ward, a space that the participants felt most comfortable with. During the interview process, a sign was placed on the door asking people not to disturb. The interviews themselves lasted from 20 minutes to one hour, and each participant in this study was interviewed for 4-6 hours over an average of 3 separate occasions. The time frame for the length of the interviews was limited in many respects due to the constraints of the limited free time that the participants had available. The need to fit in with the routines of the ward and when new staff were coming onto shift was a factor in terms of how much time I was able to spend with the participants during the interviews.

Interviewing Techniques

Techniques employed during the interview process by the researcher to facilitate the interview process included the use of humour and laughter, and an awareness of body language. Laughter is used as an interactional resource in which individuals may be able to relate to each other and interpret interactions (Gronnerod, 2004). During the interviews, laughter also helped maintain contact with the participants and to put them at ease in relation to discussing and exploring their experiences. This mechanism of interaction is identified by Gronnerod (2004) as being a useful tool in the repertoire of the researcher, particularly in building and maintaining rapport with participants and managing what could be perceived as difficult or stressful situations. Laughter with the participants also enforces that insider role of the researcher in this study where laughter could be construed to act as a confirmation between the participants of their shared identity as Registered Nurses (Gronnerod, 2004). This is argued by Moran, Skeggs, Tyrer and Corteen (2002) as being influential in the meanings that are able to be produced during the interview. Part of the unseen portions of an interview also includes the body language and personal interaction with the participants that can only be descriptively identified by the researcher. During the interviews conducted for this study, the researcher was cognisant of the role that body language such as eye contact, posture and prompting had on the depth of the interview.

While I had the benefit of understanding the role of the interviews in the data collection process, the next important aspect of this thesis becomes the analysis of this interview data. To do this I decided to use the technique of thematic analysis to understand the participants voices and to further understand the phenomenon under scrutiny. The next section will further explore the process of the thematic analysis

Thematic Analysis

Thematic analysis can be defined in numerous ways. Braun and Clarke (2006; 2013) define it as a method for the identification, analysis and eventual reporting of patterns contained within data. Fereday and Muir-Cochrane (2006) refer to it as a search for patterns that emerge within a given description of a phenomenon. Regardless of the definition given, there is consensus among scholars that the main purpose of a thematic analysis is to understand a phenomenon from the perspective of the individuals, groups or communities who experience it (Braun & Clarke, 2006; 2013; Butcher et al., 2001; DeSantis & Ugarriza, 2000; Fereday & Muir-Cochrane, 2006; Vaismoradi et al., 2013). While it is important to identify that the researcher has an active role in the interpretation and analysis of the data (Braun & Clarke, 2006; 2013), it is even more important for the voices of the participants to be dominant and reflected in the analysis provided. For the purpose of this study, thematic analysis entails the identification of themes within a given data set that are used to describe and explore the given phenomenon of advocacy and autonomy within contemporary nursing practice as expressed by the participants of the study.

Colaizzi's method

Colaizzi's (1978) method for the process of thematic analysis involves the inclusion of symbolic representation, which allows the researcher to gain a deeper understanding of the phenomenon from the perspective and experiences of the individuals (Edwards & Welch, 2011). In this research project as has been detailed, data was collected by observational fieldwork and notes, as well as through engaging participants in interviews to elicit their experiences, feelings and perceptions with regards to the ideas of advocacy and autonomy in nursing practice. Many nursing researchers use and develop the methods of Colaizzi in examining nursing phenomenon (Edwards & Welch, 2011). Colaizzi's method consists of seven distinct steps, however for the purpose of this analysis, I have chosen to only use the first five steps of his analysis process.[18] Using a modified Colaizzi's method, the first five steps of Colaizzi's phenomenological data analysis (1978) have been completed as a process of this thematic analysis and include:

1. Each transcript being read and re-read to obtain a general sense about the whole content.
2. For each transcript, significant statements were extracted. These statements were recorded on a separate sheet noting their pages and line numbers (Appendix

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[18] Step 6 is describing the fundamental structure of the phenomenon and Step 7 is returning to the participants. Step 6 of the analysis process using Colaizzi's analysis method is about returning the descriptions to an essential structure which is an unequivocal statement of identification of the fundamental structure of the phenomenon under question (Colaizzi, 1978). Step 7 was not completed as this is considered in many ways to be controversial as the researcher and the participants will have different perspectives. Step 6, rather than being part of this initial analysis will be completed as part of the overall conclusion of the two parts of both the thematic analysis and the Foucauldian analysis.

I).

3. Meanings were then formulated from these significant statements (Appendix I).

4. The formulated meanings were sorted into categories, clusters of themes, and themes (Appendix I).

5. The findings were integrated into an exhaustive description of the phenomenon under study (Appendix I).

Each of these steps will be unpacked in more detail below to provide a sense of how the analysis was conducted.

Step One

The first step of the analysis involved reading and re-reading the transcripts in their entirety. This step was undertaken to gain a sense of the content as a whole. At this stage of the analysis, the recordings of the interviews were also listened to multiple times, allowing the researcher to gain a ‘feel for them’ and facilitate familiarity with the content. This is identified by de Wet and Erasmus (2005) as an essential step in the analysis of the data. One of the key challenges in this first step of the analysis was to ensure that the voices of the participants were heard and that this was what was presented in this analysis process. This was achieved by the researcher identifying the complexities associated with being an insider/outsider researcher and developing strategies for managing bias in conjunction with the supervisory team. Understanding and acknowledging preconceived ideas brought to the research project by the researcher helps allow the participants’ views and voices to be dominant.

Step Two

Significant statements from the participant interviews were identified to reflect the participants’ experiences and identification with the topic being discussed. Significant statements identified by Colaizzi (1978) are those statements that are considered to be of direct relevance to the phenomenon that is of interest. Identification of these statements led to them being written in a table and labelled based on transcript, page and line number. In this step of the process, any statement which related directly to the phenomenon being studied was included.

Each of the significant statements was chosen on the basis that it demonstrated the individuals' understanding of the concepts and identified the journey undertaken by the participants. When developing significant statements, firstly all the interviewees' answers were tabulated for ease of reading. From this table the researcher re-read the statements to identify – and highlight – key phrases or words that participants had used in the excerpts. From these key words, the researcher then formulated a meaning that reflected the essence of the statement made by the participant. For example:

> *Mostly it's just a voice for the [inaudible] to make sure that - making sure that they are safe and also if they aren't able to make a decision or to maybe have a voice of it if they haven't got anybody responsible, they can't make it themselves. I think it's just to have someone there to be a voice, look after them yeah.*

From this process, formulated meanings were developed. Initial identification of repetition allowed the researcher to identify preliminary patterns and key concepts within the significant statements. The researcher also identified the ideas and concepts that were repeated by a number of participants. 'Outliers' or differences in responses also became significant through this process. This is because it can help to understand whether these outliers or differences are due to the representation of the concept or in fact the way it is rather constructed by the participants (Phoenix & Orr, 2017). This is also where the significance of the observational data was noted as outliers or differences could be cross referenced with the observational data.

Step Three

Edwards and Welch (2011) talk about this stage of the analysis as being about general restatements or meanings from the identified significant statements. These formulated meanings were then clustered together. Significant statements were identified and referred to using key statements or words used by the participants themselves as an effort to remain true to participants' descriptions and meanings, a fundamental objective within phenomenologically orientated thematic analysis. From this process, clusters of themes were identified and extracted from each transcript.

Step Four

The final process used by the researcher before completing an exhaustive description of the phenomenon being studied, was to create a table identifying the formulated meanings;

theme clusters and then emergent themes. This is recognised by Thomas and Harden (2008) as being one of the more difficult aspects of completing a thematic analysis as it is solely reliant on the judgement and insights of the researcher. Colaizzi (1978) recognised that this particular step was challenging because of the requirement of the researcher to suspend their biases and pre-suppositions in relation to the phenomenon. This process was done through the use of a personal journal, both written and oral for the researcher to record and reflect on feelings and influencing factors. The development of these meanings, theme clusters and emergent themes was also made easier by the ability of researcher to be able to engage with the observational fieldwork data for clarification of points and to strengthen the establishment of formulated meanings, clusters and themes.

Step Five

These emergent themes were then used to complete the analysis of the transcripts. Initially there were six emergent themes that were developed out of the words of the participants that related to the experience of nurses with advocacy and autonomy. These were:

- Being careful with culture;
- Understanding your patients so as to give them a voice/speak for them;
- People are not controllable;
- Remembering the person not the condition;
- Considering the context of the situation; and
- Relating on a personal level.

However, during the process of the in-depth analysis, it was identified that many of these themes had significant links and overlaps. Through a process of refinement, three main themes were identified, each of which included several sub-themes:

- Supporting Patient Autonomy;
- Advocacy in Context as Duty of Care.
- The Contextualisation of Care

This highlights that thematic analysis is both an interpretative and iterative process (Smith & Firth, 2011). As has been noted, part of the process of ensuring rigour and validity in the process of thematic analysis occurs through engaging with the respondents' voices, both through the reading of the transcripts and by engaging and re-listening to the recordings of the interviews. De Wet and Erasmus (2005) recommend this is a key point as it helps to prevent a mechanistic approach to analysis, and this is an approach that I used within this study. As with observational and one-on-one interviews, part of the challenge of ensuring quality in this study was in relation to identifying the positionality of the researcher and identifying the personal values and prior knowledge that may influence and bias the analysis of data (Caelli, Ray & Mill, 2003). Thomas and Magilvy (2011) also recognise this as being essential in relation to establishing rigour and quality in qualitative analysis insofar as personal perspectives of the researcher and the participants are influenced by cultural, experiential, environmental and contextual factors. To help to achieve rigour, open and frank discussions about the data analysis with the supervisory team were had to ensure that what was being presented was an accurate reflection of the data. Also helpful was the use of a personal journal where I was able to use this as a format for writing down queries about bias and bring these up for discussion in supervisory meetings.

Conclusion

The need to locate the historicity of the researcher as central to the research practice highlighted a turn to hermeneutic phenomenology as an underpinning methodology, and the practice-based nature of nursing required a use too of ethnographic methods. This combination of phenomenological and ethnographic techniques allowed me to combine my unique insights as an insider with my outsider perspectives, providing entrée to the process of thematic analysis. At times the need to undertake an outsider role and to challenge my insider perspective was difficult but a necessary learning and developmental process for me to undertake.

Phenomenology, particularly hermeneutic phenomenology, along with ethnographic methods thus provide the theoretical basis for an exploration of the experience of the participants that would offer insight into the interpretation and the enactment of advocacy and autonomy within contemporary nursing practice. These approaches recognise the productive, over the inhibitory, influence on experience that one's historicity has. This accentuates how the individual experience developed as being-in-the-world shapes and influences the viewpoints that may have developed in relation to advocacy and autonomy within current practising nurses. This is true not only for the participants, but also for myself as a researcher. The advantages and disadvantages of the insider/outsider role complicates how the voices of the participants are presented. From this experience I have recognised that a person's historicity influences and challenges an individual's experiences and perspectives. In the following chapter I present the thematic analysis developed from my data collection using Colaizzi's method of analysis. Here the analysis focuses on the rich experiences of the participants and on presenting their thoughts and views in relation to advocacy and autonomy within contemporary nursing practice. Interwoven with the voices of the participants are also points from the literature as well as excerpts of the observational fieldwork able to provide a more detailed contextual basis for the reader.

Chapter 4 - Thematic Analysis

Introduction

In the previous chapter I have outlined for the reader the main methods and methodology used to frame this first section of the study, including participant observation and one-on-one interviews, as well as details about the participants – including how they were recruited – the ethical considerations of the study, and Colaizzi's method[1] of data analysis for informing the development of a thematic analysis. It is the findings from this thematic analysis that will now be presented within this chapter. As explained in the preceding chapter, I used a semi-structured model for the collection of interview data from the participants. While this allowed for some structure in relation to the questioning used, it also facilitated a more conversational style of interaction between the researcher and the participants – important for an approach oriented by hermeneutic phenomenology. This conversational style allowed the participants to freely express points that they believed significant in relation both to their nursing practice and to their understandings of the functions of concepts of autonomy and advocacy within their nursing practice.

As has been noted, the interview transcripts were analysed using a modified version of Colaizzi's method of thematic analysis which stressed the importance of understanding and further outlining the phenomenon from the perspectives and experiences of the individuals. Initially each interview transcript was read through with the intent of identifying patterns of significant statements. It was through this process and the others also outlined by Colaizzi (1978) that emergent themes were ultimately identified. Developing understandings were grouped together to provide the foundation from which initial themes and sub-themes were able to be identified, each one arising from ongoing and close contact with the views and voices of the nursing participants. These sub-themes demonstrated the development of deeper and richer understandings of the phenomenon, but also allowed the articulation of more nuances with regards to the participants' voices, experiences embodied by the interview and observational data. However, it was not until the fourth step in Colaizzi's approach that the sub-themes were most effectively distilled

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[1] For a comprehensive understanding of how the Colaizzi method of analysis applied to this thematic analysis please refer back to Chapter 3 – Methods and Context.

under the major themes. The themes and sub-themes identified through the culmination of Colaizzi's approach were as follows:

- Supporting Patient Autonomy
    - Getting to know your patient
    - Being careful with culture
- Advocacy in Context as Duty of Care
    - Communication
    - First line of care
    - Rapport, trust and veracity
    - The caring side of nursing
- The Contextualisation of Care
    - Considering the context of the situation
    - People are not controllable
    - The environmental context of healthcare

Before I begin to outline the first theme, there are a couple of additional points that need to be made. As has been noted, this chapter presents the culmination of the analysis process following Colaizzi's steps. More specifically, the aim is to give voice to the experiences and perspectives of the participants via use of the thematic identification method set out by Colaizzi, as well as to situate these perspectives with regards to the literature examined in previous chapters. That is, themes and subthemes are identified and outlined with direct reference to the experiences and understandings shared by participants regarding advocacy and autonomy. These themes and subthemes are then considered with regards to key points arising from my examination of literature and policy in Chapter Two. Importantly, given the diversity of views that have been shared by the participants – not all of which would be subscribed to by the researcher – all excerpts from transcripts are verbatim and true to the words of the participants. Although this diversity is not analysed in detail in this chapter, it will become significant for the analyses set out in Chapters Six, Seven and Nine respectively. In addition, it is important to note again that historicity is always a precondition of understanding and thus significant with regards to the identification and development of the themes. It is with these points in mind that I identify and outline these three main themes and their sub-themes as a representation of my participants' experiences and understanding of autonomy and advocacy within their nursing practice. As noted, these representations will be further contextualised through links to the observational data.

Supporting Patient Autonomy

As identified, the first key theme concerns how to best support autonomy – with nurses' views able to be identified as clustered around methods that they consider help them to support autonomy. These include the importance of being aware of both the personal and cultural contexts of the patient, points that are linked back to the importance of nurses developing rapport and the therapeutic relationship. These are important issues because, as has been discussed with regards to support for autonomy in Chapter Two, it has become apparent that psychosocial factors are significant with regards both to a patient's presentation to a healthcare facility and the subsequent work needed to support their autonomy within the healthcare encounter. Nurses identified that to support patient autonomy it was important to *get to know your patient*. This was seen to support patient autonomy in relation to building and supporting therapeutic relationships and tailoring individualised care for patients. The second sub-theme, *you have to be careful with culture*, goes further to identify that culturally competent care has also been identified as significant with regards to *supporting patient autonomy* in contemporary nursing settings.

A) Getting to know your patient

It was clear to participants that understanding previous levels of a patient's functioning would assist nurses in tailoring and implementing individualised plans of care for the patient. This was seen as key to supporting patient autonomy.

> *If you know all the background then you know, okay, they live alone….do they have any carers come in... How many times? I often find that out in the shower because you're doing stuff and, like yourself, you know or you change them or they're just chatting to you and you might be just preparing their brekkie and you see how much they can do* (Linda).[2]

Another participant identified that developing a holistic understanding of patients with complex medical histories was important for both supporting autonomy and the provision of care. Having nurses focus on holistic care for the patient is, of course, spoken of in the

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[2] As noted above, all interview excerpts are taken verbatim from the words of the participants. As will become clear, there is a diversity of viewpoints shared with regards to various issues and practices and these do not all align with those held by the researcher.

literature as being one of the cornerstones of nursing practice. As this perspective makes clear, taking a holistic view is important as what matters is:

> *Well, their diagnosis, their mental health, their physical health, the whole package* (Rebecca).

With regards to understanding the differing contexts of patient presentation, one participant, Linda, identified that the mental health of patients in nursing practice was particularly important.[3] Certainly physical conditions tend to be the cause for presentation to the facility for treatment, however patients may also have a pre-existing mental health illness which can complicate their physical condition and their ability to be autonomous.[4] Linda's experiences within mental health sectors of health care may also have been influential in the development of her responses:

> *I just think sometimes we don't have enough mental health input as far as what's the norm for them or this is what we do which helps with that behaviour* (Linda).

Interestingly, some participants linked their abilities to understand the 'patient' and not just the presenting condition as being closely aligned with their mature age. In particular, one participant, Linda, recalled that her knowledge about mental health illnesses and caring for patients with these conditions is part of her life experience. This participant also stated that she believed her age was influential for being able to provide the necessary support and nursing care that these patients required:

> *As I've got older, I can see where they're coming from and able to manage it where I used to probably not say enough, or I just wouldn't address it or go and try and get someone senior* (Linda).

The main ideas presented in this sub-theme concern the importance of understanding the patient in relation to their social and psychosocial influences and how this can affect their autonomy. As was also identified, it is important not to neglect psychosocial issues as these can have a profound impact on the treatment provided and on how autonomy is

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[3] An example of this was observed in relation to the ideas of the patient's own ideas about health. In this example, a patient is talking to a pastoral care worker and is complaining about his deteriorating health. He is talking about being younger and working on his dad's dairy farm but how his failing health and deteriorating kidney function has made him less able to function and the consequence of this has been that he has had to leave his home to enter residential care. Recognising this patient's frustrations and concerns are instrumental to developing rapport and tailoring individual care.

[4] One of the patient interactions observed was in relation to a patient that had been admitted with an exacerbation of her Chronic Pulmonary Obstructive Disorder. This patient had an underlying history of both depression and anxiety but also complex social issues that included a low socio-economic status and substance abuse issues within the immediate family.

being supported clinically. In this sub-theme, then, participants identified that by knowing their patient, they can better enable and facilitate the provision of the kind of holistic care that supports patient autonomy. The idea of being experienced as a nursing professional is also highlighted in the sub-theme as it entails exposure to different patients and contexts of care. Such issues are important with regards to how they underpin a further sub-theme to supporting autonomy, that of the importance of providing culturally competent care.

B) You have to be careful with culture

The contexts of culture[5] that this sub-theme foregrounds include the familial structure, as well as issues to do with ethnicity, and the operationalisation of these structures in the clinical context in relation to supporting autonomy. Participants commented in particular upon the cultural interpretation of family and the construction of the family unit in different cultures and how understanding this may ultimately support patient autonomy. For instance, one participant recognised the importance of extended familial support for the support of patient autonomy and general comfort:

> *But I think some patients feel secure if they've come from such a big family dynamic that if everybody's there and everybody knows then they're happy.* (Linda).

It is also worth noting that experiences of extended familial support were also seen as potentially problematic within the delivery of nursing care by some participants:

> *Italians they come in large numbers, but they never do anything, but they want to make sure that we provide. Indians, I have noticed, they are very needy. Just a pain, it may not be much, but for them it's the end of the world, the whole family will be pooling around them, rubbing and - so I've noticed - you know….but you need to look at that when you're dealing with it.* (Kylie)[6].

As this example shows, although maintaining an awareness of the culture of the patient is seen as important with regards to being able to support patient autonomy, it is also important to recognise the influence of the nurses' own culture on how they may perceive

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[5] Marsella (1987) defines culture as the shared, learned behaviour passed from one generation to another that incorporates language, values, belief systems and societal norms. Human culture is by definition, diverse and complex. However, cultural groups are not homogeneous in nature and therefore when looking at culture and its impact on understanding and meaning it is important that this is taken into account. Heterogeneous cultural groups are a mixture of genders, ages and have varying personal values and beliefs and experiences that can all influence understanding and meaning.

[6] Such comments do of course suggest a level of cultural stereotyping and seeing people as their cultural ethnicity rather than as individuals. While these are certainly problematic views in the context of nursing aims of personalised care, they are none the less the views of this participant. Given this chapter is concerned to set out both the points of commonality across participant views and some of the outlying views that may be present, these points of divergence are of course of interest and will be examined in the thesis in later chapters.

and provide care to patients. All of the participants had varying interpretations of culture and the influence that this may – and should – have on nursing care. While each of the nurses are from diverse cultural backgrounds, one participant, Rose, reflected directly on how this has influenced her nursing practice and about the confidence she has gained since understanding and appreciating what she refers to as ‘Australian culture’:

> *Yeah, especially when I was new, I'm still kind of learning the Australian culture. It is so different. But now I'm an Aussie now and I get - I can talk to them, you know, with any conversation, I can still, you know.* (Rose).

Another participant highlighted that her cultural perspectives and understandings of different cultures are different from many of the patients that she cares for.

> *I think it can be a hindrance because I was always taught to stand on your own two feet ..., you’re an adult, you’re the number one, you might have thought your husband or your significant other but really in the end it’s your decision. But with other cultures it’s highly offensive if they said yeah, I’m fine. They can’t possibly make a decision. So, it’s all about how - what I think’s the norm and they think’s the norm.* (Linda).

Another participant, Kylie, mentioned that it was easy to deal with patients from the same culture as her and that she had been called upon in practice to interact with families from the same cultural background as herself on numerous occasions:

> *I have noticed with families, I can be a bit more harsher and tell them, rather than the whole - and they do that. Over here the nurses know. They'll tell, Kylie can you go and talk to - which I can tell them, and they won't get offended. So, you have to keep that in your mind.* (Kylie).

Participants also noted different conceptualisations of gender identity and roles within different cultural backgrounds. They recognised that these cultural conceptualisations are not only important for the patient’s and family’s own understandings of individual autonomy, but that they can potentially influence nursing care:

> *It’s a matter of respect…. just understanding that the main person is the male figure and not the female. Yeah, it’s just lots of those...* (Linda).

From the healthcare perspective, participants identified that having a broad range of experience when dealing with different cultures empowered nurses to provide culturally appropriate care for patients:

> *So, I suppose, again, experience with the different cultures. .... They will come here and so many different nationalities and it is a big eye-opener because, as you say, their health care, the way they treat their health and the cultural differences is huge. Over the years then, I've got to know how they sort of each deal with*

> *different things so then you give them that respect for their different cultural attitudes.* (Rebecca).

Sometimes people are different, like different views and just have to respect that because you are all different, like diverse, you know, like this is good for me, but may not be good for you. (Rose). What is important here, then, is that while there is understanding that an awareness of culture is a core component to supporting an individual's autonomy, this understanding differs between participants and is put into practice differently. When these two sub-themes are considered as to their assumptions regarding supporting autonomy, what also stands out is that they both also cluster around and give life to some of the ideals of patient-centered care (PCC), as outlined in Chapter Two. As was noted in that chapter, PCC has many definitions within current nursing literature, but broadly it encompasses care that is considered to be essentially empathetic and compassionate, and that incorporates the needs, values and preferences of the patient to enable informed decision making (Rathert, Williams, McCaughey &Ishqaidef, 2012). Significant concepts for PCC that were established within this theme included the role of culture and understanding the individual as a person in a context. As participants noted, the cultural background of the patient affects the way they might interact with and experience illness and healthcare, and thus their ability to seek out appropriate support and treatment. Most prominent here were discussions about the role that family may have in relation to facilitation of care for individuals. In all of these instances, the focus is on the individuality of the patients and supporting their capacities – very pertinent points for understanding and supporting patients and their varying levels of autonomy.

Some participants would, however, also seem to be referencing an older set of ideals with regards to their assumptions regarding the appropriate delivery and construction of nursing practice and healthcare. These ideals, of course, are that of the biomedical model which frames the body as a set of biological mechanisms, paying less attention to the psychosocial and cultural aspects of the individual.[7] Such ideals also hearken back to liberal ideals of patient autonomy which would hold that the role of the family should remain negligible in relation to autonomous decision making – a view perhaps echoed by the participant who was critical of the presence of extended family within the healthcare

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[7] Refer to Chapter Two for a detailed discussion of the biomedical model.

setting. These points of tension will merit further discussion (see, for example, Chapter Nine).

Advocacy in Context of Duty of Care

The nurse-patient relationship is often espoused as being fundamental to good nursing care, with nurses also framing themselves as advocates for the healthcare of individuals who may be considered to be vulnerable and have a reduced capacity for autonomy and self-regulation (Dinc & Gastmans, 2013). Part of the role of being an advocate and supporting patients within this nurse-patient relationship is by what was referred to as giving the patient a voice, and this idea was seen as key by many participants and came out strongly through this analysis. The sub-themes identified within this theme include *giving patients voice*; the *first line of care*; *rapport, trust and veracity*; and *the caring side of nursing*. As will be seen, these sub-themes are closely interlinked with each other.

A) Giving Patients Voice

Communication is clearly essential in relation to both the contexts of the patient and the nurse. As the focus of healthcare becomes more encompassing of the patient, aiming to be supportive of their autonomy, the need for communication between the patient and the provider becomes even more important. Effective communication between patients and healthcare providers enables concordance and gives patients a greater command of their own autonomy. This particularly plays out through practices of respecting patient preferences[8] (Bruera, Neumann, Mazzocato, Stiefel & Sala, 2000; Stevenson, Cox, Britten & Dundar, 2004).

All of the participants identified that communication, in all its forms, was fundamental to their practices of advocacy in relation to patient care. This was evident through the types of language used by the participants. Phrases such as *"being a voice for the patient", "standing up for the patient", "stepping up for the patient", "supporting the patient", "patients coming first", "looking out for the patient",* and *"upholding the rights of the patient"* were all used by the participants to describe communication and how it

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[8] An example of this during observational fieldwork was witnessed with a patient and her medications. The nurse begins dispensing the medication and the patient says "*I take the Somac first and then wait for ½ hour and then take the others*". The nurse says "*sorry I know everybody has their own routines with medications*". Natasha did as the patient usually does at home with her medications. The nurse later states that "*I let her do her own medications, she knows them better than I do and she has her own routine. She's capable of doing them so I let her help me out*".

influenced nursing care, the role of the nurse as an advocate, and support for the autonomy of the patients:

> *Mostly it's just a voice for the patient… if they aren't able to make a decision… I think it's just to have someone there to be a voice, look after them yeah.* (Linda).
>
> *I think it's just probably looking out for the patient…assist the patient best you can and support them…. … Sort of step up for the patient and say what you want done.* (Rebecca).

Other participants referred to speaking on behalf of patients in terms of a duty of care and that having an open and honest relationship with the patient facilitated communication and, therefore, enhanced the nursing care for the patient and the ability of the nurse to enact an advocacy role:

> *I can speak for my four patients right now to you because I know what's going on…. It's for the benefit of the patients really and then you can liaise with other services in the hospital and it makes easier for everyone, you know…. you speak for - and you know exactly what their problem - I mean, you know what their concerns are, they'll tell you.* (Rose).
>
> *They were really appreciative, because I explained what I was doing and why I was doing it. So, they finally understood as to why we do the things that we do. They were more accepting of the fact that we were doing these things.* (Natasha).

As is apparent, many participants saw the concept of best care as influential in the idea of nurses being advocates and providing a voice for patients. This is of course in alignment with current standards and guidelines for nursing practice. Participants thus discussed the process of communication as like putting together a jigsaw puzzle and filling in the gaps for patients so that they are able to make informed decisions regarding their healthcare options and treatment, and thus maintain their autonomy:

> *I think we just sort of come along and pick up the pieces, yeah…. Put the jigsaw puzzle together* (Rebecca).
>
> *I think I just put myself in their shoes and how would I feel or if it was my mother or my relative? Then that's how I would like to be treated and I'd like to know everything that's going on and be informed* (Rebecca).

Another participant described this process as trying to incorporate patient rights into healthcare and provide the best care options for patients:

> *…..the end of the day they have the rights and - to decide for their health care……you have to inform them that these are the plans and this is the doctor's plan and this is plan……at the end of the day you have to decide what would you*

> *like for your health care from us and from the doctors….They have the right to choose about their health care because there are rights* (Rose).

Another, speaking about patients who may have reduced capacity in relation to decision making, drew attention again to the importance of nurses advocating on behalf of the patient to ensure their best interests and wishes are heard:

> *In a case where patients are not capable of making decisions, as a nurse, to stand up for them and to make sure that they get the best care* (Kylie).

Alongside recognition of the importance of communication for the role and work of advocacy, participants also noted a number of different requirements and challenges with regards to this work. Specific points noted by participants clustered around being aware of and able to engage the different facets of good communication, including non-verbal communication. For participants, good communication that would support both patient autonomy and their own advocacy work needed to be open and considerate of patient perspectives. For instance, it was identified that if communication felt rushed or was not considered transparent and honest by patients, this would constrain both advocacy and being able to recognise and support patient autonomy:

> *You can't judge, and you've never been in that situation and many times I've said - and patients have said that to me - I've said, it's going to be okay, or, it's alright. I really did mean it when I said that and then the patient will tell me back, it's not alright* (Kylie).

> *I think sometimes we do tend to forget that - we've got to remember too that they're people. Even though we nurse them every day I think sometimes we forget that how would I feel or what I say does it make an impact on that person* (Linda).[9]

A patient's ability to be able to comprehend and communicate using English was also seen to have the potential to affect advocacy work and the capacity to support autonomy:

> *I think English and non-English speaking backgrounds, I think a lot of that can be barriers. We don't mean to make it a barrier, but I think that can be…You know, if you're demented and you're from a non-English speaking background what happens? They know English but they always go back to their mother tongue, so it is very, very hard. There's a fine line of like what can we do, what we can't do* (Linda).

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[9] This content – forgetting (and having to remember) that patients are people, for example – could hint at some of the practices of depersonalisation that can occur in nurses, often as a coping strategy for dealing with issues such as burnout (Harkin & Melby, 2014). Such practices may be implemented by nursing professionals as protection strategies, but they do have significant impacts with regards to supporting patient autonomy and the role of the nurse as an advocate.

Participants did, however, identify that although language can be a barrier to effective communication, there are support strategies that can be used to support patient autonomy and any advocacy:

> *First thing is the language barrier, which we can organise with interpreter; their culture, you have to be very, very careful with their culture* (Rose).

Participants also identified the danger of assuming that communication has been complete and shared amongst all relevant parties:

> *I think it's all about perception. I think they perceive that we know and that they know but nobody's said anything, so it's all a bit like the doctors will assume that we know and then we assume that they know but we both all don't really know* (Linda).

A second issue with regards to maintaining good communication with patients was identified by participants with regards to the context of handover. As participants noted, there is a large focus in clinical practice in relation to handover and the dissemination of information between healthcare professionals in relation to patient care (Matic, Davidson & Salamonson, 2010). This is particularly important in the context of the role of the nurse as an advocate who works to support patient autonomy. Handover thus provides healthcare individuals important information about the patient and their continuity of care. Without this handover process this information may become lost, misplaced or misconstrued. At the same time, however, handover can also include the labelling of patients, with possible negative implications for effective communication and advocacy:

> *Yeah, yeah. I do agree with that, because you will - let's say you are handing over, you handed over and tell them that a patient is difficult. I don't know, when I get there, it's a different story…. It is fair to say just watch, she's had a bit of this attitude, and then see how you go, but don't label them as difficult and aggressive and stuff like that. Let yourself find out by how you deal with them, because it's different* (Rose).

This point strongly reflects findings from the literature. Research completed by Garcia, Duberstein, Paterniti, Cipri, Kravitz and Epstein (2012) highlights that the labelling of patients by healthcare professionals can lead to the patient feeling labelled, judged, lectured and rejected by the healthcare system. As Rose suggests here such labels can undermine patient autonomy.[10] The other side to this may be reactions of antipathy and alienation that nurses may then transfer onto the patient[11] (Dickinson & Hurley, 2011). Such points will be examined later in the thesis (see Chapters Six, Seven and Nine).

Overall, participants identified that while the process of handover and communication about patients is influential in the care and advocacy then provided for patients, it was important to listen to, but not be influenced by, other opinions about patients during the handover process:

> *You've got to try and not form this opinion in your head and of course it's very difficult* (Linda).

The role of the nurse as an advocate can, however, be limited not only by the views of the individual nurse, but also by the attitude, behaviour, or demeanour of the patient themselves:

> *That time maybe the patient is really in pain and you did not address that well as when I came maybe there's no pain anymore and so he's different…. It is hard to judge people really* (Rose).

The third main point concerned non-verbal communication. With much of the care delivered by nurses to patients being face-to-face and intimate in nature, participants stressed the importance of good non-verbal communication. The list of non-verbal communication includes, but is not limited to, touch, facial expression and tone of voice (Friedman, 2000; Marcinowicz, Konstantynowicz & Godlewski, 2010). Friedman (2000) identifies that in conjunction with verbal communication, there are subtle clues which assist in the expression of messages and the emotion behind these messages. Phutela

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[10] This is obvious in the observational fieldwork where conversations about patients' residential status was common. For example, one patient came from a lower SES area, referred to by nursing staff as 'Birdsville'. The speech pathologist cannot find any reason for a patient to be having swallowing problems and states that it is probably all 'psychological'. She states "some *patients are just hypochondriacs*". A second example is from discussion with some of the participants in relation to the communication of information occurred at a morning tea. One participant was telling us about a man that had come in and who was blind and distressed. She said that everybody was feeling sorry for him but then somebody said that he had been a violent man who had sexually abused his daughter at a very young age. The point that the participant was trying to make was that each patient comes into the hospital with a history that nurses are not necessarily aware of.

[11] This was evident in a meeting that I observed. The I/C says, *"the patient maybe a discharge later today depending on what happens in the meeting"*. The co-ordinator says *"I'm not sure what we are going to do there with the baby"*. The I/C of the nursery says *"we don't bloody want the baby, that will mean I will need more nursing staff. Can't you give the baby to the father?"*. The co-ordinator says *"he's incarcerated up in the psych prison…."*. The labour I/C said, *"why is she here?"*. The co-ordinator said *"it's a long story but there is a long history of mental issues for both mother and father"*. The nursery I/C says *"then give the baby to the grandparents"*. The labour I/C says *"we can't do that, there is only his mother and the baby won't be safe because that's where she'll go when she's discharged"*. The nursery I/C said *"just send the baby to Anglicare or foster care then. Just make it someone else's problem"*.

(2015) identifies that non-verbal communication supports the social nature of being human, and the relationality of interactions, both of which help to provide patients with support and comfort. Friedman (2000) refers to non-verbal communication as creating positive expectations, emotional support, and functions to ensure patient co-operation. Stickley (2011) also identifies that this type of communication develops the interpersonal relationships which help provide empathy and compassion, and that are considered by the nurses as being essential for quality nursing care and essential for advocacy in nursing to support patient autonomy.[12]

Collins, Schrimmer, Diamond and Burke (2011) and Stepanikova, Zhang, Wieland, Eleazer and Stewart (2011) further identify that non-verbal communication is essential in relation to building rapport and trust, a point which was also identified by the participants as important in the nurse-patient relationship, particularly with regards to advocacy roles and support for patient autonomy.[13] As the participants noted, however, the development of rapport and trust is not always easy given the ongoing demands of nursing practice:

> *I keep one foot ready to……because I'm busy, and that always is taken as a negativity, that you don't have the time for - but the experience as I'm talking, it clicks in me what I'm doing so I quickly go in. Because I've noticed that in the past I didn't - and that itself rubs off, oh she doesn't have the time for me. So, you have to make sure, even though you're busy, you take the time to sit and talk to them* (Kylie).

> *So sometimes, you know, when you're perhaps putting up their electrolyte replacement or doing an hourly sugar or whatever, you try and fit in that little bit of a conversation there because that's your only opportunity that you can. So, while you're putting up the bag of fluid or whatever, you'll explain what you're doing. Well, you try to, even though you are so flat out. Sometimes you've got to stop and think, well, this is a patient in a bed* (Rebecca).

Kylie clearly identified in her interviews that body language and the use of non-verbal communication was important to consider in terms of supporting patients:

> *so, when I'm talking, I never stand. If the patient is in the bed, I always make sure that I either am sitting in her level - because I think that standing it's overpowering….Definitely, it's the whole lot…..Yeah, the body language….So*

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[12] An example of this was demonstrated through the actions of one participant when dealing with a critically ill patient. The patient was deteriorating but, having had cancer treatment, had lost all her hair and was wearing a wig due to being self-conscious about having no hair. The patient stated that "*I am so hot, I need to take this wig off, is there a cap I can have to put over my head?*". The nurse says "*no not on this ward but I could try and maybe get one from OT*".

[13] These concepts will be further elaborated later in this chapter.

> *there is quite a lot, and in the tone of your voice, you have to make sure that you do …* (Kylie).

The point being made by participants here was that the healthcare professional's manner and the way that they approached the patient was significant with regards to building rapport, itself a key step towards recognising and supporting autonomy. It was recognised that communication is not a one-size fits all approach and should be tailored to suite the individual's needs and personality:

> *So, approach them with good manner. If you ask politely and - or some people don't like a direct oh, you're going to get up today. You're going to use the frame today - that type of approach. So if you know you can build rapport with your patients and know how they are, you know which - in what way you should try and approach them with the - make the move…Personalities are different and that plays a - has a lot to do with the way that you talk to someone. Things that you can get done as well, depending on how you talk to someone…. But if you're straight up, they tend to listen to you a lot more* (Natasha).

In this sub-theme, giving patients voice and communication in all its forms was a priority for the participants. The recognition that open, honest and transparent communication – verbal and non-verbal – was important in providing patient care, advocating for patients, and acting in support of patient autonomy was dominant for all the nurses interviewed. Many of the participants also talked about 'putting the jigsaw together' for patients and this was framed using the legal notions of patient rights and the duty of care that nurses have towards patients.

B) First Line of Care

Part of the argument that exists in the contemporary literature that relates to nurses undertaking advocacy roles to support patient autonomy is in relation to the omnipresence of the nursing professionals within healthcare settings. This was also identified by each participant as one of the reasons for nurses undertaking the role of advocate. They thus commented that in situations where patients were considered to be clinically deteriorating, nurses were often the first to provide care and identify the patients' needs.[14] In particular, participants referred to this form of advocacy as being the first line of care:

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[14] This was seen clearly in the relationship of the deteriorating patient. The next patient is 11A. *"This patient is particularly unwell and there is a huge query over what we are actually doing for him"*. The nurse tells the team that the wife is very teary and *"over the weekend I had to ask the son to leave as he was becoming very aggressive and threatening the staff"*. The nurse says, *"I'm not sure about his IQ, I think it's pretty low and the family is very frustrated as Dad isn't getting any better"*. The physiotherapist asks, *"do we know what the plan is for him?"*. The nurse says *"that is half the problem. The doctors come in and review him and tell us to wean him off BiPAP, but literally all he does is sit hunched over the side of the bed gasping for breath.*

> *We are the first line. We are the first line of what - we speak for them. We are 24 hours with - we spend more of our time with them than the doctors for like 24 hours with them so, we - yeah, we are the first line…* (Rose).
>
> *Because we are there with the patients 24 hours…. Imagine if we are not there, …. we are the ones who are by the bedside and who knows the patient* (Kylie).
>
> *the doctors come in, come out so there has to be somebody - and because we're the ones that are with the patient for the eight hours and doing their showers with them, we're doing the whole sort of process through, if it's not us, then who would it be?* (Rebecca).

Although there was a definite consensus between the participants and the literature in relation to nurses undertaking this advocacy role, in practice all of the participants identified that this role is not solely the domain of the nursing profession. As they noted, other healthcare professionals, also through advocacy-like roles, are able to influence patient outcomes:

> *I think Pastoral Care does a lot, social work and sometimes to a point even - I'll go out on a limb here - sometimes even just PSAs because they will actually come and say it. This is such and such she's not responding to me. Isn't she oh I'll just go have a look? They do it without even realising and they'll say to you - the good ones will say oh they haven't drank their drink or they haven't eaten today, and you haven't had time to notice and they've taken their tray away* (Linda).

However, some of the participants saw limits to the input of the other healthcare professionals. As they put it, nurses would use the other healthcare professionals to facilitate patient care only in very specific instances:

> *…Allied Health play a big part in advocacy for patients, because they are the ones that organise for a patient to get home. That's usually what we use them for* (Natasha).

One participant also identified that a team, rather than one profession, was involved in the delivery of patient care, but still commented that it felt that nurses were the first line of care:

> *We work as a team…. but as I said, we're the first line…as soon as the patient comes, we can see that* (Rose).

Even the effort of voiding makes him so breathless that he goes a horrible grey colour". The physiotherapist says *"I agree, we can't even mobilise to the toilet and back, we need a clear plan'.* The nurse says *'yes, I am going to speak to the doctors today, they have to develop a plan of care for this patient."*

It was also noted that the 24/7 presence of nurses can have a positive influence on patient outcomes and patient autonomy, although this could also mean a sense (by the nurse) of being taken-for-granted:

> *Because you are looking after them all the time or you do see them a lot. That helps definitely in them - obviously, you are building rapport with your patients. The more you see them, the more that they get accustomed to you and work with you, to do the things that they need to do….Yes, I think that we are dismissed at times, because of the way that patients look at our role. Because only we know our role. We are aware of what we do and how we do it…. So, a lot of the time, patients come in and they see us as a person that just does things for them.* (Natasha).

The close relationship and the role of the nurse in relation to providing 24/7 care was also seen as influential in assessing – and sometimes dismissing as unrealistic – the goals that set for patients by other healthcare professionals:

> *Sometimes Allied Health or doctors, even other nurses make unrealistic goals for them and I think sometimes we just have to - like sometimes you just have to say something and say look that's really not going to work and they go but why and you go this is why because you've tried four times this week and it still hasn't - yeah it's just little things like that yeah* (Linda).

The presence of the nurse and being a confidante was also identified as being beneficial for patient advocacy.

> *It's for the benefits of the patients really and then you can liaise with other services in the hospital and it makes easier for everyone, you know. If you are advocating for this patient, you know, you speak for - and you know exactly what their problem - I mean, you know what their concerns are, they'll tell you* (Rose).

In summation, in seeing themselves as the first line of care, participants identified that nurses have a unique position within the healthcare context as advocates as they are the only professionals who are available for patient care on a 24/7 basis. It is this presence that has been considered to place the nursing profession in the ideal position to act as an advocate for patient needs, interests and further support patient autonomy where possible. It is this presence that also facilitates some of the framing of the nurse-patient relationship that will be discussed in the next sub-theme: rapport, trust and veracity.

C) Rapport, Trust & Veracity

Rapport and trust are highlighted throughout the transcripts as being particularly important for building the relationship between the nurse and the patient so as to facilitate nurse advocacy roles and support for autonomy. Trust is considered essential in the nurse-patient relationship as it forms the basis of not just rapport but advocacy, communication, patient-centered, and culturally competent care (Kim-Godwin, Alexander, Felton, Mackey & Kasakoff, 2006; Stasiak, 2011; Warda, 2000).

Participants similarly referred to rapport in their interviews as being important within their nursing practices to develop the therapeutic relationships significant for advocacy work and for supporting patient autonomy:

> *Yeah, for me, once you have informed them, you get the trust and yeah, there will be a very good patient relationship, yeah…. Then it's like there's a rapport happening* (Rose).
>
> *So, if you know you can build rapport with your patients and know how they are, you know which - in what way you should try and approach them with the - make the move.* (Natasha).

As is evident in these excerpts, however, the context for these participants identifying rapport is varied. In one instance rapport was referred to as the basis of trust and was important in the development of good patient relationship. One participant, Natasha, identified that rapport was built by spending time with a patient, and that it helped to facilitate trust and, therefore, had implications in providing care for the patient:

> *I think that you can use that to encourage them to do things. Because you are looking after them all the time or you do see them a lot. That helps definitely in them - obviously you're building rapport with your patients. The more you see them, the more that they get accustomed to you and work with you, to do the things that they need to do.* (Natasha).

It was also recognised that time and building rapport and trust are all important in supporting patient autonomy within healthcare:

> *Yeah. If you haven't got rapport and you haven't got the trust and it's almost nil, you're going to get antsy people and then people get antsy because then they feel insecure because they don't know. People that don't know get angry and it manifests as in angry or they get tearful or oh they're just being pathetic and it's not that, they just don't know* (Linda).

Part of the nurse-patient relationship identified by the participants was also in relation to the importance of empathy and compassion for the patients' experience. While this may be difficult to understand from the patient's perspective, it was identified that opening up to patients on a personal level by divulging a little bit of your own experiences, may help to build rapport with the patient:

> *I'm not afraid to share a little bit of my life with my patients, if it helps me build rapport or relate to someone on a personal level* (Natasha).

> *Sometimes, if maybe you've had your own experience, or you know of somebody that's gone through that same thing, that helps. If you're an empathetic person, I think you just - you can put yourself in their shoes and think, well, how would I feel if that was me so - yeah.* (Rebecca).

Veracity was also seen as important by my participants. As defined by Constantino, Bourroughs and Hwang (2014), veracity includes truthfulness, trustworthiness, and transparency. In some of the interviews this meant being truthful with patients, even as participants recognised that there are always complexities in being genuinely honest within the healthcare setting:

> *If you go against the family, they execute you for it. Then if you go against the patient - obviously they don't know, but they're your patient. I don't know. I feel that the patient should always be told the truth. The more that they know, the better they are at doing things for themselves… as a human, people have the right to know things…. I think that everyone should not hide things* (Natasha).

Participants also reflected that facilitating veracity within nursing practice facilitated an open nurse-patient relationship that was fundamental to rapport and quality patient outcomes, and hence the advocacy role and supporting patient autonomy:

> *They were really appreciative, because I explained what I was doing and why I was doing it. So, they finally understood as to why we do the things that we do. They were more accepting of the fact that we were doing these things* (Natasha).

In turn, discussions around the concepts of honesty within the nurse-patient relationship was understood as one strategy for fulfilling the duty of care to the patient and supporting their autonomy:

> *I always tell them what I am up to and then what is expected of me and for them, you know… if you are informed I don't think there will be a big problem, because you know what is happening. This is the worst thing that when people come and said, nobody has told us, now we're in the dark and nobody has told us what's happening, you know….Because sometimes they really don't know the degree of their illness and we still have duty of care to tell them that this is what's happening and this is what's going to happen* (Rose).

Ideas of rapport, trust and veracity all draw attention to what my participants referred to as essential components of the nurse-patient relationship with regards to advocacy work and supporting patient autonomy. At the same time, and also significant for advocacy work, is the ability to be compassionate and caring towards patients.

D) The Caring Side of Nursing

The participants' giving of value to the use of empathy, compassion, and caring in their nursing practices is also considered significant for advocacy and support for patient autonomy within nursing practice. The idealisation of empathy and compassion as being fundamental to good nursing practice is not lost in the literature (see Brunero, Lamont & Coates, 2010). Empathy, referred to as being a socio-affective dimension of nursing practice, is linked, for instance, to being able to understand, share and create meaning within the nurse-patient relationship[15] (Cunico, Sartori, Marognolli & Meneghini, 2012). Empathy is also identified by Ward, Cody, Schaal and Hojat (2012) as defining the quality of the patient's experience and care and the patient outcomes. The importance of empathy is a common theme in the interviews, but there were different conceptualisations provided by my participants with regards to how empathy should be enacted within nursing care.

Participants generally used empathy to try to understand patients by trying to put themselves in the position of the patient:

> *I like to treat people the way that I'd want to be treated if I was the patient. I wouldn't force anyone to do anything that they didn't want to do. Because if they*

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[15] A touching example of this that I was intimately involved in was with a palliation patient who had come from a residential facility with extensive pressure areas. This excerpt describes how the nurse and I tried to treat this patient with compassion and empathy. In Bed 3, this patient looks really unwell and is basically skin and bone. She is a 90 year old Italian lady who has been admitted to the hospital with sacral and trochanter ulcers. She has Alzheimer's and dementia with renal impairment and anaemia. She is having daily dressings to the wounds and she has recently been removed from a nursing home and was being cared for by her family. The Doctors want to review the wound after the dressing is removed. There is talk about a referral needing to be sent to RDNS and PAC for dressings post-discharge. The family wants to take the patient home with them to die. The dressing comes down and I am able to see the wound for myself. The sacral ulcer is 2.5cm deep and is tracking for about 3 cm towards the trochanteric ulcer. There is little or no tissue left because the patient is very malnourished. The doctors come back into the room to review the wound. The doctor says "oh the poor thing, this is not a nice wound is it". The smell from the wound is quite offensive and the wound itself has a deep necrotic black area with a sloughy section on the lower end. Around the wound itself it is very cellulitic and it is obviously very painful for the patient as she is moaning and keeps saying *"mamma mia, mamma mia"*. She speaks no English so the nurses are trying to reassure the patient by holding her hand and talking to her saying *"it will be over soon."* The doctor says *"I don't know what we can do for her. The family has requested conservative management only. What do you think?" "The only way to heal this kind of wound is take a surgical debridement and then start all over again"*. The doctor says *"the family said these developed over a 10 day period, I find that hard to believe"*. One nurse suggests that we could do a manual debridement on the ward and the doctor says *"go for it"*. So the nurse proceeds to organise herself with the dressing trolley and then she starts to manually debride the wound. The patient is visibly distressed so the nurse says *"I am not going to do this. She's in too much pain. We need to get her pain organised first. I will just cut off this dead part here and then put a dressing on it"*. The nurse, once the wound has been dressed speaks to the doctors about organising adequate pain relief for the patient before dressings. *"She had 2.5mg of Morph S/C and this didn't even touch the sides. If we have any hope at all of preventing this from getting worse we need to make sure she has adequate pain relief."* The doctors agree and write up an order for morphine to be given before dressings changes.

> *came in and I was like no, I wouldn't want them pestering me about doing something or taking something. But if a patient has dementia or a mental illness, it brings so much more on the plate that it's hard to draw that line* (Natasha).

Rebecca contextualised empathy by referring to putting herself in the shoes of the patient:

> *How would I feel if someone came in and just told me all this jargon and no one sort of stuck up for me? I think I just put myself in their shoes and how would I feel or if it was my mother or my relative? Then that's how I would like to be treated and I'd like to know everything that's going on and be informed* (Rebecca).

Kylie also referred to empathy as putting yourself in the position of the patient, however she identifies that this may be difficult as often nurses can see themselves as healthcare workers there to provide a service:

> *You have to think yourself, in that position, which we don't, we sometimes think ourselves as health care workers* (Kylie).

In addition, participants talked about a how lack of empathy and understanding can lead to nursing becoming a job and how this may detrimentally affect the nurse-patient relationship and patient autonomy:

> *So it can be like that, but I think you - in order, all this extra to come, you have to be really caring and compassionate…You can't judge and you've never been in that situation and many times I've said - and patients have said that to me - I've said, it's going to be okay, or, it's alright. I really did mean it when I said that and then the patient will tell me back, it's not alright.* (Kylie).

As part of this compassionate side of nursing, the practice of reflection was also identified. This idea of using reflection to gain rapport and empathy with a patient is part of the professional expertise and behaviours of the nursing profession that is considered key for patient care and for also managing "difficult" behaviours and personalities. As one participant suggested:

> *You've got to reflect on what you've said and yeah I think it's a big thing because then sometimes you can go back and say what I mean was....and I think sometimes we've got to do that because some personalities will just - the difficult ones if they don't have a boundary they'll keep pushing it all the way yeah and they'll have...* (Linda).[16]

Part of this conceptualisation of empathy by the participants interviewed was in relation to being able to treat their patients the way that they would want to be treated. This was

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[16] The ideas around non-compliance are considered later in this thesis

framed by participants in relation to a duty of care, but of course also relates to the advocacy role of nurses.

> *in nursing, they always say that we are responsible for our patients and their care. We have a duty of care to the patient…* (Natasha).

In total, the need for empathy and compassion on behalf of the participants was identified as being essential in nursing practice. Many of the participants referred to this as being able to put themselves in the shoes of the patient and treating patients the way in which they would expect to be treated if they were a patient. Both of these ideas are fundamental for effective advocacy. However, this care, empathy and compassion can be difficult to practise when the patient is considered to be non-compliant and this can affect the nurse-patient relationship and advocacy work. Such issues will be considered in detail later in the thesis (see Chapters Six and Seven). What follows next is consideration of the theme and subthemes centered around broader contextualisation of care identified by my participants and how this may influence practices with regards to advocacy and autonomy.

Contextualisation of Care

This theme and associated sub-themes cluster around and give life to some of the complexities of the contextualisation of healthcare and the contexts in which care occurs. With regards to these issues, one of the biggest variables within healthcare is that of the patient themselves. Each individual assuming the role of the patient has, after all, a distinct personality and attitude which can – as noted by participants – negatively or positively influence patient care and support for patient autonomy. Also influencing patient care is the notion of patient acuity. The sicker, or higher the acuity of a patient, care will usually revert to a more biomedicalised model, and thus the contextualisation for care reverts back to more task-focused and orientated nursing care and subsequently focuses on advocacy rather than attempts to support autonomy. Within this section focus also turns to understanding the influences that professional expertise and knowledge have on the development of the nurse-patient relationship and the influence that this may have on practices to do with advocacy and the support of autonomy. These issues also led to participants considering the impacts of the healthcare environment itself, including fiscal and time management, for the patient. Lastly participants noted how the unequal relationships between healthcare professionals and patients can place unfair judgements on patients and how these have the potential to influence patient care, as well as practices regarding advocacy and autonomy. The sub-themes within this theme include *considering the context of the situation*; *people are not controllable*; and *the environmental context of healthcare*.

A) Considering the Context of the Situation

It is clear that the context of where and how care is delivered influences how a person will utilise healthcare services available to them. Litaker, Koroukian and Love (2005) identify several contextual variables that influence how patients interact with and utilise healthcare available to them. These variables can be individual, behavioural, environmental, and provider-related variables (Litaker et al., 2005). Zhang, Yu and Chin (2005) also identify that medical costs and resources are contextual factors of both the individual and the environment. Pope, Van Royen and Baker (2002) also suggest that perspective and attitudes of the healthcare providers may influence the context of the healthcare environment.

These were issues that participants reflected upon. Some participants thus highlighted that it is the patient, their personalities and attitudes which have the most influence on a nurse's ability to deliver and provide appropriate nursing care for patients and to enact advocacy roles. They identify this as the person taking on the persona of a patient and how this can potentially influence the delivery of nursing care for that patient:

> *The patient is a big one. I think that the patients, or most of the patients, are under this false impression that because they're in hospital and they're sick, that they can't do anything for themselves. Or they just rely on us to do everything for them…* (Natasha).[17]
>
> *I guess if the patient doesn't want to hear what you've got to say, either… then their attitude. If they've totally put a wall up to - then you can't get - you can't get past that* (Rebecca).

Personality and context of the patient is multifaceted and to understand and provide appropriate nursing care for each patient, including with regards to advocacy and support for autonomy, the approach has to be individualised and tailored to that individual no matter how they may act or present. This is part of the underlying principle of patient-

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[17] Such a view comes across as quite judgemental and, as has been noted earlier, has the potential to position patients in particular ways which can influence patient care. The problematics of such views will be examined later in the thesis.

centered and holistic care that is supported in the nursing literature. One participant, Rose, identifies this clearly in her interview:

> *Sometimes people are different, like different views and just have to respect that because you are all different, like diverse, you know…. Sometimes others have some attitudes, just personality…. Some people are like, they have a closed mind and like no* (Rose).

Another of the participants, Linda, talks about the persona and the perceptions of the patient that individuals adopt in relation to healthcare:

> *People play you too because they like to be that victim role. So, it's all about just working it out - the even - sometimes you get it right, sometimes you don't* (Linda).

Another participant talks specifically about how such factors might have the potential to influence nurse practice:

> *There is certainly a lot of patients that we've had that give you the attitude and the language and so forth. Sometimes you get hardened to that and you think, well, you know what, you're going to go home so here's the form. You know what I mean? You get so tired of that sometimes… some just treat you so poorly that you think, well, you know what, do whatever* (Rebecca).

The context and the persona of the patient is also often linked closely to the acuity of the patient. Usually, as noted earlier, the higher the acuity of the patient, the more biomedically focused care becomes and the more reliant on the professional expertise and knowledge of the healthcare professionals. This was clear from both the observational data and the interview data. This biomedical focus, as participants stressed, allows for determination and prioritisation of care to occur efficiently. In the context of this discussion, the higher acuity the patient is considered to have is often reflected in relation to the time that the nurse will spend with that patient and influences the notion of PCC and the role of the nurse as an advocate. Participants discussed that the acuity of the patient influences the duty of care that nurses have as a legal obligation to patients:

> *Because sometimes they really don't know the degree of their illness and we still have duty of care to tell them that this is what's happening, and this is what's going to happen if you don't stay for another 24 hours* (Rose).

One participant identified how a patient's family situation may further influence their decision-making processes within healthcare. This was exemplified with regards to gender roles and associated cultural expectations:

> *Sometimes also men if they like, [say] I want to go home, you know, but they are - because I am the head of the family I have to be home, but sir, you're sick, what about these options, you know….* (Rose).

In other words, a focus on acuity can over-ride the individual contexts of health and illness that the patient may have and may also neglect the idea of patient autonomy. The immediate need to provide appropriate nursing care to patients often overtakes the notions of holistic and individualised care and often supersedes the requirement for autonomy of the patient as it leads back to the paternalistic biomedicalised notion of healthcare.

> *Just depends on the type of patients you have…. If they're really full on patients, if they're all full nursing care, then really the time that you have is minimal. If depending on how many drugs they have and things like that. So, everything just adds onto the workload* (Natasha).

It is when patients are resistant to this technical care and potentially endanger themselves that they may negatively influence the nurse-patient relationships.[18] Participants

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[18] Examples of this were commonplace where patients, for one reason or another, declined appropriate care. This was seen with Patient A: *"you don't understand I have so much to do. I can't be here. I just want to go home". "I understand but we need to get the DE and dietician to see you first" "well when will that be?" "Hopefully today sometime. I'll try and find out when for you, but it just depends on how many patients. they have to see". "This is no good. I just want to go home".*

The patient was BIBA after a period of vomiting and reduced appetite and nausea with associated epigastric pain worsening over a four-day period. The history given to the ambulance officers was that he has not taken his insulin for 10 days and had been drinking a bottle of whisky every day for the last week. The patient has been sitting by the window but has been pacing the corridors. He goes out of the room and finds Lisa in the corridor. *"I want to go home today" "I'll have to get the doctors to come and see you first" "No, I want to go home" "Well if you are insistent then I will have to get you to sign a discharge at own risk form" "Yeah, sure I will do that" "Just let me ring the doctors" "Okay but I want to go as soon as I can".* The patient is becoming more frustrated and angry about being in hospital.

The doctors are doing the pm ward round so they come into see the patient. Sam says to the patient. *"did you feel the low BSL's last night? 'Well what happened was I was not on insulin until last night so my sugars have been all over the place" "No you received insulin via the drip" "My diet is different from what I have at home, I don't eat outside of my home at all. I am a vegetarian" "The truth is I have so many things to do and I won't get to do anything again until February. I am already here for 3 days" "will you at least stay until the DE comes at 2pm?" " yeah, sure no problems" "I have an appointment. with my diabetic consultant next month" "I want you to see the DE to give you some education regarding what to do when you're fasting and with alcohol" "Just wait until the DE comes after 2pm then you can go home if you wish". "Given you have had a drop in BSL's overnight then I think it will be safer to drop the insulin levels just for the moment" "okay, okay".* This demonstrates how biomedicalised care can become and indeed can be viewed as blaming and paternalistic in some ways. The educative response to this patient would not be sufficient to address the psychosocial aspects of this patients care and needs however this was observed in practice and was the way in which this situation was handled by the treating healthcare professionals. The doctors are going through the patient's medications and clarifying the insulin dose with the patient *"do you have somebody at home that you can ring if you need to if you need help or advice with your insulin" "yes, yes".* Then the nurse tells me that the patient said that he knew he shouldn't mix medications so he was drinking alcohol and therefore didn't take his insulin. Lisa says *"he'll be back, he won't be compliant with his regime. He was really unwell when he came in."*

demonstrate how frustrating this can be for nurses in relation to providing appropriate care for patients:

> *Yeah, I guess, for me, I get really frustrated when they come in so sick, fix them up - and with him in particular, I've had him the last few days - so we've done full-on nursing care with him, medicine-wise, electrolyte replacement, the whole bit. To find then he's just going to go back and, you know, be probably back in again - so it is, to me, it's really frustrating but you kind of have to put that aside and still plod on and hope that you maybe make a difference somehow by telling him, you know… Yeah, you do find it difficult. Sometimes you give up because you think, I can't do this anymore…..It's certainly a lot harder because you know they're going to do what - the opposite to what you're going to do….someone who's just got their hand in your face and, you know, I'm not going to have anything more, and getting verbally aggressive and you can see that this is going to escalate - I just wouldn't even bother* (Rebecca).

One of the main ideas in this sub-theme centres on the acuity of the patient where healthcare professionals fall back into dominant biomedical frameworks of care that focus on the biological mechanisms of dysfunction. This professional expertise and knowledge supports the role of the nurse as an advocate but may in the short term be less supportive of patient autonomy. This is because that in these types of situations the patient is often unable to advocate for themselves due to decreased autonomy due to a number of competing factors.

B) People are not Controllable

Typically, nurses have control over the clinical environment which, in turn, may have a flow-on effect for patients trying to be autonomous.[19] Factors such as possessing an 'insider' knowledge of the clinical environment, and professional knowledge are all influential in the nurse-patient relationship but also imply that the nurse-patient relationship is unequal, a point which can also affect patient autonomy. Part of the problem, as identified earlier by participants, lies with the use of technical jargon and profession specific language. Such language has the potential to replace the person with the condition and, therefore, influence patient care. Technical jargon was defined by one of the participants as:

> *Just language that the lay person out there that doesn't know the terminology that we're so used to* (Rebecca).

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[19] For example, restrictions in relation to access to certain areas through limitations on how many people are able to visit these patients. This is conveyed to people through signs up on the door on the entrance to the room clearly stating that patients would only be allowed to have a maximum of two visitors at a time.

It was therefore stressed by participants that part of being a nurse is understanding how to interact with patients to achieve their desired healthcare outcomes:

> *If I had gone in and said straight away that, no this is not right, I would have rubbed with her and the conversation would have ended there….I always make sure at the desk I don't confront…I'll talk to them one to one, but I try not to in front of people and try to create - even though they may not be right* (Kylie).

It was also discussed that the biomedical relationship can feed into the ways of referring to patients that may be commonplace within biomedical models of healthcare, but problematic for aims of supporting patient autonomy:

> *When you're handing over, you know. The by-pap patient or the DKA patient and, yeah, sometimes you've just got to stop and think, well, they are a patient in that bed* (Rebecca).

Such ways of referring to patients were also considered by other participants in relation to interactions with people, especially in relation to communication and the impact that such communication may have on the individual:

> *I think sometimes we do tend to forget that - we've got to remember too that they're people. Even though we nurse them every day I think sometimes we forget that how would I feel or what I say does it make an impact on that person* (Linda).

> *It's not until sometimes, you know, they might sit and have a look on their face of fear or whatever it might be, and you think, oh, yeah, I'd better go back and explain myself….* (Rebecca).

Participants identified that having an insider perspective can be, at times, limiting to patient care. As they saw it, the use of jargon and specialised healthcare language can potentially put a barrier between the patient and the nurse and prevent the development of rapport and trust and thus impede the roles of the nurse as advocate and a support for patient autonomy. At the same time, it is this professional expertise and knowledge that can lead to nurses assuming that patients need to have an advocate. This, in turn, draws attention to the notion of consent as inherent within and fundamental for the nursing relationship:

> *Well, no one does. You sort of just take it on yourself and - well, I think what I do is I put myself in their shoes. How would I feel if someone came in and just told me all this jargon and no one sort of stuck up for me? So, I guess you just - well, no one gives you consent. You just go ahead and do it* (Rebecca).

The perception of the relationship between the patient and other healthcare professionals can also have a profound effect on the nurse, reminding them – to use the wording of a participant – that it is a person that they are caring for. This may influence the development of the nurse-patient relationship and further influence the ability of the nurse to act as an advocate for their patients. One participant, Kylie, spoke specifically in relation to an incident that changed her behaviour with patients and shows how the power of the position of the healthcare professional can be influential in-patient care:

> *I do feel - the patient was lying, and he stood right in front of her, and the leg was on the side rail. I thought, oh my goodness, if it was me, the patient, you would feel - so that incident is always in my mind…. So, when I'm talking, I never stand. If the patient is in the bed, I always make sure that I either am sitting in her level - because I think that standing it's overpowering* (Kylie).

The development of the nurse-patient relationship was also described as dependent on the type of personal qualities seen as important in the nursing profession:

> *I think we are the ones because we are there 24 hours, but it also depends the type of nurses. Not everyone can pick that, but many - especially the younger generation - it's just a job for them…..So it can be like that, but I think you - in order, all this extra to come, you have to be really caring and compassionate* (Kylie).

The context of the environment in which nursing care occurs can also influence the development and the nature of the nurse-patient relationship. Participants described the professional limitations and the contexts of care that are placed on nurses that may influence the development of the nurse-patient relationship:

> *But if you worked in ICU and your patient required full nursing care, or they were intubated or something, and you've been doing everything for them. The moment that they come to and try to do things for themselves and couldn't, would you sit there and argue with them, as to whether they should do it or not?....Most of the time, in this hospital and in every hospital….there is such a big push for beds that you're constantly just trying to get people out the door* (Natasha).

As part of the nurse-patient relationship, there is, for example, a need to set and maintain professional boundaries with patients. This is supported through the NMBA guidelines developed in 2016. Rose and Linda both identified that the need to set boundaries in the relationship is important:

> *I always tell them what I am up to and then what is expected of me and for them, you know* (Rose).

> *People play you too because they like to be that victim role. So, it's all about just working it out - the even - sometimes you get it right, sometimes you don't…. they probably need to stand on their own two feet a bit* (Linda).

Conversely the manipulation of patients was identified by all of the participants as being something in which they routinely participate.[20] Whether overt or covert in practice, the use of manipulation to achieve nursing outcomes is common practice.[21]

> *Yeah, we do and that comes with experience, once again, and confidence, you have the confidence to say, well, no, you're going to do it my way, and that's how it is…Yeah, we are, actually, when you say it like that. (manipulative)* (Rebecca).

At the same time, the participants identified that when dealing with patients, the context of the patient's beliefs and values are important to consider supporting patient autonomy. Many of the participants disclosed strategies that they have been advised by others to implement when dealing with those patients who have been labelled as 'non-compliant' or 'difficult'. These strategies are not always conducive to the conceptualisation of patient-centered care or to being supportive of patient autonomy and do not consider the patient contexts as they focus on the need for the nurse to complete nursing tasks:

> *I always get - the girls are always like to me, don't ask. Because if you ask, he's going to say no* (Natasha).

The other interesting point here was in relation to consent and patient care. Incidents described by participants such as the organisation of social supports without direct consent from patients were commonplace, with participants justifying their actions through reference to their professional background and knowledge, meaning that consent is not considered to be required for some aspects of care:

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[20] One example of this is as follows. The social worker is organising a transfer to another hospital and there are no names mentioned but the phone call is very loud and there is a subsequent discussion with the ANUM and physio regarding the patient. The term 'good cop/bad cop' is brandished around. The discussion is around the need for the patient to receive additional hospital care (GEM) rather than going home by herself. The nurse says to the social worker that the patient would rather go home than go to the GEM unit as she feels that she doesn't need the additional time in hospital. The social worker says that she does require the additional rehab on offer and the physio agrees with the social worker. The social worker says to the nurse *"I'll come with you and have a chat to her. I'll be bad cop and you be good cop".* They come back to the nurses' station after the discussion with the patient and the patient has been talked into going to the GEM unit and the social worker begins to organise the transfer.

[21] This was also demonstrated by some of the participants when they used techniques such as distraction that are used to allow the nurses to engage within therapeutic care for the patients. For example Pt. A wants to go to the toilet and is meant to be NWB on his R) leg and using a gutter frame. The pt. states that he doesn't need the frame. The nurse says to him "*but you have been using it all weekend"*. He says "*no I haven't I didn't need it"*. The nurse says *"yes you have I have been here the last 2 days"* and grabs the frame. As the pt. begins to mobilise the nurse says *"see you can walk with the frame".* The nurse then comments on the patient's dressing gown saying *"I like your dressing gown".*

> *So to get them back and explain to and whether they need any pastoral care or social work intervention to make sure, which they may not ask for but as a nurse, I would make sure that they do because sometimes if you are busy you don't have the time to sit with them* (Kylie).

Natasha did identify that, in general, patients are grateful for the nursing presence and the care provided.

> *Yes, I think that we are dismissed at times, because of the way that patients look at our role. Because only we know our role. We are aware of what we do and how we do it…So a lot of the time, patients come in and they see us as a person that just does things for them…But I think that when I talk to a lot of people, they are generally more grateful for the things that we do for them, because we're always around* (Natasha).

This subtheme, *people are not controllable*, identifies the continual struggle that nurses experience when caring for patients in the context of the inequalities that are inherent in the nurse-patient relationship. Although many of the participants saw themselves as trying to interact with their patients as equals and as trying to be supportive of patient autonomy, the nature of their professional contexts and training placed limitations on this possibility. That is, technical and professional knowledge, including the use of jargon, limited how equal the relationship can actually be with patients. Many of the nurses interviewed talked about setting up boundaries for patients when interacting with nurses, which again stresses a focus on advocacy rather than patient autonomy. The perceptions of the nurses interviewed in relation to manipulation of patients are also another interesting component of the nurse-patient relationship that will warrant further analysis (see Chapters Six and Seven).

C) The Environmental Context of Healthcare

Healthcare in the current environment is driven by an underlying notion of financial accountability and responsibility. Changes in government and funding always force a focus on fiscal management of the environment rather than on the management of patient care and, therefore, such focuses have a direct correlation to practices concerning patient care. These points were not unnoticed by the participants who identified, in particular, pressures such as a lack of time and the management of available time, the routine of doing things, workload issues as well as demands on nurses, and the constant push for bed availability so as to take more patients. There may be other factors that influence nursing care and quality, but the participants interviewed identified the points noted above as major concerns they felt impacted on their ability to be able to provide care for patients and to undertake roles such as advocates in healthcare settings.

This subtheme was identified by all the participants as being an influential factor in patient care but potentially problematic with regards to supporting patient autonomy. In particular, they were aware that the healthcare environment itself, where care is delivered to patients, can influence patient outcomes. Indeed, participants identified that the conceptualisation and enactment of advocacy within a clinical context is always strongly influenced by environmental constraints and contexts:

> *There might be a definition if you look, but it doesn't fit - it differs in each situation…. So, it's a situation you have to look at the - it's hard to say, each one is different* (Kylie).
>
> *But it just depends on the clinical setting that you're in. With medical patients, it's good to have advocacy and to be an advocate for your patients, because it's an acute medical ward. Everyone's going to go home eventually. When they do get that discharge planning going with the patients, you've got to have - they've got to be ready to go home*[22] (Natasha).

The issue around workloads and having appropriate amounts of time to deal with patient care and the intricacies that this may present for nursing staff was also identified as an issue. Workload was identified as influenced by the context of the patient in terms of acuity, disability and illness, which in turn influenced communication between the nurse and patients. There was also acknowledgement that a lack of time and the context of the workloads can change nursing practice from being patient-centered and supportive of patient autonomy to just being one of completing set tasks within a time efficient matrix:

> *I think the biggest reason is because most of the times we're running around like crazy. We don't have the time to do it. We're just like bang, bang, bang. We do the things that we need to do. We forget to tell them why we're doing it…I think that the demand - the workload and the demand makes nurses really busy. At times, we are so in the routine of doing things that we just do it for them, because we know that it's going to be quicker. It saves us time. It saves them time and it just gets done. In the end, that's what - I guess as long as you do your work, it's the most important thing for most. But at the same time, it's not helping that situation. So if a patient needs a lot of encouragement to do something and it takes them a while, we tend to take over that - a lot of the time, it's because we don't have the*

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[22] This was also a concern of patients in relation to being able to be functional after discharge at home. For example, while undertaking routine nursing care the nurse and the patient had a discussion about discharge plans. The nurse commented on the pt.'s BP and the pt. states *"good, I am glad something is bloody normal"*. The pt. says *"I hope they don't send me home like this. I have to look after Mum, and if I can't look after myself then how can I look after mum?"*.

> *time…Most of the time, in this hospital and in every hospital, we're - there is such a big push for beds that you're constantly just trying to get people out the door* (Natasha).

A solution to the immense time pressures faced by nurses was proposed by the participants and involved the integration of conversation into the delivery of essential patient care as a means of spending more time with the patient. The problem, of course, occurs when there are higher acuity patients being cared for. In such circumstances, the reality of nursing care for higher acuity patients and inclusive of tasks take precedence. Participants however generally recognised that having more time would be influential in the care of patients:

> *Yeah, well, yeah, because you're busy. Yeah, look, you still - I still try and get it in there even though you might be flat out. But, yeah, it does still impact because if you've got longer time - if you've got more time to spend with the patient, you can sit down and say, well, look, this is what you should be doing, or just having a chat with them sometimes is enough. When you are flat out and acuity is there, you're too busy putting up your electrolyte replacements and that's all the clinical side of it, without actually looking at the patient.* (Rebecca).

There was also discussion about the focus of nursing being on the completion of tasks and how this may act as a barrier to communication between patients and healthcare providers, and thus constrain attention to the support of autonomy:

> *I think the biggest reason is because most of the times we're running around like crazy. We don't have the time to do it. We're just like bang, bang, bang. We do the things that we need to do. We forget to tell them why we're doing it* (Natasha).

It was also identified that sometimes communication is no more than a process or another task that has to be done and as such does not function to promote patient empowerment or autonomy:

> *Sometimes it's just a process and then - yeah it is frustrating I have to admit because sometimes I just know what works* (Linda).

The nurses interviewed reflected on the environmental contexts of healthcare and how they may influence nursing care and constrain the kinds of support provided to patients. Important environmental and professional constraints identified included time pressures and the associated fiscal management of the healthcare environment. This was noted by the participants to limit practices that would be supportive of patient autonomy, as they mean a push for beds and a heavy focus on completion of the nursing tasks that facilitate patient care. Identified pressures were also closely linked to acuity of the patients and how this may be influential in relation to the nurse-patient relationship. This impact of reduced time influences how nurses are able to facilitate the advocacy role as well as support patient autonomy.

Conclusion

This chapter has outlined the three main themes identified through the interview data and supported through the observational data: Supporting Patient Autonomy; Advocacy in the Context of Duty of Care; and Contextualisation of Care. Each of these major themes also generated significant sub-themes that helped make visible some of the operationalisation of concepts of advocacy and autonomy within my participants' nursing practice. The first theme Supporting Patient Autonomy outlined some of the complexities and intricacies of nursing practice in relation to issues of supporting patient autonomy, and also made visible some of the movement between frameworks of the biomedical frameworks of care and PCC frameworks and between which the nurses moved seamlessly. Such movements have implications for nurses undertaking roles of advocacy in practice as well as supporting patient autonomy.

The second main theme, Advocacy in Context as Duty of Care, focuses on the professional contexts of healthcare with a main focus being the nurse-patient relationship and the significance of this specialised and professional relationship in relation to advocacy and autonomy. With phrases such as 'first line of care' and the presence of the nursing profession within the clinical setting being '24/7', nursing professionals saw themselves as holding a unique position as advocate within the healthcare environment. The third and final theme centres on the Contextualisation of Care. This theme highlighted that there are many variables that add layers of complexity to healthcare and nurse-patient interactions and relationships, with flow-on effects for advocacy and autonomy. What this theme highlighted is that with increasing acuity, there has to be a greater reliance on the nurse-patient relationship, but with increasing focus on biomedical concepts, this relationship tends to be more unequal due to the reliance on professional expertise and knowledge to provide nursing care.

As has been seen, there are consistent overlaps between the main overarching themes and their sub-themes. This is not surprising given that nursing care is often interwoven with ideas concerning both advocacy and autonomy, with ideals of best practice also caught within a range of broader constraining factors. In addition, it should be noted again that the purpose of the thematic analysis was not to compartmentalise the responses of the participants, but to rather map the insider perspective of the participants. By providing the verbatim voices of the participants I have demonstrated some of the complexities of the ideas behind patient autonomy and nurses undertaking the role of an advocate within contemporary nursing practice. Importantly, it was this interview data and my resulting analysis that pushed me to look at myself and nursing practices from not only an insider perspective, but also from an outsider perspective.

It is this complexity that brings me to the next section of the thesis. As has been noted, this thematic analysis (TA) has been presented as a means of identifying and mapping how the participants perceive the idea of advocacy and autonomy in practice. To put this another way, in allowing for the participant's voices to be heard, the thematic analysis has presented the normalised views of autonomy and advocacy. This thematic analysis is, however, also a turning point for this thesis insofar as it makes visible some of the problematics of insider perspectives with regards to core nursing ideals of autonomy and advocacy. That is, it is now evident that the thematic analysis does not by itself problematise and challenge the understandings of advocacy and autonomy that are clearly, at least with regards to the observed practice of nurses during the course of their work, already unstable. It is evident that these perceptions of the participants need to be considered through a new lens in order to examine in more detail the actual roles and operationalisations of advocacy and autonomy in contemporary nursing practice. As such, the thematic analysis serves as the empirical foundation for a more detailed investigation. Using the lens of Michel Foucault's concepts regarding power and knowledge, and disciplinarily and governmentality, the second half of this thesis strives to further investigate the power-knowledge relationships that have so far been identified as influencing the notions of patient autonomy and the work of nurses as patient advocates in contemporary nursing practice. The next chapters thus aim to critically re-examine the various relationships and tensions that have become visible between nurses and patients, the nurse-patient relationship, nursing practice, and my core concepts of advocacy and autonomy. To enable this next phase of analysis, the next chapter introduces and outlines core concepts from Foucault's work.

Chapter 5 - Theoretical Framework

Introduction

The preceding chapters have identified that there are multiple factors that inform but also problematise the roles and possible enactments of ideals of advocacy and autonomy within contemporary clinical nursing practice. In particular, it has become clear that some definitions of autonomy can come into conflict with advocacy assumptions and practices, with implications for patients as consumers of healthcare. Some of these tensions are due to the gatekeeper roles that healthcare environments and professionals can play in relation to the understanding and enactment of these ideals within practice. Further tensions arise from shifts between biomedical values informing healthcare – and the understanding and enactment of these ideals – and more contemporary models of patient-centered care (PCC). The thematic analysis' key role was to give voice to participants' perspectives; however, this analysis has also made visible the need for further reflection and examination of the enactment of concepts of advocacy and autonomy in contemporary nursing practice. What the thematic analysis thus achieved was to open up the ideas to allow for a broader examination of perspectives and viewpoints concerning advocacy and autonomy. To do this, I turn to the work of Michel Foucault (1926-1984). In the forthcoming chapters, then, I engage the work of Foucault to help me further examine these ideals, their relationality, and their contested enactments.

Prior to a considered explanation of each of these ideas, it is important to outline the key concepts of Foucault's philosophical work. This will be important for this thesis as it will allow for a deeper exploration of not only some of the assumptions and practices that influence healthcare with regards to the two ideals of advocacy and autonomy, but further consideration of how these assumptions and practices have been framed and enacted by nurse participants (see Chapter Four). Indeed, to assist the reader with the often abstract and philosophically challenging ideas of Foucault, exemplars drawn from the preceding chapters and from fieldwork observations have been used to ground my discussions in this chapter of Foucault's work. These discussions will finally lead to a comprehensive analysis of the various relations of power and knowledge currently at play within the clinical healthcare framework, and that impact on the enactment of these ideals. This analysis and subsequent discussion will be carried out in subsequent chapters.

Turning to Foucault

As has been discussed, there has been a shift in emphasis in healthcare from biomedical ideologies to the more modern and contemporary frameworks of patient-centered care. What has been presented so far, however, also makes visible that there are several very evident tensions that exist between various presuppositions concerning the roles of autonomy and advocacy in healthcare, and the models of care that have been established as being influential within both the nursing literature and clinical practice. As demonstrated earlier in this thesis, both the biomedical framework of care and the contemporary model of PCC are influential in contemporary nursing practice. This was evident in the thematic analysis when the participants who were interviewed discussed patients in accordance with biomedical viewpoints by referring to them by their diagnosis but, on the other hand, were also often discussing patient autonomy in terms of supporting and advocating for the patient to make appropriate choices. Such a focus is often framed as constitutive of PCC. At the same time, within generalised nursing practice, we can often see that as patients have increasing acuity and healthcare needs, engagement with PCC practices tends to decrease, and there is increased focus on the biomedical aspects of care. This demonstrates that these two competing approaches assume different values within healthcare and can promote different types of practices. To put this another way, these differing approaches to and within healthcare comprise what Foucault would call different regimes of truth. It is with this concept that I begin my discussion, and it is a concept that will be integral to forthcoming chapters.

As is well known, Foucault had an interest in exploring practices and their contexts – including those of healthcare – through an examination of their dynamics of relationality and power. If the preceding chapters have set out what can be considered the normative dimensions of autonomy and advocacy as conceptualised and enacted within healthcare, this and succeeding chapters offer a critical consideration of these normative dimensions, drawing closer attention to where these various ideals of advocacy and autonomy come into conflict, or are overwritten or subsumed, via practice. Analysing advocacy and autonomy in contemporary nursing practice through a Foucaultian lens does not necessitate such an analysis being informed by a comprehensive summary of the work of

Foucault.[1] The focus for this thesis is rather on the later philosophical work of Foucault, in the 1970s, which centered on examining the relationships between power and knowledge as they are played out through the practices of societal institutions, such as the hospital (Best & Kellner, 1991). In *Discipline and Punish* (1977), for example, Foucault examines the concepts of disciplinary techniques and practices of power and focuses on how divergent discourses shape power and knowledge relationships. In *The History of Sexuality Volume 1* (1990/1978), the concept of normalisation through discourses is explored and, in subsequent volumes of this text, Foucault focuses on how subjects and knowledges are constituted and made through discourses. This text is also the first time that his perspective on the constitution of the subject is transformed to incorporate the notion of biopower. Also, of interest for this thesis is his concluding focus on technologies of the self, ethics, freedom, and governmentality. It is these ideas, then, that are the primary focus of this chapter and will inform my later discussions.

Regimes of Truth

Foucault recognises that within any society, there is a prevailing regime of truth that normalises certain discourses and practices, constructing them as the basis for knowledge and truth (Foucault, 1980/1972a). These truths and the knowledges that they produce are, however, constructed and negotiated realities that are influenced and supported by powerful, politically dominant discourses and institutions such as hospitals, universities and the media (Foucault, 1980/1972a; Usher & Edwards, 2003). Although regimes of truth are not discourses per se, they are supported by, and also support, the dominance of those certain discourses which are accepted as and function as true or legitimate within their specific (societal) context (Brown, 2000; Foucault, 1980/1972a). A regime of truth thus orders procedures in relation to the production, regulation, distribution, circulation, and operation of statements as true or false – or legitimate or illegitimate – within its associated discourses (Foucault, 2002/1969). This means that the 'truth' in any regime of truth is knowledge deemed to be so legitimate that it is privileged to guide cognition and action in that (societal) context. Truth, then, becomes a kind of object of its supporting

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[1] Foucault's work in the 1960s can be described as archaeological with a focus on systems of knowledge (Best & Kellner, 1991). More relevant to this thesis are *The Order of Things* (1994/1970) and the *Archaeology of Knowledge* (2002/1969), which are the first works of Foucault that bring into question the concept of objects as part of knowledge and the historical origins of discourses. Foucault's first major work *Madness and Civilisation* (1988/1965) examined the social construction of 'madness' and this was followed by *The Birth of the Clinic* (1973), which examined the changes in the medical establishment. Although these two works are influential in the philosophy of Foucault, they do not play a large part in this thesis.

discourses and the mechanisms through which they are produced (through institutions such as hospitals, for example) (Foucault, 1980/1972a; 1984).

For instance, when the two models of nursing practice that have been talked about previously – the biomedical model and PCC – are considered, then what becomes visible is that both of these models operate, in effect, as regimes of truth, with each supporting and legitimating particular discourses and practices. Looking at the biomedical model, for example, what is supported is for knowledge, expertise and the speaking of truth to lie variously within the domain of the professional healthcare worker. This can be compared to the regime of truth of the PCC model. Within this framework of nursing practice, the production of knowledge and truth is much more collaborative in nature. That is, both the nurse (and other healthcare professionals) and patient collaborate in the development of knowledge and in the speaking of truth with regards to patient experience and consequent decision-making.

As noted, regimes of truth are established through their discursive practices and formations, each of which enables the creation of truths and objects, with these furthermore determining the formation of subjects and even of who can and cannot speak (Foucault, 1980/1972a; 2002/1969; Mills, 2013). Regimes of truth thus work to create privileged positions for those who are considered official holders and speakers of knowledge. For instance, within the biomedical model only (some) healthcare providers inhabit this privileged position (privilege is dependent on professionally accrued expertise), while patients, conversely, inhabit a marginalised and subjugated position (Foucault, 2002/1969). The situation is different within PCC, with patients being positioned as also holding some privilege. Indeed, in many ways, PCC marks a converse to the biomedical model, and the two regimes of truth can be seen to be operating in tension throughout healthcare practices.

The final point to make about regimes of truth here is to stress again that they do, in effect, stand for social worlds which enable, position and manage their constitutive truths, objects, and subjects or subject positions (Daniels, 2010). Subject positions, then, are produced and sustained within regimes of truth, meaning that subject positions are always legitimated within and through a regime of truth's discourses and practices (Epstein, 2011; Gill, 2014). Individuals are hence able to define and understand themselves – and to be understood – by adopting a particular subject-position within a discourse or regime of truth (Epstein, 2011). At the same time, the self-understanding of any individual in relation to their subject position within a regime of truth or within any of its associated discourses is fluid in nature (Daniels, 2010). This, then, is a reminder that even the idea of a health professional or of a patient can be constructed and understood differently not only across different regimes of truth, but even within them. That is, although regimes of truth support certain institutions, certain practices, ways of knowing and ways of being (subject positions), Foucault also argues that none of these are static or completely comprehensive.

Power/Knowledge

What Foucault stresses throughout his work is that there can be no such things as universalised fixed meanings, unified subjectivities or any completely centralised theory of power (Arslanian-Engoren, 2002). Power, as identified by Foucault (1980/1972a), is rather ever-present and is imbued throughout every regime of truth and, thus, informs each regime's legitimation of certain social relations and practices, and subject positions. Foucault (1980/1972a) thus recognises that power is exercised within contexts rather than possessed once and for all (Bradbury-Jones et al., 2008; Gallagher, 2008; Henneman, 1995; McGowen, 1994; Rabinow, 1984). Power, following Foucault's conceptualisation, is thus not repressive in nature but productive, and runs throughout the social body (Foucault, 1980/1972a; 1977; McHoul & Grace, 1993; Rabinow, 1984), marking the capacity to shape, facilitate and generate social practice and social relationships. In many institutional practices and hierarchised professions, such as healthcare, power is seen to operate by structuring choices, decisions and practice (Cooper, 1994).

Foucault also refutes the idea that knowledge can only exist where power relations do not exist. Foucault understands that power, rather, produces knowledge, and vice-versa, and that neither are conceivable outside of what he understands as discursive practices (Driver, 1994; Foucault, 1977, 2002/1994a; Gordon, 2000; Rabinow, 1984). Foucault also recognises that power and knowledge invest in bodies, turning them into objects or subjects through processes of subjugation (Rabinow, 1984). This, however, is never a one-way process, there are always counter points where there can be resistance from the subjects of power (Cooper, 1994; Edkins & Pin-Fat, 2005; Foucault, 1991/1978). To return to the examples traced in the previous chapters, there are times when 'patients' try to resist their positioning in and by certain discourses and regimes of truth. Within the field notes, for example, there was one example where a patient attempted to resist his positioning by challenging the nurse and doctors and attempting to discharge himself against medical advice.[2] In this instance, although the patient was not successful in discharging himself, the fact that he was able to achieve multiple rounds of negotiation with various healthcare professionals indicates the constant potential that exists for the disruption of normative power relations. This, then, identifies some of the issues within nursing practice in relation to the socially determined subject positions which are often internalised at a subconscious level where the reality of resistance is minimal (Cooper, 1994). This is referred to by Deveaux (1994) as individuals contesting fixed identities.

The counterargument here is that if subject identities are produced through the interplay of power, then resistance can only be established if the subject rejects the internalised and socially accepted positions. However, acts of resistance can also be restricted to what is considered to be acceptable within a regime of truth, constrained by those behaviours considered normative (Cooper, 1994; Edkins & Pin-Fat, 2005). Such constraints were played out, for example, in the instance of a patient who was considered by the nurse to be 'non-compliant': "*he'll be back; he won't be compliant with his regime. He was really unwell when he came in"*.[3] Here the nurse who was looking after this patient discussed with me the fact that this patient had done this before and was known to the nursing staff as engaging in normatively problematic behaviours. The patient was so framed for drinking significant amounts of alcohol, not taking his diabetic mediations properly, and not eating to accommodate the changes in his blood sugar levels.

In Foucault's view, in summation, power is a web of relationships that informs the development, acquisition, circulation and affirmation of knowledge (Foucault, 1977). Power is thus relational and functions to legitimise (or not) different worldviews – which can become regimes of truth – through knowledge and discursive practices which work to potentially control and order the subject (Foucault, 2002/1994a). Knowledge, as defined by Foucault, thus has a complex correlative relationship with power. Knowledge also functions as the space in which subject positions are developed and objects become

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[2] This example was discussed earlier in Chapter Four in Footnote 12.
[3] This example was also discussed in Footnote 12 in Chapter Four.

known (Foucault, 2002/1969). As will be further discussed below, power is central to the development of the subject, and the subject is constituted by the dominant discourses and the techniques of power that are used in relation to objectification and subjectification (Foucault, 1977). As a result, knowledge is seen to extend and reinforce the effects of power (Rabinow, 1984). To explore these concepts in more detail, however, it is necessary to first dig more deeply into Foucault's ideas concerning discourses and the object and subject.

Discourses

Foucault adopted the term 'discourse' to denote a historically contingent social system that produces knowledge and meaning. In accordance with Foucault's understandings, knowledge is constituted as and through what comes to be taken as normative within regimes of truth and their discourses (Foucault, 2002/1969). Foucault, in turn, understood discourses as identifiable collections of utterances, or groups of statements, governed by rules of construction and evaluation allowing for the identification of what may be said, by whom and in what context and effect (Foucault, 2002/1969; Gordon, 2000). They are, in other words, regulated practices. He also stresses that discourse is distinctly material in effect, producing practices that he sees as systematically forming the objects of which they speak. Discourses, thus, not only inform regimes of truth, but they also enable the construction and entrenchment of both subjects and objects. In turn, regimes of truth also function to counter regulate and identify the discourses that are then able to be visible.

From a Foucaultian perspective, what has to be understood and kept in mind is that, within both a discourse and a regime of truth, Foucault recognises that there is no universal truth, only versions of truth that operate and function at a particular time within that given social system. These normative 'truths' function through discourses which are how power and knowledge relationships are managed within regimes of truth. The discourses that therefore operate within regimes of truth are mechanisms for the maintenance of truth, objects and subjects, and a means of circulating power in particular ways. Foucault also makes the point that within any regime of truth, certain discourses and discursive practices will become normative to the extent that they become dominant.

As I have noted previously, then, currently within healthcare there are multiple discourses that, dependent on differing regimes of truth, influence the perspective of power and knowledge relationships, object and subject identification and, ultimately, what can be described as 'truth' at any particular point in time. One of the current discourses in healthcare, that of the biomedical model, aligns, for instance, with assumptions of specialised knowledge which give power over the lay patient (Foucault, 2002/1969). Here the patient is constructed through normative discursive practices surrounding health and illness and becomes invisible in effect as a person, rather being observed and objectified as a process of disease (Foucault, 2002/1969; Peerson & Yong, 2003). If the subject of the patient is considered, however, from perspective of PCC, it is evident that this perspective gives the patient substantially more input into their nursing care and treatment outcomes and management. The relationship between the nurse and the patient is said to be more equal in PCC in relation to its power differentials and, therefore, the object/subject references in this regime of truth change. It is, therefore, important to realise that the fluidity of power, knowledge, and truth as they play out in discourses and in a regime of truth has substantial implications for how objects and subjects are construed and understood. Indeed, one has to pay close attention to the operation of a regime of truth to understand how objects and subjects may be being conceptualised. These issues are discussed next.

Object/Subject

Through discourses, discursive practices, and the power/knowledge relations informing regimes of truth, objects are formed (Foucault, 2002/1969) and subject positions are identified, legitimised and maintained (Foucault, 1977). It is through these processes of subjectification and objectification that the regulation of roles and capacities of subjects and objects within regimes of truth and their attendant discourses becomes clear. Foucault's conceptualisation of subjectification and objectification followed three main areas of interest: scientific objectification; dividing practices; and individuals turning themselves into subjects. In each instance, I will explore these ideas using the contexts of healthcare I have been examining throughout this thesis.

Subjectification and the Subject

What the previous chapters have made clear is that the contextual relationships between regimes of truth, discourses and their legitimated subjects (and objects) that inform healthcare are not fixed. Foucault (2002/1969) sees these relationships as embodied by the subject who is objectified through previously defined domains, and whose position has been determined within a discursive formation. This would include, for example, the domain of the individual as a patient, as well as healthcare professionals such as doctors and nurses.

There are two meanings of the word subject – firstly, that the individual is subject to somebody or something through control and dependence (subjection) and, secondly, that the individual is tied to an identity through conscience or self-knowledge (subjectivation) (Best & Kellner, 1991; Foucault, 2002/1994a). Importantly, however, these two meanings for Foucault both imply relationships that work through subjugation and also through production (Foucault, 2002/1994a). Foucault (2002/1994a) thus understood that subjects are both produced but also have a resistive position in which they are also able to act out – and against – any position of a subject. Indeed, as described by Foucault (2002/1994a), there is always an asymmetry that exists between the subjection-subjectivation positions.[4] In addition, as noted previously, understanding of the subject is always through the discourses which form social practices (Foucault, 2002/1994a). With regards to the healthcare setting, then, individuals are influenced by both understandings of the term subject. For instance, within the different regimes of truth and discourses that are operationalised in healthcare, the term 'patient'[5] is used to refer to the subject, and individuals becomes subjectified as patients. This then allows patients to become subject to the control and dependence of the medical professionals providing care and treatment. Traditionally, within the biomedicalised regime of truth, the idealised image of a patient has been one of passivity, obedience, making the patient an unquestioning individual who is a recipient of instructions in relation to healthcare (Stimson, 1974). Gerson (1976) further identifies that this label of a patient is objectified[6] according to the degree to

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[4] As these concepts are engaged with further in this chapter and thesis, it becomes more obvious that this asymmetry influences the conceptualisations of autonomy and, therefore, the influences of power and power relations that can exist.

[5] Note, of course, that the identity of patient is just one of the many identities that the individual can create or be positioned in, in relation to the context of the healthcare environment (Saari, 2001). Other identities and subject positions will be discussed throughout the following chapters.

[6] For Foucault, when he referred to objectification, he was referring to the process of turning the subject into an object. The way this was done was through 3 main processes: 1) dividing practice; 2) scientific classifications; and 3) the process of subjectification (Foucault, 2000/1994a). Dividing practices are usually social and spatial in nature and rely on social grouping or being separated spatial. For example, a person could be objectified based on their differences from a group of people because they have a specific illness. Through this process the individual is given both a social and a personal identity (Foucault, 2002/1994a). This has seen the power of the healthcare system that has worked and Foucault in his work referred to this as the *Birth of the Clinic.* This is where the process of medicalisation and normalisation of disease works to further shape and objectify the subject further (Foucault, 2002/1969). Coupled strongly with this was the scientific classification where the body was turned into a thing that could be measured, studied and tested (Foucault, 2002/1969). This has given way to the idea of privileged knowledge and expertise and again supports some of the ideas around supported social norms within healthcare. It also supports the development of two of the

which the individual conforms to the 'norms' of that role. Again, though, these norms and patterns of behaviour are closely linked to the discourses and practices that are operationalised with different regimes of truth. That is, if a discourse changes, what is understood as normative subject and object positions will also change. What is also important to note is that the individual who will take the subject position of the patient does not construct the norms of the role of the patient. These positions and their norms are rather constructed through broader systems such as regimes of truth and their normative discourses and practices (Gerson, 1976).

Following the Foucaultian understanding of subjectification, the individual, as a member of a collective 'patient', internalises appropriate behaviour in an attempt to adopt and conform to those accepted contextually based behaviours. That is, through accepting labelling as a patient, the individual adopts accepted norms and values of the healthcare professionals and of the broader discourse or regime of truth (Kotarba & Seidel, 1984). Patient identity, then, is based on normative rules and classification imposed and maintained by the healthcare professionals (Foucault, 2002/1969). This, of course, will be subject to change based upon the regime of truth which is dominant at that time (a point that will be discussed in detail below and in subsequent chapters). This subjectification is thus reiterated by the medical professionals who assess and adopt normality and prescribe techniques of power that work to enhance this same subjectification (Foucault, 1977; Lukes, 2004; Wellard, 1998). To put this another way, the subjectification of the individual and the adoption of that social personality are imposed through what Foucault will come to call disciplinary power (Foucault, 1988/1965).[7]

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regimes of truth that are discussed within this thesis, the biomedical model and the Sick Role. Foucault specifically talks about the use of documentation that can be used to 'Capture' and construct knowledge about the body and the person. Foucault referred to this writing as a mechanism of social control (Foucault, 2002/1969). This writing also functioned to give subject, now objectified, fixed identities such as 'patient' or even worse referring to them by their clinical diagnoses, such as the 'Diabetic' (Foucault, 2002/1969). The third way that a subject becomes objectified is when the person turns themselves into the subject (Foucault, 2002/1994a). Foucault (2002/1994a) recognised that this was only possible because of an internalised personal discourse that was guided by set social standards and norms. It is through these accepted social standards and norms through which we have formed the identity of the self thus objectifying the subject

[7] Disciplinary power refers to the often taken for granted and normalised practices that are embedded within daily practices within many of the environments that individuals find themselves interacting in (Foucault, 1991/1978). Disciplinary power is diffuse in its operation and acts on everyone. It is considered to be somewhat invisible in the respect that it is everywhere and therefore difficult to resist. Disciplinary power is also linked to all aspect of life and subjects everyone to the possibility of surveillance at all times. (Foucault, 1991/1978). The movement from more corporal punishment to that of a more modern power (disciplinary control) where the standard is to adhere to the societal standards or norms that have been set as what is considered to be "normal" and accepted by society (Foucault 1991/1978). Foucault refers to this disciplinary knowledge being constrained or supported by dominant discourses (Foucault, 1991/1978). These discourses

To understand how this power of subject construal operates throughout the healthcare environment, it is necessary to identify the regime of truth that a discourse is operating within and, therefore, how this works to define a subject and interrelates with power and knowledge. The subject is seen to be part of the regime of normalisation through the influence of power-knowledge relationships that impose an identity for the subject (Vighi & Feldner, 2007). This is very evident in the medical discourses that influence nursing practice. In nursing and medicine, as previously discussed, one influential set of relationships is that of the biomedical regime of truth which places individuals into reductionist categories, the dominant category being that of illness, and then subjectifies them as patients (Coyle, 2007). The term patient, then, when seen in this context, brings with it discourses around passivity and dependence (Coyle, 2007). An example of this was given in Chapter 4 when one of the participants, Rebecca, identified that during handover nurses tend to refer to patients by their conditions, for example, the DKA patient. At the same time, Rebecca mentioned in contrast – and arguably thereby showing an alignment with the alternative regime of truth discussed so far, that of PCC – that you also had to stop and remember that the patient in the bed was a person. These issues will be explored in detail in the following chapters.

The complementing spatial, temporal, and social compartmentalisations of institutions are also responsible for both the objectification and subjectification of the individual (Rabinow, 1984). This occurs in healthcare, for instance, when healthcare professionals talk about the cohorting of patients in terms of their diagnoses. Foucault further recognised that individuals have the potential to turn themselves into subjects, which he refers to as subjectification (Foucault, 1982; Rabinow, 1984). However, Brockling, Krasmann and Lemke (2010) recognise that the process of subjectification is always within a historical context and limited through the experiences of the individual. The past experiences of the patient in relation to healthcare influences their current interactions with the system and healthcare providers. By accepting that individuals also influence the idealisation of the subject, however it is evident that the position of the individual as a patient can be composite and contradictory (Daniels, 2010).

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help the individual to define way of acting, speaking and interacting appropriately and on the flip side to this also define the inappropriate ways in which people will be punished for their actions (Foucault, 1991/1978).

It is clear, within these discussions alone, that there are multiple discourses that at any one time can be dominant within nursing and at any one time can compete with one another. What has also been set up in this discussion is the recognition that there are also at least two dominant regimes of truth: the biomedical model and that of PCC. Within these frames for nursing practice, several key stakeholders hold positions of both subjects and objects. With the role of the subject, the patient can be heard and visible. If a patient is conversely produced and understood as an object within a regime of truth or associated discourse, they become objectified and silent.[8] Such objectification of the patient changes the power-knowledge relationship, placing the nurses in a position of power. Detel and Pippin (2005) do, however, stress the point that as there is always, according to Foucault, a reciprocal relationship between the healthcare professional and the patient, there is always the potential for a new regime of truth to be established and produced.

The Subject Position

In nursing practice, and healthcare in general, as has been discussed, there is a tendency to label patients. Labels can vary from that of being non-compliant, to the traditional label of being ill or sick, to label from a diagnosis or specific symptoms. Each of these stands for different kinds of subject positions for a patient (itself also a subject position as noted above), which come with expected behaviours and models of interaction for both the patient and, further, the healthcare professionals they interact with. As Foucault describes this, subject positions are created and made available within discursive frameworks; they mark out specific positions of agency and identity in relation to particular forms of knowledge and practice. More specifically, if subjects are produced within discourses and subjected to discourses (and, of course, regimes of truth), then subject positions entail the becoming of a subject to and of a particular discourse, both subject to its meanings, power and regulation and the bearer of its power/knowledge. This process is best described via an example.

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[8] While it is important to note that these statements talk about silence being within a verbal context, there are many other ways to be verbal and to be heard rather than relying on speech alone. The use of body language is a powerful tool that has been mentioned within this thesis as being influential during patient and healthcare professional interactions. However, for the context of this discussion I am referring solely, in this space and time, to the use of verbal communication.

In the context of the subject of the patient, as framed in particular through biomedical discourses, there are as noted several additional subject positions that patients may be located within and which then frame models of interaction within healthcare. For instance, if we examine the issue of labelling patients as compliant or non-compliant, the notion of compliance clearly relates to one subject position created by healthcare professionals, typically when informed by the biomedical model. Compliance simply refers to a patient or individual following the advice that is given to them, specifically in this case from healthcare professionals (Aronson, 2007). Rafii, Fatemi, Danielson, Johansson and Modanloo (2014) further included that there should always be an emphasis on the activity and responsibility of the patient in relation to their treatment. This of course does lead itself to aligning with PCC frameworks of care. More specifically, if compliance means following medical advice, then a non-compliant patient is a patient who does not take a prescribed medication or follow a prescribed course of treatment (Kleinsinger, 2003), whether this is by deliberate rejection of treatment or due to ignorance or misunderstanding.

With regards to managing this subject position of the non-compliant patient, Gerson (1976) stresses that perceived problematic conduct of the patient (non-compliance) tends to be treated symptomatically, more often via a process of further prescription rather than of negotiating with the patient. This is particularly evident within the biomedical model of care where the person already tends to be treated reductively and framed in terms of their symptoms, rather than being treated holistically in a way that can look at the larger picture which might include those social aspects of health and care that might themselves inform a performance of non-compliance. At the same time, it should be remembered that any responses to non-compliance will always be in the favour of the healthcare professional due to the organisational structure of healthcare (Gerson, 1976; Wellard, 1998). Additionally, it should be noted that all such labelling of individual patients effectively allows for a homogeneous entity to be developed where individuals are standardised to allow for somewhat standardised care options (Herzlich & Pierret, 1985). In other words, the labelling of the patient, both as a patient and as non-compliant (or compliant), is always about framing the patient into a subject position that is itself institutionalised, accepted and managed. Similar framings play out with regards to the framing of patients in terms of the sick role discussed previously in Chapter Two.

One specific example of these processes of constructing and managing patients as non-compliant discussed in Chapter Four was in relation to an elderly patient who was being transferred to another ward. A social worker was working with the nurses as the patient was requesting to go home rather than to the additional rehabilitation Geriatric Evaluation and Management (GEM) Ward within the hospital setting. The social worker said to the nurse *"I'll be bad cop and you be good cop",* and together they achieve talking the patient into going to the extended rehabilitation unit. Illustrating a process of managing non-compliance, this also exemplifies key features of the autonomy versus beneficence distinction discussed in Chapter Two.[9] The beneficence model, based on the idea of the need for paternalistic behaviours – found in the Belmont Report (1979), for instance – is highlighted within this interaction with the nurse and patient. Although the patient is competent and has the capacity for rational and autonomous choice, a label of being non-compliant is considered to change the ability of the patient to be autonomous and to demand intervention so as to enable compliance.

A further example is a patient who had significant social issues at home and wanted to discharge himself earlier than was being recommended. The patient was requesting to be discharged from hospital because his wife was suffering from a mental health condition and there was nobody to look after his children. There was a complex social history with the children and the social issues for the patient were extensive. In this example, the healthcare professionals who are dealing with this patient once again negotiate with the patient to stay until they can organise for home nursing to come in and see him. Once again, we can see that this demonstrates the standard healthcare response to non-compliance – intervention until the patient becomes compliant again – highlighting not only the power inequality that informs healthcare interactions structured by the biomedical model, but a lack of support for patient autonomy.

That is, the constructed subject position of non-compliance that may come to frame a patient and their behaviour dictates how autonomous s/he is then able to be, and further

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[9] Just to recap from a beneficence model, beneficence is constrained by the other principles of autonomy, non-maleficence and justice (Gillon, 1997). The ultimate goal of this model is to provide a benefit for patients while causing or inflicting minimal harm (Beauchamp, 2007; Gillon, 1996). Within an autonomy model, as proposed through the work of Beauchamp and Childress (2013), autonomy is considered before the principle of beneficence and there is a subtle change in terminology where autonomy is now referred to as respect for autonomy rather than respect for persons.

supports the expectation of a need for paternalistic and beneficent behaviour on the behalf of the healthcare professionals. However, it should also be recognised that the individual has agreed, to a degree, to take on the subject position of ‘patient’, which in turn expects compliance. This, as such, influences his or her subsequent framing by the institution and the healthcare professionals. Foucault (2002/1994a) also recognises that an individual is never completely determined by their situation, their function within specific subject positions, or perceptive capacity. Certainly they might be dominated by and subject to the rules of the discourse that are apparent and enforced by those individuals who are perceived to have power – in the examples above, discourses around compliance work to give power to the healthcare professionals – but these can also never completely control individual interpretations and constructions of the subject. At the same time, however, Cremonesi, Irrera, Lorenzini and Tazzioli (2016) also note that the constitution of the subject and the construction and managing of subject positions is always reliant on discursive processes of subjection and subjectivisation and cannot be separated from these processes. For Foucault, then, both identity and agency are constantly in flux, with agency always including the capacity to resist or to act outside the prescribed norms in the hope to make a difference (Foucault, 1990/1978), to be non-compliant even as this in turn sparks particular kinds of responses.

Disciplinary Power

Disciplinary power is another form of power central to the ideas of Foucault which needs to be discussed. Disciplinary power, as defined by Foucault (1977) refers to discipline that works to construct and control the body. More specifically, disciplinary power works to discipline and create docile bodies through techniques such as observation, the recording of the observations and eventually the internalisation of this discipline by the individuals being observed and recorded. Developed out of his work in *Discipline and Punish* (1977), discipline is considered a type of power, a modality for its exercise. It comprises a whole set of instruments, techniques, procedures, levels of application, targets. It is, in effect, a technology of power. Disciplines, then, are techniques for assuring the ordering of human groups with the following aims: to exercise power at the lowest cost and maximum efficiency and effectiveness; to increase the docility and utility of the people who are disciplined. As such, Foucault understands disciplinary power as the power informing a regime of truth or a discourse, for example, that allows it to mould, shape and normalise subjects so that they then speak, think and, eventually, act in the desired way (Foucault 1991/1978). To put this another way, through its various techniques, disciplinary power organises space, time and everyday activities, so working to train the body (and mind) and to make individuals into objects (Foucault, 1977; Rabinow, 1984). Techniques used in this form of power include, but are not limited to, hierarchical observation, normalising judgements, and the examination (Foucault, 1977; Rabinow, 1984).

One of the techniques used in relation to disciplinary power is that of hierarchical observation, which, for Foucault (1977), means the ability for one of higher status to see and hence monitor the actions of the individual. To achieve this effectively within healthcare, there has been a manipulation of the environment, specifically in relation to the management of space. Here, Foucaultian concepts such as the panopticon[10] can be used to discuss how hierarchical observation can be applied within healthcare as a mechanism by which disciplinary power can be applied. Drawing on Jeremy Bentham's ideas (1798) as noted below, the panopticon is a structural design that makes individuals observable from a central supervisory position but makes this central observing position itself unobservable. The idea is that being under such observation demands self-regulation. However, according to Foucault, simply establishing the appearance of omnipresent observation is often sufficient, as those potentially being watched will regulate their own behaviour. That is, as Foucault pointed out, the power of the panoptic gaze is the possibility of observation, which need not actually occur in every instance to still be effective.

Considered a type of power applied to individuals through continuous possible supervision, and hence working to produce a docile body around a norm (Foucault, 2002/1994a; McHoul & Grace, 1993), panopticism is fundamental for the automatisation and disindividualising of power (Foucault, 1977). The panopticon is designed to work through promoting an internal, articulated and detailed control over the bodies inside it (Rabinow, 1984). It also functions to increase efficiency in relation to the normalising

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[10] The panopticon is an institutional building originally designed by English philosopher and social theorist Jeremy Bentham during the later stages of the 18th century. As a model for prisons, the design consists of a circular structure with a centralised building from which the institutional controllers are able to watch prisoners stationed around the perimeter. The prisoners assumed that they were being constantly watched and, through objectifying the prisoners, these individuals effectively controlled their own behavior (Foucault, 1991/1978)

judgement (Driver, 1994). Foucault recognises that it is through its spatial ordering that the panopticon exerts its power and control over the individual body, the group, and, therefore, any associated knowledge (Rabinow, 1984).

Space

The design of institutional space is representative of the dominant culture of the time, which is strongly influenced by its relationship to power (Gillespie, 2002). More specifically, as noted above, an architectural structure can itself function as a multiple, automatic and anonymous power (Foucault, 1977; McHoul & Grace, 1993; Rabinow, 1984). Driver (1994), Foucault (1977) and Schwan and Shapiro (2011) thus highlight that the use of space can be an analytical tool which allows for better supervision of the individuals. This, of course, is particularly the case with panoptic organisation of space. St-Pierre and Holmes (2008) note, for example, that, through distribution, partitioning and ranking, all of which benefit discipline, the panopticon makes individuals easier to locate and easier for surveillance to occur. Panoptic architecture is used to transform the individual into an object and make them docile through hierarchical surveillance and observation.

When referring to the disciplinary management of space within healthcare there are several issues that can be noted. The hospital space can be seen as an administrative and political space influenced by the need to provide appropriate therapeutic options for individuals (Foucault, 1977). Initially we have the larger structure of the hospital itself. Then, within the hospital, the space itself is broken up and designed to be smaller and compartmentalised areas that are based on clinical specialties and clinical services that are provided to patients. In a Foucaultian sense, however, the overall effect of the hospital can clearly be likened to that of the panopticon. Within the contemporary healthcare setting, for instance, hospital rooms traditionally can be either single rooms, double rooms or a four-bed room. In the ward where the observations of this study took place there was also a higher acuity section of the ward which had a small four-bed room with a separate nurses' station within the room. The nurses' station was situated centrally, and the four beds were spread out in front of it with each bed visible from the nurses' station and also from each of the three other beds. The bathroom facilities were adjacent to the nurses' station but, again, could be seen from each of the beds in the room. At the side of each bed is monitoring equipment and a chair for patients or visitors to sit in. This particular area of the ward was also restricted to visitors. On the door of the room was a sign stating that only two visitors per patient were to enter at any one time and that visitors must check with the nurse before entering.

This idea of these spaces being set up based on the clinical speciality, the ward scenario described above, and the acuity of the patient is, according to Gillespie (2002), an explicit way to contextualise, situate and manage social interactions. That is, through this management of space, bodies are individualised into subject positions through their location, a process which furthermore distributes and circulates them in a network of relations (Driver, 1994; Foucault, 1977). The use of space is thus one way in which the norms of prevailing discourses – as, for instance, set out in the biomedical model – are perpetuated (Foucault, 1977; Gillespie, 2002), reinforcing dominant social divisions and cultural norms of behaviour (Hofmeyr, 2006; McNay, 1994).

Normalising Judgement and the Examination

If normalising judgment is Foucault’s description for how the prevailing norms set by discourses and regimes of truth work to make visible and correct any deviations from acceptable behaviour – a process of disciplining and punishing – this work is played out through the examination. Indeed, the process of the examination combines hierarchical observation and normalising judgement (Bradbury-Jones et al., 2008; Ells, 2003; Foucault, 1977; Rabinow, 1984). Basically, the examination objectifies its subjects by requiring the creation of something visible that can be evaluated. Results of the examination are then documented in ways that aim to identify certain aspects of the individual, and which facilitates the calculation of a standard to which individuals may be compared. According to Foucault, this system of examination and documentation resulted in the creation of the individual as an object that could be described, analysed, and compared; and a comparative system through which individuals may be evaluated based on a measure of similarity or difference to others

To put this another way, the main purpose of the examination is, through a process of objectification, to arrange objects (Rabinow, 1984). This is a highly ritualised process, subjectifying individuals as objects and objectifying those who are subjects (Foucault, 1977; Rabinow, 1984). Ells (2003) and Rabinow (1984) highlight that the examination, with its documentary techniques of surveillance, works by making each individual a ‘case’ through classification and the coding of symptoms. In the context of healthcare, then, the examination entails that knowledge, specific to the healthcare professional, can be used as a technique of power over the patient (Foucault, 2002/1969; Rabinow, 1984). That is, once categorised as a case, individuals can be classified as abnormal and then framed as objects which need to be normalised (Ells, 2003).

The other way in which the examination controls and manipulates the individual is through the process of documentation, what Foucault (1977) refers to as a network of writing. By writing, individuals become formalised within the power relations through a process of homogenisation established through the technique of examination (Foucault, 1977; Rabinow, 1984). This, of course, is apparent in healthcare through the process of documentation. Indeed, the saying ‘if it’s not documented, it didn’t happen’ is one that is taught to undergraduate nursing students. Documentation in healthcare is the process of not only communication between other healthcare professionals, but also comprises a legal defence for healthcare providers that can be used in a court of law (Blair & Smith, 2012). Nursing notes are meant to demonstrate the critical thinking and clinical reasoning that is behind the care of the patient (Blair & Smith, 2012). But another component of the documentation is to accurately, as discussed by Blair and Smith in 2012, demonstrate the health status of the patient and the care that was delivered by the nurse while incorporating and reflecting the patient’s perspectives of their health and healthcare. Not only does this disciplinary technique work by making the individual an object, this object can then be analysed, categorised and manipulated. In summation, then, the aim of disciplinary power is to make an object, what Foucault has also called a docile body that can be subjectified, used, transformed, and improved (Brown, 2000; Foucault, 1977; Rabinow, 1984). Docile bodies are considered an outcome of specific techniques of power that regard the individual as both an object and an instrument of its exercise (Foucault, 1977). The docile body, after all, is the useful and productive body.

Biopower and Normalisation

The techniques of disciplinary power all work to normalise certain kinds of subject positions, subjects, objects and knowledges within discourses and Regimes of Truth (Rabinow, 1984). Through the process of normalisation, as discussed, the effect of power is to produce homogeneity but also to individualise (Foucault, 1977; Mc Houl & Grace, 1993; Rabinow, 1984). The main benefit of disciplinary power is that it is invisible but

visible. Through maintaining the individuals within their own subjection, the individual becomes responsible for their own discipline (Foucault, 1977; Rabinow, 1984).
In addition to his ideas of disciplinary power, Foucault (1977) refers to biopower to describe the technologies that are employed in relation to subjugating bodies and which, therefore, work to regulate populations through a process referred to as normalisation. The process of normalisation works to create, classify, and then control the social body (Rabinow, 1984). Normalisation imposes homogeneity but also individualises (Foucault, 1977). The idea is that by establishing and maintaining norms, subjects can be manipulated and controlled. More specifically, Foucault refers to normalisation as a system of graduated and measurable intervals where individuals are distributed around a norm, which has the capacity to organise (Rabinow, 1984). This normalisation is essential in relation to the control of biopower (Rabinow, 1984).

The conceptualisation of biopower is thus another explanation as to how the human body can be seen and referred to as an object that can be manipulated and controlled (McNay, 2009; Rabinow, 1984). Through the technologies of biopower, bodies become subjugated with, therefore, flow-on effects for the regulation of populations (Foucault, 1977). An example from healthcare is the clothing of patients. Each patient, upon entering the hospital system, is usually given a hospital gown to wear. This creates the illusion of conformity, de-individualising people into the subject positions of compliant patients, for example. The hospital gown further tends to signify the extent of the illness of the patient. Those patients who are perceived to be in recovery or very ill are usually in the hospital gown, whereas others who are well enough are in their own personal clothing.

Governmentality and Institutions

The healthcare institution, particularly the acute care setting, is structurally and ideologically set up to maintain specific hierarchical dynamics between healthcare professionals and patients (Gillespie, 2002; Jensen, 2008). There is, for example, a physical separation that occurs between patients and healthcare professionals (Foucault, 1977; Gillespie, 2002). This is seen by the use of the nurses' station/desk that separates and acts as a boundary between administrative and nursing staff, and patients and their visitors. This can also be seen by the various areas on the ward that are off limits to the patients and visitors by means such as keypads and being locked, including handover and drug rooms. This reinforces this concept of the professional having some form of power over the lay person (Gillespie, 2002). This panoptic type of architecture has the dual purpose of excluding and controlling behaviour, as noted above, but also serves as a reassurance for visitors and patients (Gillespie, 2002; Schwan & Shapiro, 2011). Governmentality refers to the micro powers that determine government of the self and others, and Foucault examined power through what he referred to as conduct of conducts (Ahonen, Tienari, Merilainen & Pullen, 2014; Brockling et al., 2010). Governmentality examines how power is imbued within actions, attitudes and discourses that then influence and determine behaviour and conduct of individuals (Guta, Strike, Flicker, Murray, Upshur & Myers, 2014). The concept of governmentality is thus also about the control of populations, the objectification of individuals within these populations, and the subsequent management and regulation of both the population and individuals (Ahonen et al., 2014; Brockling et al., 2010; Lemke, 2010; Lukes, 2004; Morrissey, 2013; Oksala, 2013; Ojakangas, 2012; Simons, 2013). McGowen (1994) identifies this as working at two extremes.

Upon entering a healthcare environment, particularly that of an acute care setting, an individual's identity is changed to that of the 'patient'. This is when the individual is subjectified (Martin, Leslie, Minion, Willars & Dixon-Woods, 2013), framed within a subject position. This initially gives the individual a new identity, which is separate from the identity that they have outside the healthcare environment. This identity is constrained with various expectations and demands that are explained and demonstrated by other 'patients' and the healthcare professionals. This ensures that the 'patient' is now manageable – compliant – through the adoption of the identity of the 'patient', they therefore become the docile body with the understanding of Foucault's disciplinary power frameworks. Indeed, this becoming a 'patient' and docile, enables the prediction and interpretation of behaviour that is assigned to the category and subject position of 'patient' (Bradbury-Jones et al., 2008; McKinlay & Taylor, 2014). Kopecky (2011) recognises that this is more than an identity, but rather it becomes an obligation by the individual to portray the persona of the patient, through a process called responsibilisation.

This conceptualisation of an identity exemplifies Foucault's changing perspective on power, which is seen in his later work. As he has stressed, the production of identity is historically and contextually situated, with experience and culture working to establish an identity (McKinlay, Carter & Pezet, 2012; Vintges, 2012). For Foucault this is the work of modern power, which produces subjects who are monitored, measured, and managed (McKinlay et al., 2012). Whereas earlier works of Foucault, for example *Discipline and Punish* (1977), highlighted that the individual is created and socially constructed (Ells, 2003), governmentality constructs both the population and the individual (McKinlay et al., 2012). However, because of this process of individualisation, individuals are dependent on the institutions, in this case for treatment of illness (Kopecky, 2011; McGowen, 1994).

In the context of governmentality, Foucault also refers to the disciplinary technologies which aim to create the docile body (Ghatak & Abel, 2013). These technologies aim to produce, reproduce, and regulate the customs, norms, and traditions which monitor and manage individuals and populations (Ghatak & Abel, 2013). In this sense, healthcare professionals can themselves be seen as agents of governmentality (Ghatak & Abel, 2013). Through their positions of power within and over the ‘patient’, we can see that health care professionals work to uphold and normalise the patient, thus shaping their subjectivity and dictating acceptable behaviour (Ghatak & Abel, 2013; Lemke, 2010). Best and Kellner (1991) and Lukes (2004) also recognise that technologies of the self are influenced by the cultural, societal and the subject positions through a process of socialisation. Bradbury-Jones et al., (2008) identify that these technologies of the self are ways in which individuals are able to transform themselves. Ghatak and Abel (2013) refer to this as ritualised behaviour in which the individual is manipulated to conform to different values, normative behaviours and expectations and a social obligation.

The importance of self-care and self-responsibility is an issue with the patients that I have described throughout this chapter. This, in turn, influences the treatment and the way that the ‘patient’ is conceptualised. In both of these examples, labelling of the patients as non-compliant is in response to their wilful disregard to their own health and the expectations of being sick within the population. This allows the ‘patient’ to be judged, compared to ‘normality’, and then labelled as deviant and in need of intervention (Holmes & Gastaldo, 2002).

This is in part due to the role of the institution in healthcare where there are agreed shared values and behaviour which determine the subjectivity of the ‘patient’ (Ghatak & Abel, 2013). It could indeed be argued that the population is controlled through social institutions, such as hospitals and schools, where collective intervention, direction, and modification are able to influence the individual (Guta et.al, 2014; Oksala, 2013). It is also important to understand that the role of the institution, in terms of normative behaviour, not only affects the patient but also the professionals working within the institution itself. It is the institution and the practices of the institutions that construct the subject and enable the individual to be able to adopt and maintain subject positions (McKinlay &Taylor, 2014).

From a professional perspective, the notion of accountability is at the forefront of governmentality (Kopecky, 2011). This encompasses individual responsibility and homogenisation which, through disciplinary techniques such as observation and documentation and examination, the healthcare professional - in this instance we refer to nurses - themselves become objects and subjects (Hodge & Harris, 2012; Kopecky, 2011). In both instances, the ‘patient’ and the ‘nurse’ construct identities through a process of subjectivity (Holmes & Gastaldo, 2002). As already noted, these identities are facilitated by the dominant discourses that recognise and accept knowledge and institutionalised practices (Universities and Hospitals alike). However, unlike the ‘patient’, the ‘nurse’ has been given a powerful position by the institution to mould and construct the ‘patient’ through the eyes of the institution (Holmes & Gastaldo, 2002).

So how does an individual become moulded into the subject position of the nurse? Undergraduate education is based on the regulatory mechanisms of the registering and governing bodies which include the Australian Health Practitioner Regulation Agency (AHPRA) and the Nursing and Midwifery Board of Australia (NMBA). These two agencies are responsible for the accreditation and regulation of nursing practice throughout Australia. Therefore, they form part of the governmentality that ensures the docility of nurses expected both from a professional level and also at the institutional level. The ideologies of power and knowledge as expressed by Foucault show that there is a hierarchical and panoptic effect of the standards that are used to create and sustain the subject position referred to as ‘nurse’. It clearly states that the standards are used to assess performance and to enable registration to occur. They also refer to the use of these standards as a governing mechanism for universities when assessing nursing students and also through the development of the nursing curricula. There is also an artificial way of trying to dispel the power inequalities that exist in the nurse-patient relationship by alluding that the standards are used to communicate to consumers the standards that are expected from nurses in relation to the delivery of nursing care.

It is obvious, however, that the language used in the document is powerfully aligned with that of the nurse as a subject position, rather than that of the patient as a subject position. So, the functionality of this section has to be questioned from a consumer point of view. The technical language and use of jargon make it inherently powerful for nurses rather than for the patient. The standards are said to be broad-based and principle-focused but are not inherently transparent to the patient, or even to some nurses. There are certainly key catchphrases throughout, such as ‘independently’, ‘interdependently’, ‘accountability’ and ‘responsibility’ which, in a professional scope, are differentiated in the literature as aligning with the ideas around professional autonomy of nurses. But again, the individual interpretation and enactment of these codes and standards produces the varied responses observed in practice.

Throughout these standards there is an emphasis around the normalisation of behaviour and the attempt to provide a heterogeneous nursing profession. Identification around issues such as lifelong learning and professional development is just one strategy that exists in the nursing profession as a regulatory mechanism. Mandated continuing professional development (CPD) set out by the NMBA (2010) works as a control over the nurse to ensure that there is maintenance, improvement and broadening of nursing knowledge, expertise and competence. The standards thus strengthen the docility and normalisation of the behaviour inherent in the nursing role, such as with regards to CPD responsibilities and also the recognised duty of nurses to self-regulate behaviour. In this sense the standards themselves are like an ever-present panoptic gaze stressing that nurses have a responsibility to recognise and respond to unsafe or unprofessional behaviour (NMBA, 2016).

Dominant and Subjugated Knowledges

Dominant knowledge is created and sustained by those who are considered to be in power and it becomes the accepted way of speaking about a particular subject (Foucault, 1980/1972b). It is through spoken, written and behavioural expectations that are shared within cultural groups that this dominant knowledge becomes normative. The other type of knowledge is considered to be subjugated in nature. The concept of subjugated knowledge, from a Foucaultian perspective, is the knowledge, which is considered to have no place, to be unqualified, or even disqualified, and often confined through dominant discourses (Foucault, 1980/1972b). The second part of subjugated knowledge would be the local beliefs and understandings of the subjects. Within some of the regimes of truth of healthcare, for instance, the personal experience of the subject, in this case the patient, is often dismissed as being irrelevant. For example, if we refer back to Chapter Four in Footnote 12, the patient is talking specifically about his diet. Diet is an important factor for diabetic control, especially in relation to pharmacological management with insulin. The patient is stating that he is a vegetarian and that his diet is very different within the hospital setting as to what he is able to eat at home. The patient states to the doctors that he does not eat outside of his home at all, but this is ignored by the doctors as irrelevant. The patient's statements that he has important duties outside the realm of illness and hospitalisation are also dismissed.

Conclusion

While this is just a snapshot of the philosophical work that Foucault completed in his lifetime, these concepts are the most relevant to my thesis and the work that I have conducted with regards to the different understandings of advocacy and autonomy within nursing practice. From the first section of the thesis, it now seems apparent that there are competing discourses and regimes of truth that are at play in relation to the differing understandings and promotions of advocacy and autonomy within nursing practice. These have been summed up as the biomedical model and PCC. Each of these both inform and are played out differently in the context of powerful and dominant institutions, such as that of the hospital. What recognition of these differing regimes of truth allow is the understanding that there are different discursive practices and privileged assumptions regarding knowledge and truth that influence the conceptualisations of subjects and subject positions. This is the recognition, for example, that within these frameworks of the biomedical model and PCC what can be said, by whom and in what context and with what effect, can be different.

For Foucault, in other words, regimes of truth and their underlying discourses are responsible for the formation of objects and subject positions which are identified, legitimised and maintained. As discussed, those in need of healthcare, when framed within the regime of truth of the biomedical model, are often referred to as patients, a description connoting passivity and obedience. The objectification and the creation of the subject position of the patient within the biomedical model, thus, has a link to dependence and control which can be normalised to an internalised dialogue where the person themselves maintains themselves within that specific subject position. This can be compared to the subject position that is common within the regime of truth of PCC, where although ‘patient’ may be used interchangeably with other terms such as client, resident or consumer, those inhabiting this subject position hold a more active role in their care through a process of what is referred to as shared decision-making.

What is also clear is that the institutions that govern healthcare and the discipline of nursing use disciplinary power and biopower. As has been discussed, disciplinary power relies on, and is informed by, the taken-for-granted practices embedded within daily life which produce and normalise both subjects and objects. Disciplinary power is used within healthcare specifically through the techniques described by Foucault such as hierarchical observation, normalising judgements and the examination. Within healthcare there is also the use of space as a form of power. Not only within healthcare do we see the formation of subjects from the perspective of the patients, but the regulatory bodies that govern nursing practice and the institutional bodies in which nursing practice is governed and in which nursing is practiced, also work to produce nurses as subjects. This can be seen as part of the governmentality that Foucault refers to where subjects are constrained by an identity and, therefore, by that assumed identity are made docile. As a result, the power/knowledge relationships that exist between institutions, healthcare professionals and patients are complex. While regimes of truth, the biomedical model and PCC, have so far been identified, there may be others functioning within healthcare that may also work to normalise and conceptualise definitions of advocacy and autonomy. The next section of this thesis will focus on using the work of Foucault to re-examine these frameworks and themes that have been so far influential in conceptualising advocacy and autonomy in contemporary nursing practice. Given the importance of an empirical foundation for Foucaultian analysis, this next section – specifically Chapters Six, Seven and Eight – will illustrate its analysis with insights gained from participant interviews and observational data along with reference back to the policies and standards that are influential in contemporary Australian nursing practice.

Chapter 6 – Examining the Biomedical Regime of truth

Introduction

The concept of the insider view was first discussed within Chapter Three, but it also clearly has relevance to Foucault's understandings regarding the operations of power and knowledge frameworks within regimes of truth and their associated discourses and institutions. To briefly recap, the concept of belonging as an insider – and of viewing the world from that perspective – implies there must be commonalities shared between individuals, including a shared identity, language and experiential basis (Asselin, 2003; Kanuha, 2000). Hence, with regards to the way the concept of the insider has been used in this thesis, the researcher and participants have a commonality in that they share an identity as a nurse. This is because of the shared language and practices developed and normalised as a result of the nurses' and the researcher's educational preparation and the experiential basis of nursing. Through these the participants and the researcher share and take for granted an understanding of nursing practice which privileges ideals of advocacy and the support of autonomy for patients. An insider view thus refers to the world of nursing that is normalised and accepted by both the researcher and participants.

As has been made clear in preceding chapters, particularly from my earlier discussions of the findings from the initial data collection and thematic analysis process, these insider views have been shaped and influenced by specific ideals of contemporary nursing practice which are embedded in the nursing codes, standards and frameworks of the nursing profession and disseminated through the nursing literature. However, to fully understand the construction, maintenance and efficacy of this insider perspective, an issue clearly important to Foucault in his work, these viewpoints, where they originate, and their interactions need further examination. As has been shown in preceding chapters, the viewpoints that comprise the insider views are informed by two main regimes of truth – those of the biomedical model and Patient Centred Care (PCC) – and associated discourses in healthcare. While these appear to be informed by different power and knowledge claims and relations, these two regimes of truth are both not only foundational within contemporary nursing practice but remain influential in the understandings and constructions of advocacy and autonomy that inform nursing practice. What this and the following chapters will thus provide is a further Foucaultian analysis that aims to examine more closely these regimes of truth and their various interactions as significant to the construction and maintenance of insider viewpoints, and finally to consider what these may mean in relation to contemporary nursing practice. What we consider through the application of Foucault's concepts is the way that different subjects, identities and practices are constituted and maintained through regimes of truth that, in effect, work to produce – and correspondingly to disguise and delimit – specific ways of understanding the world. Given my focus of understanding how nursing practice has become organised around ideals of advocacy and autonomy, Foucault's concepts will help me map the force and play of the discourses and relations that operate in and frame these ideals, as well as trace these relations as they interconnect in surprising ways.

This chapter thus focuses on unpacking the biomedical regime of truth, and how it has come to be conceptualised and enacted within nursing practice – thereby casting further light on the kinds of assumptions and practices shown to be taken for granted by nurses in the preceding thematic analyses. This analysis will utilise the participants' views and thoughts through excerpts from the thematic analysis along with insights from the observational data collected by the researcher. Together these strengthen the analysis and, following Foucault's lead regarding the cross-cutting operations of power and knowledge informing any regime of truth, examination of the hierarchical structures and operations of healthcare when conceived under the biomedical model. Because the focus at this stage of the thesis is on considering how nursing practice – as demonstrated by views of participants – is informed by operations of power and knowledge, participants pseudonyms have now been removed from the excerpts. This is a reminder that these excerpts are now treated as not descriptions of particular experiences of one participant or another, but as a documentation of the operations of power and knowledge that play out in nursing practice. After a brief reminder concerning the basics of the biomedical model, issues for consideration will include biomedical structures of health management, biomedical conceptions of professional expertise and the way this is maintained through disciplinary techniques of power such as techniques of diagnosis, the professional interpretation of signs and symptoms, and normalising judgements. Also examined will be the use of medicalising language or jargon, and the hierarchical framing and normalising of individuals into limited subject positions, particularly those of the patient as being a passive, submissive and obedient subject as well as an object that can be measured and examined. Finally, I consider key points where the biomedical regime of truth starts to fail in its own maintenance, where it appears no longer able to sustain its own normative models regarding the operation and professionalisation of the healthcare domain. It is at these points, after all, that it becomes possible to see the biomedical regime of truth being interrupted by, for example, the contrasting ideals of PCC (this to be the focus for Chapter Seven).

Biomedical Model

As has been discussed previously, the biomedical model is a health model, and a regime of truth, with its origins within the biological sciences. The Western biomedical model can be predicated by five interlinked principles that are comprised of mind-body dualism,[1] mechanical analogy, physical reductionism, the body as a focus of control, and there being causative factors of disease (Engel, 1977; Longino, 1997). As I have noted earlier, it was during the period of the Enlightenment – and explicitly in work by Descartes in the 17th century – that ideas developed that the body should be understood as a machine "composed of nerves, muscles, veins, blood and skin, [so] that though there were no mind in it all, it would not cease to have the same functions" (Descartes, 2000/1637, p. 49). Under this mechanical and clearly reductionist analogy of the body as a machine, the body is then treated as series of interdependent parts. Just as a car needs to be serviced regularly or when a car part needs replacing, the same analogy applies to the body, with the physician (doctor) taking the role of the mechanic.

As Foucault highlighted in the *Birth of the Clinic* (1973), this model of bodily mechanics came to dominate scientific thinking (Holloway, 2001), and came to be widely used in the categorisation and measurement of disease and other bodily conditions. Indeed, it was through this mechanical analogy that the scientific method was able to be introduced into the realm of health and the control of disease. Under this model, the biology of individuals became calculable, allowing the definition of particular signs and symptoms to align with particular diseases. This, in turn, allowed for the development and expansion of treatments for specific illnesses and diagnoses, and facilitated the development of control over public health and the spread of disease.[2] It is in alignment with these ideas

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[1] The mind-body dualism by Descartes (1996/1641) in his work *Meditations on First Philosophy* identifies that whilst mind and body should be understood as different substances, mental events can cause bodily events and vice versa. This means that the two entities, often separated in the Biomedical model (the body and the brain), are inextricably linked.

[2] An example of this is with regards to the 1854 Broad Street Cholera outbreak in the Soho District of the City of Westminster, London, England, which inspired one of the first studies done around germ-

that the current biomedical model reduces the individual – and disease – to a series of causally interlinked biological mechanisms (Borrett, 2013).

Hand in hand with this mechanical reductionism is a physical reductionism according to which the social and psychosocial aspects of the human being can tend to be ignored in the search for biological causes and, therefore, scientific and proven treatments that can be applied (Engel, 1977). This also informs the biomedical assumption which proclaims that each disease only has one (or one set of) causative factor(s). The effect of these assumptions is that under a biomedical focus, symptoms that are closely aligned with changes in pathology – rather than those that are unexplained or appear psychosomatic – tend to be given more credence and treated with more credibility.

These assumptions that inform the biomedical model are clearly evident within the practice standards and the guidelines for nursing practice. For instance, Standard 4 *Comprehensively conducts assessments* (NMBA, 2016) and Standard 5 *Develops a plan for nursing practice* (NMBA, 2016) [Appendix A] demonstrate the potential for nursing care to be reduced to the tasks that are required for the systematic collection of physical data and information that is then used to plan and implement patient care. Such frameworks clearly construct the patient's body as an object about which the nurse is collects information and must learn how to study. Thus, along with informing the professional standards, these same biomedicalised frameworks and assumptions regarding health and illness inform the educational preparation of nurses. Unsurprisingly, the educational preparation of healthcare professionals, including nurses, is strongly oriented towards the collection of concrete physical observations that can be used in the planning and implementation of care that focuses on the physical conditions of the patient. One example of this within nursing education is around patient acuity and patient deterioration. Here ideas of patient deterioration and the tasks of managing deteriorating physiology become the key focus, and other psychosocial and relational aspects of health care can often be shelved or forgotten (Goodman & East, 2014). This was mentioned by the participants as being the case in clinical practice:

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contaminated water as being a possible source for the spreading of cholera, challenging earlier assumptions of cholera spreading through the air. Snow proposed germ theory and that cholera was transmitted from person to person by the ingestion of contaminated water. The outcomes of Snow's investigations were that the Broad Street's water pump handle was removed and the idea of oral-faecal method of transmission of disease started to be explored (Eyeler, 2001).

> *When you are flat out and acuity is there, you're too busy putting up your electrolyte replacements and that's all the clinical side of it, without actually looking at the patient.*

That is, if nursing is viewed as mainly dealing with ill individuals within an acute care setting, the practices that tend to be constructed will be informed by the biomedical model where the focus is on developing skills and competencies that are necessary to function within this acute care setting (Goodman & East, 2014).

In alignment, then, with Foucault's (1973) recognition that a regime of truth orders realities, relationships and identities, the biomedical model clearly constructs specific ideas regarding professional expertise and practice. In the context of the biomedical regime of truth, professional expertise is reliant on a biomedical knowledge of medicine and nursing being developed through particular kinds of educational preparation and practiced within certain settings bound by professional standards. More specifically, professional knowledge is developed through gaining the biomedicalised understanding of alterations in pathology and symptom manifestation, and further maintained through an institutional system (and surveillance) of norms and practices, according to which professionals are able to determine what is normal and abnormal (White, Faithfull & Allan, 2013).

This is Foucault's point, again, that the power relationships inherent in any regime of truth determine what types of knowledge are elevated to truths, which then become normative and work to construct realities (Foucault, 1973; Porter, 1996). To put this another way, the biomedical regime of truth maintains itself through its management of what it takes to be – and not to be – the normalised structures, practices and responses of healthcare. While some of the processes of this management are identifiable in both the practice standards and the guidelines for nursing practice discussed in Chapter Two, and in actual nursing practice as discussed in Chapter Four, others are less so. The remainder of this chapter thus engages a range of Foucault's key concepts to unpack in more detail the otherwise normalised structures, practices and responses of healthcare when understood in a biomedical model. The importance and significance of this will become clearer as the contradictory ideals and assumptions surrounding advocacy and autonomy that appear to influence contemporary healthcare and nursing practice within the Australian context are further examined.

The biomedical model in Structure and Practice

If, on the one hand, the biomedical model requires medical professionals to attain certain kinds of knowledge in relation to the identification of signs and symptoms of disease and with regards to its treatment (Foucault, 1980/1972a), another part of its success is in relation to its development of an institutionalised structure for healthcare. This, of course, is what Foucault (1973) has referred to as the birth of the clinic. That is, Foucault (1980/1972a) observes that the current hospital institution was explicitly set up as a way to combat the ravages of disease by providing a place where there could be constant, systematic and comparative observation of individuals with diseases.

As has been previously discussed not only is this aim clearly informed by biomedical assumptions of heath and disease, it is also in keeping with Foucault's (1977) ideas of panopticism.[3] The panopticon style design has been systematically applied within the institutionalised setting of the hospital as an architectural design to support practices of control and surveillance (Foucault, 1977). That is hospital environments have been designed to provide the healthcare professionals with the vantage points for surveillance to occur easily and without impediment. In one sweep of the traditional four-bedroom configuration, for example, the nurse is able to quickly survey and account for all patients (St-Pierre-Holmes, 2008). Certainly, the nurse relies on each patient remaining within that space for surveillance to occur but moving around the hospital without medical permission is discouraged by physical models of mechanistic monitoring and the imposition of new routines.[5]

That is, not only does the architectural design of the hospital deliver panoptic effects but the disciplinary procedures that are commonplace in nursing practice, such as patient examinations and the taking of observations, and the routines of nursing care, work to simultaneously individualise and normalise the body in specific ways. These thus become part of the techniques of surveillance that are characteristic of healthcare. Not only does this arrangement function to increase efficiency in disease and health management (Driver, 1994), but it is fundamental in the automatisation and disindividualising of power

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[3] Please see Chapter Five for a detailed description of the panopticon.

[5] Certainly a patient can always try to carry out an act of resistance by choosing not to stay in the room and instead to wander the corridor – an act that arguably removes him or herself from the observation and surveillance of the nurse for a period of time – but achieving this in a hospital gown and while attached to a range of monitors makes this a difficult accomplishment for many.

(Foucault, 1977; McHoul & Grace, 1993; Rabinow, 1984) which inform the power relations constructed between patients and health professionals. In particular, as Foucault (1977) points out, the arrangement produces both professionalised experts (doctors and nurses, for example) and patients as docile bodies. The construction of these different subject positions is considered in more detail below, starting with the construction of professional expertise and an examination of the techniques of power these subject positions depend on.

Professional Expertise

As has been already unpacked, under the biomedical model the doctor/physician[4] is explicitly constructed in what Foucault would call the dominant subject position – as the expert – due to their education and expert practice with regards to their treating and diagnosing of illness. Nurses and other medical professionals are also constructed as holders of expertise, although this is conventionally less than that held by doctors. These experts, then, are given charge of the care and treatment of the patients who – either through their own volition or as a consequence of illness or accident – enter into the healthcare setting. Patients, in their turn and as will be discussed below, are constructed as being in need of and subject to professional expertise, meaning that their entry into the healthcare setting instigates a structure of treatment. This care begins with a diagnosis for the individual which, in turn, depends on certain understandings of signs and symptoms and the normalising of biomedicalised judgement.

Diagnosis

The functionality of the diagnosis is not only to be able to individualise care and to provide appropriate treatment, but also to ensure cooperation from the patient in relation to treatment options and compliance. Diagnosis is central to the biomedical model and works on the basis of experts being able to identify and define deviance of the body from what had been normalised. Foucault (1991/1978) thus refers to diagnosis as the conceptualisation or construction of something that is considered to be different from the norm, and which, therefore, allows for a classification of separate states and distinct categories that can then be applied and responded to. Diagnosis hence works as a label which provides a subject position for the patient which can then be used by other experts

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[4] Due to the history of gendered access to the profession, these dominant subject positions tend to be held by males. Indeed, there is still a conventional gendered dominance with the role of the doctor tending to be held by men and the caring and nurturing role of the nurse tending to be held by the often subservient and female nurse.

or themselves, as well as by immediate family and friends.[5] For example, for many individuals a diagnosis of cancer usually brings connotations of death, or treatments with chemotherapy or radiation therapy, and subsequent bodily changes such as losing hair or having to have radical surgeries such as mastectomies.

What the diagnosis stage thus provides is an individualised and personalised way of knowing what is wrong for each individual. But this requires, as discussed earlier, the individual seeking advice and treatment from the healthcare professional. This can arguably only be done when individuals choose to adopt the sick role (Parsons, 1951), or as noted above via the consequences of accident. In exemplifying and supporting the power of the medical professional and notions of professional expertise that are privileged and supported in the biomedical model (Burnham, 2014; Varul, 2010), the sick role allows the physicians to act as gatekeepers who then, through the process of diagnosis, can legitimise the sick role for individuals and give them permission to be ill (Burnham, 2014; Frank, 2013; Glenton, 2003; Jutel, 2009; Mik-Meyer & Obling, 2012; Tarber, Frostholm & Rehfeld, 2016).

The sick role, in combination with the institution, gives power to the medical professional. The medical professional is seen to have the knowledge and expertise within this particular setting to construct and subjugate the individual as a patient or a case, thus separating them from their personhood and disempowering them (Rose, 1994). More specifically, once an individual steps into the sick role, this role, when combined with those of the diagnosis, provides proof of existence and legitimacy of a medical condition and works to construct disease and illness (Rose, 1994). As Foucault would thus stress, the sick role exemplifies the use of technologies of the self, as explained previously in Chapter Five (Foucault, 1977), where the individual is expected to discipline themselves. Accepting this specific subject position thus marks an acceptance of the knowledge and power of the medical gaze to read the body (Lupton, 1997; Varul, 2010). It also marks an acceptance of the need to work towards getting better and, therefore, of the role of the healthcare professional in facilitating the individual to achieve a state of wellbeing that is internalised and normalised (Holmes & O'Byrne, 2006). That is, once an individual has

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[5] By providing a label through diagnosis, health professionals not only determine care and medical treatment but, thanks to public health campaigns and modern media, also frame patients in terms of the dramatised versions of health and illness made popular by television shows such as *Gray's Anatomy* and *All Saints*.

been given a diagnosis, they are constructed as a patient and as such, as noted with reference to the operation of the sick role, expected to conform and behave in certain ways.

Signs and Symptoms

When a diagnosis – say, for example, the diagnosis of diabetic ketoacidosis (DKA)[6]– is identified within the biomedical frame, what is understood by this is both constructed and normalised through the practices of biomedicalised expertise. As has been noted, a diagnosis provides for healthcare professionals a way of viewing patients with DKA (or other conditions) and provides a standardised understanding of treatment options for these patients. What this work also does is delineate between what is considered to be a sign and what is considered to be a symptom (Burnham, 2014; Malterud, 1999). That is, symptoms tend to be constructed, discovered, experienced and reported to the healthcare professional by the patient, often forming the basis of the initial consultation for the patient with the healthcare professional (Weatherall, 1996). It is during the scrutiny of the medical examination, a form of surveillance that comes under a Foucaultian understanding of disciplinary power, that this symptom is then constructed into a sign. Foucault (1980/1972a) recognises that this is part of the hegemony of the biomedical regime of truth in that it has the authority to interpret and read the body and to give it meaning that the individual who is experiencing the symptoms cannot.[7]

Through the process of diagnosis, as alluded to earlier, the adopting of the sick role, or at least seeking medical intervention at the emergence of symptoms, is the first step within the diagnostic journey through the healthcare system and process. As the patient in the sick role becomes governed, it is up to the healthcare professionals to elicit information from the patient to aid in the diagnostic process. Foucault likens this to a confessional process (Foucault, 1990/1978). Although the idea of the confession has its origins as a religious practice, its application can be seen as well-established within healthcare. More

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[6] Please refer back to Chapter Four, footnote 12 for discussion around this diagnosis and the patient who presented with this condition.

[7] This is an important point insofar as the Biomedical model, by definition, privileges only certain aspects of experience in its models of diagnosis, the identification of symptoms and the carrying out of normalising judgements. More specifically, what such a model typically fails to give importance to are the social contexts of illness that may be influential in a patient's condition and, therefore, in the control and management of illness and disease (Foucault, 1991/1978; Osborne, 1993). The example provided within Chapter Four of the patient who was being treated for DKA, and who was noncompliant with his diabetic treatments and wanted to discharge himself against medical advice instantiates this. What this patient's argument for discharge demonstrated was the complicated social contexts of health and illness that tend to be disregarded or misinterpreted within the Biomedical model of healthcare.

specifically, the confessional becomes a process – and one that Foucault (1990/1978) describes as cathartic and truth producing – through which subjects, or patients, feel almost compelled to divulge information (or their sins) so that the healthcare professional is able to come to know the subject and to diagnose and ultimately treat them. If we take the idea of confession as the ability to produce a 'truth', then a confession is a very powerful form of disciplinary power that medical experts have at their disposal within the healthcare relationship. This is because what patients 'confess' to can be used to produce and manipulate truths that are useful for the medical experts in relation to providing care and making patients discipline their own existence. Foucault refers to this as a mechanism of pastoral power (1982) where the disclosure of information encourages self-examination and acts of conscience. The diagnosis and this confessional process are thus important parts of the arsenal of the healthcare professional in relation to the surveillance and ultimately the (self) disciplining of the patient (Fejes, 2008; Holmes & O'Byrne, 2006; Rolfe & Gardner, 2006)

The confession in healthcare takes place on admission to a healthcare facility where the patient is expected to tell all about their previous health encounters and to confess their indiscretions in relation to social expectations around health and illness. This would include the person's use of illicit drugs, the use of alcohol, and their sexual history. All of these areas are thus covered on the health history and pre-admission assessment that nurses collect on a patient when they are admitted into an acute care setting. Confession, in other words, works to classify the subject and produce a certain truth about that subject.

What can also be noted is that through the confessional health examination, patients may feel compelled to divulge parts of their lives that may not be directly related to the illness that they are seeking diagnosis and treatment for. One such example that became apparent within the observational data was in relation to a patient who had come in with an exacerbation of Chronic Obstructive Pulmonary Disease (COPD). This patient wanted to go home early due to significant concerns about other aspects of his personal life. This particular patient thus disclosed that his wife has significant mental health issues and that he has two teenage children, one of whom he refers to as a junkie and in trouble with the law. Insofar as the use of confessional practices works to maintain docile bodies and self-discipline (Foucault, 1990/1978; Rolfe & Gardner, 2006), it is also aligned with the obligations of the sick role where the patient is required to fulfil certain obligations to fulfil the socially sanctioned role. Because confessing to the healthcare professionals means the patient starts to give control to the healthcare professional, in some respects it also traps the patient in a relationship of unequal power with medical experts.

Normalising Judgements and Behaviours

Normalising judgements are also tools used to measure and categorise the abilities or qualities of subjects (Foucault, 1982b), and are fundamental to the operation of diagnosis and the identification of symptoms. Part of the power of the medical profession, normalising judgements work to identify the 'norm' and subsequently treat deviation from this 'norm' (Foucault, 1973). This, again, is often part of the artillery in the examination of the subject, particularly in the practices of healthcare under the biomedical model. For example, when a patient is admitted into a healthcare facility it is routine practice for a nurse to do what is often referred to as a base line set of observations (obs). What this allows the healthcare professionals to note is what may be considered normal for this particular patient and it allows for the subsequent measurement of abnormal or deviant readings post this measurement. Normalising judgements also allow healthcare professionals to broadly assign normality against what we would normally expect to see in a patient with a particular condition or disease process. Foucault (1973) recognises that this allows the professions to identify designated individuals as cases or as subjected objects of power/knowledge relations. This in turn further entrenches the dominance of both the medical institutions and the biomedical model (Foucault, 19801972a).

Overall, such practices work to establish what the medical fraternity refers to as the 'norms' of disease, and further increase the knowledge – and, Foucault would say, power – attributed to the medical profession. That is, these normalising judgements allow healthcare professionals, with a certain degree of certainty, to predict and treat patients with a similar condition in the same way. Recognised as the gaze of the discipline, and working to classify and judge (Smart, 1995), such judgements are part of the technical skills and professional expertise of the professional (McCarthy, 2005). They not only make the individual visible as a patient, but maintain dominance over them (Fairclough, 1992).

Insofar as the normalising gaze effectively informs and defines the clinical parameters used on the track and trigger charts routinely used in nursing documentation to chart patient's progress, such judgements have been evident in both the interview data and the observational data collected for this thesis. This is particularly because the normalising gaze is very evident in the area of clinical deterioration. For instance, one of the areas where data was collected for this thesis was in a higher acuity four-bed area where patients who required higher levels of care were placed. Track and trigger charts enable a visual representation of patient deterioration and make it easy for nurses and other healthcare professionals to visualise and pick up clinical deterioration in patients. If a patient has criteria that are within reportable limits as identified on the track and trigger charts, then it acts as a mechanism to allow the nurse to escalate care for the patient to include medical emergency team (MET) calls to ensure quick and efficient assessment and treatment for the deteriorating patient.

The Medicalising of Language

What the preceding discussions have made clear is that one of the key aspects of the power of the medical profession under the biomedical model has been the development of what may be called medical empiricism (Osborne, 1993). Medical empiricism refers to ideas around production of knowledge in relation to medicine that sees knowledge as needing to be based on experience and observation (Pentzopoulou-Valals, 1990). Fundamental to practices of diagnosis, the identification of symptoms and the development and making of normalising judgements, the empiricism of the biomedical model has also supported the emergence of its own specialised language. It is through the use of this language that the experts of biomedicine are able to interpret, examine and normalise disease and the sufferers of these diseases.

Within the thematic analysis set out in Chapter Four, for instance, it was evident that many of the nurses referred to individuals based on their diagnosis, for example the *oncology patient* or the *by-pap patient* or the *DKA patient*. This referencing of patients again demonstrates the biomedical tendency to reduce the patient to a set of recognisable and treatable signs and symptoms. It is also noteworthy that the nurses assumed that, due to the diagnosis of the patient, she would be then able to accurately predict what would happen next and that the progression of his disease:

> *This man's an oncology patient so I knew what was happening and why he was awake and also had to then move on to those ends of life care….*

Such use of language also supports the reduction of nursing care to the completion of medicalised tasks. For example, Rebecca talks about how the delivery of nursing care easily becomes the work of “putting up their electrolyte replacement” or “doing an hourly sugar”, almost as if other models for patient care should be secondary to the achievement of the scientific or biomedicalised work of nursing. Chapter Four also made clear was that it is common practice in the healthcare profession to refer to patients by their disease processes. As has been noted, handover often shows nurses conversing about bed numbers, diseases, tests and treatments, and rarely do you hear in handover about Alice who had her grandchildren come and see her today.

In other words, then, this expert language clearly delineates between lay knowledge and the expert knowledge common to the profession (Olson, 2002). The professional boundaries it erects, and supports are thus formalised in a range of ways through education and practice. For nursing professionals this is through their education and within the Standards, Codes and Frameworks that regulate the nursing profession. What is also clear is that these professional boundaries further operate to regulate and make nurses accountable in relation to nursing care.

While medicalising language is used to diagnose and as a mechanism of power for the healthcare professionals, if we view it from the perspective of a patient, medicalising language can also often be at direct odds with the subjective explanations of health and illness that patients provide. This can lead, as described by Barbaro, Opoczynska, Rostworowska, Drozdzowicz and Golanski (2008), to patients denying their experience in the process of diagnosis. However, as Barbaro et al. (2008) also note, when a patient conforms and begins to use the same language as the medical professionals, this can be almost claimed as a victory for the healthcare professional. That is, it shows that the patient has begun to internalise and accept the medicalised norms of illness and health as well as conform to the ideals of the patient role. When this occurs, patients demonstrate their acceptance of the rules of the institution, the language, the power of the healthcare professionals and the associated normalised rituals and symbols that go along with this (Barbaro et al., 2008). They become the patient; docile, they enter into the subject position set for them by the biomedical model.

Subject Positions

What is clear, then, is that the biomedical regime of truth facilitates the creation and promotion of certain identities, or subject positions, as available for individuals to enter into. As has been discussed in the previous chapter and shown above, Foucault (1980/1972b) argues that subject positions are determined by assumptions, practices and rules that determine the position, role, authority and efficacy of any speaker within a regime of truth. The availability of subject positions and where these positions are located discursively can be determined by either the speaker or by others who are deemed to be in positions of authority (Dreyfus & Rabinow, 1982). The subject position that can be adopted, or is given to an individual, shapes the roles and the identities (subjectivities) that are then available to that individual within that normalised regime of truth.

Entering the biomedicalised healthcare arena, each of the available subject positions – those of different kinds of health professionals and patients – marks an entry into social interactions and differing power relationships which are constructed and determined by already normalised discursive rules and practices. That is, Foucault (1994/1970) recognises that when an individual enters into or speaks or acts in accordance with a certain subject position, there is a historical and a subjective being that is influential in the process. In addition, the significance ascribed to a regime of truth and associated frameworks and discourses that the individual sees themselves as operating within influence that individual's taking up of subject positions and consequent responses to events.

In terms of the biomedical model, then, healthcare professionals hold the most authority. Nurses, as professionals and experts in the arena of healthcare, become legitimised speakers of the medical discourses – even if subject to the doctor's higher levels of authority and expertise – while patients take up the position of docile subjects (Foucault, 1977). Indeed, within the biomedical healthcare context, patients are expected to be docile insofar as they are required to be used, transformed and improved (Foucault, 1977). As has been discussed above, for the patient this has been meant being diagnosed (subjected), examined (used), tested (transformed) and cured (improved). Such judgements clearly function as objectifying practices (Foucault, 1977) which reduce patients into passive objects within the healthcare relationship (Borrell-Carrio et al., 2004). We can see this clearly in an example from Chapter Four where a patient is expected to remain a docile subject in relation to understanding and responding to the complexities of their treatment. One of the examples that we discussed in Chapter Four was in relation to the patient who wanted to have a cigarette immediately after returning to the ward after a general anaesthetic. This request was refused by the nurses and the patient, although begrudgingly, became complaint and docile.

What this example also highlights is that the success of these practices relies on the adoption of such subject positions by the individual themselves and the internalisation of this position. The self-maintained docility of patients as they enter into the sick role is one obvious outcome of these practices. However, healthcare professionals, with all of their educational preparations and constant professional surveillance, also need to be recognised as disciplined and, therefore, docile bodies. That is to say that the same norms and judgements that construct patients, also construct tight parameters – articulated through the various standards for healthcare, for example – for the behaviours of healthcare professionals. Indeed, it is these kinds of normalised behaviours – a form of docility – that work to establish nurses as professionals who are then able to take on the role of turning their disciplined status onto others so that these others can maintain their own (self) disciplining (Frank, 2013). Once again, this is only possible due to the professional expertise nurses come to hold – and are recognised as holding – through their educational preparation into their role as well as their professional knowledge.

It is also important to keep in mind, however, that subject positions are not completely fixed. After all, there are always a number of conflicting and alternative positions which can be taken up by a subject at any particular time, relevant to all of the roles ascribed in healthcare practices. Indeed, Foucault consistently argues that all subject positions hold spaces for acts of resistance which have the potential to revise relationships of power. Such points of resistance, Foucault stresses, cannot be underestimated in their effects with regards to challenging not only the assumed docility of the patient, for example, but also the positioning of doctors and nurses as experts holding the power in the relationship. In one of the examples given above, it is clear that the patient is trying to move from acting the docile subject by demanding that he should be able to discharge himself at his own risk. Although in this instance the attempt at resistance by the patient was ineffective – the nurse used the privileged position of the doctor to entice the patient to comply with her request, in this case to stay until the doctor had come and reviewed him – such attempts show the potential of resistance to these kinds of disciplinary techniques.

Becoming a subject and taking on a subject position is, thus, always influenced by the disciplinary techniques used by those in positions of power to train individuals into the docility required (Foucault, 1977; Rabinow, 1984). As has been discussed in this and the previous chapter, these techniques include, but are not limited to, hierarchical observation, normalising judgements, and processes of diagnosis and examination, along with the use of language designed to uphold expert authority (Foucault, 1977; Rabinow, 1984). We can also see the correlation between the institutionalised nature of the healthcare setting for the biomedical model insofar as the focus is consistently on the reduction of the patient to issues of illness and bodily dysfunction. To reiterate, within the biomedical healthcare setting the body is often abstracted and theorised through processes of surveillance, which reduce it to minute and isolated parts (Candlin & Candlin, 2002). Within this setting healthcare professionals are considered responsible for the surveillance, measurement and reporting of the body in relation to any deviations from relevant norms (Candlin & Candlin, 2002). This, as has further been noted, is also work that is expected to be undertaken by patients of themselves and others.

Criticisms of the biomedical model

The persistence of this particular regime of truth, the biomedical model, is mainly due to its success in its ability to treat diseases and situations in public health that at one time would have been catastrophic in populations (Adibi, 2014). One such example is the introduction and broad scale roll-out of the smallpox vaccination. However, despite its very evident advances in understanding diseases and their treatments, the biomedical model has also been criticised from both within medicine and from such social and behavioural disciplines as sociology and psychology. At the heart of this criticism is its reliance on assumptions concerning the dualism of body and mind and its continued downplaying of the importance of the subjectivity that informs the ‘lived body’ (Adibi, 2014).

As has been discussed earlier, the biomedical regime of truth is based on the premise that every disease has a specific pathogenic origin that can be treated through either removing or controlling the causative agent through the use of medical technology, a medical procedure or pharmaceutical treatment (Adibi, 2014). By placing both diagnosis and treatment within the realm of bodily mechanics, the result is that sickness or illness has come to be regarded as a purely physical event, with a causative agent such as a germ, virus, cancer, or genetic affliction being the basis of any dysfunction. This can mean that illnesses that cannot be treated with this option may be placed in the too hard basket or labelled – and hence problematised – as psychological in nature.[8]

Another criticism of the biomedical model is its tendency towards victim-blaming. Victim-blaming within healthcare is multi-faceted and can be linked to many factors. Usually victim-blaming arises from the attributional systems that are accredited to the patient (Bergman, 2018).[9] Bergman (2018) refers to this as focusing on victim characteristics, for example when a person is considered to be obese. The healthcare professionals, if we follow the work of Bergman (2018), finds that through the process of victim-blaming internal attributes about the victim can be constructed that then make it easier for the healthcare professional to blame the person for being obese and, therefore, unwell.

This is then supported by the policies, the training and the practices that all support the nurses to see the patients as 'victims'. Documentation made by healthcare professionals about patients can also support the victim-blaming cycle and the attribution of negative labels to patients (Brondari, Alan & Donnelly, 2017). Brondari et al., (2017) suggest that victim-blaming allows the perception that some individuals are inferior and unworthy and may have brought their illnesses and complications on themselves through poor lifestyle choices. As Watt (2007) suggests, the victim-blaming cycle fails to acknowledge and address the underlying social determinants of health. Engel (1977) notes that the traditional conceptualisation of the biomedical model, in its separation of physical from psychosocial causes of illness. Therefore, it is not able to adequately explain health and illness within today's society (also see Cockerham, 2007). This is mainly due to the

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[8] An example of this can be seen within the observational notes when the speech therapist is doing an assessment on an elderly male patient who is complaining of having swallowing difficulties. The speech pathologist talks to the nurse about patient D after her review. The speech pathologist cannot find any reason for the patient to be having swallowing problems and states that it is probably all psychological. She states *"some patients are just hypochondriacs"*.

[9] When discussing attributional systems in relation to victim-blaming what is being referred to is the motivation to assign causes to actions and behaviours and explain the causes of both behaviour and events. Attribution can be external based on the situation the person find themselves in or can imply internalised behaviour often linked to influencing factors such as culture.

social, cultural, and psychological considerations that are also now recognised as influencing health and illness (Engel, 1977). These factors will be explored further in the coming chapters and how these interplays to influence advocacy and autonomy in contemporary nursing practice.

Conclusion

Within this chapter I have examined the biomedical regime of truth, and how it has come to be conceptualised and enacted within nursing practice – thereby casting further light on the kinds of assumptions and practices shown to be taken for granted by nurses in the preceding thematic analyses. Initially, it is clear that the concept of professional expertise is extremely influential within the relationships endorsed by this regime. This is demonstrated by the privileged position afforded health professionals from their educational preparation. The chapter has considered in more detail the application of Foucault's (1977) discussions of disciplinary power in the context of the biomedical regime of truth as being played out through such techniques as normalising judgement, hierarchical observation and the processes of examination and diagnosis. These disciplinary techniques of power function to produce what Foucault referred to as the docile body, a body that this regime of truth allows to be considered in discrete parts and thus treated, examined and cured. Through disciplinary power the body of the patient becomes an object which is able to be measured, examined, categorised and then treated in various ways tending to ignore the psychosocial issues that patients experience. This can occur at the individual level within nursing practice – for example through the taking of observations – but it can also happen on an institutional level in terms of cohorting patients based on diagnosis. This means that patients, once they have been categorised, would usually be housed on a ward with the same types of patients.

Although the biomedical regime of truth does seem to be effective in explaining many of the practices that remain visible within the clinical setting and identified by some participants, further and deeper exploration is warranted as there are alternative views and subject positions – indeed regimes of truth – that appear evident in the experiences of the participants also have the potential to influence nursing practice. As Foucault has stressed, not only are there always points at which individuals are able to disrupt the normal functioning of a regime of truth and the subject positions and relationships that regime has positioned them in, it is also important to understand that within any given instance there can be several regimes of truth in concurrent operation. Some of these other regimes of truth identified through the views of the participants will be discussed within the upcoming chapters, having been already touched upon in both the Thematic Analysis and within the Literature Review. Indeed, one of the key themes visible within the thematic analysis was a possible rebuttal of the biomedical model of healthcare. This was an argument made by the nurse participants of this study that what should matter is actually the person not the condition. Such a view is supported through the idea of PCC, and this – presented and discussed as itself being a regime of truth – forms the basis for my discussions in the next chapter.

Chapter 7 – Examining the Patient Centered Care Regime of truth

Introduction

In previous discussions – of the literature, of policies, and with nurses that participated in this study – what became visible was the normalisation of certain understandings of healthcare practice, as well as some of the tensions that these give rise to with regards to presuppositions and practices of advocacy and autonomy within that context. It is important to understand, as we discussed in the previous chapter, that the functioning and interactions of these normalised understandings – as what Foucault would call 'regimes of truth' – is being examined in order to throw greater light on the construction and maintenance of the insider viewpoints that became visible through the participant voices and reflections as set out in the thematic analysis in Chapter Four. What also becomes evident is that there are tensions between some of these normative understandings and the insider perceptions of these regimes of truth that have presented possible points of contradiction within contemporary nursing practice. To better understand these tensions and points of contradiction, a turn was made to Foucault's ideas as offering strategies for considering and interrogating the impacts and tensions of normalised understandings of power and expertise within nursing practice.[1] These tensions and points of contradiction are supported and exemplified with excerpts drawn from the Thematic Analysis. The first of these normalised understandings which I named the biomedical regime of truth was thus explored using Foucault's insights in Chapter Six. It was also within this chapter that a counterpoint to this regime of truth was identified, that of Patient Centered Care (PCC). Thus, within this chapter the focus is to further explore PCC as itself marking a regime of truth, with the aim of unpacking and mapping its operations and their impacts on healthcare constructions, practices, processes and people.

In the context of this thesis, PCC is understood as standing for care that is responsive to individual patient preferences, needs and values (Van Der Eijk et al, 2013). This kind of definition of PCC is also embedded within the Registered Nurse Standards for Practice (NMBA, 2016) and also in Australian state and federal government documents that support clinical nursing practice. These latter include the discussion paper produced by

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[1] In Chapter Six, for instance, Foucault's concepts were shown to be effective in making visible the ways in which different subjects, identities and practices can be constituted and maintained through a regime of truth and, further how they work to produce specific ways of understanding the world.

the Australian Commission on Safety and Quality in Healthcare (2017) on Patient-Centered Care. It is through such documents that the key principles of PCC can be identified and defined, along with how these principles shape nurses and nursing care within the contemporary healthcare context. It is also within this framing that we start to see how PCC can be understood as a counter position to, but also entangled with, the biomedical regime of truth. These points will be considered in the section below.

When PCC is considered a regime of truth – just as the biomedical model – it also becomes important to map how it is operationalised through the kinds of subject positions, relationships and practices that its principles construct and normalise. The second part of this chapter thus looks at how PCC facilitates the construction of certain kinds of relationships and subject positions in order to present and normalise a particular model of nursing and healthcare. Through such relationships – shown to be built on processes of trust and rapport rather than the top-down processes of expertise typical of the biomedical model – the aim of PCC, as will be shown, becomes one of empowering patients to take an active role in their care. Empowering patients, as the PCC model promotes, can then allow patients to share the burden with healthcare professionals, facilitating the process of shared decision-making. These relationships and attendant processes, in turn, make available certain kinds of subject positions for healthcare professionals and patients that differ significantly from those made available and enforced in the biomedical regime of truth.

The final section of this chapter examines some of the main factors that can act as barriers to PCC. These include fragmentation of the healthcare system and confusion around terminology. Also considered is the potential discrepancy between PCC's promotion of empowerment and the institutionalised nature of healthcare, with its routines and inflexibility. The latter, it has been proposed, might constitute a barrier to the implementation of PCC. The final point considered is the possible tension between contrasting subject positions, for instance between those of the patient as being constructed alternatively with different capacities in the biomedical regime of truth and PCC. Such tensions can, as will be explored, mean that patients can themselves be their own barriers to the effective implementation of PCC. These tensions can also lead to failures in the construction and maintenance of the therapeutic relationships required by the PCC regime of truth. All of these can influence the constructs of advocacy and autonomy within contemporary nursing practice.

Patient-Centered Care in Structure and Practice

There are many ways to define the concept of PCC, and many terms are used interchangeably in such definitions (for example, the term patient-centeredness). PCC has thus been referred to as client and person-centered care, consumer-centered care, personalised care, family-centered care and patient engagement, just to name a few (Gluyas, 2015). Most basically, it is considered to involve treating people as unique individuals and customising care specifically in relation to their needs (McCance, Gribben, McCormack & Mitchell, 2010; Marshall, Kitson & Zietz, 2012). Many definitions thus incorporate ideas about being responsive to the values, beliefs and preferences of individuals (Gill, Dunning, McKinnon, Cook & Bourke, 2013; Pelzang, 2010; Santana, Manalili, Jolley, Zelinsky, Quan & Lu, 2018; Scambler, Gupta & Asimakopoulou, 2014), specifically in relation to the planning, coordination and delivery of care (Gluyas, 2015). PCC furthermore proclaims to work from a holistic view of health and healthcare that takes into consideration the physical, psychosocial and social needs of the individual (Voshaar, Van de Laar & Van Den Bemt, 2015). In pragmatic terms, as will be discussed throughout this chapter, PCC – in some instances referred to as 'new nursing' (Porter, 1996) – marks an attempt to take into more account the experience of health and illness of the individual, and facilitate patients having more control over their healthcare (McClimans, Dunn & Slowther, 2011; Atinga, Bawole & Nang-Beifubah, 2016).

Such an orientation is, of course, in direct contrast to the biomedical regime of truth where the focus is on the expert managing the signs and symptoms of a patient's disease and illness. As has been discussed previously, the biomedical model is reductionistic, reducing the individual to its operational basis of disease and pathology. This, as discussed, was considered to make patients easier to treat and diagnosis. The PCC framework to healthcare, with its holistic approach to care, is thus diametrically a different construction of healthcare practices and relationships.

The 2016 NMBA Registered Nurses Standards for Practice provides a comprehensive definition of what PCC (they refer to it as person-centered practice in this document) entails within its glossary (please refer to Appendix A).[2] Under this definition, the underlying principles of PCC are collaboration, respect, mutual trust and understanding, and good communication. In particular, it is understood that a key role of PCC is to protect the dignity of the person and to assist in empowering them in relation to decision-making within a healthcare setting. Of course, this is a key role for the nurse as an advocate, as espoused in the literature, and a way in which a patient's autonomy is upheld by the nurse. As will be seen, such practices lead to constructions of relationships and processes incorporating not only the patient's views, but also those of the family, community and significant others, as well as respecting cultural and religious diversity (NMBA, 2016).

This definition is carried through into the standards, albeit sometimes in ways that appear reliant on individual interpretation. There is, for example, *Standard 1: Thinks critically and analyses nursing practice* (NMBA, 2016). When the excerpt explaining this standard is examined it refers to using strategies and best available evidence in relation to making decisions, but frames this in terms of providing safe, quality nursing practice within person-centered and evidence-based frameworks (NMBA, 2016). More specifically, 1.3 talks about respecting all cultures and experiences, including responding to the role of the family (NMBA, 2016). Goodrich and Cornwell (2008) and Abdelhadi and Drach-Zahavy (2011) have also identified that one of the key principles of PCC is the inclusion of the patient/person and their extended support networks (for example family members, community members and spiritual supports) in healthcare decision-making. Indeed, unlike the biomedical regime of truth, PCC explicitly acknowledges and accepts that patients are entrenched within a network of relationships that are culturally and socially situated (Abdelhadi & Drach-Zahavy, 2011) and which are as such also important within the regimen of healthcare and patient progress. This was something that was not lost on the participants interviewed, who themselves came from culturally diverse backgrounds. As they noted, cultural interpretations of health and illness are far-reaching and can have requirements for extended familial decision-making, or for males to make decisions on

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[2] The Australian Commission on Safety and Quality in Healthcare (ACSQH) also produced a discussion paper in 2011 on Patient Centered Care. Not only has this discussion paper been instrumental for the development of PCC frameworks, but PCC frameworks of care are also supported by the Australian Charter of Healthcare Rights, the Australian Safety and Quality Framework for Health Care, and the National Safety and Quality Health Service Standards (ACSQH, 2011).

behalf of the family in patriarchal frameworks. As one nurse identified, *"what we might not think is right is, is right for them"*.

It is perhaps Standard 2 that has the most importance for the practising nurse in relation to PCC. *Standard 2: Engages in therapeutic and professional relationships* (NMBA, 2016), discusses engaging in therapeutic relationships that are based on mutual trust and respect. Item 2.2, extending points in 1.3, distinguishes that communication should be effective and respectful of a person's dignity, culture, values, beliefs and rights (NMBA, 2016). Item 2.3 explicitly recognises that people are the experts in their own illness and their life experiences are valuable within healthcare experiences (NMBA, 2016). Item 2.7 refers to how other healthcare professionals can collaborate to provide a culture within healthcare that enables the sharing of knowledge and practice that develops and fosters person-centered care (NMBA, 2016). *Standard 3: Maintains the capability for practice* (NMBA, 2016), specifically 3.2, refers to providing information and education to people so that they are able to take control over their health. *Standard 5: Develops a plan for nursing practice* and *Standard 6: Provides safe, appropriate and responsive quality nursing practice* (NMBA, 2016) stress that planning for nursing care should be agreed upon with relevant persons, although it is not specified who these persons actually should be. Broadly speaking, however, one of the assumptions that is normalised throughout PCC is the importance of the engagement of the patient and their significant others in the patient's personal care and decision-making.[3] It is clear that this can only be achieved through communication and the sharing of information with patients, carers and their families. All of these components of these standards works to understand how a patient's autonomy can be influenced. However, they also go to highlight the role of the nurse in relation to advocating for the patient to support autonomy.

What should thus be evident is that PCC can be understood as a counter position to the biomedical regime of truth within healthcare[4] and is explicitly constructed as a way for

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[3] Interestingly, this new assumption has also been framed recently in more biomedical terms. That is, it has been identified in the discussion paper by ACSQH (2011) due to the increased rates of complex and co-morbid conditions that patients are presenting with. With the increase of more chronic conditions where patients are presenting with more co-morbidities and often sicker, the concept of self-management has been highlighted as being a useful strategy for managing patient care (135-137).

[4] This inclusion of broader social networks into the care of the patient can also be aligned with the broader conceptualisation of the biomedical model proposed by Engel (1977). This was what he called the biopsychosocial model. This model was an attempt to broaden the approach to disease to include some psychosocial dimensions without sacrificing the enormous advantages of the biomedical approach. This

healthcare professionals to partner with patients (and their families) to deliver and develop individualised care (Santana et al., 2018). As was discussed in the previous chapter, the biomedical regime of truth saw the relationship between the patient and the healthcare professional as being based within a framework of care informed by a model of professional expertise. This is made evident in the work of Delaney (2018) who states that traditional – further, paternalistic – approaches to healthcare saw medical practitioners instruct and prescribe treatments to patients with little or no input from patients and families. Such attitudes were clearly illustrated in the previous chapter through elaboration of the regime's constructions and maintenance of hierarchical expertise and its mechanisms of examination and diagnosis that work to maintain professionals in positions of power according to which the 'doctor knows best'. Although these constructions still clearly hold some weight for healthcare professionals, my interactions with nurses showed that alternative models for healthcare such as PCC are also now influential.

So, what does PCC look like in practice? PCC can be enacted in several ways within clinical practice. But what should already be evident is that rather than the biomedicalised approach which prioritises the signs and symptoms of a disease process and a consequent standardised model of care based on biological mechanisms and treatment, PCC calls for a more holistic approach which also considers a patient's values, personal preferences and biopsychosocial needs and comfort. Given its aims to meet healthcare needs by the provision of individualised holistic care, PCC prioritises models of communication that are inclusive, respectful and supportive. For instance, one recent recommendation for the implementation of principles of PCC regarding communication and practices of information exchange is around clinical handover. Under the biomedical model clinical handover was an event carried out purely between healthcare professionals. It was, as such, isolated from the patient and their input. Within a PCC framework, however, clinical bedside handover is now a standardised norm and, according to a report in 2008 written by Chaboyer, McMurray, Wallis and Chang, should lead to patients being active participants, with the aim of increasing not only patient safety, but patient and nurse satisfaction. Similar issues were also touched upon by the research of Rutherford, Lee and

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model was based on Engel's (1977) identification that behaviours, thoughts and feelings can influence a physical state.

Greiner (2004), who saw this remodelling of the handover process as enabling patients and their significant others to provide healthcare professionals with further information about their experiences of their illnesses and their medical history

PCC is also enabled within contemporary healthcare settings at a governance level. Here the idea is that patients, carers, families and health professionals work in collaboration with each other in the areas of program and policy development, health service design delivery, and evaluation (Ranieri, n.d.; also see Santana et al., 2018). This can work by asking for consumers of healthcare to be involved in providing feedback on recent hospital stays and evaluating the quality of care. This is usually done by surveys sent out to patients after discharge by independent companies employed by the organisation.

Overall, one of the key processes for PCC identified in the 2017 ACSQH discussion paper concerned the construction and promotion of shared decision-making and, therefore, the conceptualisation of power as needing to be shared within the relationship between the patient and the nurse (Curtis-Tyler, 2010; Rigby, 2014). This requires, however, as is evident in the mismatch between these ideas and corresponding ones from the biomedical model, a different construction of not only patients, but healthcare professionals including nurses. That is, to understand and implement PCC within nursing practice, given the continuing influence of the biomedical regime of truth in the sector, what is also clear is that nurses (and other health professionals, and indeed patients) need to understand – and reconstruct themselves in terms of – some of the key principles that underpin PCC. It is no surprise that PCC has in turn inspired the further education and training of healthcare professionals to ensure that established biomedical models of professional practice are able to be challenged and reconceptualised.[5] Of course to facilitate Advocacy and therefore autonomy, there is the need to develop and nurture a therapeutic relationship between the nurse and the patient.

Building Relationships

As mentioned above, the assumption that patients are participants in their own healthcare journeys is fundamental to the PCC regime of truth. As such, underpinning what is considered to be good nursing practice within PCC is the idea of the therapeutic

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[5] In Australia there is not much focus on PCC frameworks and education. In the international context the situation is different, however large organisations such as the National Health Service (NHS) in England show extensive investments in PCC and further education for nurses.

relationship or alliance. Although such a relationship is also important within the biomedical regime of truth – albeit being conceived differently as entailing patient compliance with healthcare directives – PCC, as noted above, focuses explicitly on eliciting the wishes of patients and integrating them into healthcare planning, thus normalising the idea of responding to a patient's individual needs, as well as recognising that such needs may be physical, emotional and psychological in nature (Kornhaber, Walsh, Duff & Walker, 2016; Mitsi, Kourakos, Poulimenakou, Latsou & Sarris, 2018). This was clearly a normative idea for the nurse participants, with them talking about the importance of *"holistic care"*, *"individualised care"*, of a *"caring approach"* and of *"looking after the patient's wellbeing"*, by which they meant the patient's *"diagnosis, their mental health, their physical health, the whole package"*.

The therapeutic relationship that informs PCC is, consequently, aligned with ideas of non-judgemental behaviour, of care needing to be supportive, and of the importance of respectful and effective communication between healthcare professionals and the patient (Kornhaber et al., 2016). One of the nurses in this study talked in detail about some of the factors she saw as important for such communication:

> *Yeah, the body language, which I've done many times but I always watch the doctors, like the surgeons, and I do feel - the patient was lying and he stood right in front of her, and the leg was on the side rail. I thought, oh my goodness, if it was me, the patient, you would feel - so that incident is always in my mind. This happened seven/eight years back so when I'm talking, I never stand. If the patient is in the bed, I always make sure that I either am sitting in her level - because I think that standing it's overpowering.*

Unsurprisingly, other key practices identified as integral for the building of the therapeutic relationship in PCC include the need for health professionals to be responsive, compassionate, respectful and empathetic (Fredericks, Lapum & Hul, 2015). Agarwal (2018); Drach-Zahavy (2009) and Rigby (2014) also include reflective listening and increased self-awareness (talking about health professionals, but also clearly applicable to patients). Also important were ideas around respect and knowing the person, and around trust and building rapport (Ferguson, Ward, Card, Sheppard & McMurtry, 2013). These practices were also normalised by my participants, with them talking about the importance of sitting at the same level as their patient, as well as modulating the tone of voice used in patient communication:

> *So, there is quite a lot, and in the tone of your voice, you have to make sure that you do care.*

One of the other nurses referred to her experience of how to deliver care so as to give members of different cultures the respect that they deserve in relation to their healthcare and decision making:

> *Over the years then, I've got to know how they sort of each deal with different things so then you give them that respect for their different cultural attitudes.*

Agarwal (2018) refers to the therapeutic relationship as privileging the lived experience of the patient. Furthermore, enabling patients to express and interpret their experiences of their own illnesses and their signs and symptoms is considered important for patients to feel empowered to accept and take care of their body. An example of this was seen by one of the nurses, Natalie, when she allowed her patient to administer her own medications in the order that she normally would at home. This small gesture by the nurse allowed this particular patient to regain some of the control that she verbalised as having felt that she had lost through her unexpected diagnosis of cancer and subsequent admission to hospital.

What stands out from these examples is that for patient empowerment to become possible within the therapeutic relationship, rapport and trust need to be established between the nurse and the patient (Jerofke-Owen & Bull, 2018). It is this rapport and trust that then set the foundation for a mutual respect, providing continuity of care and creating a safe clinical environment in which care takes place (Jerofke-Owen & Bull, 2018). Through this, patients are constructed as being able to be interested and involved in decision-making about their care.

Subject Positions in PCC

What these points all make evident is that the PCC regime of truth constructs and maintains subject positions that vary considerably from those discussed previously with regards to the biomedical regime of truth. In that regime of truth, healthcare professionals, nurses and doctors were all seen to be experts with professional knowledge – albeit as being themselves positioned hierarchically with regards to the extents of their recognised knowledge. It was this expertise with regards to the specific signs and symptoms of illness that made them able to diagnose and treat patients. Although such professionals are still recognised as possessing expertise and knowledge within frameworks of PCC, their role is conceptualised differently. For PCC, as explored earlier within this chapter, what matters is the development of a holistic model of care which is delivered through a supportive therapeutic relationship itself built on mutual trust and rapport.

This means that the roles of both the doctor and the nurse, within PCC frameworks of care, have a duality to them that is not necessarily seen within biomedicalised versions of care. That is, while healthcare professionals still need to possess the expert knowledge required for the technical delivery of nursing and medical care for patients, there is also the requirement that rather than delivering a reductionistic task driven care, that nurses and doctors become co-producers with regards to knowledge and decision-making with their patients. In other words, the roles of health professionals are reconceived as being about the transfer of knowledge so as to support patients in making their own decisions with regards to their own healthcare treatments and plans. This is a construction that also recognises other sources and sites of knowledge than those attained and held by the healthcare professional. That is, it requires the recognition of the patients themselves (specifically their experiences) as a source of significant knowledge that matters in itself – and not just in the sense that it can help the healthcare professional slot the individual patient into generic models of symptoms, diagnoses and treatment, as is typical of the biomedical models of patient examination. Under PCC, the burdens of knowledge and decision-making are to be shared, a point I will return to and outline in more detail shortly.

Importantly, then, the PCC regime of truth also reconceives the subject position and roles of the patient. Unlike biomedical models of care where the most important knowledge comes from the professionals, in PCC frameworks there is a recognition of the importance of patient experience in relation to healthcare planning and treatment. This shift in focus is made visible through PCC's very explicit reconception of the subject position of the patient. In the previous chapter, within the biomedical regime of truth, the subject position that patients are brought to assume tends to be one of being submissive to both the expertise of the healthcare professional and the operation of the broader healthcare institution. This subject position thus constructed patients within a paternalistic framework where the professional expertise and hierarchical nature of the medical profession place them at a disadvantage in relation to the institutionalised processes of healthcare.

Within PCC, conversely, the conception of the ‘patient’ – as being patient, docile, subject to the medical professional’s authority, and examined reductively – becomes replaced by other descriptive titles. That is, if the patient is no longer a passive object for visualisation, diagnosis and treatment by the healthcare expert, but must be active in a number of ways, other constructions become possible. Seidel (2016), for example, suggests that changes in terminology – for instance, from patient to client or consumer[6] – have been implemented in reflection of the encouragement of patient empowerment within the PCC regime of truth. Tomlinson (2012) also recognises that changing the terminology has been an attempt to change the subject position of the patient, in an effort to modify and challenge their relationships with illness, society and healthcare professionals.[7] While practising nurses and other healthcare professionals may interchangeably use many different terms to refer to patients or consumers of healthcare, the NMBA Registered Nurses Standards for Practice (2016) specifically refer to consumers of healthcare as persons or people, thereby keeping attention on the whole person rather than simply their condition. Specifically, it defines person/people as any individual who has entered into a therapeutic and/or professional relationship with a Registered Nurse. The interesting point with these standards is that the consumer of healthcare is thereby not limited to the traditional conceptualisation of the patient. It has, in fact, been expanded to include colleagues and students dependent on the professional relationship in which the Registered Nurse is engaged at any particular moment. In addition, it acknowledges that it is not just the person receiving care who should be

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[6] Such terminology changes appear dependent on context, however. For example, in acute care settings, people are still most commonly referred to as patients. However, if other community-based settings where care occurs are also considered, the terminology that is most strongly favoured there moves towards referring to people as consumers or clients.

[7] What may potentially be missed here, however, is the PCC focus on the individual as opposed to simply reconceiving the subject position of patient. That is, these labels, or terminology, have been instigated by healthcare institutions and healthcare professionals rather than by the healthcare consumers themselves. These terms, therefore, may not necessarily be how patients or consumers of healthcare view themselves and, therefore, may not necessarily work in the way they are expected to. Confusion is also possible when terms are used interchangeably (Austin Health, 2016). Another issue, discussed later in this chapter, is the institutionalised nature of the term ‘patient’ within the Biomedical regime of truth. This framework of what it means to be a patient and to be engaged within healthcare may continue to be placed on people via healthcare institutions, portrayals of subject positions within the media, and also via people’s past experiences.

considered the focus, rather it should also encompass families, carers, groups and/or communities that may be associated with the patient.

Patient Empowerment with Regards to Knowledge and Decision-Making

As the previous section has made clear, PCC constructs patients as healthcare consumers or clients so as to foreground their active participation in their healthcare journey. Furthermore, they are considered as being able to contribute to their journey by talking to nurses and doctors about their healthcare experiences and what it means to them to be ill. This is the idea that patients are (to be) empowered and able to share the burdens of decision-making with regards to their healthcare.[8] In other words, empowerment in the PCC context, as described for instance by Pelzang (2010), is about expanding the role that the patient plays in his or her own health care. Kramer et al. (2014) stresses that empowerment is about respecting the patient's autonomy. This construction in turn assumes that the patients are experts in their own right, that they are able to identify their own needs and expectations, and able to autonomously make their own decisions and choices about what it is they need and want from their healthcare journey and experience. Healthcare providers, although still seen as powerful and knowledgeable, are constructed as sharing power with the patient.

For patients within this framework, this is often referred to as the process of shared decision-making, a process that is seen to depend on the recognition of models of lay expertise considered able to be held by patients. In this framework, lay expertise is developed from the fusion of two modes of knowing: experiential knowledge and expert knowledge. According to Storni (2013), the concept of experiential knowledge is knowledge developed by the patient as a consequence of having an illness and dealing daily with the actualities of the disease. This is the idea that the individual with a disease has an intimate understanding and perception of the disease process that will be significant for any treatment plan. Expert knowledge, on the other hand, from the perspective of a consumer, refers to the knowledge they have re-appropriated from healthcare professionals – knowledge that has been shared so as to better involve the patient in decision-making. This is knowledge that can be used by the consumer to

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[8] For such shared decision-making models to occur, Van Der Eijk et al. (2013) recognise the need for the PCC paradigm shift in the location of power and control.

facilitate more equal discussions between patients and healthcare professionals and hence challenge the reductionist tendencies of expertise that have been prevalent throughout the biomedical framework (Storni, 2013). In other words, this process of shared decision-making allows for the experience of the patient to be included within the consideration of the treatment and care of the patient. This is recognised by Fredericks et al., (2015) as meaning that healthcare professionals are being invited to partake in the lives of the patient, a very different configuration to the biomedical paternalistic viewpoint which sees the healthcare professional as the gatekeeper to health and treatment. Such a reframing of roles impacts, in turn, on a range of healthcare practices.

Previously, for example, I discussed that the processes of examination through to diagnosis, informed by practices of surveillance, work by making each patient an object through a series of observations. In accordance with the biomedical regime of truth, once a patient is classified as an object they can then be viewed as either normal or abnormal and treated accordingly. However, within a PCC framework of care, the conceptualisation and processes of examination are markedly different. In PCC, the patient is invited to participate, in conjunction with the healthcare provider, in a reconceived notion of the examination. Within a PCC framework, the examination focuses more on attaining a holistic picture of the patient and requires the patient to provide the ‘lived’ experience of the illness. This lived experience in turn informs treatment plans and options open to patients.

As discussed earlier, PCC frameworks call for the inclusion of patients’ experiences, patients’ families and extended support communities in relation to treatment and decision-making opportunities. In particular, engaging support systems that patients have available to them and utilising extended support networks of patients is one way in which PCC frameworks of care can be thought of as significantly different to that of traditional biomedical regimes of truth. An example that one nurse gave was in relation to the breaking of bad news to patients. In this example the nurse described that when she had to be a part of this type of intervention with a patient, she often found it beneficial to have a family member or a significant support person there with the patient. She stated that this was not only to do with the importance of patients having support, but that because she had found that patients might only be able to hear parts of the conversation – particularly in cases of bad news – and might miss other important information.

Barriers to Patient Centered Care

The first parts of this chapter have outlined PCC as a regime of truth along with some of the key relationships, subject positions and practices it strives to normalise within nursing practice. However, as has also been noted, there are a range of barriers that can make PCC hard to fully accomplish in contemporary healthcare settings. These barriers can be loosely grouped in two categories as those influenced by the healthcare/nurse and those that are influenced by the patient themselves.

Healthcare/Nurse Barriers

Many of the barriers to PCC identified as influenced by either the institutions of healthcare or by nurses themselves are due to the continuing influence of the paternalistic models of the biomedical regime of truth, which are in many ways more established as a regime of truth. Gluyas (2015) and Weaver (2015), for instance, identify that the biomedicalised fragmentation of the person into conditions is still prevalent within the healthcare environment, a prevalence clearly visible in the views of participants. As discussed previously, this is the framing of the patient in terms of their symptoms or diseases, a framing that is considered – by the expert – to make them easier to deal with within the healthcare setting. Hence, the orthopaedic trauma patient with the fractured tibia and fibula becomes a functionality of a number of different departments, depending on the stage of the biomedically oriented diagnosis and treatment. For example, initially radiology when diagnosing the severity of the fractures. This is highlighted in an example by one of the nurses when she discusses reducing patient care to the completion of tasks:

> *…. When you're perhaps putting up their electrolyte replacement or doing an hourly sugar or whatever*

Gluyas (2015) recognises that this can cause a lack of continuity in care for patients which impacts on the dynamic of the patient-nurse or patient-doctor relationship to the point that the therapeutic relationship collapses back into a paternalistic one. In addition, the professionalisation of the nurse, and other healthcare professionals, as compared to that of the patient, can itself set up the patient at a disadvantage according to which they may be vulnerable and frightened and, therefore, dependent on the status quo of the healthcare system that they are enmeshed within (Bear & Stockie, 2014).

What the literature also notes is that PCC is not well understood by participants and nurses in general (see, for example, work done by Moore, Britten, Lydahl, Naldemirci, Elam & Wolf, 2017). As Moore et al. (2017) recognise, poor understandings of PCC frameworks of care can lead to nursing professionals doing one of two things: first they slip back into the biomedical frameworks of care; or second, they develop more robust holistic notions of care. When a slip back into the biomedical frameworks of care occurs, even as nurses might proclaim to be constructed and working under the auspices of PCC frameworks, it is usually within the context of acutely unwell patients who are clinically deteriorating. Such situations – involving recognition of diminished autonomy, capacity and competency (although it is important to be mindful that this is often temporary) due to acute illness – tended to see the resurgence of more paternalistic biomedical styles of healthcare. Within the interviews, one of the nurses refers to this specifically when she constructs herself as able to predict patient outcomes because of her professional expertise and experience. Another participant justified her biomedicalised interactions with patients with:

> *Only because we know that it's in their best interest*

This suggests that one of the largest barriers that may need to be faced to truly put PCC principles and frameworks (such as those cited in the ASQHS [2017] discussion papers) into operation may be the nurses themselves – along with other healthcare professionals – who may still construct themselves with reference to the biomedical regime of truth. Moore et al. (2017) indeed identify that traditional – biomedical – practices and institutional structures are one of the top barriers to implementing and sustaining a PCC culture and framework for practice. This was also evident within the observational fieldwork that I observed, with the care of the patient who had the DKA episode being a pertinent example.

This patient, recapping, had been non-compliant with his diabetic treatment and had suffered a complication of DKA. During his treatment, he had been placed on an IV Insulin infusion. He was, however, becoming increasingly distraught and wanted to discharge himself as he felt that he was much improved and would be able to manage his condition better at home. This was due to a number of reasons. He told nursing staff that he was a vegetarian, that he did not eat food that was not prepared within his own home, and so his eating habits in hospital were themselves affecting his blood sugar readings. He also stated that he needed to go home as he had so much to do at home and that this was his only time off and he could not be stuck in hospital. On this basis, the patient talked to the nurse about discharging himself against medical advice. The nurse convinced the patient to stay until the doctors were able to review him. When the doctors came to review him, they were dismissive of his concerns regarding his diet and were more concerned about the biomedicalised blood sugar readings that they were reading from his chart. The patient was then talked into staying until the Diabetic Educator was able to review him on the basis that, if his blood sugars were stable, then he would be able to be discharged from the hospital.

What is clear from this narrative is that the intent of the patient was to discharge himself as quickly as he was able to, and that if that was against medical advice then so be it. However, the system constructed biomedicalised discharge criteria for this patient that were linked to his blood sugar levels and having received diabetic education. Whether or not this was to the detriment of the patient's own interests remains to be seen but it does lead nicely into the next point. Certainly, the patient at any stage could have demanded to be allowed to leave, and legally there would have been little that the nurses or doctors could have done to stop him, but the patient was given several choices to make along the way. The question is whether or not these choices in any way entailed or demonstrated the kind of the empowerment of the patient PCC foregrounds.

Another related barrier to PCC facilitation within clinical practice concerns the institutionalised routines of nursing care (Moore et al., 2017; Oxelmark, Ulin, Chaboyer, Bucknall & Ringdal, 2018). It is clear that in some instances the use of routines and schedules – as envisaged within the biomedical regime in particular – are required for operationalisation purposes. Take, for example, an operating theatre (OT). For cleaning purposes and use of equipment it is important to be able to schedule the same types of operations in the same OT. This makes sense from a cost-effectiveness point of view as well as being able to ensure that qualified staff are available to care for these patients. However, on general nursing wards, the use of routines can also trap patients into biomedicalised ideals of patient care, where nursing care becomes more about achieving tasks. When this happens, holistic notions around PCC can often be lost. Trivial examples of this occurred within the observational data in relation to patient hygiene and giving patients choices in relation to this. One of the nurses was asked about being an advocate in terms of empowering her patient and giving them choices. This particular nurse talked about giving the patients the power to make choices about their routine of care during the day but then contradicted this in practice:

> *You can have your shower when you're ready for a shower, but I would prefer you to have a shower at this time, like between 9 and 10*

Another example of this occurred with another nurse, in an interview, stressing:

> *Don't ask. Because if you ask, he's going to say no. But if you say we're going to have a shower today…*

The ASQHS (2017) discussion paper stresses that a key dimension of PCC is respect for patients' preferences and values. However, if a patient's personal preferences, such as a preference to shower in the evening or at night, do not fit in with the already normalised routines of healthcare they may be disregarded – especially if the patient requires assistance with hygiene.[9] This can be challenging for patients insofar as they are expected to adopt new routines that perhaps do not fit their lifestyle or healthcare needs, but fit the needs of the institution and the nurses that provide the care. These are points that will be shown to be increasingly important for my analysis of healthcare and will be explored in more detail in the following chapters.

Another barrier that can prevent the facilitation of PCC within contemporary healthcare settings is the failure of the therapeutic relationship. As Santana, Manalili, Jolley, Zelinsky, Quan and Lu (2017) identified, as healthcare professionals work longer in the profession, they can become less empathetic and display decreased compassion. Failure of the therapeutic relationship, specifically with regards to the dimensions of empathy and compassion noted earlier, can potentially lead to patients feeling unheard and disrespected and overall dissatisfied (Fix, Lukas, Bolton, Hill, Mueller, LaVela & Bokhour, 2018). It is this issue of the failure of the therapeutic relationship that also leads into a consideration of some of the patient factors that can present as barriers to PCC in practice.

Patient Centered Barriers

For many patients, being sick and requiring some form of medical treatment and potential hospitalization presents a unique set of challenges. These can include for some individuals, as recognised by Marshall et al., (2012), the distinct lack of control that

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[9] In many healthcare settings it is normal for hygiene requirements to be completed within the morning shifts.

comes from being a patient.[10] While the idea of PCC is to provide patients with an opportunity to remain active participants in their personal care, it has also been recognised that such an aim can fail due to a number of competing factors, such as the effects of illness and injury (as in the taking up of the sick role position), and the perception of power imbalances (Marshall et al., 2012). Richards, Coulter and Wicks (2015) further note that regardless of PCC aims, patients and the public simply do not usually possess the knowledge or capacity needed to be able to shape the services available to them. Such issues can thus lead to feelings of disempowerment and to frustrating interactions within healthcare contexts.

One of the challenges that persists for patients is that many of the choices that are made available to them within healthcare frameworks are often already limited and constructed in relation to norms set up by the healthcare institutions. That is, they tend to be constructed in such ways as to work in favour of the healthcare professional' preferences rather than to actually empower patients in the management of their own healthcare. Not only is this a theme in the current literature (see Asimakopoulou, Gupta & Scambler, 2014), it was a common theme in the interview data collected.

Scambler et al., (2014) recognise, for instance, that patient choices are always limited within the parameters of what is judged to be clinically appropriate. This, however, raises concerns about whether or not such a limited choice can truly ever be considered patient centered. That is, such limitations mean that every interaction a patient might have within the healthcare institution and with healthcare professionals (such as doctors and nurses) is already framed in terms of certain already normalised constructions of the patient – or of this 'type' of patient. Furthermore, these versions are controlled, manipulated and acted upon at different times and in different ways, dependent on the context in which care occurs. Indeed, even within PCC frameworks there are techniques of manipulation and disciplining of the patient that occur through the processes of nursing documentation, the use of patient gowns, and the environmental constraints of the ward. Each makes patients visible as patients and, therefore, more easily governable, but each can also influence patient behaviours and attitudes toward their own health and illness (Holmes & Gastaldo, 2002).

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[10] This will be discussed in more detail in the analysis of autonomy and advocacy.

As has been set out in the previous sections, PCC relies on patients being able to express their needs and wants to healthcare professionals, and to be active and equal participants within their own healthcare journeys. This is clear within the 2016 NMBA Registered Nurses Standards for Practice under Standard 2 where it states that *nurses need to recognise that people are the experts in the experience of their life.* For PCC such experience must be able to be communicated effectively with healthcare professionals in a shared and supportive therapeutic relationship. There are times, however, when due to various reasons patients are unable to express their needs or wants to healthcare professionals. In such instances the frameworks of PCC become intangible and more paternalistic biomedicalised care will often be reverted to.[11]

Moore et al. (2017) and Oxelmark et al. (2018) also recognise in their work that some patients choose not to engage within a PCC framework of care and, in fact, would appear to prefer construction within the biomedicalised model of care where decisions are made by the healthcare professionals. While this might be an active choice made by some patients, and of course one that should be respected, it can also be perceived in some instances as a barrier to the facilitation of PCC. As PCC relies on patients being co-producers of the healthcare journey and sharing their experiences of their illnesses with healthcare professionals, if patients are unable or unwilling to undertake this role it becomes harder for the framework of PCC to be implemented. It also makes it more difficult for nurses to build a therapeutic relationship with the patient and individualise patient care and thereby potentially reduce the reductionistic focus dominant within the biomedical regime (Holmes, 2002; Holmes & Gastaldo, 2002). Although the therapeutic relationship is productive and formative in allowing nurses to ‘know’ their patients (Riley & Manias, 2006), nurses do, arguably, lack coercive power (Porter, 1996) and are at the mercy of the consumer to divulge and engage with the new subject position afforded them.

Thus, while PCC promotes greater involvement in healthcare decisions by patients, including increasing their capacities to give permission (or not) for treatment to occur,

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[11] Examples of this may be seen in patients who may not have extended family or familial support to draw upon and do not have capacity or competency to be active decision-makers in relation to their everyday healthcare needs.

this new power is not always supported. What is also clear is that nursing professionals can undermine attempts by patients to resist practices and actions deemed significant within the healthcare institutions. Strategies adopted by nurses, as part of their privileged position – demonstrated, for instance, in an earlier example given around a patient being talked out of discharging himself against medical advice – can thus include inducement, encouragement or persuasion. Although such strategies are used to influence the behaviours of patients in both regimes of truth (the biomedical and PCC), they can in some ways be even more influential within PCC given that they play out within the trust framework inherent in therapeutic relationship developed between the nurse and the patient (Porter, 1996).

This is one of the challenges of the PCC regime of truth, where the biomedicalised nature and origins of nursing practice work against a true enactment of PCC according to which the patient should be able to become a more equal player in the therapeutic relationship. To put this another way, the aim of the therapeutic relationship – which is to empower and support the patient in their decision-making – may be compromised through the subject positions that the nurses and the healthcare institutions place the patient in.
As mentioned previously, although PCC models of empowerment have facilitated the use of different terminology to refer to patients in an attempt to breakdown the traditional biomedicalised subject positions, not every patient may want to be empowered and some may even prefer to remain framed through biomedicalised frameworks of care. This may be due to factors such as fear, illness trajectory and the treatment that is involved (Gluyas, 2015; Hooks, 2016). Voshaar et al., (2015) also recognise that this unwillingness by some patients to be active participants in their care can be due to the continued power imbalance that exists from the biomedical model between the patient and the doctor. This is the traditional conceptualisation of healthcare where the all-knowing medical professionals use their expertise to shape the way patients can engage within shared decision-making. As discussed in the previous chapter, some of this comes down to the use of technical jargon that can work to maintain power differences and alienate the consumer of healthcare (Gluyas, 2015; MacDonald, 2016).

Bernabeo and Holmboe (2013) also identify that the style of interaction that can commonly occur between healthcare professionals and institutional contexts can reinforce and support traditional patient roles of passivity, trust and compliance. Hooks (2016), Bernabeo and Holmboe (2013), and Rademakers, Delnoij, Nijmna and de Boer (2012) also note that the health literacy and competency of patients and their education may align them more with a paternalistic style of healthcare according to which patients relinquish control to the professionals. Tomlinson (2012) suggests more broadly that no matter how healthcare is constructed, there is an underlying and connected context that implies a power struggle between the regulation of healthcare and the consumers and providers of healthcare.

Other issues can also problematise the empowerment model. For example, patients may ignore medical advice and opt for alternative treatment options or may disagree with a diagnosis and elect not to have associated treatment. In these instances, within a framework of PCC, the obligation, and therefore the responsibility of the outcomes, is placed onto the individual, absolving the healthcare professional of responsibility (Scambler et al.,2014). However, under these frameworks of PCC and empowerment models of care, what may also be seen is the process of victim blaming, discussed previously. That is, healthcare professionals may move from a true empowerment model to one more of victim blaming. This was observed within the observational fieldwork with the DKA patient where the nurses placed the responsibility of this patient's healthcare back onto the patient himself. When a patient fails to live up to the expectations of PCC and empowerment models, then healthcare professionals can almost wash their hands of them:

> *Sometimes you get hardened to that and you think, well, you know what, you're going to go home so here's the form. You know what I mean? You get so tired of that sometimes*

A similar framework is also engaged with reference to non-compliance. In one of the patient interactions discussed with one of the participants, when one of the nurses was looking at a patient's history she commented on the repetitive behaviour of the patient and referred to the patient as a 'frequent flier'.[12] This is a term that is commonly used in nursing circles that refers to those patients who have repeat hospital admissions, usually in quick succession and usually for the same problems. Clayton (2006) discussed the use of such language in healthcare in an edition of the *Journal of the Royal Society of*

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[12] A slang term for a patient who is admitted repeatedly to the same hospital for the same non-resolving cluster of symptoms ("Frequent Flyer", 2012)

Medicine. Here he attacked the use of such slang terms to refer to patients as demeaning, trivialising and morally abhorrent. He referred to this as a mechanism to shift the blame from the inadequacies of the healthcare systems that are in place onto the patient, through the guise of PCC, making patients accountable and responsible for their own health outcomes. Clayton (2006) refers to this as a dehumanising experience and this again can be linked to the reductionistic version of the biomedical model that was discussed earlier where the body is reduced to its symptoms. These different subject positions, whether or not they are as a result of the institutional frameworks that are imposed on patients or that are accepted and embraced by patients affect the way in which nursing care is implemented.

Patients who are institutionalised as frequent fliers are often influenced by their own medicalisation through the healthcare systems. That is, such patients, just by the nature of their illnesses and co-morbidities, become institutionalised so that they begin to use professional language and terminology to refer to their conditions and ailments rather than describing in their own words their signs and symptoms. To put this another way, such patients become slaves to a system that makes them pseudo-professionals in their own right. This can also make it difficult to implement effective PCC frameworks because patients lose their unique narrative which can also have the effect of isolating them in the eyes of the healthcare professionals (Moore et al., 2017).

Conclusion

This chapter has served to demonstrate that while PCC functions in several ways as a regime of truth and is described in many of the governmental and international codes and ideals for nursing practice, in reality the subject positions, relationships and practices that comprise PCC remain in tension with the subject positions, relationships and practices constructed through the biomedical regime of truth. While there are strong arguments that exist for nursing practice to move away from the traditional biomedical regime of truth to the more encompassing and holistic model of PCC, it has to be recognised that frameworks of PCC could be construed in some ways as idealistic in nature. Nonetheless, the multitude of discourses and practices that surround patient care due to the constructions and operations of both PCC and biomedical regimes of truth provide space for the renegotiation of traditional idealisations and conceptualisations of the healthcare environment. It is this space, according to Foucault, that enables the re-examination of knowledge and subject positions that may be marginalised within, and by, dominant cultural expectations and practices.

What this chapter has also made clearer is that nursing practice and the two regimes of truth – biomedical model and PCC – that have been discussed in both this and the previous chapter (Chapter Six) are underpinned by a complex web of standards and frameworks which also determine how nurses should practice. Although these do not have a central remit entailing that they themselves operate as a specific regime of truth – rather comprising an array of strategic pressures loosely organised around concepts of efficiency, professionalisation, risk management, and so on – these strategic pressures do appear extremely influential in the shaping and carrying out of healthcare practices.

As such, it is now the complexities of these strategies and power/knowledge relationships that have to be mapped and examined to understand their influence on the process of providing care to patients. This leads into the next chapter which will consider the power of nurses and the issues around duty of care. As my participants noted and as made clear in the previous two chapters, nurses operate within a web of relationships that are imbued with complex hierarchised power relationships. Not only do nurses have a duty of care to the institutions that employ them to work as professionals, but they are also expected to uphold societal obligations that influence nursing practice. Also, as the literature suggests, they have an obligation to act as an advocate for the patient to protect and uphold their autonomy within the healthcare environment. The question has to be asked, however, as to what happens when professional obligations do not align with an individual's personal and moral compasses? Where does the duty of care then lie and how does an individual decide which path to follow? The next chapter will review how governmentality disciplines nurses and the consequences of this on the dominant regimes of truth specifically in relation to the central tenet of nursing practice – caring.

Chapter 8 – The Governmentality of Care

Introduction

The previous two chapters have worked together to describe two of the dominant regimes of truth, the biomedical model and Patient Centered Care (PCC), that function within healthcare and, as such, clearly frame the assumptions and practices of my nurse participants as set out in Chapter Four. What has also become evident, however, is that both my participants and the healthcare systems and the practices they put into play engage both regimes of truth. The engagement of one or the other might be a matter of context, expedience or habit – settings of acute care seem to foreground biomedical ideas, for example – or mark a response to new recognitions of what's important in patient treatment and recovery according to which a framework of individualised PCC (including its dissemination through familial and social networks and social contexts) becomes more significant. The broader point is that the constructions and operations of PCC cannot be understood as independent of biomedical regimes of truth, they are entangled and responsive to each other in complex ways. It is this entanglement that becomes the focus of this chapter. More specifically, my aim is to identify and examine through this chapter the values and disciplinary techniques underpinning both the biomedical regime of truth and PCC that not only allow healthcare practitioners and consumers to move between and variously engage these two frameworks, but which govern them as they do so. Such considerations will be further illustrated through examples drawn from the Thematic Analysis outlined in Chapter Four. These values and techniques, I suggest, comprise what Foucault might call the governmentality of nursing and the profession as a whole.

As has been discussed in Chapter Five, the Foucaultian idea of government refers to all the programs, types of thought and action that seek to guide the conduct of others (Foucault, 1991/1978). It is the conduct of conduct. Governmentality thus examines how power is imbued within actions, attitudes and discourses that then influence and determine behaviour and conduct of individuals (Guta et al., 2014). As Foucault recognises, techniques or technologies of government – broadly defined as "any set of social practices that is aimed at manipulating the social or physical world according to identifiable routines" (O'Malley, 1996, pg. 205) – may work to govern the individual or guide a cohort's conduct in desired directions. Importantly, when understood in this way as being interconnected with the idea of guidance, the work of technologies cannot be disconnected from issues of values. This means that a further question for this chapter, then, concerns what are the values and technologies that drive the governance of nursing, shaping, guiding, or affecting the conduct of people and systems within the healthcare profession regardless of which regime of truth is considered to be in operation.

With this focus, this chapter comprises two main sections. First, I briefly identify and trace what I consider stands as a core value of nursing practice, regardless of which regime of truth is considered to be dominant. This value is *care*, although it has been interconnected in the literature and by my participants with a range of other values including kindness, compassion, and empathy. This outline is followed by a discussion as to how this value has been embedded within technologies of government, which play out across both individual and institutionalised levels of nursing and inform the operations of both the biomedical regime of truth and PCC. These technologies can be summed up in the professionalised concepts of duty of care. Although these technologies are framed with reference to this value of care, as I show in the second section, they are also technologies of professionalisation which are themselves driven by sets of external and internal pressures and, as such, do not always operate in accordance with care. It is the impact of these tensions that in turn drives what will be my aim in the following chapter – to consider what the operations of both these regimes of truth and these technologies of professionalisation mean for the other key value of nursing and the focus of my research questions: the dual focus on advocacy and supporting autonomy.

Care as a Value of Nursing

As the previous chapters have made clear, one of the most basic understandings of nursing is that a nurse is a caregiver for patients who helps to prevent illness, treat health conditions, and manage their physical needs. That is, nursing is presented as the caring profession, which provides patient care – recently framed explicitly as PCC – informed by empathy, compassion and kindness. This is a subject position that operates across both the biomedical regime of truth and PCC, and which all of my participants accept. Indeed, demonstrating this acceptance, they have described themselves as needing to be "*really caring and compassionate*", as having a "*caring nature*".

As caregivers, nurses are also framed – and frame themselves – with reference to a range of associated values. Nightingale, for example, conceptualised nursing as alleviating suffering through acts of compassion (Kaplan, de Blois, Dominguez & Walsh, 2016; Mascaro, Darcher, Negi & Raison, 2015; Straughair, 2012a; 2012b), but also aligned it with such moral virtues as kindness, compassion and competence (Bradshaw, 2011; Zulueta, 2013). Indeed, it is often highlighted that nurses should be empathetic, compassionate,[1] kind and trustworthy (Alicea-Planas, 2016; McKeown, Ridley, Newbigging, Machin, Poursandiou & Cruse, 2014; Pacquiao, 2008). These are interconnected qualities. Thus, the Codes of Ethics for Nurses (NMBA, 2008a) refer to kindness as demonstrative of gentleness, consideration and care; and compassion is considered to be based upon empathy (Straughair, 2012b). Furthermore, defining kindness as acts of sensitivity and goodwill towards the feelings and thoughts of other links into the constructions of PCC that are central to current debates in nursing practice (Crowther, Wilson, Horton & Lloyd-Williams, 2013; Faust, 2009). Indeed Mace (2012) talks about kind words and gentle touches as working to reduce the power imbalances in the therapeutic relationships built in nursing practice, while Rose, like the other nurses interviewed, expressed that empathy[2] was an important skill to have and to express:

> *I always put myself into theirs [their shoes], just like if I am the person. This is what I want to do. That is why for me, I tell you the truth, if I have a student with me, I tell them that this is what things should be done, because when I become a patient, I want to be treated the way I treat my patients.*[3]

From a consumer perspective, the work of Hofmeyer, Toffoli, Vernon, Taylor, Klopper, Coetzee and Fontaine (2018) identified that it is a public expectation that nursing care is

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[1] Given its origins within religious sects and ideologies (Straughair, 2012a), it is not surprising that the ideas about compassion that inform nursing have held through the transition of nursing from being a sacred to a secular calling, to the modern-day institutionalised profession. Broadly, compassion is said to be intrinsic to the human experience and is related to our need to be interconnected (Zulueta, 2013). Whitehead, Kuper, Freeman, Grundland and Webster (2014) and Zulueta (2013) identify that compassion promotes equality within relationships even in the face of power differentials and social inequalities and supports the development of PCC.

[2] The ability to be empathetic has been identified by Curtis (2014) as being essential to enable people to connect. Empathy is about being able to reconstruct and reinterpret a person's experience (Faust, 2009). It is an effective response and is about emotionally connecting with another person (Andreychik & Migliaccio, 2015; Decety & Jackson, 2004; Mascaro et al., 2015).

[3] Kylie conversely recognised that the ability to empathise with patients is not always the best way to engage with patients. Part of this is that sometimes this is not seen as genuine by the patients and, therefore, this may cause conflict and tension within the nurse-patient relationship. As she put this:

> *You can't judge, and you've never been in that situation and many times I've said - and patients have said that to me - I've said, it's going to be okay, or, it's alright. I really did mean it when I said that and then the patient will tell me back, it's not alright.*

not only technically excellent, but also compassionate and personalised. Skills such as active listening and being able to adequately respond to another's pain or suffering are considered key to compassionate care (Hofmeyer et al., 2018). Care is also closely aligned with some of the concepts that were highlighted in the previous chapter as being linked to the PCC framework and its foregrounding of the development of the therapeutic relationship. This was in relation to the nurse needing to develop therapeutic relationships with patients with a strong foundation of respect, interpersonal skills and knowledge of each patient's personal context and preferences (Hofmeyer et al., 2018). This is in direct comparison to the reductionist nature of the Biomedical models of care where patients may be reduced to and cared for within the constraints of their illnesses.

The Professionalisation of Care: The Duty of Care

Although this idealisation of nursing as a caring profession is common, and one certainly seen as integral by my nurse participants, care has also become a professionalised value. Nurses are granted by the state and regulatory bodies a certain authority over individuals under their care to enforce and enact certain norms of behaviour and responsibility (Perron, Fluet & Holmes, 2005), and, further, expect patients to trust that they and other healthcare professionals have their best interests at the forefront when they are providing care to them (Sumner & Townsend-Rocchiccioli, 2003). This is seen within both biomedical and PCC Regimes of Truth. Although the operationalisation of care will be different under each of these Regimes of Truth, what is common is that this operationalisation is formulated under ethical,[4] moral and legal doctrines regarding a duty of care.

Nurses are thus expected to meet high levels of ethical, moral and legal responsibility in relation to the nursing care they provide, responsibilities that have been framed under the concept of duty of care. Most broadly, this is the idea that, as Stuifbergen and Delden (2011) discuss in their work, if an individual is vulnerable or dependent on another, then the other person has a responsibility to protect that dependent person. This responsibility was not lost on my participants with two of them explicitly referring to the duty of care concept. One nurse, Rose, specifically referred to this duty of care in relation to when patients needed to understand their illness and their plan of care:

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[4] As Chapter Two outlined, the ethical foundations of the caring nature of nursing practice are bound within the bioethical principles of autonomy, beneficence, justice and non-maleficence (Orr, 2000).

> *So, things like that. Because sometimes they really don't know the degree of their illness and we still have duty of care to tell them that this is what's happening*

The duty of care and the subsequent legal responsibility of the healthcare professional towards the patient thus begins when the healthcare professional accepts the responsibility of the treatment of the patient (Kelly, 2010). Rebecca referred specifically to the concept of duty of care such as a responsibility for their patients:

> *You know how we - in nursing, they always say that we are responsible for our patients and their care. We have a duty of care to the patient*

As the last two chapters have suggested, this responsibility can take a number of forms, drawing attention to different aspects or understandings of the care relationship, which can themselves be played out with reference to ideals of advocacy. Most importantly, however, as indicated above, it has been written into – and as – a range of professional virtues and principles (Reid, 2005), and thus explicitly framed as a legal duty.

For instance, conceptions of the duty of care are written into the Code of Ethics for Nurses in Australia (NMBA, 2008b) in, appropriately enough, Value Statement 1 which states that *nurses are required to value quality nursing care for all people*. The Code of Professional Conduct for Nurses in Australia (NMBA, 2008a) also points to a duty of care in stating that professionals will uphold exemplary standards of conduct as exemplified in *Conduct Statement 1: Nurses practice in a safe and competent manner.* This conduct statement thus draws attention to nurses' personal accountability in relation to providing safe and competent care, and the importance of the maintenance of competence including professional development. In this same document, *Conduct Statement 2: Nurses practise in accordance with the standards of the profession and broader health system*, foregrounds ideas of responsibility and professional standards as a way of enhancing the safety of people under the care of nurses (NMBA, 2008a). This is again mirrored in the Code of Ethics for Nurses in Australia (2008b) in Value Statement 6 where it states that nurses need to engage in a culture of safety through processes such as prevention, monitoring, early identification and early management. Furthermore, duty of care is imposed as a legal framework on healthcare professionals with reference to issues of negligence (Eisenberg, 1990). That is, negligence is itself defined with reference to the professional role and the duty of performing that role to a specified standard (Eisenberg, 1990; Young, 2009).

What this framing of care as a duty of care also does, then, is it bundles care into a professional discourse of competency (Eisenberg, 1990), where scope of practice, particularly in nursing practice, is tied in with evidence-based practice (EBP) (Young, 2009). Young (2009) thus identifies that in nursing practice the scope of practice for both care and competence is linked with the standards of practice and the codes that frame and determine appropriate nursing practice. Thus *Standard 6: Provides, safe, appropriate and responsive quality nursing practice* (NMBA, 2016) specifically stresses the scope of practice of the Registered Nurse (RN). It also describes the legal requirements of nurses to practice in accordance with relevant policies, guidelines, standards, regulation and legislation. In addition, this standard has an element of whistleblowing within it where the nurse is also expected to identify and report any practice that may be below standard. Such standards are thus, as Foucault might note, not only mechanisms of surveillance, and a functionality of a panopticon effect, but they also create self-regulation, docility and normality. These are issues that will be discussed in greater detail below.

Conduct statement 1 in the Code of Professional Conduct for Nurses in Australia (NMBA, 2008a), unlike the RN Standards for Practice (NMBA, 2016), also specifically outlines what constitutes a legal scope of practice for nursing as being based on the educational preparation of the nurse, their own personal knowledge base, their demonstrated competency, the extent of experience they hold, and the lawful authority that they have as a nurse to practice (NMBA, 2008a). Furthermore, the RN Standards for Practice (NMBA, 2016) state that the RN is responsible and accountable to the NMBA, and for the supervision and delegation of nursing activities of the Enrolled Nurses (ENs) and others. This is explicitly laid out in *Standard 3: Maintains the capability for practice.* This standard thus refers to individual RNs, ensuring that they are capable of safe and quality nursing practice which includes self-management and the concept of continuing professional development and teaching and supervising others. It is, to put this another way, a requirement to ensure that nurses are competent in achieving their duty of care. The other side of this standard concerns providing information and education to patients to enable informed and appropriate healthcare decision-making to occur – itself an aspect of the duty of care of healthcare professionals important under both the biomedical framework and PCC. Importantly, none of these documents work in isolation. Although, in practice, it is rare for any of these regulatory documents to be used unless there is an issue or concern with a practising nurse's scope of practice or performance, the RN Standards for Practice (NMBA, 2016) are designed to be used in conjunction with the Code of Professional Conduct for Nurses in Australia (NMBA, 2008a) and also the Code of Ethics for Nurses in Australia (NMBA, 2008b). Together they are expected to outline the dimensions of the duty of care expected to be accepted and carried out by nurses, and together they make visible a range of the technologies of government that work to govern nurse conduct regardless of the regime of truth in play.

Technologies of Professionalisation

What the concept of the duty of care of nurses also makes clear is that nurses have multi-faceted roles, which are always under scrutiny from various sources. Perron (2013) thus identified that nurses, while having to deal and identify with the changing needs of the patient, also have to contend with the requirements of the institutions for which they work and how these may impact on their ability to carry out the duty of care that has been discussed in the previous section of this chapter. Indeed, there are multitudes of administrative issues – what could also be called disciplinary techniques or technologies of governmentality – that influence the way in which nurses have to operate within healthcare settings, with these settings regulating how nurses carry out their duty of care. Perron (2013) recognises that some of these operationalise nursing care in such a way as to standardise the type of care that is provided, thus ultimately maximising and professionalising the functionality of the institutions. Such models of standardisation and such a focus on maximising institutional efficiency, while arguably integral to care as carried out under the biomedical regime of truth, would appear to fly in the face of the principles underpinning PCC. These technologies of institutionalised professionalisation would thus include mechanisms of self-regulation, standardised care plans, distancing, manipulation, and discretion. All of these can be seen as strategies that function to enable nurses to 'do care'; they become standardised practices and technologies of governmentality. Each will be discussed in order below.

Specific and localised contexts of healthcare are typically complex with multiple and often competing demands providing circumstances where nurses need to adopt different roles, depending on their function and patients. There is always some degree of fluidity and uncertainty around professional and individual expectations and, therefore, the space for discretion, and thus innovation and resistance, also has to remain fluid. However, it is also important to remember that regimes of healthcare and the disciplinary concepts (highlighted by Foucault) are successful due to simple biomedically oriented instruments that have been integrated into the healthcare experience. Foucault (1977) recognises that these instruments include hierarchical observation and normalising judgements, which together culminate in the examination. The changing nature of the examination – as noted across the previous chapters – works as a critique and a mechanism of accountability, both for the patient and the nurse, and has, as such, become a major focus of healthcare and its political accountability. Part of this political accountability that is highlighted in the frameworks and standards that govern nursing practice is the identification of the role of self-reflection and the need to monitor and regulate one's own behaviours.

Self-Regulation

As has been noted earlier, techniques or technologies of governmentality work to manage and regulate the behaviours of both populations and individuals (Ahonen et al., 2014; Brockling et al., 2010; Lemke, 2010; Lukes, 2004; Morrissey, 2013; Oksala, 2013; Ojakangas, 2012; Simons, 2013). Because of such techniques of governmentality, subject identities are created, and new expectations and understandings of behaviour are developed (Cawley & Chaloupka, 1997). As shown in the above discussions, of particular importance in the contexts of nursing and its duty of care – regardless of whether that duty of care is informed by the biomedical regime of truth or PCC – is the technique of self-regulation. Van Rensburg, Rau, Fourie and Brascke (2016) recognise that when embedded in what are considered norms – themselves distributed and maintained via the standards of regulatory bodies – individuals become self-regulating in relation to their perceptions, actions and values.

It has already been made clear, both above and in previous chapters, that there are several key regulating bodies that influence and monitor the nursing profession and individual nurses concerning the duty of care detailed above. These include the Nursing and Midwifery Board of Australia (NMBA); the Australian Nursing and Midwifery Accreditation Council (ANMAC);[5] and the Australian Health Practitioner Regulation

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[5] The Australian Nursing and Midwifery Accreditation Council (ANMAC) establishes high-quality standards of nursing and midwifery education, training and assessment. ANMAC is the independent accrediting authority for nursing and midwifery education under Australia's national registration and accreditation scheme and also assesses the skills of nurses and midwives who wish to migrate under the general skilled migration program. The Council is also responsible for developing and reviewing accreditation standards for

Agency (AHPRA). As is common for such institutionalised governance techniques, however, the nursing profession also relies heavily on the ability of its members to self-govern and engage in processes of self-reflection and reflective practice.[6] Indeed, the concept of self-surveillance is very clear throughout this documentation and, as outlined above, insofar as it is highlighted that it is the nurse's responsibility to regulate their capacity to work within their scope of practice. This internalised and normalised behaviour is commonplace within the nursing profession and is one way that nursing practice is governed and the nursing professionals within it are disciplined if required. Breaches within the scope of practice of an individual are determined to be very serious as they can potentially have consequences for the patient that are far reaching.

Not only do nurses need to be aware of these three documents set out by AHPRA and the NMBA, but also there are a number of clinical guidelines and policies and procedures set out by institutions that also influence ideas of a nurse's duty of care. These include the National Institute for Health and Care Excellence (NICE)[7] and the National Safety and Quality Health Service Standards (NSQHS) 2017 developed by the Australian Commission on Safety and Quality in Health Care. Conduct Statement 3 in the Code of Professional Conduct of Nurses in Australia (2008a) is a mirror image of Statement 6 seen in the RN Standards for Practice (NMBA, 2016) in relation to reporting inappropriate and unsafe practice of other nursing professionals.

Indeed, analysing the language within the Standards for Practice (NMBA, 2016) we can see that there is a continuous focus on language that exposes the need for self-regulation. This is through terms like reflection, responsibility and accountability. This is clear, for example, in *Standard 1: Thinks critically and analyses nursing practice*, particularly in 1.2, which states that *RNs develops practice through reflection on experiences, knowledge, actions, feelings and beliefs to identify how these shape practices* (NMBA, 2016). The key word here is 'reflection'. This is also reiterated in the Code of

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nursing and midwifery programs of study in Australia and whether programs meet required education standards (Australian Nursing & Midwifery Accreditation Council [ANMAC], n.d.).

[6] The ideas of self-reflection and reflective practice are heavily imbued within the Registered Nurses Standards for Practice NMBA, 2016). For example, see *Standard 1: Thinks critically and analyses nursing practice*, 1.2 *develops practice through reflection on experiences, knowledge, actions, feelings and beliefs to identify how these shape practice*; and *Standard 3: Maintains the capability for practice, 3.5 seeks and responds to practice review and feedback.*

[7] The National Institute for Health and Care Excellence (NICE) provides national guidance and advice to improve health and social care (National Institute for Health & Care Excellence [NICE], n.d.).

Professional Conduct of Nurses in Australia (2008a) where, in Conduct Statement 10, it is stated that the *nurse is expected to practice reflectively and ethically and learn through experience and contribute to both their professional and personal practice and also to the development of others.*

Self-regulation is dynamic and includes behavioural and psychological reactions in relation to self-judgement around competence and areas for improvement (Kuiper, Pesut & Kautz, 2009). Reflection and the use of reflective practice is, thus, a key way nurses engage in a governing of the self that can then be used reflectively to change behaviour (Gilbert, 2001). Linda discussed how she uses reflection in her nursing practice:

> *Facilitator: So, do you think that - when you're saying could I have handled that better do you think that reflection is part of being an advocate?*
> *Interviewee: Yeah, I think so. You've got to reflect on what you've said and yeah, I think it's a big thing because then sometimes you can go back and say what I mean was...*

Van Rensburg et al. (2016) contend that this process of being reflexive ensures behaviour is regulated internally by the docile body and that the individual then uses this as a mechanism of control in relation to the control of others (in this case, patients). The next technology of professionalisation that I want to discuss is the notion of the standardised care plan and how this influences the concept of duty of care.

Standardised Care Plans

A standardised care plan (SCP) can be defined as a way to introduce high quality, evidence-based cost-effective care that clearly defines the standards of care, expected outcomes and timeframes for selected patient groups (Ballantyne, 2016). Most nursing practices become standardised due to both biomedical assumptions regarding effective healthcare and external pressures that influence the delivery of healthcare systems. The significance of these systems from a Foucaultian perspective is twofold. Firstly, they engulf all in an architectural labyrinth of information, a form of panopticon establishing a level of surveillance of both the worker and the service user, constantly monitored through electronic forms of audit. Secondly, they institutionalise particular discourses in the very operation of the system through the nature and types of questions asked.
While the introduction of SCPs has been argued in the literature to allow for a standardised and consistent plan of care for specific cohorts of patients (Dahm & Wadensten, 2008), this can be argued as reductionist and a move away from the 'new

nursing' that has been promoted in the literature. As noted above, SCPs can become a vehicle for surveillance of individuals, in relation to nursing practice, through auditing processes that take into account how individuals fill out (or don't fill out) the care plans.

In addition, while they may aim to provide standardised and consistent care for patients and are often recorded as a measurement of the care provided (Ballantyne, 2016), they can also mean neglect of the individualised variations of nursing practice that are a functionality of both the individual as a patient and the individual as a nurse. SCPs can be seen as processes of protocolisation, which are aimed to reduce the time spent on activities and to monitor how productive staff are. This, from a Foucaultian perspective, provides routinisation and can define certain patterns of normalisation. However, in providing timeframes of managed care that are authorised and normalised for patients with the stated conditions, such plans can thus exacerbate neglect of the sociocultural backgrounds of patients. The regulation of nursing practice and the standardisation of nursing practice through national registration schemes and the care plans described above shift the focus subtly towards a mechanism of surveillance and monitoring.

One of the major issues that can influence the provision of healthcare services is referred to by Booth et al. (2006) as temporal discrimination. What he means by this is that a narrow, normative and prescriptive viewpoint within healthcare has the possibility of reducing the practitioners' ability to use their professional judgement and analysis to the detriment of the patient who is often at their most vulnerable. The reliance on heavily normalised care plans, and reference to individuals as variants rather than people, is just one of the versions of temporal discrimination that occurs within healthcare professions. As recognised by Garrett (2003), the issues with care plans is that there can be a mechanistic use where care plans are used as checklists without differentiation or consideration of the 'variants', or individual responses, to illness and, therefore, recovery. An example of this is that time is a key fiscal management area of most healthcare institutions. The meeting of KPIs in terms of bed availability and reduction of length of stay is one of the constraints that influences this notion of temporal discrimination. Booth et al. (2006) recognises that part of the challenge is patient co-operation as a key factor in temporal management in relation to committing to change and working effectively to promote health and wellness in individuals. But what this does is constrain the practitioners, here the nurses, and undermines the autonomy of the professional to provide a narrow focus on nursing care and patient outcomes. This promotes a reactive rather than a proactive response to patient care.

Distancing

Zulueta (2013) and Kagan (2016) also note ways that the compassionate dimensions of nursing can be said to wane within professionalised conceptions of practice. One of these – referred to as distancing – could be understood as a protective mechanism by nurses to protect themselves from emotional and psychological burnout. And yet, in many undergraduate programs, students are still actively taught to refer to patients by bed numbers and by their conditions, all under the guise of maintaining and respecting patient confidentiality and privacy. Furthermore, in emergency situations, patients as individuals always become their lowest common denominator. They become their obs and the ritualised, mechanistic tasks that are associated with the deteriorating patient. I have mentioned previously the effect such labelling can have on patients – dehumanising them – but, as noted above, such practices can also make emotionally, and psychologically, challenging patient encounters easier to deal with for the nurses and other healthcare professionals. Such practices clearly align, once again, with the biomedicalised reductive practises discussed in detail in Chapter Six.

Examples of these techniques were commonplace in the clinical environment. For example, when I was sitting by the nurses' station as a new observer into the clinical environment, the ward clerk was asking a nurse about a patient. The ward clerk was using the patient's surname and the nurse seemed not to recognise or know who the ward clerk was referring to. It wasn't until the ward clerk said, "*you know the patient in Bed 12*", that the nurse said, "*oh yes, what do you want to know"*. As she was walking off, that nurse mentioned to the ward clerk that "*I only know them by their bed numbers, not by their names"*.

In handover, as has been discussed, the use of patient diagnoses to discuss patients is also common. It is very rare to have a handover that discusses Mrs Jones, rather what is discussed is Bed 1 – Mrs Jones type 1 diabetic with a below knee amputation. Again, this has the potential to reduce patients to their conditions and to the ritualised tasks that nurses perform for these patients such as wound dressing, activities of daily living and medications. Such processes clearly create and maintain power inequalities. Kagan (2016) recognises that nurses and institutions also do this by taking clothing away and providing normalised hospital gowns, thus removing individuality. Putting ID bands on patients further reduces the need to refer to people by their names. Giving spiels on patients' rights which tells them how they should act and what will be tolerated by the institution, along with the taking of patients' valuables from them, all also work to deindividualise patients and reinforce professional frameworks and expectations. Kagan (2016) refers to this as othering. Through such techniques, patients become framed through what Foucault referred to as the medical gaze, a process which allows the healthcare professionals to maintain the patients as objects and as subjugated.

As Leary (2014) rightly points out, these techniques of professionalisation have come at the expense of some of the care frameworks that nursing – at least in rhetorical terms – has held in high esteem. Thus, instead of a focus on empathy, compassion and caring for patients, there is a distinct focus on competence (Whitehead et al., 2014), and on meeting the standardised requirements of a duty of care. At best it is assumed that the ideas around PCC and holistic care are embedded in the social identity of nursing and, therefore, that it does not matter that such ideas are only implicit in practice. This can also be viewed in the language used in the Standards of Practice (2016) and Codes of Professional Conduct (2008b) and Codes of Ethics (2008a). In these documents the language of compassionate care is implicit, rather than explicit, and, as Whitehead et al. (2014) recognise, this suggests that these qualities are less valued overall.

Manipulation and Discretion

Concepts of manipulation and discretion are inextricably linked. It is hard to define whether or not nursing practice relies wholly on coercive manipulation and, therefore, manipulative practices framed under the guise of discretion based on professional expertise. Some authors such as Habibis, Hookway and Vreugdehil (2016) further suggest that the use of kindness and compassion and frameworks of a patient's best interests in nursing practice is actually to do with processes of manipulation in the nurse-patient relationship. This was a notion that was not lost in the interview data collected, where the idea of manipulation was also broached. This is exemplified in the following long extracts:

Facilitator:	*Do you think that sometimes - and whether it's intentional or unintentional, I'm not sure but do you think sometimes that we're pretty manipulative?*
Interviewee:	*Yeah. Yeah, we are, actually, when you say it like that.*

Facilitator: *[Laughs]. Only because, obviously, as an advocate, we feel that we should be trying to encourage them to do the best for what's them and, obviously, we think that, in some respects, know what's best so we tend to say to them, oh, you know, just wait until such-and-such or - so it sounds a little bit coercive and a little bit manipulative. Have some lunch and then, you know...*

Interviewee: *Yeah and talk about it.*

Interviewee: *Yeah, we do and that comes with experience, once again, and confidence, you have the confidence to say, well, no, you're going to do it my way, and that's how it is.*

Facilitator: *Yeah, that's right. How do you think that affects someone's autonomy?*

Interviewee: *Well yeah, if they're feeling intimidated [laughs].*

Interviewee: *It depends on how, you know, you come across. Yeah, this person could sit there and think, oh, God, she's scary so I won't - you know, yeah, absolutely. Or, yeah, it could be a matter of talking them around and then them changing their mind and thinking, well, perhaps I will wait till after lunch, give her the benefit of the doubt and decide then.*

Facilitator: *Yeah, you can only just try, can't you?*

Interviewee: *Yeah.*

An extract from interviewing another nurse also supports this viewpoint:

Facilitator: *Do you think that is manipulative? Or do you think that's just using your skills that you have to get the best outcome for patients?*

Interviewee: *I think it can be a little bit of both. I think - I always ask, because I think it's polite to ask. That's just how I always am. I have to ask someone. If then they refuse, I will keep going. Be like you know what? It's probably good for you. You're sick, bugs on the beds. Or we need a fresh change of clothes or something like that. It will help you getting better, rather than the bug spreading. If you explain it to them, most people will say yes to you anyway, even if they don't want to have it. But it can be seen in both ways. I can see that as manipulative at one - on one side. On the other, I can see how it benefits. Some people can be really difficult and it's just - like with the dementia patients. That's - I've seen that used a lot. Only because we know that it's in their best interest. At the same time, you're not forcing them to have a shower. But if you're straight up, they tend to listen to you a lot more.*

Facilitator: *You mention in the patient's best interest, and you've mentioned it a couple of times. Which is fine, but who decides what's in the patient's best interest?*

Interviewee: *You know how we - in nursing, they always say that we are responsible for our patients and their care. We have a duty of care to the patient. Everyone has to look at it in a way that as long as it's not going to hurt them or hurt themselves. Then you make a decision. I find it hard to - it's a very, very fine line. I find that you can find yourself in trouble, if you don't approach it correctly. I don't know. Oh, that's a hard question.*

I like to treat people the way that I'd want to be treated if I was the patient. I wouldn't force anyone to do anything that they didn't want to do. Because if they came in and I was like no, I wouldn't want them pestering me about doing something or taking something. But if a patient has dementia or a mental illness, it brings so much more on the plate that it's hard to draw that line. Especially when the doctors come around and order things. The patient doesn't want to take it and you don't know what to do. Or you have to try your best to talk to them and make them understand. Then get them to take the tablets or things like that. Yeah, that one's a bit hard…

A further concept that is often linked with such processes and practices of manipulation is that of propaganda. Propaganda is embedded within healthcare in many ways, some of which were discussed in the last chapter in relation to the framework of PCC. When we define propaganda at its most raw state, it is the encouragement of beliefs and actions with the least thought possible (Ellul, 1965). When we look at propaganda specifically within healthcare, it can be aimed at both consumers of healthcare (patients) and the providers of healthcare (healthcare professionals). Gambrill (2010) identified in her work that one of the powers of propaganda within the healthcare settings is in relation to Evidence Based Practice (EBP), which works to maintain models of professional power and expertise with regards to clinical decision-making. Although this can be beneficial, as noted with regards to the operation of parts of the biomedical regimes of truth, Gambrill (2010) goes one step further and identifies that propaganda within healthcare is set-up ideologically to maintain the illusion that healthcare professionals are in possession of unique knowledge. Wray and Deery (2008) notes that this is just one way that biomedical knowledge and, therefore, expertise becomes legitimised and accepted. Additionally, as I mentioned in Chapter Seven, one of the barriers to true PCC is that the idea of patients having choice within healthcare environments is itself an illusion which is, in turn, supported through the use of propaganda.

Durose (2011) understands that discretion within nursing practice is the operation of a form of judgment within recognised professional boundaries. Indeed, the exercise of discretion is often taken as the archetypal activity that defines professional practice and has provided the focus for a significant amount of debate and analysis concerning the status of professions (Hunt, 1997). According to Hoyle (2014) and Taylor and Kelly (2006), there are three types of discretion: (1) rule discretion, bounded by legal, fiscal or organisational constraints; (2) value discretion, determined by notions of fairness or justice and involving professional and organisational codes of conduct and ethics; and (3) task discretion, the ability to carry out prescribed nursing tasks. The alignment of these ideas of discretion with the frameworks and practices of professional autonomy are clear – where professional discretion is aligned with the concept of professional autonomy in relation to having the ability to make judgements and act within a professional knowledge base. Such alignments are clearly articulated in the RN Standards for Practice (NMBA, 2016), Code of Professional Conduct for Nurses in Australia (2008a), and the Code of Ethics for Nurses in Australia (2008b). At the same time, it should be recognised that both these boundaries and alignments within which and according to which judgements can be made, will themselves be framed within the regimes that nurses are working within – either, for instance, the biomedical or PCC regimes of truth.

What is important to note here is that the affordance of such discretionary behaviour by professionals is based entirely on the special privileges accorded them through educational status and accompanying professional expertise and knowledge (Gambrill, 2010). Indeed, Gambrill (2010) specifically refers to this education as being the basis on which members of the profession have been afforded the ability to exercise professional discretion in relation to making decisions. At the same time, the process of discretionary judgement is based heavily on the accepted frameworks of professional obligation and ethical conduct that inform the behaviour of healthcare professionals towards patients (Gambrill, 2010). The use of discretion is, hence, about the interpretation of rules and policies according to which professionals fill in the blanks between the rhetoric of practice outlined in these policies and rules and actual practice. That is, the use of discretion itself requires professional judgement by professionals as to when to apply ‘rules’ and when to bend them and exert a degree of professional autonomy. In these instances, discretion provides a paradoxical space for the operation of power both enticing resistance and inviting surveillance. It is, to put this otherwise, clearly a political activity occurring in contexts of uncertainty and complexity where actions cannot be pre-prescribed, and which necessitates negotiation while highlighting localised and relational aspects of power (Gilbert, 2001).

As should be evident, discretionary activity often occurs in relation to negotiating power relationships between nurses and patients. As was noted earlier, it can be easy for the nurse to end up manipulating a patient, and not give them any ‘real’ voice in their care. This is an example of where the blurring of the lines occurs in relation to discretion and manipulation. It is clear, for example, that this particular participant combines both discretion and manipulation in terms of providing patient care:

> *I would say. But I know over the years, I know who we can talk to. You know. I would definitely, like today, 20, I know her history, she does have drug use, she lives alone, she drove on the wrong side to Geelong. So, I wanted to make sure that she was okay at home. So actually, she does need help, if I look at her, but she refused it. But I have documented that I have done my part, which I think I'm responsible as a nurse. So, I went, and I asked her whether you need any help at home, how you're managing and this type of help, because some of them don't know that, that you can get all this help. So you can ask them in a nice way whether you want it, and I can see that you manage but I still want to make sure and with their sugars, and she wasn't managing with her sugars, so I asked her how much do you give and I said to her in a nice way, I don't think that's the right dose but I'm not sure, we'll get the diabetic - so I got the diabetic educator which she was happy to come and talk to her and it wasn’t.*

In these instances, processes of manipulation and discretionary behaviour are justified by the concepts of best interest and duty of care, where the nurses use ideas around doing what is in the best interests of the patient to make their manipulation and discretionary behaviour of the situation professionally acceptable.[8] Interestingly, the Code of Professional Conduct for Nurses in Australia (NMBA, 2008a) does openly discuss the topic of power within the nurse-patient relationships in Conduct Statement 8. This conduct statement talks about nurses needing to promote and preserve the trust and privilege that is inherent in the nurse-patient relationship and identifies that there is an inherent power imbalance that exists between the patient and the nurse. The Code further outlines how this imbalance can make the patient potentially vulnerable and open to exploitation. This is a point that has been raised in earlier chapters. Indeed, the introduction of PCC frameworks – particularly the concept of a therapeutic relationship that is informed by rapport and trust and is the cornerstone of PCC frameworks – has arguably attempted to counteract this power imbalance by making the relationship between the patient and the nurse about shared decision-making and changing the way that the nurse and the patient interact with each other. As the points above make clear, however, such ideals can in turn be undermined by standardised practices. This can be seen in Conduct Statement 9. While these stress the building of trust within the community and the need to maintain the confidence invested into the nursing profession,[9] it is also clear that such ambitions can be undermined by other forms of professionalised strategic decision-making.

The Code of Ethics for Nurses in Australia (2008b) also discusses the power in the nurse-patient relationship, albeit in a slightly different way. In Value Statement 2, the discussion around power occurs in relation to kindness in nursing practice and how the simple act of kindness is useful in addressing the potential power imbalances in the nurse-patient relationship. However, the act of kindness in itself may be a naïve way of addressing the power imbalance that exists, especially when the framing of this value statement is

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[8] Note that this concept of best interests is itself often framed in terms of compassionate care and being kind, a frame supported in the Standards for Practice (2016) and the Codes of Professional Conduct (2008b) and Codes of Ethics (2008a).

[9] If you do a google search for the most trusted profession in Australia for 2017, the Roy Morgan Research institute tells us that nurses are still the most highly regarded profession both in terms of their honesty and ethical practice (Image of Professions Survey, 2017).

around the nurse being at the service of the patient. Whilst acts of kindness may help with patients in relation to making them feel less anxious, alleviating fear and making them more comfortable, it is also very clear that nursing care does not have to include kindness to be effective (Faust, 2009; Mace, 2012) and that such kindnesses may not, in fact, operate as expected. Hufford (2009), for example, talks about the manipulation of others through acts of kindness and that patients who are tired, unwell or stressed may actually feel that kindness in healthcare is counterfeit. So understood, practises of kindness might actually suggest points of resistance for patients. Deligiorgi (2016) refers to kindness in turn as a form of maternalistic interventionism designed to manage both patient and professional cohorts in very specific ways, promoting models of discretion and surveillance in nursing practice.

Conclusion

This chapter has served to further identify and map some of the complexities and pressures that inform the concepts and practices of caring within nursing, complexities that impact practices of advocacy and the support of patient autonomy. Initially this chapter reviewed how care has traditionally been viewed as a value within the nursing profession. This concept of care has been professionalised – legalised – into a duty of care to the patient. This duty of care to the patient, however, is inherently entwined with the professional capability of the nurses themselves. This is in relation to maintaining the ability to reflect and improve on practice. This is part of the governmentality of caring that is entwined within the ideas of the art and science of nursing. The second part of the chapter discusses a range of what I am calling technologies of professionalisation. This part of the chapter thus examines, for example, the models of self-reflection, standardised care plans, and the roles of distancing, manipulation and discretion within nursing practice. In many respects, this second part of the chapter demonstrates how ideals of care – as informing PCC – are still dominated in practice by other pressures.

Indeed, it almost seems that the conventional constructions of nursing care – including those that have been rewritten into the PCC regime of truth, and centre on ideals of advocacy and support for autonomy – are infused with technical requirements for practice. This is to the point that the specific nursing qualities that have been understood to separate the nursing profession from the biomedicalised medical professions – which itself arguably allowed the conceptualisation of a nurse advocacy role in support of patient autonomy – appear to have been lost. This in turn supports the notion that there is an entanglement of the biomedical and the PCC regimes of truth in practice. That is, while these two regimes of truth were initially unpacked independently from each other and there seemed to be two discrete frameworks able to be operationalised at their own levels, in practice as shown, there is considerable overlap with both being informed by other techniques to do with professionalisation. While I acknowledge that there are times when technical care and skills have to trump the need for some of the empathetic and compassionate sides of nursing as care, it leaves nursing vulnerable to becoming an offshoot of medicine and losing the identity that has been carefully constructed. That is, if nurses are not more than another cog in the wheel of institutionalised – biomedical – care, then the profession of nursing loses what is perceived to be the differential between the nursing and medical professions in relation to holistic and PCC care.

As this chapter has shown, Foucault's disciplinary power provides the point of reference that can explore and describe the kinds of tensions that nurses experience from operating within the framework of contemporary nursing practice while trying to remain autonomous as professionals in a complex system of power relations. Up until this point, the ideal of advocacy has still retained some framing as a form of care for the autonomy for patients. However, as demonstrated within this chapter, the decreased care occurring in healthcare due to competing pressures impacts on the ideals of autonomy and advocacy as care. Advocacy designed to protect the autonomy of patients is constrained by the institutional and hierarchised nature of healthcare that exists. In addition, patients may never be able to demonstrate personal autonomy due to a number of competing factors including being vulnerable due to illness and the constraints of the environment. What follows next is a discussion around the implications of nursing practice, in particular the need to acknowledge and challenge the status quo in relation to naively adopting advocacy as a role for nurses and the need to challenge assumptions around advocacy and autonomy. This will be framed from the power imbalances that exist and the need to recognise that power and knowledge are synonymous.

Chapter 9 - Conceptualisation and Operationalisation of Advocacy and Ideals of Autonomy

Introduction

This thesis has been a journey that has taken the phenomenon of the idealisation, embedding and enactment of concepts of advocacy and autonomy in the frameworks of nursing care and examined it through the perspectives of currently practising nurse clinicians and in the context of Australian nursing policies and standards. This has been conducted through analyses using both a hermeneutic phenomenological and Foucaultian lenses, and has involved me in exploring practising nurse and policy perspectives with regards to the importance and roles of advocacy and autonomy and then examining the ways these perspectives are themselves framed and interrupted by broader power/knowledge relationships. This latter work saw my identification of two main regimes of truth – biomedical and Patient Centered Care (PCC) – and a broader suite of technologies of governmentality that intersect with and impact on both. All three of these sets of discursive relationships have been shown to impact on the ways advocacy and autonomy are framed, understood and operationalised within nursing care and healthcare more broadly. It is these impacts that are the focus for this chapter.

More specifically, engaging the model of the hermeneutic circle inspired by hermeneutic phenomenology, this chapter marks my circle back to consider where I have come to so far with regards to my research aim and research objectives. These were to explore the various constructions/ideals of advocacy and autonomy that are seen as fundamental for both nursing and being a nurse and to examine how well they cohered with the actuality of nursing practice in the current Australian context, as well as to examine the impacts and implications of any tensions regarding the operationalisation of these concepts. As has been noted, this has involved both investigating how ideals of autonomy and advocacy are constructed within nursing literature and policy and by nursing practitioners in and through their nursing practice, as well as analysing how these constructions support and maintain specific ideals, subject positions and practices which, themselves, work to either maintain or disrupt these constructions. As such, this chapter will firstly identify and discuss some of the challenges that were faced during the collection of data and how this may have influenced the results presented within this thesis, along with considering the ways Foucault's ideas have helped me come to critically reconsider the ideals and work of nursing care. The next part of this chapter circles explicitly back to my thesis aims, paying attention to the conceptualisations and operationalisations of autonomy and advocacy that have become evident throughout the preceding chapters. The final part of this chapter, and indeed this thesis, will be my recommendations for contemporary nursing practice in relation to these considerations of autonomy and advocacy, thus leading ultimately to a suggested reconfiguration of the expectations of the nurse in relation to these concepts within contemporary Australian nursing practice.

Research Challenges

During any research process there are always reflections that occur both during the research process and during the analysis of data. Such reflections often come about as a response to particular challenges regarding the research process, or mark points of recognition that there are other choices that could have been made. As part of this analysis, I have presented three chapters: Chapter Six, Examining the Biomedical Regime of Truth; Chapter Seven, Examining the Patient Centered Care (PCC) Regime of Truth; and Chapter Eight, The Governmentality of Care. Each of these drew attention to some of the main factors that this project has identified as shaping the framing and operationalisation of autonomy and advocacy within contemporary nursing practice. What needs to be recognised is that there are also potentially other regimes of truth and discourses that I have not identified in this thesis that may also be influential in relation to autonomy and advocacy. There are two additional points that should also be noted.

First concerns the roles of the insider and outsider within this research process. As has been noted, I considered myself to be both an insider, as a currently practising Registered Nurse, but also an outsider in relation to being the researcher who entered the research field. In this capacity my role was to observe and study clinical practice, and to engage those nurses whose practices I observed in a series of interviews. This process of data collection thus drew on both an ethnographic model of observation – specifically a moderate participation observation style (Spradley, 1980) focused on examining the everyday interactions and culture of a discrete community with a limited number of participants (Alvehus & Crevani, 2018; Bikker et al., 2017) – and engaged a phenomenologically oriented model of research interviewing that gave nurses the ability to elaborate further and explain their nursing care, adding further depth to the observed data. Observations allowed me to observe the therapeutic interactions between nurses and patients, while interviews allowed me to create a shared social experience with my participants. As I have noted, my insider status was invaluable here as it meant conversations were not held up by having to establish common ground. In both of these processes, given my own clinical background, operating as an insider was uncomplicated on many levels.

What this experience of entering the research setting and operating comfortably within it as an insider did foreground, however, is the importance of recognising that my own historicity and preconceptions influence and shape not only my own processes of data collection and interpretation, but thus the study outcomes. That is, it should be noted that not only my own historicity but further the responses and experiences elicited from participants both shape and are shaped by my data collection processes. As the researcher I both constructed the process of the research, and the analysis and therefore in many ways have controlled and maintained the knowledge that has been produced through this thesis.

Secondly, the focus of my research aims, proposed and presented in Chapter One, has meant that the findings of the study have been framed by both current policy as well as the views of the participants within this study. However, the webs of discourse in which I as the researcher and the participants are embedded are themselves affected and influenced by the interactive processes that work in relation to the maintenance and construction of power/knowledge relations. Therefore, at any one point in time, it is only possible to capture a snapshot, or a version of the world that the participants found themselves in during the interviews and during the observational period. As a result, some other possible discourses may not have been represented in this thesis.

Throughout the journey of understanding I have undertaken through this thesis; I have maintained the utmost pride and respect for the participants of this research and for the sometimes unrecognised work that nurses engage in. This thesis has the potential to change the way that nurses think about and attempt to operationalise advocacy and autonomy within nursing practice and may be the catalyst of change that is required to occur for modernisation and acceptance of the active consumer role of individuals within healthcare arenas. This links back to the frameworks of PCC that have been discussed in detail throughout this thesis (see Chapter Seven in particular) and links to the key aims of this study itself.

Learning with Foucault

While the first half of the thesis set out how autonomy and advocacy have been conceptualised with regards to nursing practice and how they are viewed by nurses who strive to operationalise these concepts in their everyday practice, the second half of the thesis has shown that there are many tensions around these ideals despite the ways they have been packaged as essential to good nursing practice and wrapped up as evidence based practice. In fact, the fracture points that have become visible in relation to the enactment of advocacy as a role for nurses in practice, and their flow on effects in relation to the ideals of autonomy, are some of the most poorly discussed and identified issues within nursing literature and practice. Indeed, this thesis has demonstrated that the rhetoric behind these concepts and attempts to genuinely actualise these ideals into practice are not always in alignment.

What I would like to draw the reader's attention to here specifically is what Foucault has helped me to see through this thesis and the learnings that are influential in the conclusions that are ultimately drawn from this study. As previously discussed, within each distinct regime of truth, there exist certain subject positions that can be taken up and held within a discourse. These subject positions are influenced by the power and knowledge relationships that are dominant at any one time. However, regardless of which regime of truth is being used to examine the ideals of autonomy or advocacy from, it needs to be recognised that it is possible to also explore these ideas from alternative positions. Therefore, when the operationalisation and conceptualisation of these concepts is being considered, it is also important to think about the fluidity of the subject positions within these regimes of truth and that this may impact on the framing of these concepts within nursing practice. This fluidity regarding the subject demonstrates the variability of knowledge, power and of subjectivity, all of which can influence the operationalisation and conceptualisation of advocacy and autonomy.

For instance, just as there has been fluidity in the conceptualisation in the subject position of the 'patient', the subject position of the nurse is also no longer clear or coherent. As demonstrated, there are subject positions for the nurse presented within the different discourses of the biomedical framework and PCC that do not align neatly. Furthermore, only some of the subject positions for the nurse that are enforced within these discourses include the ideals of the nurse as advocate and therefore as supporting the ideals of patient autonomy within contemporary nursing practice. In addition, what the discussions presented in Chapters Six, Seven and Eight all show is that the work of advocacy – and the support of autonomy – is simply not at the forefront of nursing practice, and that there is a distinct lack of coherence with regards to the values and contested space within which nurses now operate.

Initially, then, the work of Foucault has helped me understand that the ideals regarding autonomy and advocacy in contemporary healthcare are not well supported within the environment of practice. These concepts as they are currently conceptualised in practice and in theory lack cohesion, as evidenced by my observational fieldwork and interview data collected and examined throughout this thesis. Certainly, advocacy has long been claimed as part of good nursing practice and is espoused in the literature as essential to nursing practice and supporting patient autonomy. However, advocacy in practice appears to blur into paternalistic versions of itself which rather limit a person’s autonomy and therefore further destabilise the concepts of autonomy and advocacy embedded in nursing documentation and ideals. This is due primarily to the ways institutions of healthcare govern the normalised versions of healthcare that currently exist. It is fair to say that these ideals which the guidelines, codes and standards of nursing practice are based upon struggle to be responsive to the changing environment of contemporary healthcare and conceptualisations of patients.

As the previous chapters have shown, there are multiple conflicting assumptions in relation to the ideals of autonomy and advocacy and how they should be enacted within healthcare. This is in part due to the multiple and conflicting power relationships – examined in previous chapters – that occur within the complex and multi-faceted system of healthcare. Given that the two concepts of autonomy and advocacy remain significant within contemporary nursing ideals and practice, the complexities outlined through this thesis raise the question ‘how autonomy and advocacy could be operationalised in the critical relationship between the nurse and patient?’ Further, how *should* they be operationalised, and why? The next part of this chapter will thus reconsider the understandings of the biomedical and PCC regimes of truth, paying specific attention to what they have meant for the operationalisation of advocacy and autonomy in nursing practice.

Reframing Understandings

The work of this thesis has been to investigate how ideals of autonomy and advocacy are constructed within nursing literature and policy and by nursing practitioners in and through their nursing practice, as well as to analyse how these constructions support and maintain specific ideals, subject positions and practices which, themselves, work to either maintain or disrupt these constructions. Each of these needed to be addressed to help in understanding how advocacy and autonomy might need to be reframed and reconceptualised within contemporary nursing practice. To consider this effectively I need now to go back through each of the two identified regimes of truth and associated techniques of governmentality in order to further examine the complex operationalisations of advocacy and autonomy in nursing and healthcare. To begin this discussion, however, I will first return to the perspectives of my nurse participants. These will once again provide useful context for my re-examination of advocacy and autonomy in the light of the complexities of the various regimes of truth and technologies of governmentality that interconnect with contemporary healthcare.

Examining the Thematic Analysis

From the Thematic Analysis (TA) it was clear that many nurses referenced PCC as being the dominant underpinning framework of contemporary healthcare. PCC, as discussed, involves the psychosocial and social aspects of healthcare that can be undervalued in the biomedical regimes of truth. The nurses identified these aspects as being important in being able to provide individualised patient care, and this underpins holistic care for the patient. As such, there was a large focus on the need to respect the individuality of the patient, as well as on ideas that it was important to support patients and therefore their autonomy. At the same time, what was also evident through the observational fieldwork and referenced by the nurses themselves, is that biomedical regimes of truth are also still highly influential in nursing care. Indeed, despite their PCC commitments, the nurses thought that at times some PCC mainstays – extended familial input, for example – hinder the capability of patients to be fully independent and relationally autonomous.

The nurses interviewed believed that they were providing PCC and aligning with frameworks of PCC by spending the time to getting to know their patients on a more intimate level, although as noted they also made visible some of the disconnection between aligning the psychosocial and social aspects of care with biomedicalised frameworks of care. In relation to understanding autonomy and advocacy, the participants identified that the main role of the nurse as an advocate was implied when the patients demonstrated decreased capacity for autonomy. All the nurses expressed that they were well placed to be advocates for clinical practice due to the omnipresence of the nursing profession which gave them the ability to listen to and then speak on behalf of their patients. The nurses referred to this, rather than advocacy, as being more of a voice for patients when they were not able to be autonomous. As all the nurses recognised, their presence and experience have a huge impact not only on their ability to be able to manage the healthcare complexities of patients but also to take on the complexities of the role such as being an advocate for patients.

All the nurses thus identified that it is the nurse-patient relationship that underpins and makes possible the advocacy relationship. However, as they recognised, there has to also be mutual respect and the formation of empathy for the relationships to be functional with respects to advocacy. The interviewed nurses also talked about advocacy as a duty of care and thought of it as an obligation of care that required a certain level of professional knowledge and expertise to facilitate. As they saw it, this meant using forms of communication that would be understood that by the patient. However, the problem is that, despite these commitments, there was also a tendency to function in a biomedicalised reductionistic way with regards to patients when they were acutely unwell. That is, there was a tendency to forget the people and instead focus on their conditions, a tendency that compromises a patient's autonomy.

Re-examining the biomedical regime of truth

As has been noted throughout the thesis, biomedical models of care are often referred to as reductionistic in nature in that they neglect not only the social and psychosocial aspects of being human, but also of care. They paint a picture of patient health that prioritises physiological – biomedical – signs and symptoms, and professional expertise, over the social and psychosocial aspects of health and healthcare. Within the context of nursing, this has facilitated some of the ideals of care becoming more centred around the task, with the patient's body becoming an object. Such forms of reductionism have important implications for ideas of advocacy and autonomy, as has been suggested in Chapter Six.

For example, the biomedical regime of truth constructs healthcare professionals, including nurses, as the holders of expertise, while patients are constructed as in need of this expertise. Aligned with the hierarchy of professional knowledge and expertise, professional identification and the treatment of signs and symptoms further allows for the normalising of biomedical judgements and provides reference for what is 'normal'. Together these measures produce a diagnosis, and therefore an individual subject position is created for use by the patient and their significant others, as well as other healthcare providers. Such subject positions furthermore construct the individual in such a way that the individual begins to internalise and normalise this subject position, becoming what Foucault would refer to as a docile body. Patients, to put this another way, cannot be autonomous in the healthcare context, and their lack of autonomy increases not just with increased acuity but also with each application of professional expertise through the uses of examination, diagnosis and treatment. Under this framework, then, all patients need advocates, but in practice this advocacy is paternalistic to the point that it itself further compromises patient autonomy. Healthcare workers always 'know' best, and patients should remain docile and compliant in the face of their expertise. At best, patients will only be able to exercise their autonomy when in compliance with the information and education that they receive from healthcare professionals. This is a long way away from the assumptions of autonomy and indeed of advocacy.

Re-examining the Patient Centred Care regime of truth

While the biomedical regime of truth is reductionistic in nature and foregrounds the professional expertise of the professionals that operate within these spaces along with sets of diagnoses, PCC frames itself as being responsive to an individual patient's preferences, needs and values, and as explicitly incorporating these into a patient's care and treatment plans. PCC, in other words, involves treating people as unique and relies on the customisation of care, and is as such built on mutual trust, respect and understanding, with a large focus on collaborative care. Unlike biomedical regimes of truth where patients require professional knowledge and expertise to support their diminished autonomy – played out through paternalistic advocacy – PCC stresses a model of empowerment that functions to support patients to engage in shared decision-making processes. In addition, the PCC recognition that people are entrenched within a network of relationships that are culturally and socially situated further shifts the way the work of patient advocacy should be performed. First, as noted above, patient advocacy is not framed paternalistically but rather through ideas of patient empowerment. Indeed, what is important with regards to the work of advocacy in the PCC context is that it assumes that patients should be responsible for their own healthcare and their own healthcare decisions, further if patients possess expertise with regards to their own disease. What this means in practice is that under PCC the aims of advocacy become aims of constructing a therapeutic relationship which can facilitate patient empowerment. Second there is the recognition that because patients are socially embedded, there are also non-healthcare professionals who may choose to undertake advocacy work for them. That is, advocacy work may also be undertaken in some capacity by patient's family and extended family circles. As such, through PCC frameworks, advocacy work requires healthcare professionals to partner with patients and with their families and their carers.

Given these assumptions, PCC also understands patient autonomy differently to the biomedical model. For instance, while the biomedical regime of truth effectively dismisses the idea of patient autonomy – while framing itself as working to support patient autonomy (via the influential bioethical principles) – PCC supports a very different reading of autonomy. That is, if the biomedical model of autonomy is based upon the requirements of liberal autonomy and judgements of competence and capacity independent of a person's social and relational context, PCC would seem to understand autonomy in much broader social terms.

Re-examining the Governmentality of Nursing

The final set of issues to be noted here is that concerning Governmentality in Nursing. As Chapter Eight has shown, nursing practice is usually understood as underpinned by concepts such as care, empathy, compassion and kindness. All of these essential qualities have also been considered important for advocacy in that they are thought to help to reduce the power imbalances and inequalities that exist between the healthcare professionals and patients – points also important for the support of patient autonomy. What Chapter Eight has also shown, however, is that these qualities have become framed in terms of professionalised techniques and power/knowledge relations informing a duty of care. As has been discussed, these technologies of practice/professionalisation include such mechanisms as self-regulation, standardised care plans, distancing, manipulation and the use of discretion within nursing practice, each of which further rely on techniques described by Foucault as hierarchical observation, normalising judgements and, finally, the examination.

As such, although this duty of care of nursing refers to both quality nursing care – itself framed in regulations and guidelines using the rhetoric of PCC – and an expectation that nurses can and will advocate on behalf of their patients to ensure that their voice is heard during the healthcare journey and that they can become empowered in their decision-making, this resultant model for advocacy works in practice as a form of regulation of both patients and nurses. In addition, the regulatory techniques underpinning the nursing duty of care further work to reduce both patient and nurse autonomy. Furthermore, while there are arguments in the literature with regards to professional autonomy and the role that this plays within nursing practice, the ideas surrounding autonomy in this sense are based around the educational preparation of the nurse as a professional and having the authority to make decisions autonomously within this given professional knowledge base. While such authority may hold true for some contextualised areas of nursing practice, overall the current understandings of professional autonomy are very limited and constrained by the hierarchised and self-disciplining systems that are dominant within healthcare institutions.

As these preceding chapters have also shown, despite PCC rhetoric, contemporary healthcare practices are founded within the biomedical model of care where there is a reliance on the hierarchy of the medical expertise. This hierarchised and biomedicalised framework is particularly prevalent in instances of clinical deterioration occurring with patients. As such, in the reality of healthcare, the choices for patients are limited and constrained by the professionalised techniques of healthcare meaning that patient autonomy is always constrained.

What these points demonstrate, then, is that the rhetoric of theory and practice is mismatched with regards to the roles for advocacy and autonomy in nursing practice. That is, these concepts as they are currently conceptualised in theory and operationalised in practice lack cohesion. From the above discussions, I have demonstrated that the ideas and enactment of advocacy and autonomy within nursing practice are complex and arguably messy. There is as such a need to refocus our understandings of advocacy and autonomy within contemporary nursing practice.

Reconceptualising Liberal Autonomy

As can be recalled, Chapter Two began to tell the story of how the ideals of autonomy that are embedded in healthcare unfold in relation to bioethical contexts. As was seen in The Belmont Report, the ideal of autonomy was constructed more around paternalistic notions of care, where an individual was being potentially non-autonomous and requiring protection. This limitation in an individual's ability to be autonomous increased the need for advocacy as a supportive mechanism for autonomy. Definitions of liberal autonomy also historically showed a disregard for the humanistic and social aspects of being human. As has been shown, ideals of liberal autonomy tend to isolate individuals in assuming that social and support networks are not required – and in fact could be detrimental – in relation to their decision making. This argument is supported by the dominant biomedical models which show a reluctance to appreciate the social nature of health and illness conceptualisations. Within the healthcare environment, however, it is also clear that the choices available to patients are constrained and limited. This is based partially on a patient's lack of knowledge and experience that would enable them to be able to be autonomous within the healthcare setting. This is further compounded by illness and vulnerability which can influence a person's decision-making capacity. These points together cast doubt on whether ideals of liberal autonomy can be sustainable within the healthcare environment and therefore question what the role of the nurse as an advocate would be if understandings of autonomy within healthcare change.

From my continued examination of these conventional liberal ideals and roles of autonomy within the scope of healthcare practice, there is a need to develop a deeper understanding of the contextualisation of autonomy within practice. As previously outlined, the construction of both the patient and what have been considered the 'norms' of healthcare influence and construct the subject positions for individuals within the healthcare environment, and therefore, in turn, the subjectification of these individuals. These perceived norms of healthcare, as demonstrated within the previous chapters, place the patient at a disadvantage in relation to autonomy. Adding to this, understandings of vulnerability and the constructs of health and illness compound the ability of individuals to be autonomous within healthcare settings. Furthermore, to not recognise the social dimensions of personhood in the way ideals of liberal autonomy do, can only place the patient within a disempowered position within healthcare. In response to this problem, Kukla (2005) and Rendtorff (2007), for example, rebuff a reliance on liberal understandings of autonomy as they argue that as patients do not have the necessary expertise and authority within the healthcare context to be solely autonomous, and they should rely on healthcare professionals to assist them in decision making specific to healthcare. At the same time, it could also be argued that such a perspective increases the need for paternalistic models of the provision of expertise and advocacy. This is a view not lost on the participants of this study.

One of the ways that I am proposing that this can be opened to consideration is through challenging the taken for granted implementation of liberal autonomy within nursing practice and its influence on patient care. Rather than the normalised liberal definitions of autonomy which neglect the social interconnectedness that maybe influential in an individual's ability to make healthcare decisions, it may be more constructive to define and view autonomy as relational in nature, a term coined by feminist author Meyers (1989).[1] This is based on the point that the idealisation of an independent, rational and self-interested individual, in reality, is a misnomer and cannot truly exist (see for example Baylis, Kenny & Sherwin, 2008). As such, rather than the liberalised versions of autonomy where the individual is expected to be solely responsible for their decision making independent of others, relational autonomy recognises that in being embedded within social values, relationships and power structures, the individual is always interdependent (Brison, 2000; Dodds, 2000; McLeod & Sherwin, 2000; MacDonald, 2002a). To put this another way, relational autonomy still recognises the need for an individual to be self-governing in making healthcare decisions, but also recognises that such decision making will also incorporate their social connectedness and influential relationships. As Scully, Banks and Shakespeare (2006) recognise, for a person to be autonomous their social relationships must be a precondition.

Viewing autonomy as relational implies that to be autonomous the individual has to learn a skill or competency and that this is always influenced by both the subjective reality in which the individual finds themselves and also by their social connections and the enmeshed power relationships (Atkins, 2006; Christman, 2004; 2005; Donnelly, 2010; Ells, Hunt & Chambers-Evans, 2011; Goering, 2009; Mackenzie et al., 2007). Although

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[1] Meyers (1989) understands that the competency and skills associated with being autonomous is inherent within cognitive and practical skills obtained through social connections and relationships.

relationality is often ignored within healthcare, especially in acute care environments, it would be remiss of health care professionals to ignore the social contexts of patient decision-making, given they have the potential to strengthen, and consolidate autonomous decision-making (de Oliveria & da Silva, 2010). This kind of relational understanding of autonomy does, however, underpin one of the discourses discussed earlier, PCC. This is supported in the literature by Christman (2004) who argue that although an autonomous decision needs to be eventually made by a patient, it is to be expected that assistance would be sought and required from professional experts, such as doctors and nurses, but also from that individual's social networks (e.g. significant others, partners or spouses) and relationships. This is seen to counteract the power inequalities that are inherent in the nurse-patient relationship by transferring some power from the healthcare professional to the patient. Of course, for this to occur successfully and not mark a paternalistic relationship, there must be consideration and acceptance of the social interconnectedness of the patient as well as the incorporation of their concepts and beliefs in relation to health and illness.

The points made here highlight the argument proposed that the current conceptualisation of the liberal autonomy model as purported by Beauchamp and Childress (2013) is a misnomer. Baylis et al. (2008) support this by stating that reinterpretation of core bioethical principles must occur to shift the focus from that of liberal definition of autonomy to a relational one. I have just spent considerable time laying out why individual autonomy does not appear to operate within the current healthcare setting, but it is known that as individuals the value of autonomy is highly regarded and protected in society in general. Humans are social constructs that are highly contextualised and socially interdependent on each other. Therefore, rather than defining autonomy as liberal, the consideration of the benefits of a relational alternative where the role of the healthcare professional becomes one of support, socialisation, education and reflection (Cole et al., 2014). This undoubtedly would also align well with the framework of PCC. If it is agreed that autonomy, defined as relational, is a better fit conceptually for contemporary healthcare than standard liberal concepts of autonomy, then the question must be asked in relation to what this means for advocacy in practice and how should advocacy be enacted and practiced by nurses in the clinical environment? This is the focus of the next section.

Reconceptualising Advocacy

There has long been acceptance that one of the roles of the nurse should be as a patient advocate. This is written into the governmentality of the nursing profession and demonstrated in the Literature Review (Chapter Two) of this thesis and has been positioned as a philosophical and inherent requirement of the nursing profession. In normalised versions of nursing practice, then, nurses are told that they must be an advocate for their patients (Macdonald, 2006; Simmonds, 2008). This foundational focus on advocacy is further established within the concept of the nurse-patient relationships (highlighted in Chapter Seven) within PCC frameworks, and is communicated to nursing professionals through governing bodies by way of their codes, guidelines and standard for practice. In this view, the basic point is that when there are unequal power relationships in existence, the weaker party requires some form of support. Within the contexts of healthcare, then, insofar as patients are both compromised in their autonomy due to their health conditions and, further, interdependent on healthcare professionals to help with the navigation of healthcare systems, there is a requirement of some form of support or advocacy. However, insofar as I am suggesting the need for a stronger focus upon the social aspects of autonomy, I also question what the role of the nurses as an advocate might look like in contemporary nursing practice.

While the nurses interviewed understood advocacy in the terms of being a voice for their patient and believed that they enacted advocacy from their own clinical practice perspective, it has to be questioned whether this can only ever be a limited version of advocacy. Indeed, advocacy roles that encompass everyday nursing practices have come under criticism as not being advocacy in the genuine sense. There are several reasons for this.

First, the role of the nurse as an advocate has often been limited to things such as providing information to the patient. This is said to be able to support a patient's wishes and therefore facilitate their decision making. All of this is further considered to assist patients to develop the skills and confidence in monitoring and being responsible for their own health and healthcare decisions. However, as described previously within the thesis, the subject position of the patient – particularly under the biomedical regime of truth but also within PCC – typically implies that the patient adopts and internalises the healthcare professionals' expertise and expectations and therefore remains docile and compliant.

This is further complicated by the point that advocacy work is also often framed as warranted in situations of acute clinical care – and often when there are complex patients who are clinically deteriorating – when a patient's autonomy is compromised. Such advocacy work is carried out under a paternalistic framework, and often not even under the guise of supporting a patient regaining autonomy. It should also be noted that when it comes to being able to inform patients about healthcare options and treatment or to advocate on their behalf, there is always a hierarchised structure that occurs within healthcare. Nurses, for instance, will often take on the subject position of a handmaiden to doctors, which further challenges the notion of the nurse as having power and capacity to effectively advocate for patient interests. If nurses have limited power due to their position in the hierarchy, how can they effectively advocate for a person with even less power in the system?

Secondly, as Blackmore (2001) and Breeding and Turner (2002) note, in a genuine advocacy relationship, the patient would be able to choose their advocate. In healthcare, nurses undertaking advocacy roles do so as merely a consequence of their professional role. This suggests that advocacy work is constrained to the professional role of delivering appropriate nursing care to patients and is further constrained by the random allocations and re-allocations of nurses to patients. Finally, although PCC frameworks in particular stress the importance of supporting patients to make choices that are well informed, it has also been shown that choice within healthcare for patients is always limited because of the institutionalised nature of healthcare as being set-up in favour of the healthcare professionals. The complexity of the healthcare system and the inability of most patients to navigate such a system by themselves thus stresses the importance of advocacy, whilst also ensuring that any advocacy work is always itself already constrained by institutional and professional interests. To put this another way, when advocacy functions as this kind of benevolent paternalism it consistently restricts the self-determination of the patient. This is particularly the case in institutionalised settings such as healthcare when dominant subject positions such as the healthcare professional are ideally placed to be an advocate. To sum these points up, whether conceived with regards to the biomedical or PCC regimes of truth, advocacy for patients remains paternalistic and limited by professional expectations and interests. That is, nurses and nursing practice are left in a quagmire of living up to professional expectations while attempting to advocate for patients in a way that would uphold the rights and autonomy of the patient.

What these points suggest is that nurses may take on an advocacy role without critical thought as to what this entails or may see it as a way that the nursing profession could differentiate themselves from other healthcare professionals. Indeed, the nurses within this study linked their advocacy work back to a requirement of the ethics of the profession. However, if relational and social ideas are adopted into autonomy, and there becomes a focus on better operationalising the actual ideals of PCC frameworks, and because advocacy has also been traditionally aligned with the idea of one person pleading a case for another based on individual concepts and neglecting many influential and relational aspects of care, there may also be a need for a new conceptualisation of advocacy for nursing. .

What is being proposed here is that rather than continuing to stress and enact a constrained model of advocacy, nurses should undertake a role of supporting empowerment for patients. In healthcare, as has been noted previously, the concept of empowerment is most often used to focus the target of healthcare outcomes back on the patient and assist them to become responsible for their own health outcomes. That is, the idea of empowerment is to turn patients into active participants in their healthcare rather than the passive objects as described by the traditional sick role and the docile subject position of the patient. As such, if empowerment were put into practice as a key concept, patients would be able to develop the knowledge, skills, attitudes and the self-awareness to manage and improve their quality of life. These points demonstrate how this notion of empowerment fits nicely with the ideals of patient centred care (PCC) examined in Chapter Seven, but it is also important to note that the concept of empowerment does not conflict with the social dimensions of relational autonomy. This also means that rather than working within the constraints of traditional paternalistic advocacy models, nurses should work to a model of empowerment based on the premise of supporting an individual's autonomy – including their relational autonomy. To put this another way, the work of empowering patients is not solely that of the healthcare professional. In fact, it is clear that rather than the atomistic versions of advocacy that have been written into traditional conceptualisations of healthcare, empowerment is always more relational in nature and relies on a multitude of influences to ensure patient care and influence decision making.

The problem, of course, is that some models of patient empowerment, although espoused as a way of mitigating the disparity in interpersonal power between patients and healthcare professionals, are still in many ways firmly rooted in concepts of patient education and information sharing that are also inherent within the biomedical model of paternalistic healthcare. That is, as Vinson (2016) suggests, patient empowerment can itself fall into a form of medical paternalism when it is used strategically by healthcare professionals who make assumptions regarding patient capacity to be empowered and deal with illness and negotiation of the healthcare system itself. While patients have the benefits of the lived experience of their illness, they are likely not to have the professional knowledge or expertise of their nurses and doctors and as has been noted the contemporary health environment can perpetuate their disempowerment.

If I return to the story of the individual who was trying to discharge himself against medical advice, for instance, the healthcare professionals were quite scathing of his choices in relation to his healthcare journey. While it is understood that patients have the right to make these choices, even if healthcare professionals believe that this might be the wrong decision for the patient to make, the patient in many ways was still empowered enough to try and make a choice and be resistive to normative constraints of healthcare. In the end, however, as seen in the example, the choice eventually made by the patient was constrained and controlled by the healthcare professionals. This is what Scambler et al. (2014) recognise as a situation where the concept of empowerment remains controlled by the healthcare professional and is not really a patient-centric notion. In such situations, genuine empowerment is unlikely (Sellman, 2005). This kind of criticism is limited, however, in that it does not appear to consider the relational dimensions of empowerment. As such, regardless of these concerns, I would suggest that empowerment can be an effective antidote to the unhealthy reliance on healthcare professionals that has been fostered through the paternalistic understandings of autonomy and advocacy within biomedicalised healthcare.

This thesis suggests that a deeper understanding of the role of the nurse within the constructs of advocacy and autonomy within contemporary nursing practice needs to be transparent. To achieve this, I have proposed that current conceptualisations of liberal autonomy and advocacy are insufficient in contemporary practice. This is because current clinical nurses do not clearly understand how these two concepts work together in clinical practice to the point that although advocacy may be practiced, it is a stop gap mechanism that does not and cannot support patient autonomy effectively. In addition, the conventional understanding of autonomy within healthcare is one informed by liberal conceptualisations despite, as this thesis has outlined, such conceptions no longer aligning with contemporary healthcare settings and practices and PCC orientations. On this basis I have proposed that liberal autonomy should be reconceptualised as relational autonomy and advocacy would be better served as being thought of as empowerment.

Finally, the reality of borrowing a definition such as that of advocacy – which has been borrowed from the legal profession – is that implementation of this concept might always be problematic out of its initial context. That is, the ideas that an advocate should speak for another or plead a person's case are specific to the context of legal practice and not necessarily something that healthcare and nursing practice should have or need to adopt so readily. This is certainly the case if a relational model of autonomy is recognised within healthcare contexts and brought to inform a new model of empowerment. In total, the current understandings and enactment of advocacy within healthcare do not align well with ideas of patient autonomy and patient empowerment, and further appears to undermine the concepts of PCC as holistic care that contemporary nursing practice is based on.

Conclusion

Throughout this thesis the subject positions of the nurse and the patient have been discussed with regards to their respective capacities for the self-determining work of autonomy and needs and capacities to practise as an advocate. This has allowed me to unpack how ideals around advocacy and autonomy are constructed and considered able to be supported and enacted within healthcare settings. What this discussion has shown is that the concepts of autonomy – particularly that of liberal autonomy – and advocacy are hard to separate. Indeed, those concepts that are deemed essential for liberal autonomy are also highlighted in the literature as being essential to that of advocacy, with ideals of self-determination, empowerment and vulnerability further intersecting in complex ways across the two concepts. Increased vulnerability decreases the ability of the individual to be autonomous and foregrounds the need for advocacy. Self-determination is constrained by power and knowledge inequality with a lack of knowledge of the healthcare setting and the routines of the healthcare setting making the environment in which care takes place a barrier for patients to realise self-determination. There is also an argument that a patient’s lay knowledge about illness and health limits their ability to be self-determining (noting that this is perhaps both less and more of an issue given ready access to the internet and illness and treatment options). Nevertheless, without the ability to be self-determining, there is query about whether autonomy or even genuine advocacy can exist for patients.

As has been noted, The Registered Nurse Standards for Practice (NMBA, 2016), Code of Conduct for Nurses (NMBA, 2018), and The ICN Code of Ethics for Nurses (2012) all set out ways to understand and conceptualise advocacy and autonomy within the health environment. Such documents further require that each nurse be able to internalise and then act upon these ideals. The Code of Conduct for Nurses (NMBA, 2018) has several domains, for instance, with one specifically describing the role of the nurse in relation to professional boundaries. More specifically, this Code acknowledges that there is a distinct power inequality between the providers of healthcare and the consumers of healthcare that must be accounted for and accommodated within healthcare – the assumption is that taking on advocacy roles will do this. It is therefore concerning that there has been no recognition that this power inequality has further implications for the advocacy role that nurses are assumed to undertake as part of protecting and advancing the health and wellbeing of individuals. It is also disappointing that this Code of Conduct, published in 2018, still relies on advocacy being only in relation to substitute decision making. There is also no mention of ways in which nurses are able to empower patients within healthcare settings to facilitate PCC and holistic frameworks of care, Such a narrow understandings of advocacy and the omission of empowerment as a mechanism for supporting patients works to limit and constrain both the understandings of advocacy and how it should work within nursing practice but also how patients are empowered in relation to decision making within healthcare.

Similar points apply to the Registered Nurses Standards for Practice (NMBA, 2016). In Standard 2, for example, 2.5 identified that nurses would advocate for on behalf of others in a manner that respects a person’s autonomy and legal capacity and competency. And again, there is no mention of empowerment and how this plays a role in holistic and PCC frameworks of care. However, as has been discussed comprehensively in this thesis, the foundational ideals of autonomy within nursing education and standards and codes have been informed by liberal understandings of autonomy which themselves can come into conflict with PCC ideals. Furthermore, although PCC frameworks are arguably set up for the benefit of the patient, practising nurses within the clinical environment are still very entrenched within biomedical frameworks of care. This sets up a further direct conflict in practice between the values of PCC and biomedical frameworks. This of course has implications for conceptualisations of advocacy and therefore how nurses support patient autonomy. While biomedical frameworks support advocacy in the frameworks of healthcare professionals, when their framework with regards to autonomy is examined it also does not support the principles of liberal autonomy that are meant to align with biomedical frameworks. Therefore, to say that healthcare is based within principles of PCC, there has to be reconceptualisation of not only principles of advocacy for that of empowerment, but also to re-examine liberal autonomy for that of relational autonomy. To put this another way, a relational version of autonomy would be needed for a PCC framework of care to come to fruition in a genuine sense. Such a shift would better support Standard 2, allowing the therapeutic and professional relationships called for in PCC to become more realistic within practice.

A perspective considering the governmentality of the nursing profession also stresses that the framework of advocacy impacts on the ability of patients to be able to exert their autonomy within healthcare settings. While the standards and Codes are thus a mix of both biomedical domains and PCC frameworks of care, the nursing profession has also to be mindful not to fall into the trap of becoming handmaidens to the bureaucracy of healthcare. Again, it would seem logical to embed empowerment with conceptualisations of relational rather than liberal autonomy, so as to provide a stronger base on which to provide nursing care. This of course has flow on effects for clinical practice.

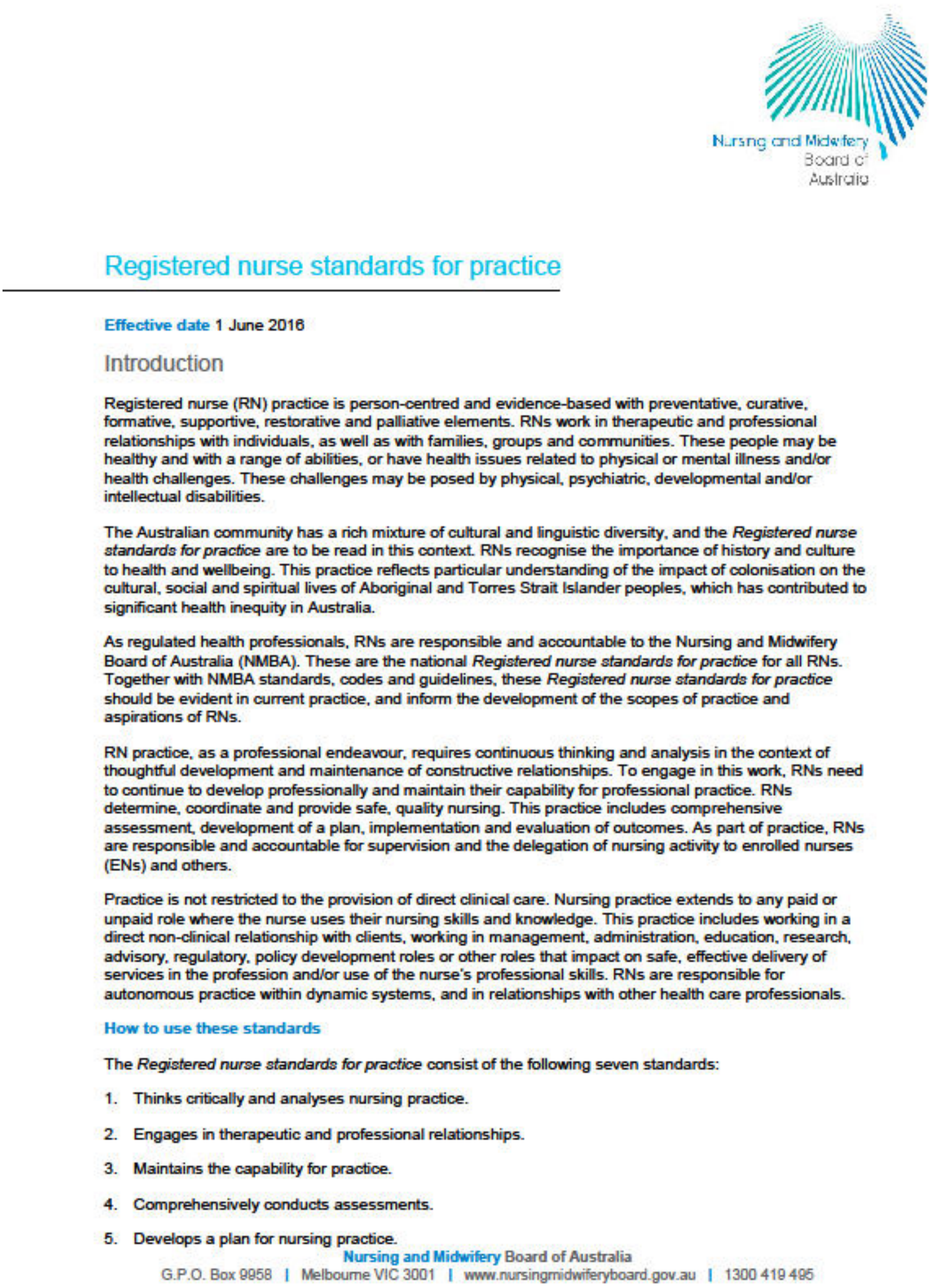
My recommendation for the governmentality of nursing practice is that there needs to be a review of all the Standards, Codes and Guidelines that are influential within nursing practice to incorporate concepts of relational autonomy and, rather than foregrounding advocacy as a key tenet for nursing practice, to embed concepts of empowerment for patients within these documents. Until there is a broader acceptance of relational autonomy within healthcare and this is established within both undergraduate nursing programs and throughout the governmentality of nursing, there will not be movement forward within changing the understanding of this concept and how it effects patient care.

Also, while the definitions of advocacy remain indistinct, then these mentions of it within these documents are at best fluid in their interpretations and which leads to what has been demonstrated as occurring within this thesis in relation to the differing conceptualisations of advocacy in practice.

What has come from this thesis and work are recommendations for both clinical practice and the broader regulation of nursing practice with regards to the healthcare ideals of autonomy and advocacy. Until the ideas behind patient autonomy and the need for advocates within healthcare are reviewed there will always be the power inequalities between the nurse and the patient that exist within contemporary healthcare. It has to be recognised that these power inequalities will not be absolved by the reconceptualisation of autonomy and advocacy within contemporary nursing care, but without this reconceptualising of autonomy and advocacy, the divide between the patient and the nurse will only continue to trouble empowerment. Reframing individual autonomy into a relational context offers, however, an appreciation of the social dimensions of being human and of negotiating healthcare contexts. Relational contexts of autonomy provide the context of PCC to be functional, even with undertones of biomedical regimes of truth. However, rather than the individualistic ideal of advocacy espoused in the nursing literature and throughout the Standards, Codes and Guidelines that underpin the Governmentality of Nursing, a relationally informed model of empowerment would also accept that autonomy is not an all or nothing approach and that it involves multiple influences. By recognising that at different times patients will have differing levels and needs for autonomy then healthcare professionals can begin to tailor and individualise the need to support and empower their patients. Therefore, rather than disempowering patients and forcing them to adopt a passive role in their healthcare experience through narrow definitions of advocacy and liberal autonomy, an alternative might be to holistically empower the patient and give patients options on how to choose to interact with healthcare providers. This would truly empower patients to be active participants and to be autonomous within their healthcare.

Appendices

Appendix a: NMBA Registered Nurse Standards for Practice (2016)



Nursing and Midwifery
Board of
Australia

Registered nurse standards for practice

Effective date 1 June 2016

Introduction

Registered nurse (RN) practice is person-centred and evidence-based with preventative, curative, formative, supportive, restorative and palliative elements. RNs work in therapeutic and professional relationships with individuals, as well as with families, groups and communities. These people may be healthy and with a range of abilities, or have health issues related to physical or mental illness and/or health challenges. These challenges may be posed by physical, psychiatric, developmental and/or intellectual disabilities.

The Australian community has a rich mixture of cultural and linguistic diversity, and the *Registered nurse standards for practice* are to be read in this context. RNs recognise the importance of history and culture to health and wellbeing. This practice reflects particular understanding of the impact of colonisation on the cultural, social and spiritual lives of Aboriginal and Torres Strait Islander peoples, which has contributed to significant health inequity in Australia.

As regulated health professionals, RNs are responsible and accountable to the Nursing and Midwifery Board of Australia (NMBA). These are the national *Registered nurse standards for practice* for all RNs. Together with NMBA standards, codes and guidelines, these *Registered nurse standards for practice* should be evident in current practice, and inform the development of the scopes of practice and aspirations of RNs.

RN practice, as a professional endeavour, requires continuous thinking and analysis in the context of thoughtful development and maintenance of constructive relationships. To engage in this work, RNs need to continue to develop professionally and maintain their capability for professional practice. RNs determine, coordinate and provide safe, quality nursing. This practice includes comprehensive assessment, development of a plan, implementation and evaluation of outcomes. As part of practice, RNs are responsible and accountable for supervision and the delegation of nursing activity to enrolled nurses (ENs) and others.

Practice is not restricted to the provision of direct clinical care. Nursing practice extends to any paid or unpaid role where the nurse uses their nursing skills and knowledge. This practice includes working in a direct non-clinical relationship with clients, working in management, administration, education, research, advisory, regulatory, policy development roles or other roles that impact on safe, effective delivery of services in the profession and/or use of the nurse's professional skills. RNs are responsible for autonomous practice within dynamic systems, and in relationships with other health care professionals.

How to use these standards

The *Registered nurse standards for practice* consist of the following seven standards:

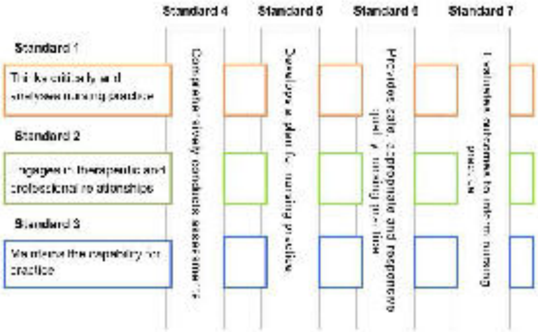
1. Thinks critically and analyses nursing practice.
2. Engages in therapeutic and professional relationships.
3. Maintains the capability for practice.
4. Comprehensively conducts assessments.
5. Develops a plan for nursing practice.

6. Provides safe, appropriate and responsive quality nursing practice.

7. Evaluates outcomes to inform nursing practice.

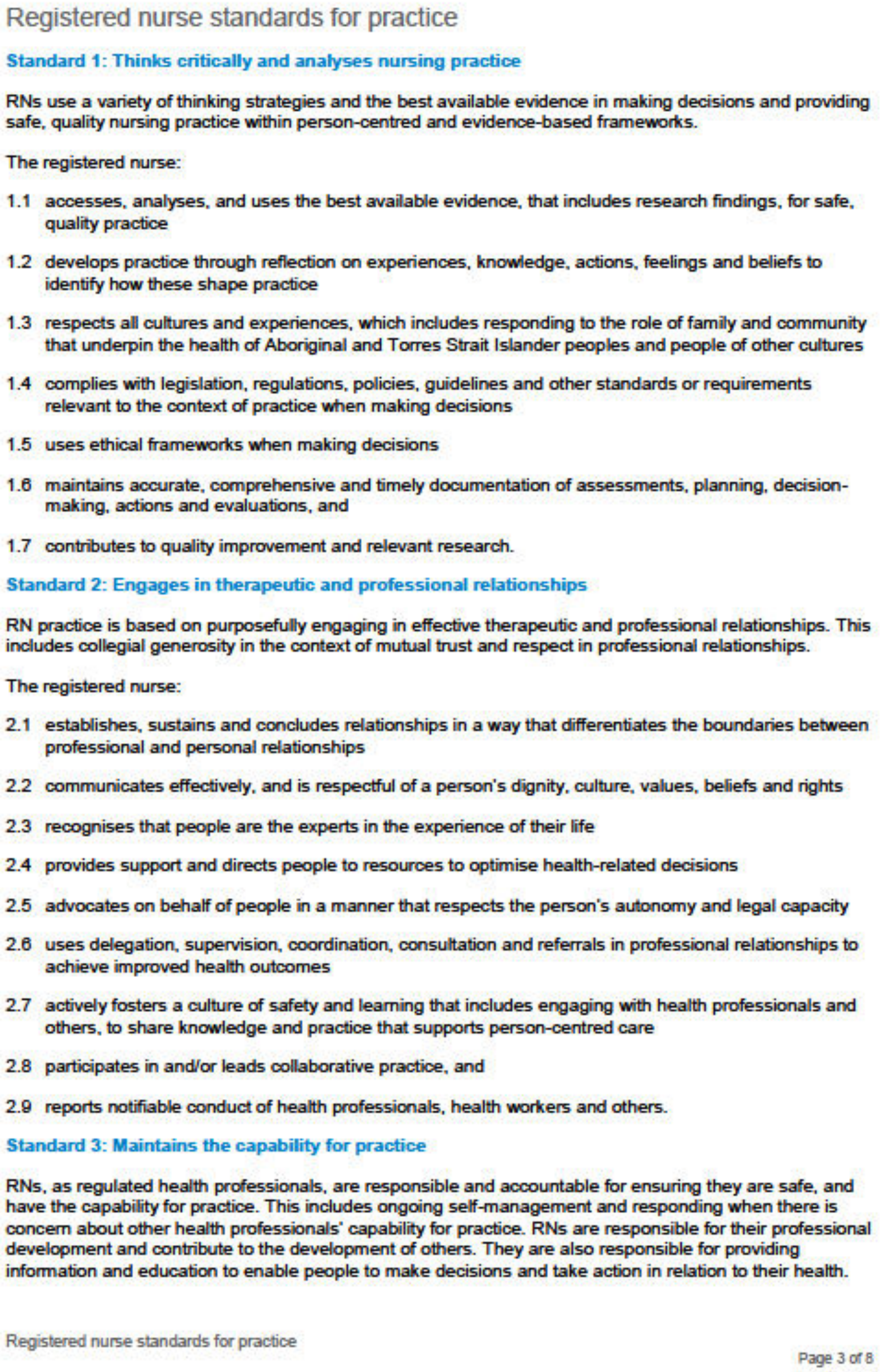
The above standards are all interconnected (see Figure 1). Standards one, two and three relate to each other, as well as to each dimension of practice in standards four, five, six and seven.

Figure 1: Registered nurse standards



Each standard has criteria that specify how that standard is demonstrated. The criteria are to be interpreted in the context of each RN's practice. For example, all RNs will, at various times, work in partnerships and delegate responsibilities, however not every RN will delegate clinical practice to enrolled nurses. The criteria are not exhaustive and enable rather than limit the development of individual registered nurse scopes of practice.

The *Registered nurse standards for practice* are for all RNs across all areas of practice. They are to be read in conjunction with the applicable NMBA companion documents such as the standards, codes and guidelines, including the *Code of professional conduct for nurses*, *Code of ethics for nurses*, *National framework for the development of decision-making tools for nursing and midwifery practice*, *Supervision guidelines for nursing and midwifery*, and *Guidelines for mandatory notifications*. The glossary is also important for understanding how key terms are used in these standards.



Registered nurse standards for practice

Standard 1: Thinks critically and analyses nursing practice

RNs use a variety of thinking strategies and the best available evidence in making decisions and providing safe, quality nursing practice within person-centred and evidence-based frameworks.

The registered nurse:

1.1 accesses, analyses, and uses the best available evidence, that includes research findings, for safe, quality practice

1.2 develops practice through reflection on experiences, knowledge, actions, feelings and beliefs to identify how these shape practice

1.3 respects all cultures and experiences, which includes responding to the role of family and community that underpin the health of Aboriginal and Torres Strait Islander peoples and people of other cultures

1.4 complies with legislation, regulations, policies, guidelines and other standards or requirements relevant to the context of practice when making decisions

1.5 uses ethical frameworks when making decisions

1.6 maintains accurate, comprehensive and timely documentation of assessments, planning, decision-making, actions and evaluations, and

1.7 contributes to quality improvement and relevant research.

Standard 2: Engages in therapeutic and professional relationships

RN practice is based on purposefully engaging in effective therapeutic and professional relationships. This includes collegial generosity in the context of mutual trust and respect in professional relationships.

The registered nurse:

2.1 establishes, sustains and concludes relationships in a way that differentiates the boundaries between professional and personal relationships

2.2 communicates effectively, and is respectful of a person's dignity, culture, values, beliefs and rights

2.3 recognises that people are the experts in the experience of their life

2.4 provides support and directs people to resources to optimise health-related decisions

2.5 advocates on behalf of people in a manner that respects the person's autonomy and legal capacity

2.6 uses delegation, supervision, coordination, consultation and referrals in professional relationships to achieve improved health outcomes

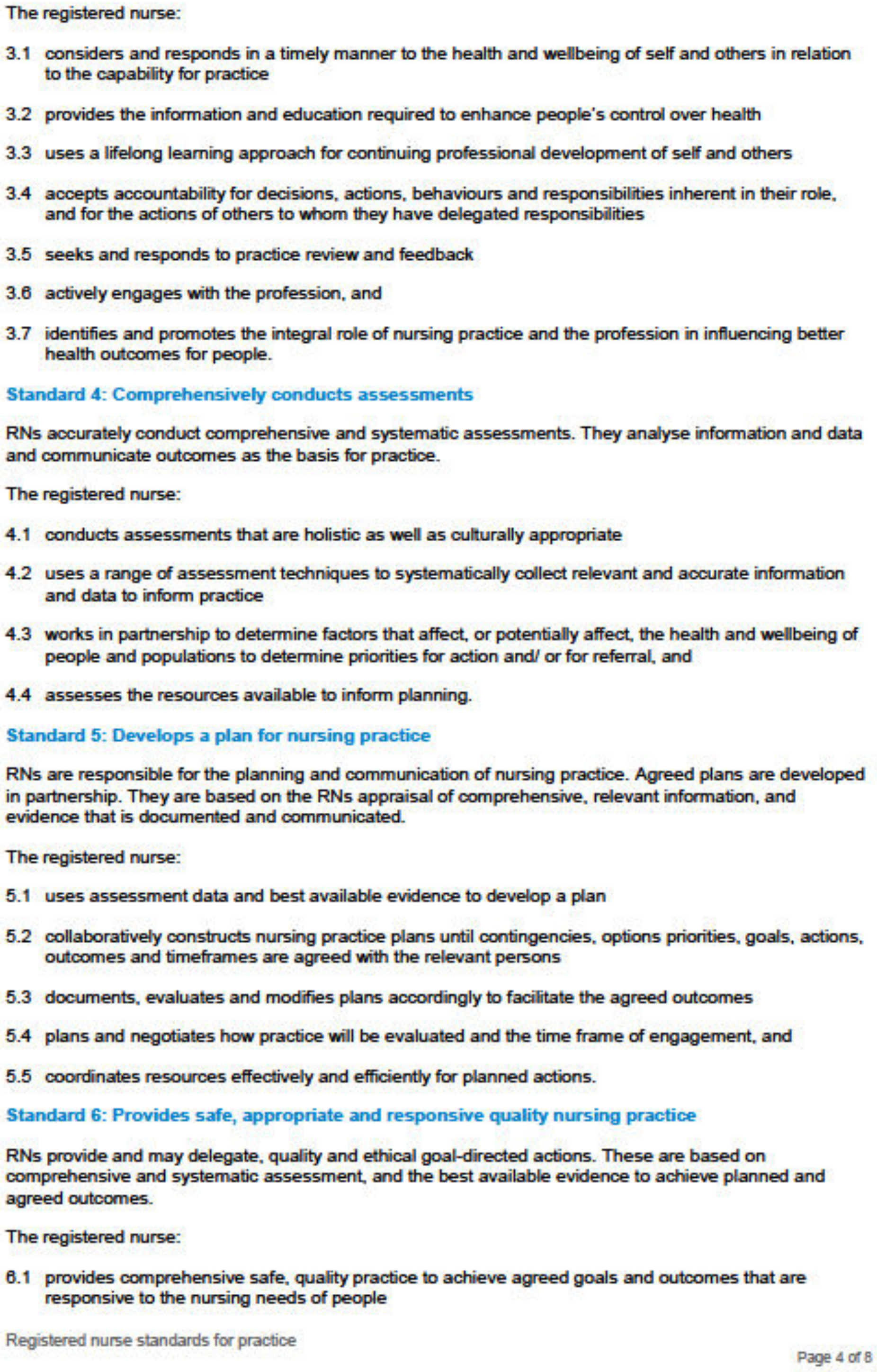
2.7 actively fosters a culture of safety and learning that includes engaging with health professionals and others, to share knowledge and practice that supports person-centred care

2.8 participates in and/or leads collaborative practice, and

2.9 reports notifiable conduct of health professionals, health workers and others.

Standard 3: Maintains the capability for practice

RNs, as regulated health professionals, are responsible and accountable for ensuring they are safe, and have the capability for practice. This includes ongoing self-management and responding when there is concern about other health professionals' capability for practice. RNs are responsible for their professional development and contribute to the development of others. They are also responsible for providing information and education to enable people to make decisions and take action in relation to their health.



The registered nurse:

3.1 considers and responds in a timely manner to the health and wellbeing of self and others in relation to the capability for practice

3.2 provides the information and education required to enhance people's control over health

3.3 uses a lifelong learning approach for continuing professional development of self and others

3.4 accepts accountability for decisions, actions, behaviours and responsibilities inherent in their role, and for the actions of others to whom they have delegated responsibilities

3.5 seeks and responds to practice review and feedback

3.6 actively engages with the profession, and

3.7 identifies and promotes the integral role of nursing practice and the profession in influencing better health outcomes for people.

Standard 4: Comprehensively conducts assessments

RNs accurately conduct comprehensive and systematic assessments. They analyse information and data and communicate outcomes as the basis for practice.

The registered nurse:

4.1 conducts assessments that are holistic as well as culturally appropriate

4.2 uses a range of assessment techniques to systematically collect relevant and accurate information and data to inform practice

4.3 works in partnership to determine factors that affect, or potentially affect, the health and wellbeing of people and populations to determine priorities for action and/ or for referral, and

4.4 assesses the resources available to inform planning.

Standard 5: Develops a plan for nursing practice

RNs are responsible for the planning and communication of nursing practice. Agreed plans are developed in partnership. They are based on the RNs appraisal of comprehensive, relevant information, and evidence that is documented and communicated.

The registered nurse:

5.1 uses assessment data and best available evidence to develop a plan

5.2 collaboratively constructs nursing practice plans until contingencies, options priorities, goals, actions, outcomes and timeframes are agreed with the relevant persons

5.3 documents, evaluates and modifies plans accordingly to facilitate the agreed outcomes

5.4 plans and negotiates how practice will be evaluated and the time frame of engagement, and

5.5 coordinates resources effectively and efficiently for planned actions.

Standard 6: Provides safe, appropriate and responsive quality nursing practice

RNs provide and may delegate, quality and ethical goal-directed actions. These are based on comprehensive and systematic assessment, and the best available evidence to achieve planned and agreed outcomes.

The registered nurse:

6.1 provides comprehensive safe, quality practice to achieve agreed goals and outcomes that are responsive to the nursing needs of people

6.2 practises within their scope of practice

6.3 appropriately delegates aspects of practice to enrolled nurses and others, according to enrolled nurse's scope of practice or others' clinical or non-clinical roles

6.4 provides effective timely direction and supervision to ensure that delegated practice is safe and correct

6.5 practises in accordance with relevant policies, guidelines, standards, regulations and legislation, and

6.6 uses the appropriate processes to identify and report potential and actual risk related system issues and where practice may be below the expected standards.

Standard 7: Evaluates outcomes to inform nursing practice

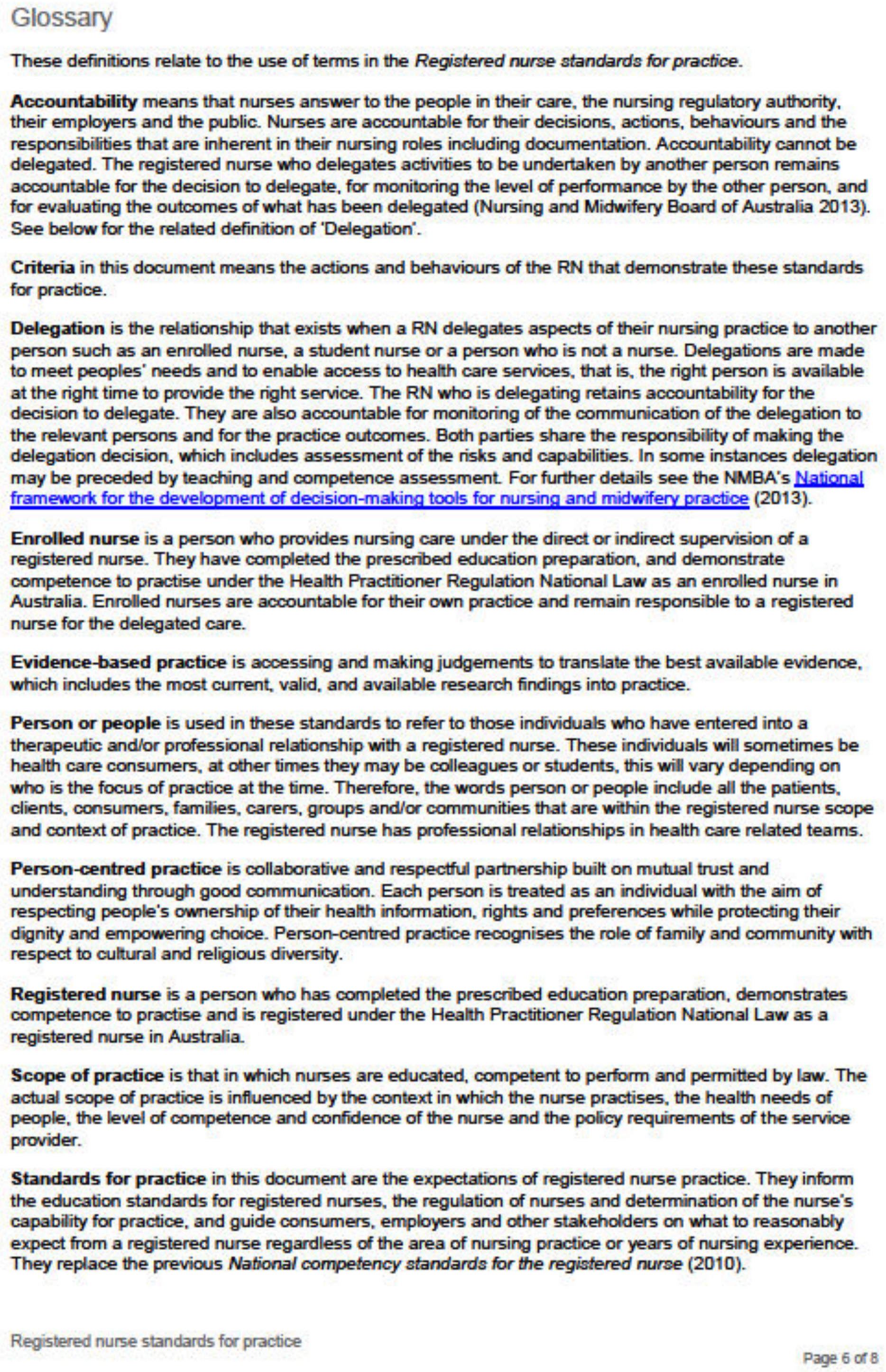
RNs take responsibility for the evaluation of practice based on agreed priorities, goals, plans and outcomes and revises practice accordingly.

The registered nurse:

7.1 evaluates and monitors progress towards the expected goals and outcomes

7.2 revises the plan based on the evaluation, and

7.3 determines, documents and communicates further priorities, goals and outcomes with the relevant persons.



Glossary

These definitions relate to the use of terms in the *Registered nurse standards for practice*.

Accountability means that nurses answer to the people in their care, the nursing regulatory authority, their employers and the public. Nurses are accountable for their decisions, actions, behaviours and the responsibilities that are inherent in their nursing roles including documentation. Accountability cannot be delegated. The registered nurse who delegates activities to be undertaken by another person remains accountable for the decision to delegate, for monitoring the level of performance by the other person, and for evaluating the outcomes of what has been delegated (Nursing and Midwifery Board of Australia 2013). See below for the related definition of 'Delegation'.

Criteria in this document means the actions and behaviours of the RN that demonstrate these standards for practice.

Delegation is the relationship that exists when a RN delegates aspects of their nursing practice to another person such as an enrolled nurse, a student nurse or a person who is not a nurse. Delegations are made to meet peoples' needs and to enable access to health care services, that is, the right person is available at the right time to provide the right service. The RN who is delegating retains accountability for the decision to delegate. They are also accountable for monitoring of the communication of the delegation to the relevant persons and for the practice outcomes. Both parties share the responsibility of making the delegation decision, which includes assessment of the risks and capabilities. In some instances delegation may be preceded by teaching and competence assessment. For further details see the NMBA's National framework for the development of decision-making tools for nursing and midwifery practice (2013).

Enrolled nurse is a person who provides nursing care under the direct or indirect supervision of a registered nurse. They have completed the prescribed education preparation, and demonstrate competence to practise under the Health Practitioner Regulation National Law as an enrolled nurse in Australia. Enrolled nurses are accountable for their own practice and remain responsible to a registered nurse for the delegated care.

Evidence-based practice is accessing and making judgements to translate the best available evidence, which includes the most current, valid, and available research findings into practice.

Person or people is used in these standards to refer to those individuals who have entered into a therapeutic and/or professional relationship with a registered nurse. These individuals will sometimes be health care consumers, at other times they may be colleagues or students, this will vary depending on who is the focus of practice at the time. Therefore, the words person or people include all the patients, clients, consumers, families, carers, groups and/or communities that are within the registered nurse scope and context of practice. The registered nurse has professional relationships in health care related teams.

Person-centred practice is collaborative and respectful partnership built on mutual trust and understanding through good communication. Each person is treated as an individual with the aim of respecting people's ownership of their health information, rights and preferences while protecting their dignity and empowering choice. Person-centred practice recognises the role of family and community with respect to cultural and religious diversity.

Registered nurse is a person who has completed the prescribed education preparation, demonstrates competence to practise and is registered under the Health Practitioner Regulation National Law as a registered nurse in Australia.

Scope of practice is that in which nurses are educated, competent to perform and permitted by law. The actual scope of practice is influenced by the context in which the nurse practises, the health needs of people, the level of competence and confidence of the nurse and the policy requirements of the service provider.

Standards for practice in this document are the expectations of registered nurse practice. They inform the education standards for registered nurses, the regulation of nurses and determination of the nurse's capability for practice, and guide consumers, employers and other stakeholders on what to reasonably expect from a registered nurse regardless of the area of nursing practice or years of nursing experience. They replace the previous *National competency standards for the registered nurse* (2010).

Supervision includes managerial supervision, professional supervision and clinically focused supervision. For further details see the NMBA's, Supervision guidelines for nursing and midwifery (2015).

Therapeutic relationships are different to personal relationships. In a therapeutic relationship the nurse is sensitive to a person's situation and purposefully engages with them using knowledge and skills in respect, compassion and kindness. In the relationship the person's rights and dignity are recognised and respected. The professional nature of the relationship involves recognition of professional boundaries and issues of unequal power. For further details see the NMBA's A nurse's guide to professional boundaries (2010).

Appendix B: National Competency Standards for the Registered Nurse (2006)

National competency standards for the registered nurse

Nursing and Midwifery Board of Australia

Introduction

National competency standards for registered nurses were first adopted by the Australian Nursing and Midwifery Council (ANMC) in the early 1990s. The ANMC was a peak national and midwifery organisation established in 1992 to develop a national approach to nursing and midwifery regulation. The ANMC worked in conjunction with the state and territory nursing and midwifery authorities (NMRAs) to produce national standards – an integral component of the regulatory framework – to help nurses and midwives deliver safe and competent care.

The ANMC officially became the Australian Nursing and Midwifery Accreditation Council (ANMAC) on 24 November 2010. The name change reflected ANMC's appointment as the independent accrediting authority for the nursing and midwifery professions under the new National Registration and Accreditation Scheme (the National Scheme) that came into effect on 1 July 2010 (18 October 2010 in Western Australia).

With the onset of the National Scheme, the Nursing and Midwifery Board of Australia (National Board), took responsibility for the regulation of nurses and midwives in Australia, thus taking ownership of the national competency standards for registered nurses.

Since creation, these national competency standards have undergone periodic review and revision, which included extensive consultation with nurses around Australia. This helped to make sure the competency standards remained contemporary and congruent with legislative requirements.

The resulting standards, while different in some areas from the previous competency standards, remain broad and principle-based so that they are sufficiently dynamic for practising nurses and the nurse regulators to use as a benchmark to assess competence to practise in a range of settings.

What are the standards used for?

The national competency standards for the registered nurse are the core competency standards by which your performance is assessed to obtain and retain your registration as a registered nurse in Australia.

As a registered nurse, these core competency standards provide you with the framework for assessing your competence, and are used by the National Board to assess competence as part of the annual renewal of registration, to assess nurses:

- educated overseas seeking to work in Australia
- returning to work after breaks in service, or
- involved in professional conduct matters.

The National Board may also apply the competency standards in order to communicate to consumers the standards that they can expect from nurses.

Universities also use the standards when developing nursing curricula, and to assess student and new graduate performance.

These are YOUR standards — developed using the best possible evidence, and using information and feedback provided by nurses in a variety of settings. Included also are the principles of assessment to help you understand how these standards may be used to assess performance. We believe you will find them user-friendly and easy to understand.

Description of the registered nurse on entry to practice

The registered nurse demonstrates competence in the provision of nursing care as specified by registration requirements, National Board standards and codes, educational preparation, relevant legislation and context of care. The registered nurse practises independently and interdependently, assuming accountability and responsibility for their own actions and delegation of care to enrolled nurses and health care workers. Delegation takes into consideration the education and training of enrolled nurses and health care workers and the context of care.

The registered nurse provides evidence-based nursing care to people of all ages and cultural groups, including individuals, families and communities. The role of the registered nurse includes promotion and maintenance of health and prevention of illness for individuals with physical or mental illness, disabilities and/or rehabilitation needs, as well as alleviation of pain and suffering at the end stage of life.

The registered nurse assesses, plans, implements and evaluates nursing care in collaboration with individuals and the multidisciplinary health care team so as to achieve goals and health outcomes. The registered nurse recognises that ethnicity, culture, gender, spiritual values, sexuality, age, disability and economic and social factors have an impact

on an individual's responses to, and beliefs about, health and illness, and plans and modifies nursing care appropriately.

The registered nurse provides care in a range of settings that may include acute, community, residential and extended care settings, homes, educational institutions or other work settings and modifies practice according to the model/s of care delivery.

The registered nurse takes a leadership role in the coordination of nursing and health care within and across different care contexts to facilitate optimal health outcomes. This includes appropriate referral to, and consultation with, other relevant health professionals, service providers, and community and support services.

The registered nurse contributes to quality health care through lifelong learning and professional development of herself/himself and others, research data generation, clinical supervision and development of policy and clinical practice guidelines. The registered nurse develops their professional practice in accordance with the health needs of the population/society and changing patterns of disease and illness.

Domains

The competencies which make up the National Board *National competency standards for the registered nurse* are organised into domains.

Professional practice

This relates to the professional, legal and ethical responsibilities which require demonstration of a satisfactory knowledge base, accountability for practice, functioning in accordance with legislation affecting nursing and health care, and the protection of individual and group rights.

Critical thinking and analysis

This relates to self-appraisal, professional development and the value of evidence and research for practice. Reflecting on practice, feelings and beliefs and the consequences of these for individuals/groups is an important professional benchmark.

Provision and coordination of care

This domain relates to the coordination, organisation and provision of nursing care that includes the assessment of individuals /groups, planning, implementation and evaluation of care.

Collaborative and therapeutic practice

This relates to establishing, sustaining and concluding professional relationships with individuals/groups. This also contains those competencies that relate to nurses understanding their contribution to the interdisciplinary health care team.

National competency standards for the registered nurse

Professional practice

Relates to the professional, legal and ethical responsibilities which require demonstration of a satisfactory knowledge base, accountability for practice, functioning in accordance with legislation affecting nursing and health care, and the protection of individual and group rights.

1. Practises in accordance with legislation affecting nursing practice and health care

1.1 Complies with relevant legislation and common law:

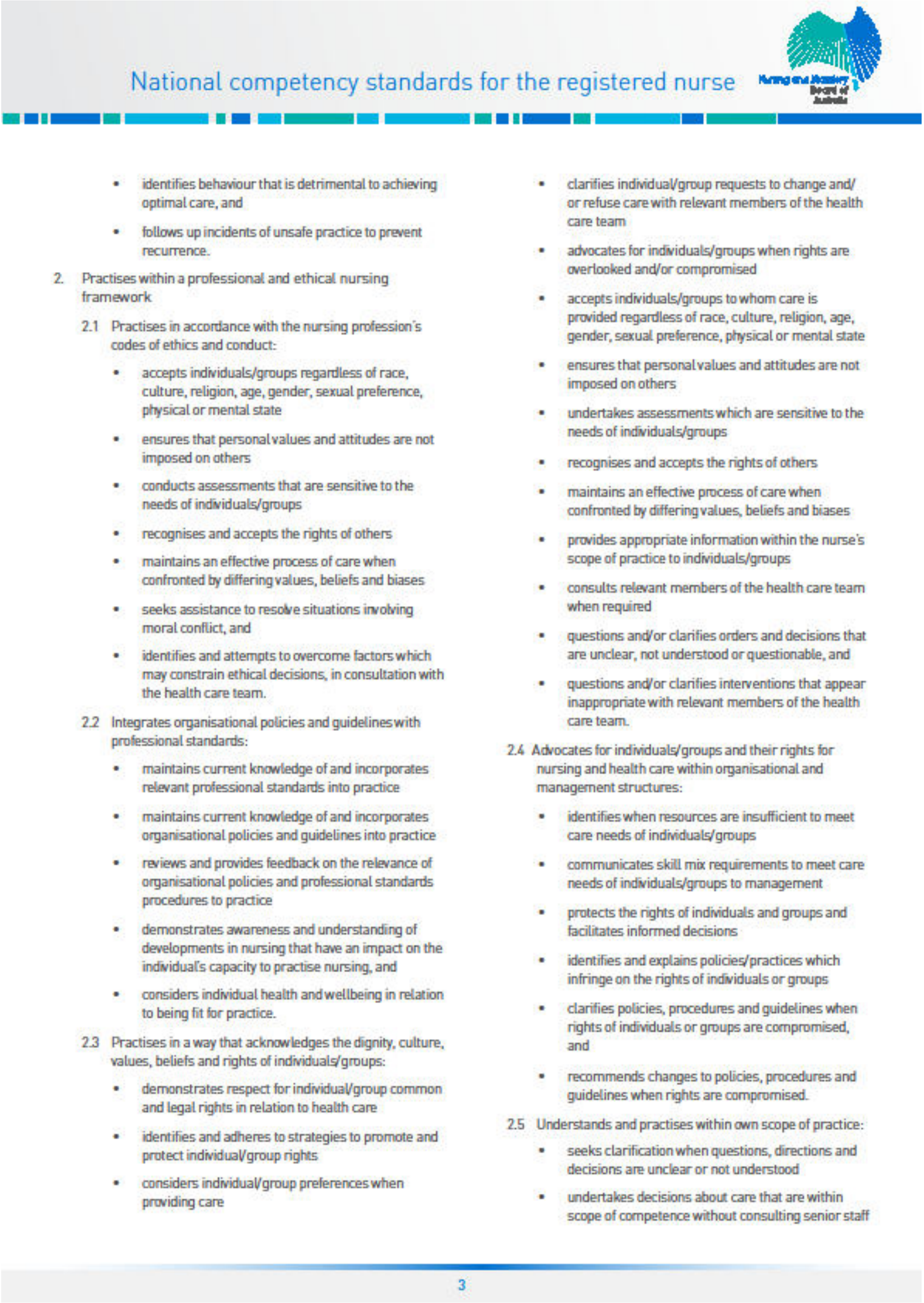
- identifies legislation governing nursing practice
- describes nursing practice within the requirements of common law
- describes and adheres to legal requirements for medications
- identifies legal implications of nursing interventions
- actions demonstrate awareness of legal implications of nursing practice
- identifies and explains effects of legislation on the care of individuals/groups
- identifies and explains effects of legislation in the area of health, and
- identifies unprofessional practice as it relates to confidentiality and privacy legislation.

1.2 Fulfils the duty of care:

- performs nursing interventions in accordance with recognised standards of practice
- clarifies responsibility for aspects of care with other members of the health team
- recognises the responsibility to prevent harm, and
- performs nursing interventions following comprehensive and accurate assessments.

1.3 Recognises and responds appropriately to unsafe or unprofessional practice:

- identifies interventions which prevent care being compromised and/or law contravened
- identifies appropriate action to be taken in specified circumstances
- identifies and explains alternative strategies for intervention and their likely outcomes



- identifies behaviour that is detrimental to achieving optimal care, and
- follows up incidents of unsafe practice to prevent recurrence.

2. Practises within a professional and ethical nursing framework

2.1 Practises in accordance with the nursing profession's codes of ethics and conduct:

- accepts individuals/groups regardless of race, culture, religion, age, gender, sexual preference, physical or mental state
- ensures that personal values and attitudes are not imposed on others
- conducts assessments that are sensitive to the needs of individuals/groups
- recognises and accepts the rights of others
- maintains an effective process of care when confronted by differing values, beliefs and biases
- seeks assistance to resolve situations involving moral conflict, and
- identifies and attempts to overcome factors which may constrain ethical decisions, in consultation with the health care team.

2.2 Integrates organisational policies and guidelines with professional standards:

- maintains current knowledge of and incorporates relevant professional standards into practice
- maintains current knowledge of and incorporates organisational policies and guidelines into practice
- reviews and provides feedback on the relevance of organisational policies and professional standards procedures to practice
- demonstrates awareness and understanding of developments in nursing that have an impact on the individual's capacity to practise nursing, and
- considers individual health and wellbeing in relation to being fit for practice.

2.3 Practises in a way that acknowledges the dignity, culture, values, beliefs and rights of individuals/groups:

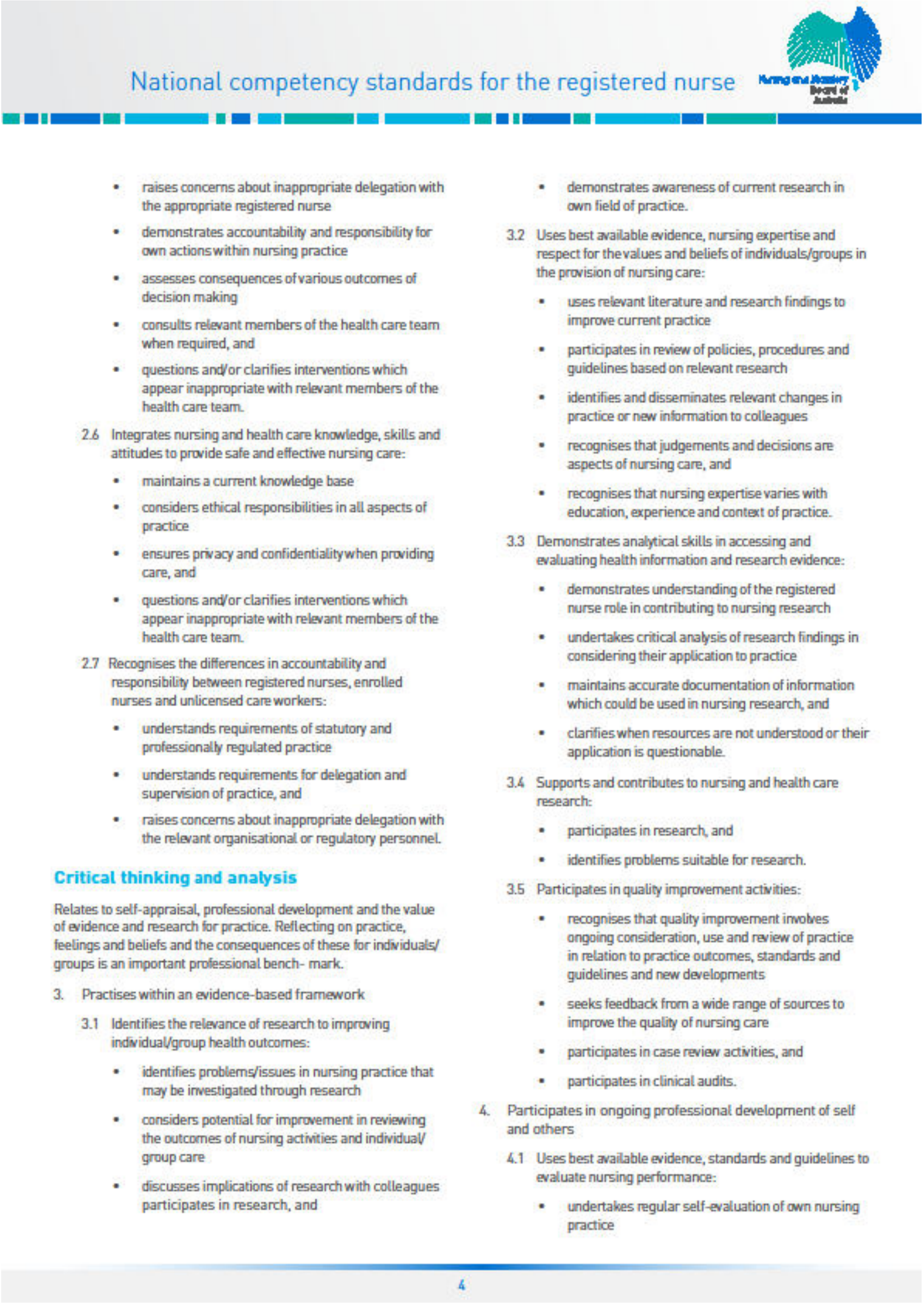
- demonstrates respect for individual/group common and legal rights in relation to health care
- identifies and adheres to strategies to promote and protect individual/group rights
- considers individual/group preferences when providing care
- clarifies individual/group requests to change and/or refuse care with relevant members of the health care team
- advocates for individuals/groups when rights are overlooked and/or compromised
- accepts individuals/groups to whom care is provided regardless of race, culture, religion, age, gender, sexual preference, physical or mental state
- ensures that personal values and attitudes are not imposed on others
- undertakes assessments which are sensitive to the needs of individuals/groups
- recognises and accepts the rights of others
- maintains an effective process of care when confronted by differing values, beliefs and biases
- provides appropriate information within the nurse's scope of practice to individuals/groups
- consults relevant members of the health care team when required
- questions and/or clarifies orders and decisions that are unclear, not understood or questionable, and
- questions and/or clarifies interventions that appear inappropriate with relevant members of the health care team.

2.4 Advocates for individuals/groups and their rights for nursing and health care within organisational and management structures:

- identifies when resources are insufficient to meet care needs of individuals/groups
- communicates skill mix requirements to meet care needs of individuals/groups to management
- protects the rights of individuals and groups and facilitates informed decisions
- identifies and explains policies/practices which infringe on the rights of individuals or groups
- clarifies policies, procedures and guidelines when rights of individuals or groups are compromised, and
- recommends changes to policies, procedures and guidelines when rights are compromised.

2.5 Understands and practises within own scope of practice:

- seeks clarification when questions, directions and decisions are unclear or not understood
- undertakes decisions about care that are within scope of competence without consulting senior staff



- raises concerns about inappropriate delegation with the appropriate registered nurse
- demonstrates accountability and responsibility for own actions within nursing practice
- assesses consequences of various outcomes of decision making
- consults relevant members of the health care team when required, and
- questions and/or clarifies interventions which appear inappropriate with relevant members of the health care team.

2.6 Integrates nursing and health care knowledge, skills and attitudes to provide safe and effective nursing care:

- maintains a current knowledge base
- considers ethical responsibilities in all aspects of practice
- ensures privacy and confidentiality when providing care, and
- questions and/or clarifies interventions which appear inappropriate with relevant members of the health care team.

2.7 Recognises the differences in accountability and responsibility between registered nurses, enrolled nurses and unlicensed care workers:

- understands requirements of statutory and professionally regulated practice
- understands requirements for delegation and supervision of practice, and
- raises concerns about inappropriate delegation with the relevant organisational or regulatory personnel.

Critical thinking and analysis

Relates to self-appraisal, professional development and the value of evidence and research for practice. Reflecting on practice, feelings and beliefs and the consequences of these for individuals/groups is an important professional bench- mark.

3. Practises within an evidence-based framework

3.1 Identifies the relevance of research to improving individual/group health outcomes:

- identifies problems/issues in nursing practice that may be investigated through research
- considers potential for improvement in reviewing the outcomes of nursing activities and individual/group care
- discusses implications of research with colleagues participates in research, and
- demonstrates awareness of current research in own field of practice.

3.2 Uses best available evidence, nursing expertise and respect for the values and beliefs of individuals/groups in the provision of nursing care:

- uses relevant literature and research findings to improve current practice
- participates in review of policies, procedures and guidelines based on relevant research
- identifies and disseminates relevant changes in practice or new information to colleagues
- recognises that judgements and decisions are aspects of nursing care, and
- recognises that nursing expertise varies with education, experience and context of practice.

3.3 Demonstrates analytical skills in accessing and evaluating health information and research evidence:

- demonstrates understanding of the registered nurse role in contributing to nursing research
- undertakes critical analysis of research findings in considering their application to practice
- maintains accurate documentation of information which could be used in nursing research, and
- clarifies when resources are not understood or their application is questionable.

3.4 Supports and contributes to nursing and health care research:

- participates in research, and
- identifies problems suitable for research.

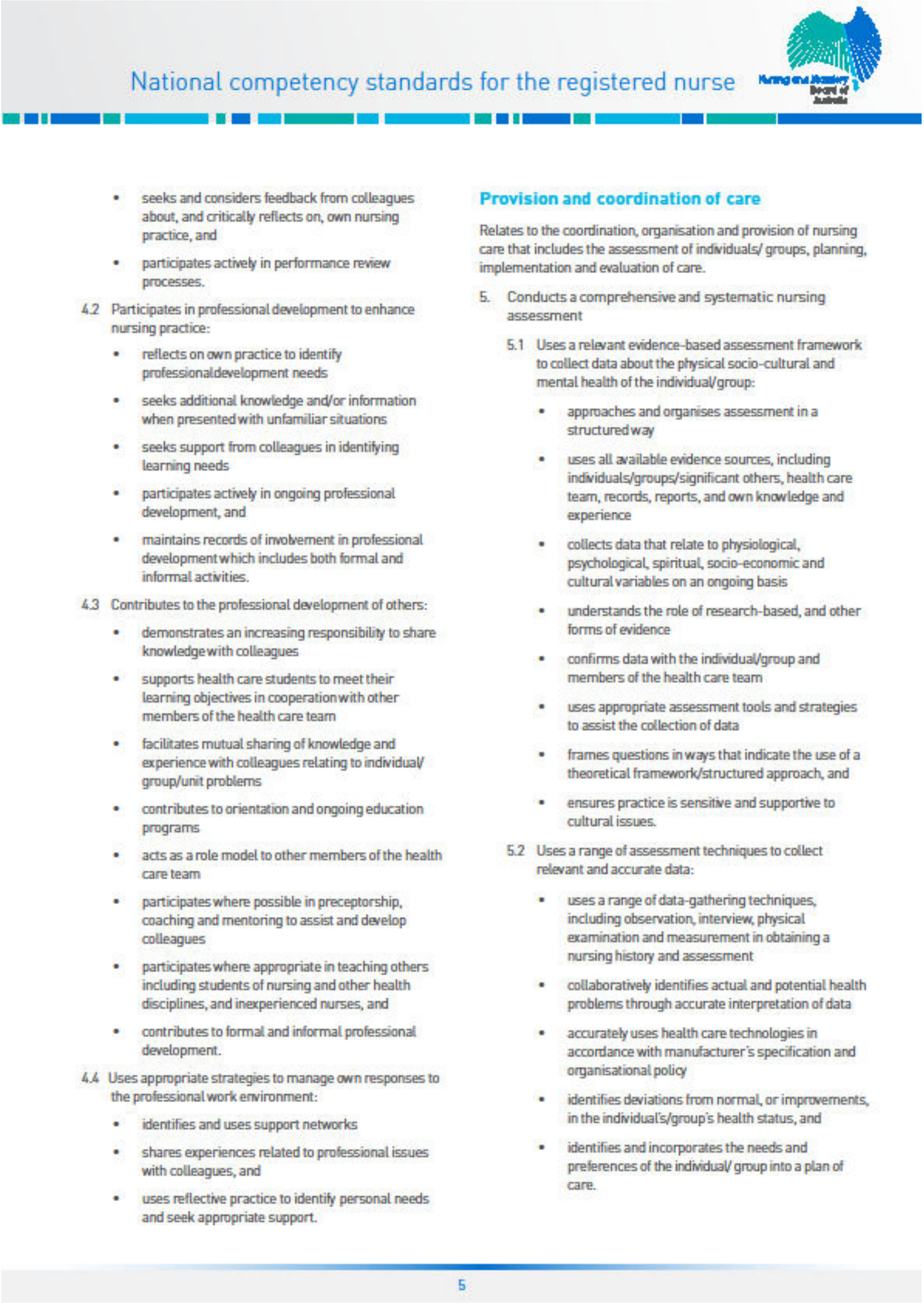
3.5 Participates in quality improvement activities:

- recognises that quality improvement involves ongoing consideration, use and review of practice in relation to practice outcomes, standards and guidelines and new developments
- seeks feedback from a wide range of sources to improve the quality of nursing care
- participates in case review activities, and
- participates in clinical audits.

4. Participates in ongoing professional development of self and others

4.1 Uses best available evidence, standards and guidelines to evaluate nursing performance:

- undertakes regular self-evaluation of own nursing practice



- seeks and considers feedback from colleagues about, and critically reflects on, own nursing practice, and
- participates actively in performance review processes.

4.2 Participates in professional development to enhance nursing practice:

- reflects on own practice to identify professionaldevelopment needs
- seeks additional knowledge and/or information when presented with unfamiliar situations
- seeks support from colleagues in identifying learning needs
- participates actively in ongoing professional development, and
- maintains records of involvement in professional development which includes both formal and informal activities.

4.3 Contributes to the professional development of others:

- demonstrates an increasing responsibility to share knowledge with colleagues
- supports health care students to meet their learning objectives in cooperation with other members of the health care team
- facilitates mutual sharing of knowledge and experience with colleagues relating to individual/group/unit problems
- contributes to orientation and ongoing education programs
- acts as a role model to other members of the health care team
- participates where possible in preceptorship, coaching and mentoring to assist and develop colleagues
- participates where appropriate in teaching others including students of nursing and other health disciplines, and inexperienced nurses, and
- contributes to formal and informal professional development.

4.4 Uses appropriate strategies to manage own responses to the professional work environment:

- identifies and uses support networks
- shares experiences related to professional issues with colleagues, and
- uses reflective practice to identify personal needs and seek appropriate support.

Provision and coordination of care

Relates to the coordination, organisation and provision of nursing care that includes the assessment of individuals/ groups, planning, implementation and evaluation of care.

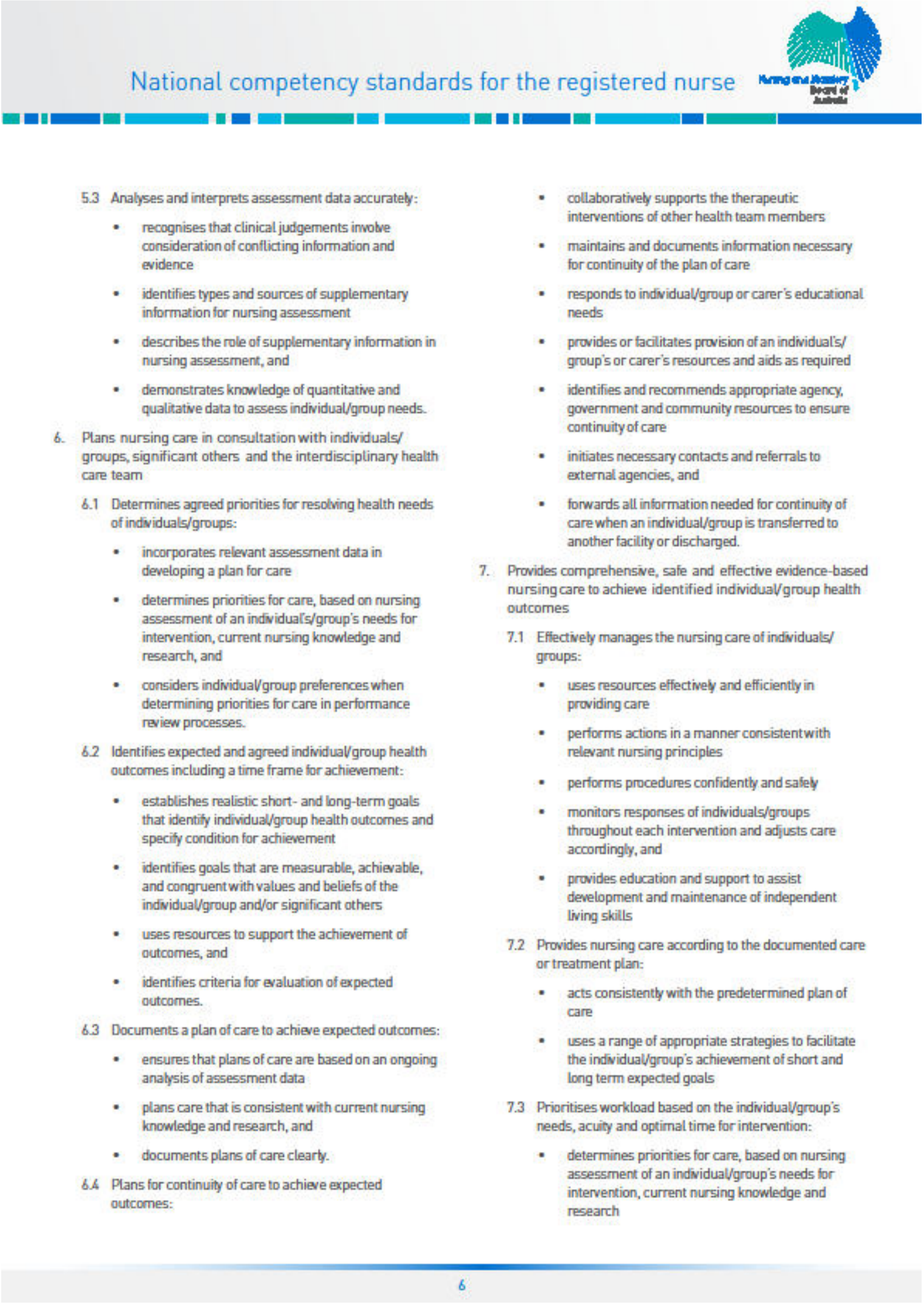
5. Conducts a comprehensive and systematic nursing assessment

5.1 Uses a relevant evidence-based assessment framework to collect data about the physical socio-cultural and mental health of the individual/group:

- approaches and organises assessment in a structured way
- uses all available evidence sources, including individuals/groups/significant others, health care team, records, reports, and own knowledge and experience
- collects data that relate to physiological, psychological, spiritual, socio-economic and cultural variables on an ongoing basis
- understands the role of research-based, and other forms of evidence
- confirms data with the individual/group and members of the health care team
- uses appropriate assessment tools and strategies to assist the collection of data
- frames questions in ways that indicate the use of a theoretical framework/structured approach, and
- ensures practice is sensitive and supportive to cultural issues.

5.2 Uses a range of assessment techniques to collect relevant and accurate data:

- uses a range of data-gathering techniques, including observation, interview, physical examination and measurement in obtaining a nursing history and assessment
- collaboratively identifies actual and potential health problems through accurate interpretation of data
- accurately uses health care technologies in accordance with manufacturer's specification and organisational policy
- identifies deviations from normal, or improvements, in the individual's/group's health status, and
- identifies and incorporates the needs and preferences of the individual/ group into a plan of care.



5.3 Analyses and interprets assessment data accurately:

- recognises that clinical judgements involve consideration of conflicting information and evidence
- identifies types and sources of supplementary information for nursing assessment
- describes the role of supplementary information in nursing assessment, and
- demonstrates knowledge of quantitative and qualitative data to assess individual/group needs.

6. Plans nursing care in consultation with individuals/groups, significant others and the interdisciplinary health care team

6.1 Determines agreed priorities for resolving health needs of individuals/groups:

- incorporates relevant assessment data in developing a plan for care
- determines priorities for care, based on nursing assessment of an individual's/group's needs for intervention, current nursing knowledge and research, and
- considers individual/group preferences when determining priorities for care in performance review processes.

6.2 Identifies expected and agreed individual/group health outcomes including a time frame for achievement:

- establishes realistic short- and long-term goals that identify individual/group health outcomes and specify condition for achievement
- identifies goals that are measurable, achievable, and congruent with values and beliefs of the individual/group and/or significant others
- uses resources to support the achievement of outcomes, and
- identifies criteria for evaluation of expected outcomes.

6.3 Documents a plan of care to achieve expected outcomes:

- ensures that plans of care are based on an ongoing analysis of assessment data
- plans care that is consistent with current nursing knowledge and research, and
- documents plans of care clearly.

6.4 Plans for continuity of care to achieve expected outcomes:

- collaboratively supports the therapeutic interventions of other health team members
- maintains and documents information necessary for continuity of the plan of care
- responds to individual/group or carer's educational needs
- provides or facilitates provision of an individual's/group's or carer's resources and aids as required
- identifies and recommends appropriate agency, government and community resources to ensure continuity of care
- initiates necessary contacts and referrals to external agencies, and
- forwards all information needed for continuity of care when an individual/group is transferred to another facility or discharged.

7. Provides comprehensive, safe and effective evidence-based nursing care to achieve identified individual/group health outcomes

7.1 Effectively manages the nursing care of individuals/groups:

- uses resources effectively and efficiently in providing care
- performs actions in a manner consistent with relevant nursing principles
- performs procedures confidently and safely
- monitors responses of individuals/groups throughout each intervention and adjusts care accordingly, and
- provides education and support to assist development and maintenance of independent living skills

7.2 Provides nursing care according to the documented care or treatment plan:

- acts consistently with the predetermined plan of care
- uses a range of appropriate strategies to facilitate the individual/group's achievement of short and long term expected goals

7.3 Prioritises workload based on the individual/group's needs, acuity and optimal time for intervention:

- determines priorities for care, based on nursing assessment of an individual/group's needs for intervention, current nursing knowledge and research

- considers the individual/group's preferences when determining priorities for care

7.4 Responds effectively to unexpected or rapidly changing situations

- responds effectively to emergencies
- maintains self-control in the clinical setting and under stress conditions
- implements crisis interventions and emergency routines as necessary
- maintains current knowledge of emergency plans and procedures to maximise effectiveness in crisis situations, and
- participates in emergency management practices and drills according to agency policy

7.5 Delegates aspects of care to others according to their competence and scope of practice:

- delegates aspects of care according to role, functions, capabilities and learning needs
- monitors aspects of care delegated to others and provides clarification/assistance as required
- recognises own accountabilities and responsibilities when delegating aspects of care to others, and
- delegates to and supervises others consistent with legislation and organisational policy.

7.6 Provides effective and timely direction and supervision to ensure that delegated care is provided safely and accurately:

- supervises and evaluates nursing care provided by others
- uses a range of direct and indirect techniques such as instructing, coaching, mentoring, and collaborating in the supervision and support of others
- provides support with documentation to nurses being supervised or to whom care has been delegated, and
- delegates activities consistent with scope of practice/competence

7.7 Educates individuals/groups to promote independence and control over their health

- identifies and documents specific educational requirements and requests of individuals/groups
- undertakes formal and informal education sessions with individuals/groups as necessary, and
- identifies appropriate educational resources, including other health professionals.

7.8 Uses health care resources effectively and efficiently to promote optimal nursing and health care

- recognises when nursing resources are insufficient to meet an individual's/group's needs
- demonstrates flexibility in providing care where resources are limited, and
- recognises the responsibility to report to relevant persons when level of resources risks compromising the quality of care

8. Evaluates progress towards expected individual/group health outcomes in consultation with individuals/groups, significant others and interdisciplinary health care team

8.1 Determines progress of individuals/groups toward planned outcomes:

- recognises when individual's/group's progress and expected progress differ and modifies plans and actions accordingly
- discusses progress with the individual/group
- evaluates individual/group responses to interventions, and
- assesses the effectiveness of the plan of care in achieving planned outcomes

8.2 Revises the plan of care and determines further outcomes in accordance with evaluation data:

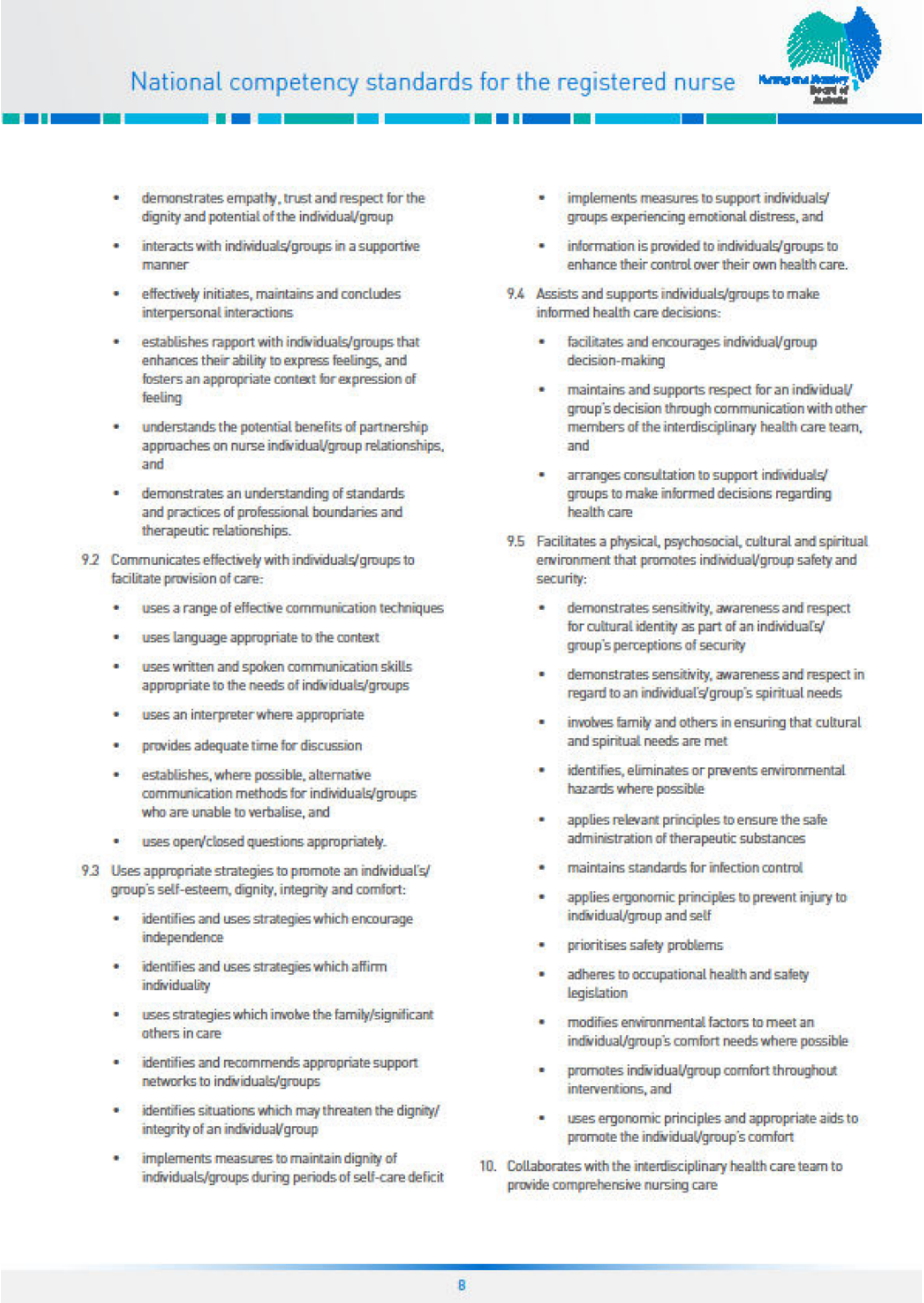
- revises expected outcomes, nursing interventions and priorities with any change in an individual's/group's condition, needs or situational variations
- communicates new information and revisions to members of the health care team as required

Collaborative and therapeutic practice

Relates to establishing, sustaining and concluding pro- fessional relationships with individuals/groups. This also contains those competencies that relate to nurses understanding their contribution to the interdisciplinary health care team.

9. Establishes, maintains and appropriately concludes therapeutic relationships

9.1 Establishes therapeutic relationships that are goal directed and recognises professional boundaries:



- demonstrates empathy, trust and respect for the dignity and potential of the individual/group
- interacts with individuals/groups in a supportive manner
- effectively initiates, maintains and concludes interpersonal interactions
- establishes rapport with individuals/groups that enhances their ability to express feelings, and fosters an appropriate context for expression of feeling
- understands the potential benefits of partnership approaches on nurse individual/group relationships, and
- demonstrates an understanding of standards and practices of professional boundaries and therapeutic relationships.

9.2 Communicates effectively with individuals/groups to facilitate provision of care:

- uses a range of effective communication techniques
- uses language appropriate to the context
- uses written and spoken communication skills appropriate to the needs of individuals/groups
- uses an interpreter where appropriate
- provides adequate time for discussion
- establishes, where possible, alternative communication methods for individuals/groups who are unable to verbalise, and
- uses open/closed questions appropriately.

9.3 Uses appropriate strategies to promote an individual's/group's self-esteem, dignity, integrity and comfort:

- identifies and uses strategies which encourage independence
- identifies and uses strategies which affirm individuality
- uses strategies which involve the family/significant others in care
- identifies and recommends appropriate support networks to individuals/groups
- identifies situations which may threaten the dignity/integrity of an individual/group
- implements measures to maintain dignity of individuals/groups during periods of self-care deficit
- implements measures to support individuals/groups experiencing emotional distress, and
- information is provided to individuals/groups to enhance their control over their own health care.

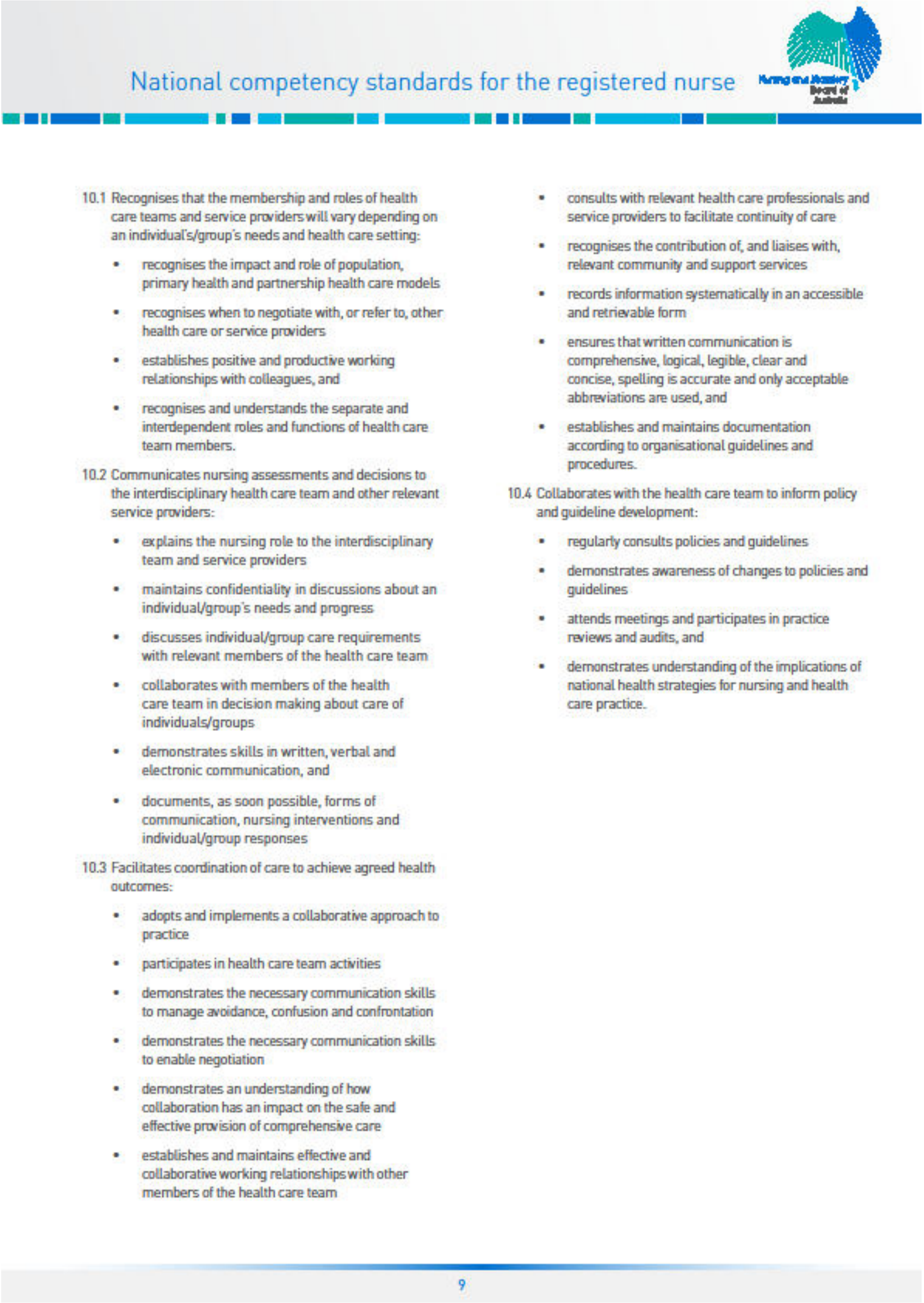
9.4 Assists and supports individuals/groups to make informed health care decisions:

- facilitates and encourages individual/group decision-making
- maintains and supports respect for an individual/group's decision through communication with other members of the interdisciplinary health care team, and
- arranges consultation to support individuals/groups to make informed decisions regarding health care

9.5 Facilitates a physical, psychosocial, cultural and spiritual environment that promotes individual/group safety and security:

- demonstrates sensitivity, awareness and respect for cultural identity as part of an individual's/group's perceptions of security
- demonstrates sensitivity, awareness and respect in regard to an individual's/group's spiritual needs
- involves family and others in ensuring that cultural and spiritual needs are met
- identifies, eliminates or prevents environmental hazards where possible
- applies relevant principles to ensure the safe administration of therapeutic substances
- maintains standards for infection control
- applies ergonomic principles to prevent injury to individual/group and self
- prioritises safety problems
- adheres to occupational health and safety legislation
- modifies environmental factors to meet an individual/group's comfort needs where possible
- promotes individual/group comfort throughout interventions, and
- uses ergonomic principles and appropriate aids to promote the individual/group's comfort

10. Collaborates with the interdisciplinary health care team to provide comprehensive nursing care



10.1 Recognises that the membership and roles of health care teams and service providers will vary depending on an individual's/group's needs and health care setting:

- recognises the impact and role of population, primary health and partnership health care models
- recognises when to negotiate with, or refer to, other health care or service providers
- establishes positive and productive working relationships with colleagues, and
- recognises and understands the separate and interdependent roles and functions of health care team members.

10.2 Communicates nursing assessments and decisions to the interdisciplinary health care team and other relevant service providers:

- explains the nursing role to the interdisciplinary team and service providers
- maintains confidentiality in discussions about an individual/group's needs and progress
- discusses individual/group care requirements with relevant members of the health care team
- collaborates with members of the health care team in decision making about care of individuals/groups
- demonstrates skills in written, verbal and electronic communication, and
- documents, as soon possible, forms of communication, nursing interventions and individual/group responses

10.3 Facilitates coordination of care to achieve agreed health outcomes:

- adopts and implements a collaborative approach to practice
- participates in health care team activities
- demonstrates the necessary communication skills to manage avoidance, confusion and confrontation
- demonstrates the necessary communication skills to enable negotiation
- demonstrates an understanding of how collaboration has an impact on the safe and effective provision of comprehensive care
- establishes and maintains effective and collaborative working relationships with other members of the health care team
- consults with relevant health care professionals and service providers to facilitate continuity of care
- recognises the contribution of, and liaises with, relevant community and support services
- records information systematically in an accessible and retrievable form
- ensures that written communication is comprehensive, logical, legible, clear and concise, spelling is accurate and only acceptable abbreviations are used, and
- establishes and maintains documentation according to organisational guidelines and procedures.

10.4 Collaborates with the health care team to inform policy and guideline development:

- regularly consults policies and guidelines
- demonstrates awareness of changes to policies and guidelines
- attends meetings and participates in practice reviews and audits, and
- demonstrates understanding of the implications of national health strategies for nursing and health care practice.

Glosssary

ANMAC
The Australian Nursing and Midwifery Accreditation Council, which is the new name for the ANMC

ANMC
Australian Nursing and Midwifery Council

Appropriate
Matching the circumstances, meeting needs of the individual, group or situation

Attributes
Characteristics which underpin competent performance

Competence
The combination of skills, knowledge, attitudes, values and abilities that underpin effective and/ or superior performance in a profession/occupational area

Competency element
Represents a sub-section of a competency unit, and contains examples of competent performance known as cues

Competency standards
Consist of competency units and competency elements

Competency unit
Represents a stand-alone function or functional area underlying some aspect of professional performance

Competent
The person has competence across all the domains of competencies applicable to the nurse, at a level that is judged to be appropriate for the level of nurse being assessed

Contexts
The setting/environment where competence can be demonstrated or applied

Core competency standards
Essential competency standards for registration

Cues
Generic examples of competent performance. They are neither comprehensive nor exhaustive. They assist in assessment, self-reflection and curriculum development

Domains
An organised cluster of competencies in nursing practice

Enrolled nurse (EN)
A person registered to provide nursing care under the supervision of a registered nurse

Exemplars
Concrete examples typical of competence. They are not the standard but are indicative of the standard

National Board
The Nursing and Midwifery Board of Australia

National Scheme
The National Registration and Accreditation Scheme that commenced on 1 July 2010

NMRAs
Nursing and midwifery regulatory authorities (states and territories)

Nursing and Midwifery Board of Australia
The national body responsible for the regulation of nurses and midwives

Registered nurse (RN)
A person registered to practise nursing in Australia

This document was originally developed and published under the auspices of the Australian Nursing and Midwifery Council. When the National Registration and Accreditation Scheme (National Scheme) began in Australia in 2010, this publication became property of the Nursing and Midwifery Board of Australia, as the body responsible for the regulation of nurses and midwives. Except to update the design and names of relevant organisations, and apply rebranding to reflect current ownership, the content or intent of the original document has not changed unless indicated otherwise.

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Appendix C: NMBA A Nurse's Guide to Professional Boundaries (2010)

A nurse's guide to professional boundaries

Nursing and Midwifery
Board of
Australia

This is a companion document to the Codes of ethics and professional conduct for nurses

Introduction

The *Code of professional conduct for nurses in Australia*[1], the *Code of ethics for nurses in Australia*[2], the *Code of conduct for nurses* (New Zealand)[3] and the New Zealand Nurses Organisation code of ethics[4] set minimum standards in the respective regulatory jurisdictions that nurses are expected to uphold both within and outside of professional domains in order to ensure the 'good standing' of the profession in Australia and New Zealand.

These two sets of companion codes, together with other published practice standards (e.g. competency standards, decision making frameworks, direction and delegation guidelines and position statements) provide a framework for legally and professionally accountable and responsible nursing practice in all clinical, management, education and research domains in Australia and New Zealand.

These guidelines are designed to be read in conjunction with the above codes and provide more detailed guidance and discussion in relation to the sometimes challenging area of managing professional boundaries; that is, identifying and differentiating the boundaries between professional relationships and personal relationships. In doing so, these guidelines aim to protect the community by helping to prevent distress, confusion, harm or abuse of people being cared for by nurses. It is intended this resource will stimulate reflection, stimulate discussion and guide decision making in all aspects of the relationship that is established when care is provided by nurses to people in the course of their professional role in all practice settings.

Companion documents to these guidelines include a more detailed background discussion paper that contains further information on professional boundaries, including references for the material used in these guidelines; and stories and scenarios that give examples of situations highlighting potential and real professional relationship and boundaries dilemmas for nurses.

For nurses who also practise as midwives, a separate but consistent set of guidelines has been developed for midwives to complement the equivalent codes of professional conduct and ethics for midwives in New Zealand and Australia.

What are professional boundaries?

A nurse enters a therapeutic relationship with skills and knowledge that include a great deal of personal information about the individual in their care; and the authority to provide the care required by the individual.

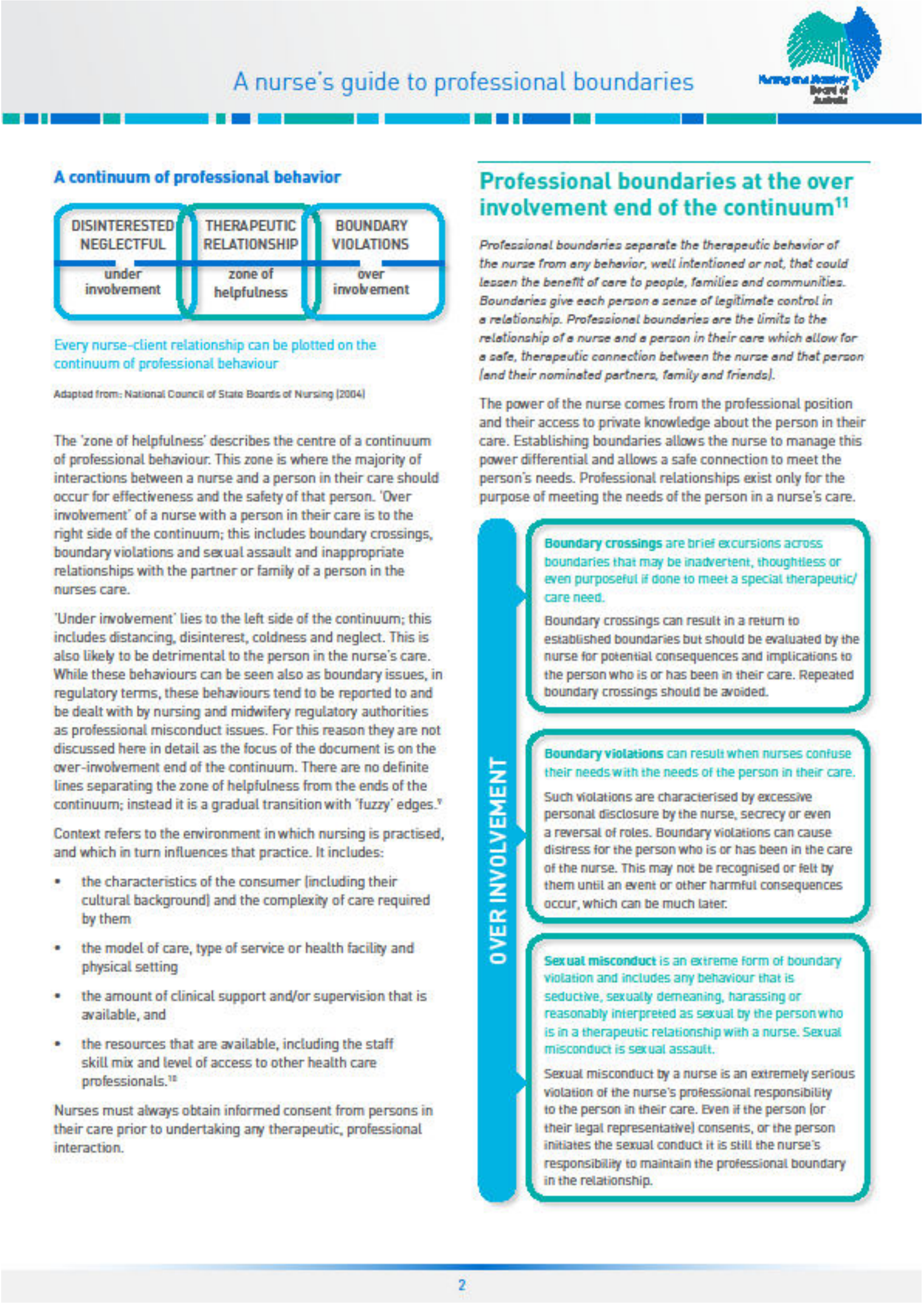
The community trusts that nurses will act in the best interest of those in their care and that the nurse will base that care on an assessment of the individual's specific needs. The power imbalance present in a professional relationship places the recipients of care in a position of vulnerability and of potential exposure to exploitation or abuse if that trust is not respected. Nurses have a responsibility to ensure that a relationship based on plans and goals that are therapeutic in intent and outcome is maintained. This means that it is the responsibility of the nurse to maintain their professional and personal boundaries, as well as assisting colleagues and the people in their care, in maintaining theirs.

Professional boundaries in nursing are defined as limits which protect the space between the professional's power and the client's vulnerability;[5] that is they are the borders that mark the edges between a professional, therapeutic relationship and a non-professional or personal relationship between a nurse and a person in their care. When a nurse crosses a boundary, they are generally behaving in an unprofessional manner and misusing the power in the relationship.[6]

In order to manage these professional boundaries we need to appreciate that:

> *An inherent power imbalance exists within the relationship between people receiving care and nurses that make the persons in their care vulnerable and open to exploitation. Nurses actively preserve the dignity of people through practiced kindness and respect for the vulnerability and powerlessness of people in their care... This vulnerability creates a power differential in the relationship between nurses and persons in their care that must be recognised and managed.*[7]

A diagram representing a continuum of professional behaviour provides a picture of therapeutic versus non-therapeutic behaviour in the relationship between the nurse and the persons in their care.[8]



A continuum of professional behavior

DISINTERESTED NEGLECTFUL	THERAPEUTIC RELATIONSHIP	BOUNDARY VIOLATIONS
under involvement	zone of helpfulness	over involvement

Every nurse-client relationship can be plotted on the continuum of professional behaviour

Adapted from: National Council of State Boards of Nursing (2004)

The 'zone of helpfulness' describes the centre of a continuum of professional behaviour. This zone is where the majority of interactions between a nurse and a person in their care should occur for effectiveness and the safety of that person. 'Over involvement' of a nurse with a person in their care is to the right side of the continuum; this includes boundary crossings, boundary violations and sexual assault and inappropriate relationships with the partner or family of a person in the nurses care.

'Under involvement' lies to the left side of the continuum; this includes distancing, disinterest, coldness and neglect. This is also likely to be detrimental to the person in the nurse's care. While these behaviours can be seen also as boundary issues, in regulatory terms, these behaviours tend to be reported to and be dealt with by nursing and midwifery regulatory authorities as professional misconduct issues. For this reason they are not discussed here in detail as the focus of the document is on the over-involvement end of the continuum. There are no definite lines separating the zone of helpfulness from the ends of the continuum; instead it is a gradual transition with 'fuzzy' edges.[9]

Context refers to the environment in which nursing is practised, and which in turn influences that practice. It includes:

- the characteristics of the consumer (including their cultural background) and the complexity of care required by them
- the model of care, type of service or health facility and physical setting
- the amount of clinical support and/or supervision that is available, and
- the resources that are available, including the staff skill mix and level of access to other health care professionals.[10]

Nurses must always obtain informed consent from persons in their care prior to undertaking any therapeutic, professional interaction.

Professional boundaries at the over involvement end of the continuum[11]

Professional boundaries separate the therapeutic behavior of the nurse from any behavior, well intentioned or not, that could lessen the benefit of care to people, families and communities. Boundaries give each person a sense of legitimate control in a relationship. Professional boundaries are the limits to the relationship of a nurse and a person in their care which allow for a safe, therapeutic connection between the nurse and that person (and their nominated partners, family and friends).

The power of the nurse comes from the professional position and their access to private knowledge about the person in their care. Establishing boundaries allows the nurse to manage this power differential and allows a safe connection to meet the person's needs. Professional relationships exist only for the purpose of meeting the needs of the person in a nurse's care.

OVER INVOLVEMENT

Boundary crossings are brief excursions across boundaries that may be inadvertent, thoughtless or even purposeful if done to meet a special therapeutic/care need.

Boundary crossings can result in a return to established boundaries but should be evaluated by the nurse for potential consequences and implications to the person who is or has been in their care. Repeated boundary crossings should be avoided.

Boundary violations can result when nurses confuse their needs with the needs of the person in their care.

Such violations are characterised by excessive personal disclosure by the nurse, secrecy or even a reversal of roles. Boundary violations can cause distress for the person who is or has been in the care of the nurse. This may not be recognised or felt by them until an event or other harmful consequences occur, which can be much later.

Sexual misconduct is an extreme form of boundary violation and includes any behaviour that is seductive, sexually demeaning, harassing or reasonably interpreted as sexual by the person who is in a therapeutic relationship with a nurse. Sexual misconduct is sexual assault.

Sexual misconduct by a nurse is an extremely serious violation of the nurse's professional responsibility to the person in their care. Even if the person (or their legal representative) consents, or the person initiates the sexual conduct it is still the nurse's responsibility to maintain the professional boundary in the relationship.

Guiding principles for safe, professional practice[12]

Context

Dual relationships & boundaries

1. Care is optimised when nurses and persons receiving care do not engage in dual relationships, for example where the nurse has a personal or business relationship, as well as a professional one with that person.
2. Where dual relationships in therapeutic care situations are unavoidable nurses are aware of the potential for harm and take all steps to minimise the risks.
3. Nurses establish and maintain the boundaries in their professional relationships with persons receiving care; and where necessary communicate these to that person.
4. Nurses recognise variables such as the care setting, community influences, the needs of the person and the nature of care or therapy they require affect the delineation of boundaries and respond accordingly.
5. Nurses understand the complexities if personal relationships develop once professional relationships end as the person may need additional care and services; making it difficult to determine when the professional relationship is truly terminated.
6. Nurses examine any boundary crossing, and are aware of the potential implications, avoiding repeated crossings.
7. Nurses seek support and guidance from professional leaders when they have concerns relating to boundaries in therapeutic relationships.

Access to or the disclosure of information

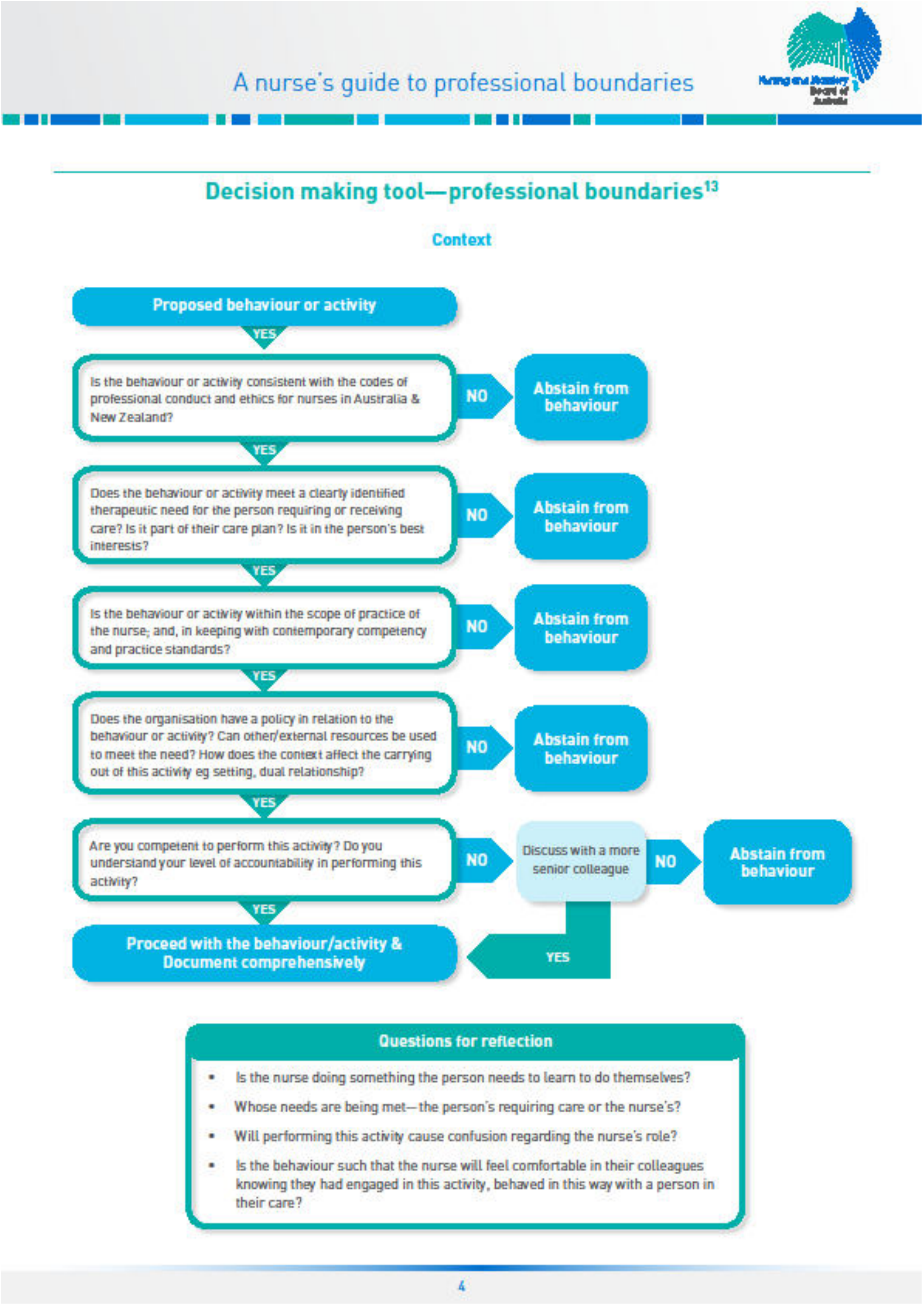
8. Nurses treat personal information obtained in a professional capacity as confidential; and do not use confidential information or their position of power to advantage themselves in any way.
9. Nurses carefully consider their motives for disclosing personal information. Self-disclosure is limited to revealing information that has therapeutic or care value and only occurs within an established therapeutic or care relationship.

Therapeutic & care relationships

10. The priority for nurses is planning care around meeting the therapeutic and care needs of persons entrusted to their care.
11. Nurses do not withhold care from a person as a punishment and recognise that any intent to cause pain or suffering as a retaliatory action in response to the behaviour of a person in their care is improper and unprofessional.
12. Nurses reflect on their own needs, behaviours, values and attitudes and beliefs and are conscious of their potential impact in therapeutic and professional relationships with people in their care.
13. Nurses are aware of the inherent power imbalance in therapeutic and care relationships, knowing that coercing a person's compliance may be an abuse of power.
14. Nurses are aware of and have the ability to validate the therapeutic or care purpose of their actions; and take into consideration the person's preferences and responses to those actions.
15. Nurses are aware of the potential for personal discomfort for both the person receiving care and themselves when care involves touching, holding, other personal contact or invasion of personal space; and respond appropriately.

Gifts, services & financial relations

- Nurses recognise that involvement in financial transactions (other than in a contract for the provision of services) and the receipt of anything other than 'token gifts' within professional relationships with persons in their care is likely to compromise the professional relationship.



A nurse's guide to professional boundaries

Decision making tool—professional boundaries[13]

Context

Proposed behaviour or activity

YES

Is the behaviour or activity consistent with the codes of professional conduct and ethics for nurses in Australia & New Zealand? — NO → **Abstain from behaviour**

YES

Does the behaviour or activity meet a clearly identified therapeutic need for the person requiring or receiving care? Is it part of their care plan? Is it in the person's best interests? — NO → **Abstain from behaviour**

YES

Is the behaviour or activity within the scope of practice of the nurse; and, in keeping with contemporary competency and practice standards? — NO → **Abstain from behaviour**

YES

Does the organisation have a policy in relation to the behaviour or activity? Can other/external resources be used to meet the need? How does the context affect the carrying out of this activity eg setting, dual relationship? — NO → **Abstain from behaviour**

YES

Are you competent to perform this activity? Do you understand your level of accountability in performing this activity? — NO → Discuss with a more senior colleague — NO → **Abstain from behaviour**

YES

Proceed with the behaviour/activity & Document comprehensively ← YES (Discuss with a more senior colleague)

Questions for reflection

- Is the nurse doing something the person needs to learn to do themselves?
- Whose needs are being met—the person's requiring care or the nurse's?
- Will performing this activity cause confusion regarding the nurse's role?
- Is the behaviour such that the nurse will feel comfortable in their colleagues knowing they had engaged in this activity, behaved in this way with a person in their care?

4

Q & A—professional boundaries[14]

How can a nurse identify a potential boundary violation?

Some behavioural indicators can alert nurses to potential boundary issues, for which there may be reasonable explanations. However, nurses who display one or more of the following behaviours should examine their professional relationships for possible boundary crossings or violations.

Excessive self-disclosure → The nurse discusses personal problems, feelings of sexual attraction or aspects of his or her intimate or personal life with a person in their care.

Secretive behaviour → The nurse keeps secrets with the person receiving care and/or becomes guarded or defensive when someone questions their interaction.

'Super nurse' behaviour → The nurse believes that they are immune from fostering a non-therapeutic relationship and that only they understand and can meet the person's needs.

Singled-out treatment or person paying attention to the nurse → The nurse spends inappropriate amounts of time with a particular person in their care, visits the person when off-duty or swaps roster allocations to be with the person. This form of treatment may also be reversed, with the person paying special or inappropriate attention to the nurse.

Selective communication → The nurse fails to explain actions and aspects of care to colleagues, reports only some aspects of the behaviour of the person in their care or gives 'double messages'. In the reverse, the person receiving care returns repeatedly to the nurse, reasoning why they cannot approach other nursing staff e.g. they are 'too busy'.

Flirtations → The nurse communicates in a flirtatious manner, perhaps employing sexual innuendo, off-colour jokes or offensive language. 'You and me against the world' behaviour—The nurse views the person in their care in a protective manner, tends not to accept the relationship with the person as only a professional relationship or sides with the person's position regardless of that position and its implications.

Sexual misconduct/assault → The nurse fails to recognise the development of an attraction of a sexual nature for the person receiving care or between themselves and the person in their care.

What are some of the nursing practice implications of professional boundaries?

Nurses need to practice in a manner consistent with the codes of professional conduct and ethics for nurses in Australia and New Zealand and other relevant professional standards. Nurses should be knowledgeable regarding professional boundaries and work to establish and maintain those boundaries. Nurses should examine any boundary-crossing behaviour and seek assistance and counsel from their colleagues and supervisors when such crossings occur.

What if a nurse lives in a small community? Does this mean that they cannot interact with neighbours or friends?

Variables such as the care setting, community influences, client needs, nature of the therapy provided, age of the client and degree of involvement affect the delineation of behavioural limits. All of these factors must be considered when establishing boundaries; and all contribute to the complexity of professional boundaries.

The difference between a caring relationship and an over-involved relationship is narrow. A professional living and working in a remote community will, out of necessity, have business and social relationships with people to whom they are providing care. Setting appropriate standards is very difficult. If they do not relate to real life, these standards may be ignored by the nurse or simply may not work. However, the absence of consideration of professional boundaries places person receiving care and the nurse at risk.

What should a nurse do if confronted with possible boundary violations or sexual misconduct in a colleague?

The safety of people requiring or receiving care must be the first priority. The nurse needs to be prepared to deal with violations by any member of the health care team. If a person's behaviour is ambiguous, or if the nurse is unsure of how to interpret a situation, the nurse should consult with a trusted supervisor or colleague. Incidents should be thoroughly documented in a timely manner. Nurses should be familiar with reporting requirements, as well as the grounds for discipline under the health professional regulatory scheme, and they are expected to comply with the legal and ethical mandates for reporting.

What if a person in their care offers a nurse, for example, bus fare or meal tickets?

There are two issues here. Firstly the nurse may have been inappropriately disclosing personal information about their private circumstances while providing care to the person which is inconsistent with the professional conduct of a nurse. Secondly, the acceptance by a nurse of money or goods from a person in their care is inappropriate in all circumstances.

Acceptable Gifts

Where nurses work in organisations, consideration should be given to the development of policy in relation to gifts. Individual organisational policy should decide the value at which items need to be officially declared. Gifts such as chocolates or flowers are generally acceptable. The process of declaring gifts received prompts nurses to consider the issue of gifts and professional conduct and acts as a stimulus to discussion around what is appropriate and what is not.

References

1 Nursing and Midwifery Board of Australia *Code of professional conduct for nurses*. Available at: www.nursingmidwiferyboard.gov.au.

2 Nursing and Midwifery Board of Australia *Code of ethics for nurses*. Available at: www.nursingmidwiferyboard.gov.au.

3 Nursing Council of New Zealand (2008) *Code of conduct for nurses*, Wellington. Available at: www.nursingcouncil.org.nz.

4 New Zealand Nurses Organisation (2001) *New Zealand Nurses Organisation Code of Ethics*, Wellington.

5 Peterson M (1992) At Personal Risk: *Boundary violations in professional-client relationships*, WW Norton & Co, New York.

6 College of Registered Nurses of British Columbia (2006) *Nurse-Client Relationships*, Pub No 406, Vancouver, 6. Available at: www.crnbc.ca.

7 Conduct Statement 8, Explanation 1—Code of Professional Conduct for Nurses in Australia.

8 College & Association of Registered Nurses of Alberta (2005) Professional Boundaries: *A Discussion Guide and Teaching Tool*, Edmonton, September, 2. Available at: www.nurses.ab.ca.

9 National Council of State Boards of Nursing (2007) *Professional Boundaries: A nurse's guide to the importance of appropriate professional boundaries*, Chicago, 4. Available at: www.ncsbn.org.

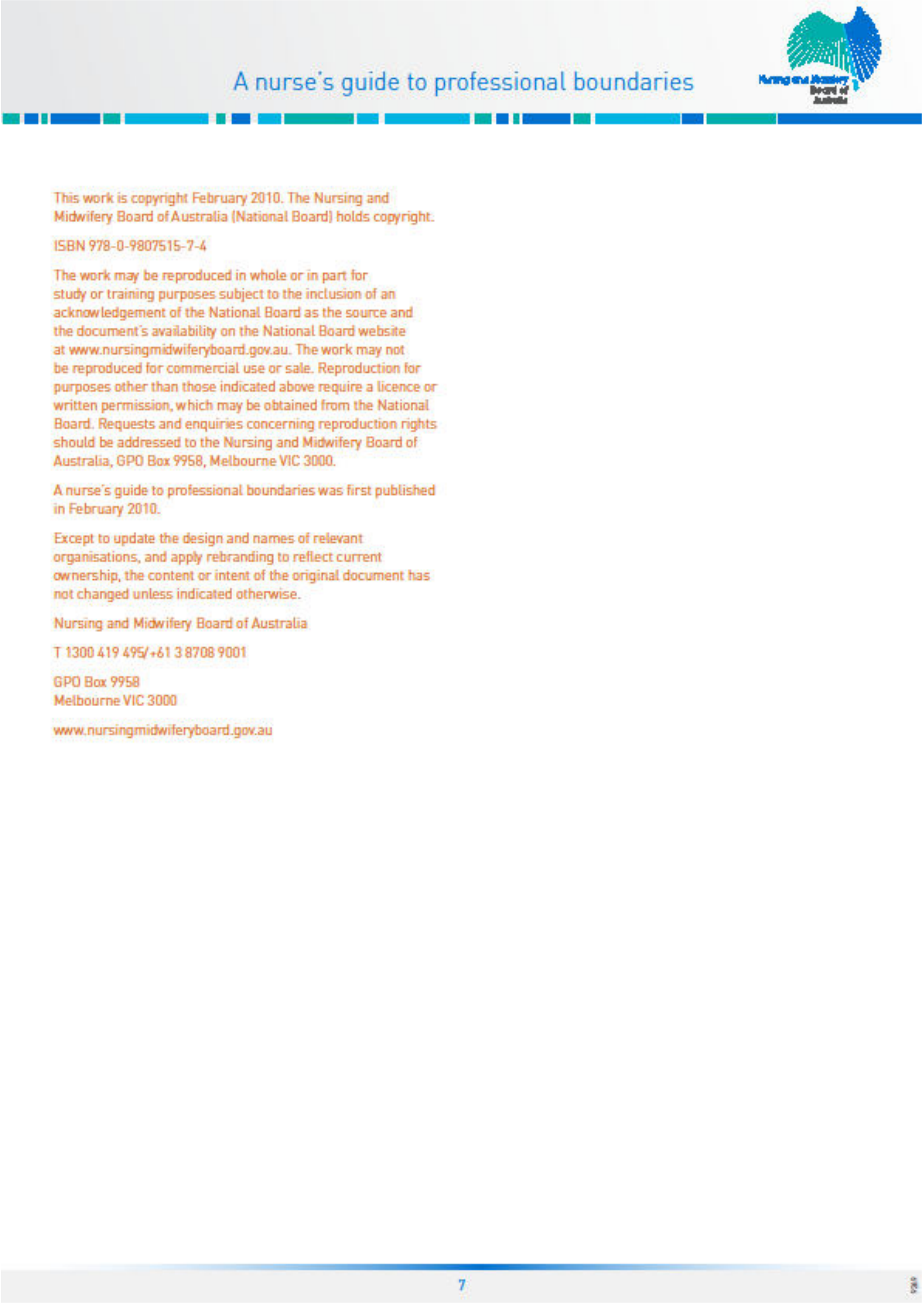
10 Adapted from Adapted from: ANMC (2007) *A national framework for the development of decision—making tools for nursing and midwifery practice*.

11 Adapted from National Council of State Boards of Nursing (2007) Professional Boundaries: *A nurse's guide to the importance of appropriate professional boundaries*, Chicago, 3. Available at: www.ncsbn.org.

12 Nursing Council of New Zealand (2008) *Code of conduct for nurses*, Wellington; New Zealand Nurses Organisation (2001) *New Zealand Nurses Organisation Code of Ethics*, Wellington; Australian Nursing and Midwifery Council (2008) *Code of Professional Conduct for Nurses in Australia* Canberra; Australian Nursing and Midwifery Council, Australian Nursing Federation, Royal College of Nursing Australia (2008) *Code of Ethics for Nurses in Australia*, Canberra. Both available at: www.anmc.org.au; The University of Newcastle (2007) *A Project Report on the Development of ANMC Guidelines on Professional Boundaries for Nurses* ; and *Draft National Guidelines on Professional Boundaries for Nurses* , October; and National Council of State Boards of Nursing (2007) *Professional Boundaries: A nurse's guide to the importance of appropriate professional boundaries*, Chicago, 4. Available at: www.ncsbn.org.

13 Adapted from: ANMC (2007) *A national framework for the development of decision-making tools for nursing and midwifery practice*; College of Registered Nurses of Nova Scotia (2002) *Guidelines for Nurse-Client Relationships*, Halifax, 5; College of Nurses Ontario (2006) Practice Standard: *Therapeutic Nurse-Client Relationship*, Toronto, 11.

14 Adapted from National Council of State Boards of Nursing (2007) Professional Boundaries: A nurse's guide to the importance of appropriate professional boundaries, Chicago, 6–9. Available at: www.ncsbn.org.



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A nurse's guide to professional boundaries was first published in February 2010.

Except to update the design and names of relevant organisations, and apply rebranding to reflect current ownership, the content or intent of the original document has not changed unless indicated otherwise.

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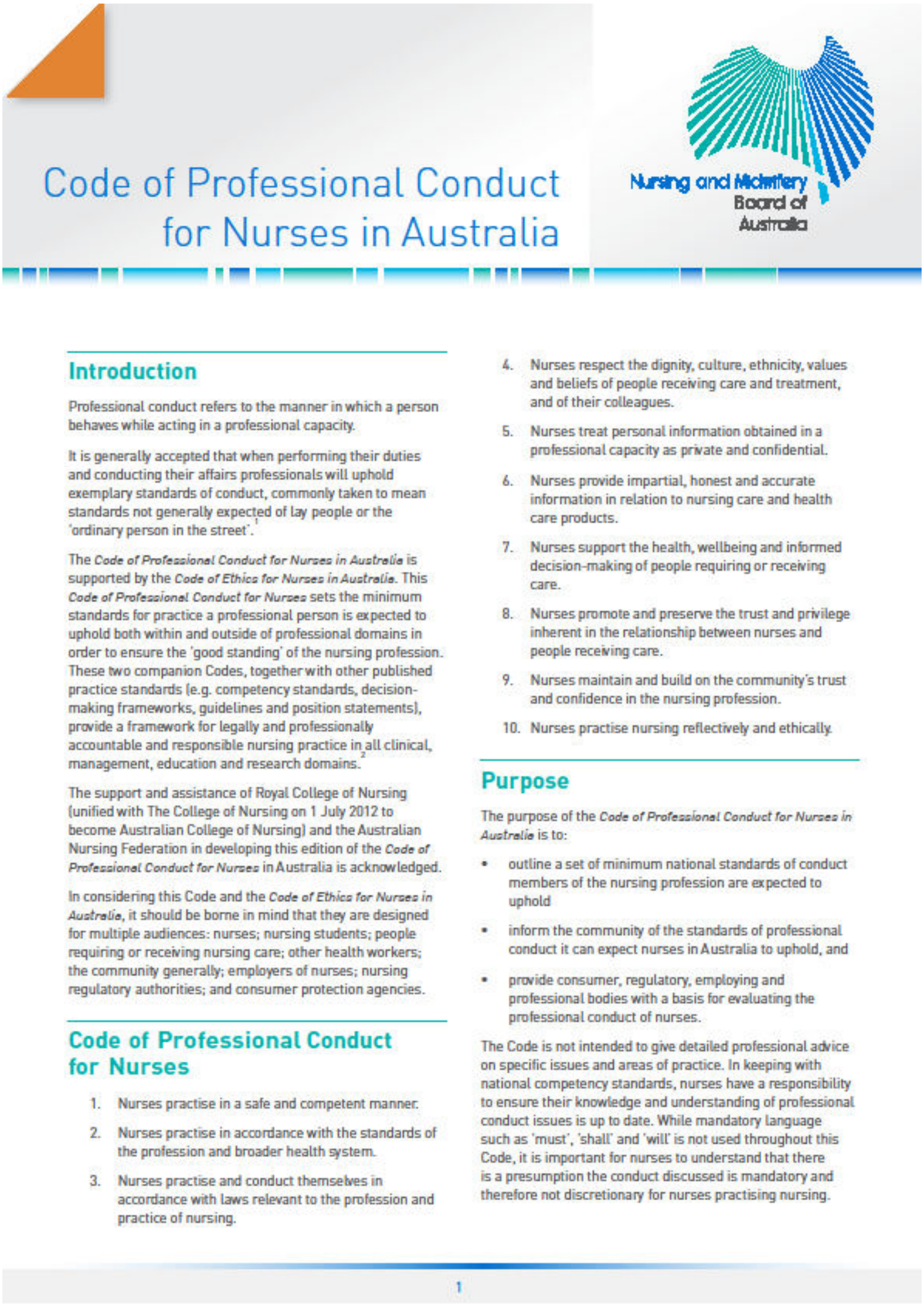
Appendix D: NMBA Code of Professional Conduct for Nurses in Australia (2008)



Code of Professional Conduct for Nurses in Australia

Nursing and Midwifery
Board of
Australia

Introduction

Professional conduct refers to the manner in which a person behaves while acting in a professional capacity.

It is generally accepted that when performing their duties and conducting their affairs professionals will uphold exemplary standards of conduct, commonly taken to mean standards not generally expected of lay people or the 'ordinary person in the street'.[1]

The *Code of Professional Conduct for Nurses in Australia* is supported by the *Code of Ethics for Nurses in Australia*. This *Code of Professional Conduct for Nurses* sets the minimum standards for practice a professional person is expected to uphold both within and outside of professional domains in order to ensure the 'good standing' of the nursing profession. These two companion Codes, together with other published practice standards (e.g. competency standards, decision-making frameworks, guidelines and position statements), provide a framework for legally and professionally accountable and responsible nursing practice in all clinical, management, education and research domains.[2]

The support and assistance of Royal College of Nursing (unified with The College of Nursing on 1 July 2012 to become Australian College of Nursing) and the Australian Nursing Federation in developing this edition of the *Code of Professional Conduct for Nurses* in Australia is acknowledged.

In considering this Code and the *Code of Ethics for Nurses in Australia*, it should be borne in mind that they are designed for multiple audiences: nurses; nursing students; people requiring or receiving nursing care; other health workers; the community generally; employers of nurses; nursing regulatory authorities; and consumer protection agencies.

Code of Professional Conduct for Nurses

1. Nurses practise in a safe and competent manner.
2. Nurses practise in accordance with the standards of the profession and broader health system.
3. Nurses practise and conduct themselves in accordance with laws relevant to the profession and practice of nursing.
4. Nurses respect the dignity, culture, ethnicity, values and beliefs of people receiving care and treatment, and of their colleagues.
5. Nurses treat personal information obtained in a professional capacity as private and confidential.
6. Nurses provide impartial, honest and accurate information in relation to nursing care and health care products.
7. Nurses support the health, wellbeing and informed decision-making of people requiring or receiving care.
8. Nurses promote and preserve the trust and privilege inherent in the relationship between nurses and people receiving care.
9. Nurses maintain and build on the community's trust and confidence in the nursing profession.
10. Nurses practise nursing reflectively and ethically.

Purpose

The purpose of the *Code of Professional Conduct for Nurses in Australia* is to:

- outline a set of minimum national standards of conduct members of the nursing profession are expected to uphold
- inform the community of the standards of professional conduct it can expect nurses in Australia to uphold, and
- provide consumer, regulatory, employing and professional bodies with a basis for evaluating the professional conduct of nurses.

The Code is not intended to give detailed professional advice on specific issues and areas of practice. In keeping with national competency standards, nurses have a responsibility to ensure their knowledge and understanding of professional conduct issues is up to date. While mandatory language such as 'must', 'shall' and 'will' is not used throughout this Code, it is important for nurses to understand that there is a presumption the conduct discussed is mandatory and therefore not discretionary for nurses practising nursing.

A breach of the Code may constitute either **professional misconduct** or unprofessional conduct. For the purposes of this Code, professional misconduct refers to 'the wrong, bad or erroneous conduct of a nurse outside of the domain of his or her practice; conduct unbefitting a nurse' (e.g. sexual assault, theft, or drunk and disorderly conduct in a public place). **Unprofessional conduct** refers to 'conduct that is contrary to the accepted and agreed practice standards of the profession' (e.g. breaching the principles of asepsis; violating confidentiality in the relationship between persons receiving care and nurses).[3]

The nursing profession expects nurses will conduct themselves personally and professionally in a way that maintains public trust and confidence in the profession. Nurses have a responsibility to the people to whom they provide care, society and each other to provide safe, quality and competent nursing care.

Code of Professional Conduct

Conduct Statement 1

Nurses practise in a safe and competent manner

Explanation

1. Nurses are personally accountable for the provision of safe and competent nursing care. It is the responsibility of each nurse to maintain the competence necessary for current practice. Maintenance of competence includes participation in ongoing professional development to maintain and improve knowledge, skills and attitudes relevant to practice in a clinical, management, education or research setting.[4]
2. Nurses are aware that undertaking activities not within their scopes of practice may compromise the safety of persons in their care. These scopes of practice are based on each nurse's education, knowledge, competency, extent of experience and lawful authority.
3. Nurses, reasonably and in good faith, advise their immediate supervisors or employers of the scopes of their practice including any limitations.[5]
4. When an aspect of care is delegated, nurses ensure the delegation does not compromise the safety or quality of care of people.
5. Nurses practise in a safe and competent manner that is not compromised by personal health limitations, including the use of alcohol or other substances that may alter a nurse's capacity to practise safely at all times. Nurses whose health threatens their capacity to practise safely and competently have a responsibility to seek assistance to redress their health needs. This may include making a confidential report to an appropriate authority.

Conduct Statement 2

Nurses practise in accordance with the standards of the profession and broader health system

Explanation

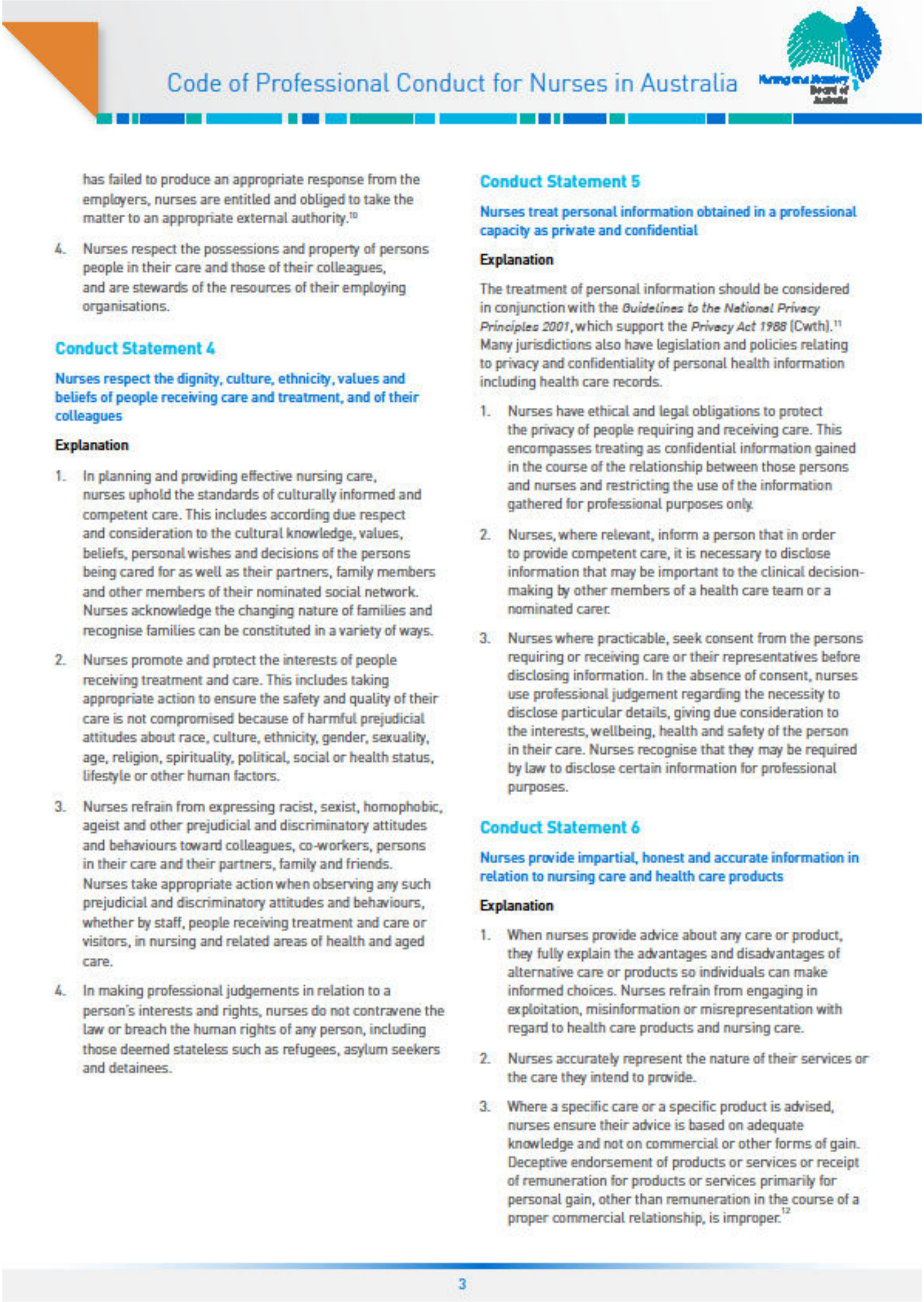
1. Nurses are responsible for ensuring the standard of their practice conforms to professional standards developed and agreed by the profession, with the object of enhancing the safety of people in their care as well as their partners, family members and other members of the person's nominated network. This responsibility also applies to the nurses' colleagues.
2. Nurses practise in accordance with wider standards relating to safety and quality in health care and accountability for a safe health system, such as those relating to health documentation and information management, incident reporting and participation in adverse event analysis and formal open disclosure procedures.[6]
3. Nurses' primary responsibility is to provide safe and competent nursing care. Any circumstance that may compromise professional standards, or any observation of questionable, unethical or unlawful practice, should be made known to an appropriate person or authority. If the concern is not resolved and continues to compromise safe and competent care, nurses must intervene to safeguard the individual and, after exhausting internal processes, may notify an appropriate authority external to their employer organisation.
4. Nurses recognise their professional position and do not accept gifts or benefits that could be viewed as a means of securing the nurses' influence or favour.[7]

Conduct Statement 3

Nurses practise and conduct themselves in accordance with laws relevant to the profession and practice of nursing

Explanation

1. Nurses are familiar with relevant laws[8] and ensure they do not engage in clinical or other practices prohibited by such laws or delegate to others activities prohibited by those laws.
2. Nurses witnessing the unlawful conduct of colleagues and other co-workers, whether in clinical, management, education or research areas of practice,[9] have both a responsibility and an obligation to report such conduct to an appropriate authority and take other appropriate action as necessary to safeguard people and the public interest.
3. Where nurses make a report of unlawful or otherwise unacceptable conduct to their employers, and that report



has failed to produce an appropriate response from the employers, nurses are entitled and obliged to take the matter to an appropriate external authority.[10]

4. Nurses respect the possessions and property of persons people in their care and those of their colleagues, and are stewards of the resources of their employing organisations.

Conduct Statement 4

Nurses respect the dignity, culture, ethnicity, values and beliefs of people receiving care and treatment, and of their colleagues

Explanation

1. In planning and providing effective nursing care, nurses uphold the standards of culturally informed and competent care. This includes according due respect and consideration to the cultural knowledge, values, beliefs, personal wishes and decisions of the persons being cared for as well as their partners, family members and other members of their nominated social network. Nurses acknowledge the changing nature of families and recognise families can be constituted in a variety of ways.
2. Nurses promote and protect the interests of people receiving treatment and care. This includes taking appropriate action to ensure the safety and quality of their care is not compromised because of harmful prejudicial attitudes about race, culture, ethnicity, gender, sexuality, age, religion, spirituality, political, social or health status, lifestyle or other human factors.
3. Nurses refrain from expressing racist, sexist, homophobic, ageist and other prejudicial and discriminatory attitudes and behaviours toward colleagues, co-workers, persons in their care and their partners, family and friends. Nurses take appropriate action when observing any such prejudicial and discriminatory attitudes and behaviours, whether by staff, people receiving treatment and care or visitors, in nursing and related areas of health and aged care.
4. In making professional judgements in relation to a person's interests and rights, nurses do not contravene the law or breach the human rights of any person, including those deemed stateless such as refugees, asylum seekers and detainees.

Conduct Statement 5

Nurses treat personal information obtained in a professional capacity as private and confidential

Explanation

The treatment of personal information should be considered in conjunction with the *Guidelines to the National Privacy Principles 2001*, which support the *Privacy Act 1988* (Cwth).[11] Many jurisdictions also have legislation and policies relating to privacy and confidentiality of personal health information including health care records.

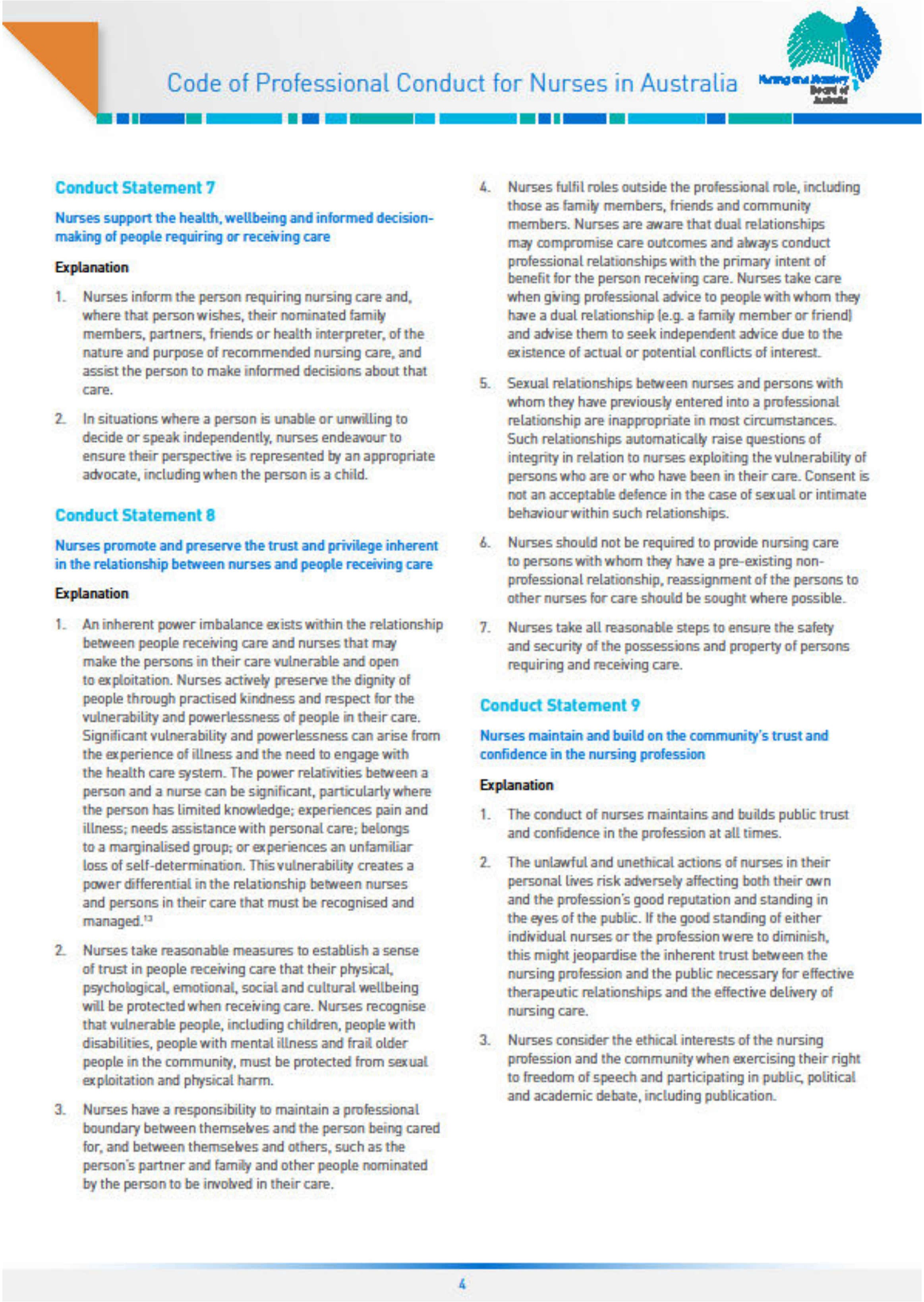
1. Nurses have ethical and legal obligations to protect the privacy of people requiring and receiving care. This encompasses treating as confidential information gained in the course of the relationship between those persons and nurses and restricting the use of the information gathered for professional purposes only.
2. Nurses, where relevant, inform a person that in order to provide competent care, it is necessary to disclose information that may be important to the clinical decision-making by other members of a health care team or a nominated carer.
3. Nurses where practicable, seek consent from the persons requiring or receiving care or their representatives before disclosing information. In the absence of consent, nurses use professional judgement regarding the necessity to disclose particular details, giving due consideration to the interests, wellbeing, health and safety of the person in their care. Nurses recognise that they may be required by law to disclose certain information for professional purposes.

Conduct Statement 6

Nurses provide impartial, honest and accurate information in relation to nursing care and health care products

Explanation

1. When nurses provide advice about any care or product, they fully explain the advantages and disadvantages of alternative care or products so individuals can make informed choices. Nurses refrain from engaging in exploitation, misinformation or misrepresentation with regard to health care products and nursing care.
2. Nurses accurately represent the nature of their services or the care they intend to provide.
3. Where a specific care or a specific product is advised, nurses ensure their advice is based on adequate knowledge and not on commercial or other forms of gain. Deceptive endorsement of products or services or receipt of remuneration for products or services primarily for personal gain, other than remuneration in the course of a proper commercial relationship, is improper.[12]



Conduct Statement 7

Nurses support the health, wellbeing and informed decision-making of people requiring or receiving care

Explanation

1. Nurses inform the person requiring nursing care and, where that person wishes, their nominated family members, partners, friends or health interpreter, of the nature and purpose of recommended nursing care, and assist the person to make informed decisions about that care.
2. In situations where a person is unable or unwilling to decide or speak independently, nurses endeavour to ensure their perspective is represented by an appropriate advocate, including when the person is a child.

Conduct Statement 8

Nurses promote and preserve the trust and privilege inherent in the relationship between nurses and people receiving care

Explanation

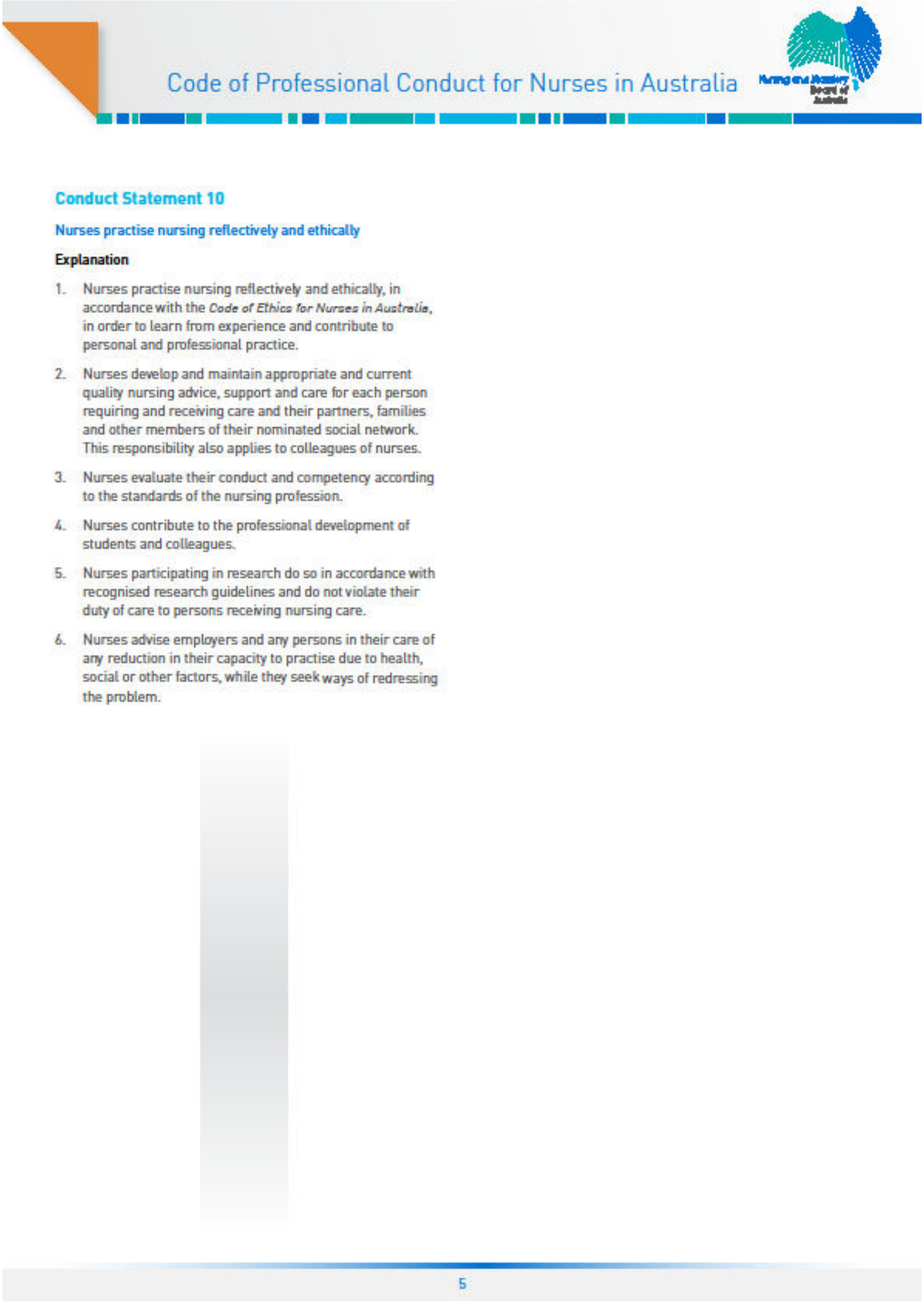
1. An inherent power imbalance exists within the relationship between people receiving care and nurses that may make the persons in their care vulnerable and open to exploitation. Nurses actively preserve the dignity of people through practised kindness and respect for the vulnerability and powerlessness of people in their care. Significant vulnerability and powerlessness can arise from the experience of illness and the need to engage with the health care system. The power relativities between a person and a nurse can be significant, particularly where the person has limited knowledge; experiences pain and illness; needs assistance with personal care; belongs to a marginalised group; or experiences an unfamiliar loss of self-determination. This vulnerability creates a power differential in the relationship between nurses and persons in their care that must be recognised and managed.[13]
2. Nurses take reasonable measures to establish a sense of trust in people receiving care that their physical, psychological, emotional, social and cultural wellbeing will be protected when receiving care. Nurses recognise that vulnerable people, including children, people with disabilities, people with mental illness and frail older people in the community, must be protected from sexual exploitation and physical harm.
3. Nurses have a responsibility to maintain a professional boundary between themselves and the person being cared for, and between themselves and others, such as the person's partner and family and other people nominated by the person to be involved in their care.
4. Nurses fulfil roles outside the professional role, including those as family members, friends and community members. Nurses are aware that dual relationships may compromise care outcomes and always conduct professional relationships with the primary intent of benefit for the person receiving care. Nurses take care when giving professional advice to people with whom they have a dual relationship (e.g. a family member or friend) and advise them to seek independent advice due to the existence of actual or potential conflicts of interest.
5. Sexual relationships between nurses and persons with whom they have previously entered into a professional relationship are inappropriate in most circumstances. Such relationships automatically raise questions of integrity in relation to nurses exploiting the vulnerability of persons who are or who have been in their care. Consent is not an acceptable defence in the case of sexual or intimate behaviour within such relationships.
6. Nurses should not be required to provide nursing care to persons with whom they have a pre-existing non-professional relationship, reassignment of the persons to other nurses for care should be sought where possible.
7. Nurses take all reasonable steps to ensure the safety and security of the possessions and property of persons requiring and receiving care.

Conduct Statement 9

Nurses maintain and build on the community's trust and confidence in the nursing profession

Explanation

1. The conduct of nurses maintains and builds public trust and confidence in the profession at all times.
2. The unlawful and unethical actions of nurses in their personal lives risk adversely affecting both their own and the profession's good reputation and standing in the eyes of the public. If the good standing of either individual nurses or the profession were to diminish, this might jeopardise the inherent trust between the nursing profession and the public necessary for effective therapeutic relationships and the effective delivery of nursing care.
3. Nurses consider the ethical interests of the nursing profession and the community when exercising their right to freedom of speech and participating in public, political and academic debate, including publication.



Conduct Statement 10

Nurses practise nursing reflectively and ethically

Explanation

1. Nurses practise nursing reflectively and ethically, in accordance with the *Code of Ethics for Nurses in Australia*, in order to learn from experience and contribute to personal and professional practice.
2. Nurses develop and maintain appropriate and current quality nursing advice, support and care for each person requiring and receiving care and their partners, families and other members of their nominated social network. This responsibility also applies to colleagues of nurses.
3. Nurses evaluate their conduct and competency according to the standards of the nursing profession.
4. Nurses contribute to the professional development of students and colleagues.
5. Nurses participating in research do so in accordance with recognised research guidelines and do not violate their duty of care to persons receiving nursing care.
6. Nurses advise employers and any persons in their care of any reduction in their capacity to practise due to health, social or other factors, while they seek ways of redressing the problem.

Glossary of terms

Adverse event – is an unintended injury or complication resulting in temporary or permanent disability, death or prolonged hospital stay and is caused by health care management rather than the person's disease.

Colleagues – includes health care workers, co-workers, staff and others lawfully involved in the care of people.

Ethics and morality – the concepts of 'ethics' and 'morality' are substantially the same and have been used interchangeably throughout this Code.

Nominated partners, family and friends – include people in consensual relationship with the person receiving nursing care and others who play an important role in the life of that person.

Nurse – means a registered or enrolled nurse authorised to practise in a state or territory of Australia. For the purposes of this Code, it may also refer to students of nursing.

Persons or people requiring or receiving care – includes the full range of alternative terms such as patient, client, resident and consumer and is employed for the sake of respect and simplicity.

Professional boundaries – are the limits of a relationship between a nurse and an individual or the individual's significant other. These limits facilitate safe and therapeutic practice and result in safe and effective care. Limits of a relationship may include under- or over-involvement in the provision of care.

Professional misconduct

Professional misconduct includes:

- conduct that is substantially below the standard reasonably expected of a registered health practitioner of an equivalent level of training or experience
- more than one instance of unprofessional conduct, and
- conduct that is not consistent with being a fit and proper person to hold registration in the profession.

Representative of a person requiring or receiving care – is a person legitimately entitled to act on behalf of another person.

Unprofessional conduct

Unprofessional conduct includes:

- breach of the National Health Practitioner Regulation Law, as in force in each state and territory
- breach of a registration condition or undertaking
- conviction for an offence that may affect suitability to continue practice
- providing health services that are excessive, unnecessary or not reasonably required
- influencing, or attempting to influence, the conduct of another registered health practitioner that may compromise patient care
- accepting a benefit as inducement, consideration or reward, for referrals or recommendations to use a health service provider
- offering or giving a person a benefit, consideration or reward, in return for providing referrals or recommendations to use a health service provider, and
- referring a person to, or recommending another health service provider, health service or health product, if there is a financial interest, unless the interest is disclosed.

Professional standards include:

- This *Code of Professional Conduct for Nurses in Australia*
- The *Code of Ethics for Nurses in Australia*
- The ICN *Code of Ethics for Nurses*
- The NMBA *Competency Standards for Nurse Practitioners, Registered Nurses and Enrolled Nurses*
- The NMBA *National Framework for the Development of Decision-Making Tools for Nursing and Midwifery Practice*
- other endorsed standards or guidelines published by the Nursing and Midwifery Board of Australia, and
- standards developed by professional nursing organisations.

References

Australian Competition and Consumer Commission and Health Care Complaints Commission (NSW) (2000) *Fair Treatment? Guide to the Trade Practices Act for the advertising or promotion of medical and health services*, Commonwealth of Australia, Canberra. Available at: www.accc.gov.au/content/index.phtml/itemId/309070/ fromItemId/654313. Accessed: 19 March 2008.

Australian Nursing and Midwifery Council (2002) *Code of Ethics for Nurses in Australia*, ANMC, Canberra – under review. Available at: www.anmc.org.au. Accessed: 19 March 2008.

Australian Nursing and Midwifery Council (2003) *Code of Professional Conduct for Nurses in Australia*, ANMC, Canberra – under review. Available at: www.anmc.org.au. Accessed: 19 March 2008.

Australian Nursing and Midwifery Council (2002) *National Competency Standards for the Enrolled Nurse*, ANMC, Canberra. Available at: www. anmc.org.au. Accessed: 19 March 2008.

Australian Nursing and Midwifery Council (2006) *National Competency Standards for the Nurse Practitioner*, ANMC, Canberra. Available at: www.anmc.org.au. Accessed: 19 March 2008.

Australian Nursing and Midwifery Council (2006) *National Competency Standards for the Registered Nurse*, ANMC, Canberra. Available at: www.anmc.org.au. Accessed: 19 March 2008.

Australian Nursing and Midwifery Council (2007) Draft ANMC *National Guidelines on Professional Boundaries for Nurses and Midwives*, ANMC, Canberra. Available at: www.anmc.org.au. Accessed: 19 March 2008.

Forrester K and Griffiths D (2005) *Essentials of Law for Health Professionals*, Elsevier, Marrickville, NSW.

Health Practitioner Regulation National Law, as in force in each state and territory. Available at: www.ahpra.gov.au under *Legislation and Publications*. Accessed: 10 September 2012.

International Council of Nurses (2006) *Code of Ethics for Nurses*, ICN, Geneva. Available at: www.icn.ch. Accessed: 19 March 2008.

Johnstone M and Kanitsaki O (2001) *Professional Conduct: A report to the Nurses Board of Victoria*, RMIT University, Melbourne.

Kerridge I, Lowe M, et al. (2005) *Ethics and Law for the Health Professions*, 2nd edition, The Federation Press, Annandale, NSW.

National Nursing Organisations (2006) *Governance Standards for Specialist Nursing and Midwifery Organisations*: A report by NNO for the National Nursing and Nursing Education Taskforce (N3ET), NNO, Melbourne. Available at: www.conno.org.au. Accessed: 19 March 2008.

Nurses Board of Victoria (2001) *Professional Boundaries Guidelines for Registered Nurses in Victoria*, NBV, Melbourne. Available at: www.nbv.org.au. Accessed: 19 March 2008.

Nurses and Midwives Board of Western Australia (2004) *Nurse Practitioners Code of Practice 2004*. Available at: www.nmbwa.org.au. Accessed: 19 March 2008.

Nurses Registration Board of New South Wales (1999) *Boundaries of Professional Practice: Guidelines for registered nurses and enrolled nurses*, NRBNSW, Surry Hills. Available at: www.nmb.nsw.gov.au. Accessed: 19 March 2008.

Nurses Registration Board of New South Wales (2001) *Professional Conduct: A case book of disciplinary decisions relating to professional conduct matters*, NRBNSW, Surry Hills.

Nursing Board of Tasmania (2005) *Professional Boundaries Standards for Nurses in Tasmania*, NBT, Hobart.

Queensland Nursing Council (1999) *Guidelines for Registered Nurses and Enrolled Nurses Regarding the Boundaries of Professional Practice*.

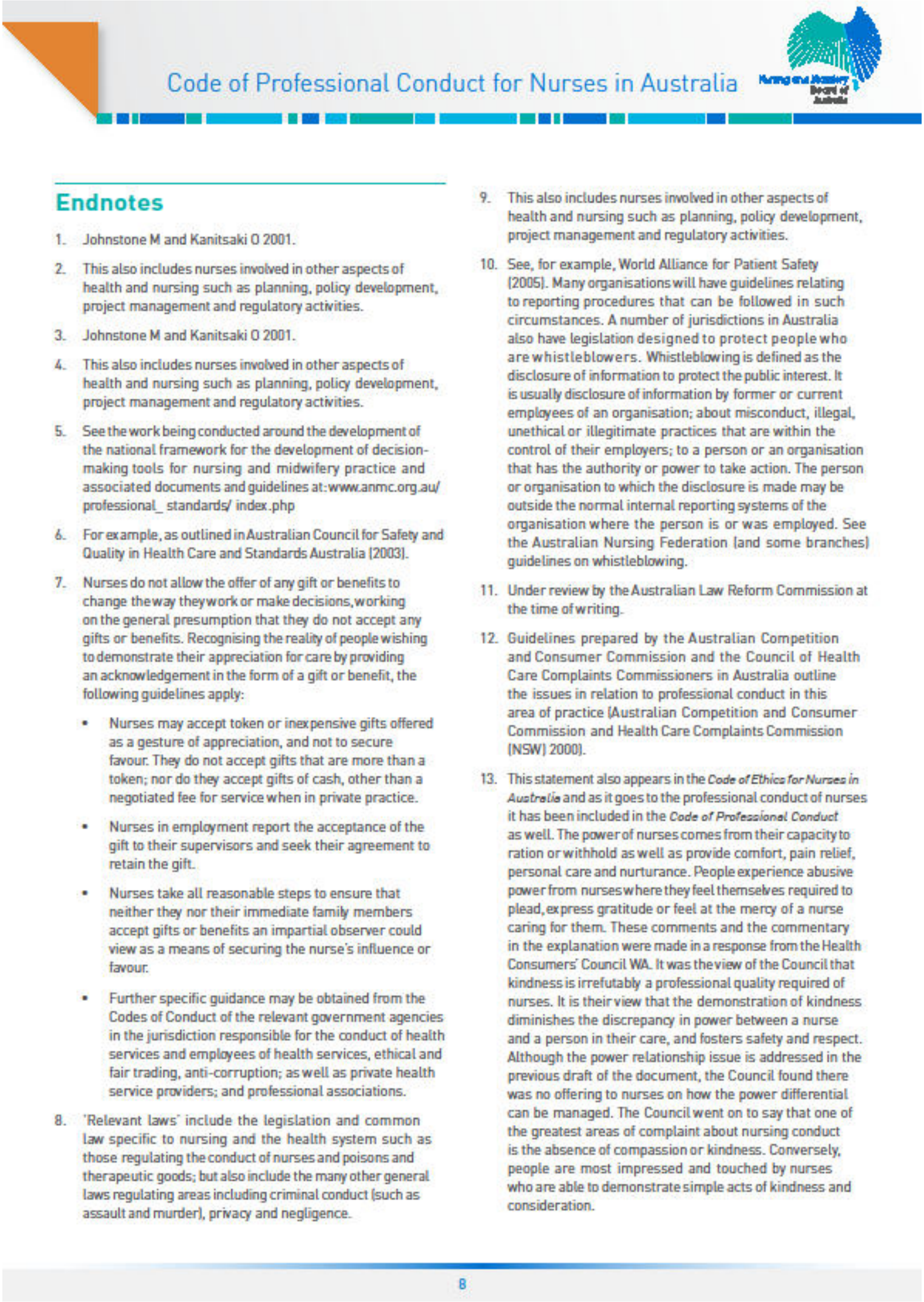
Queensland Nursing Council (2005) *Scope of Practice Framework for Nurses and Midwives*. Available at: www.qnc.qld.gov.au/publications/publications.aspx. Accessed: 18 March 2008.

Queensland Nursing Council (2005) *Statement on Sexual Relationships Between Health Practitioners and Their Patients*. Available at: www. qnc.qld.gov.au/publications/publications.aspx. Accessed: 18 March 2008.

Queensland Nursing Council (2006) *Professional Practice Policy*. Available at: www.qnc.qld.gov.au/publications/publications.aspx. Accessed: 18 March 2008.

Staunton P and Chiarella M (2008) *Nursing and the Law*, 6th edition, Elsevier, Marrickville, NSW.

World Alliance for Patient Safety (2005) *WHO Draft Guidelines for Adverse Event Reporting and Learning Systems: From information to action*, World Health Organization, Geneva. Available at: www.who.int/patientsafety/events/05/Reporting_Guidelines.pdf. Accessed: 18 March 2008.



Endnotes

1. Johnstone M and Kanitsaki O 2001.
2. This also includes nurses involved in other aspects of health and nursing such as planning, policy development, project management and regulatory activities.
3. Johnstone M and Kanitsaki O 2001.
4. This also includes nurses involved in other aspects of health and nursing such as planning, policy development, project management and regulatory activities.
5. See the work being conducted around the development of the national framework for the development of decision-making tools for nursing and midwifery practice and associated documents and guidelines at: www.anmc.org.au/ professional_ standards/ index.php
6. For example, as outlined in Australian Council for Safety and Quality in Health Care and Standards Australia (2003).
7. Nurses do not allow the offer of any gift or benefits to change the way they work or make decisions, working on the general presumption that they do not accept any gifts or benefits. Recognising the reality of people wishing to demonstrate their appreciation for care by providing an acknowledgement in the form of a gift or benefit, the following guidelines apply:
   - Nurses may accept token or inexpensive gifts offered as a gesture of appreciation, and not to secure favour. They do not accept gifts that are more than a token; nor do they accept gifts of cash, other than a negotiated fee for service when in private practice.
   - Nurses in employment report the acceptance of the gift to their supervisors and seek their agreement to retain the gift.
   - Nurses take all reasonable steps to ensure that neither they nor their immediate family members accept gifts or benefits an impartial observer could view as a means of securing the nurse's influence or favour.
   - Further specific guidance may be obtained from the Codes of Conduct of the relevant government agencies in the jurisdiction responsible for the conduct of health services and employees of health services, ethical and fair trading, anti-corruption; as well as private health service providers; and professional associations.
8. 'Relevant laws' include the legislation and common law specific to nursing and the health system such as those regulating the conduct of nurses and poisons and therapeutic goods; but also include the many other general laws regulating areas including criminal conduct (such as assault and murder), privacy and negligence.
9. This also includes nurses involved in other aspects of health and nursing such as planning, policy development, project management and regulatory activities.
10. See, for example, World Alliance for Patient Safety (2005). Many organisations will have guidelines relating to reporting procedures that can be followed in such circumstances. A number of jurisdictions in Australia also have legislation designed to protect people who are whistleblowers. Whistleblowing is defined as the disclosure of information to protect the public interest. It is usually disclosure of information by former or current employees of an organisation; about misconduct, illegal, unethical or illegitimate practices that are within the control of their employers; to a person or an organisation that has the authority or power to take action. The person or organisation to which the disclosure is made may be outside the normal internal reporting systems of the organisation where the person is or was employed. See the Australian Nursing Federation (and some branches) guidelines on whistleblowing.
11. Under review by the Australian Law Reform Commission at the time of writing.
12. Guidelines prepared by the Australian Competition and Consumer Commission and the Council of Health Care Complaints Commissioners in Australia outline the issues in relation to professional conduct in this area of practice (Australian Competition and Consumer Commission and Health Care Complaints Commission (NSW) 2000).
13. This statement also appears in the *Code of Ethics for Nurses in Australia* and as it goes to the professional conduct of nurses it has been included in the *Code of Professional Conduct* as well. The power of nurses comes from their capacity to ration or withhold as well as provide comfort, pain relief, personal care and nurturance. People experience abusive power from nurses where they feel themselves required to plead, express gratitude or feel at the mercy of a nurse caring for them. These comments and the commentary in the explanation were made in a response from the Health Consumers' Council WA. It was the view of the Council that kindness is irrefutably a professional quality required of nurses. It is their view that the demonstration of kindness diminishes the discrepancy in power between a nurse and a person in their care, and fosters safety and respect. Although the power relationship issue is addressed in the previous draft of the document, the Council found there was no offering to nurses on how the power differential can be managed. The Council went on to say that one of the greatest areas of complaint about nursing conduct is the absence of compassion or kindness. Conversely, people are most impressed and touched by nurses who are able to demonstrate simple acts of kindness and consideration.

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The *Code of Professional Conduct for Nurses in Australia* was first published in July 1990. Revised in 2003 and 2006. This document was originally developed and published under the auspices of the Australian Nursing and Midwifery Council. When the National Registration and Accreditation Scheme commenced in Australia in 2010, this publication became a document of the Nursing and Midwifery Board of Australia, as the body responsible for the regulation of nurses and midwives. Except to update the design and names of relevant organisations, and apply rebranding to reflect current ownership, the content or intent of the original document has not changed unless indicated otherwise.

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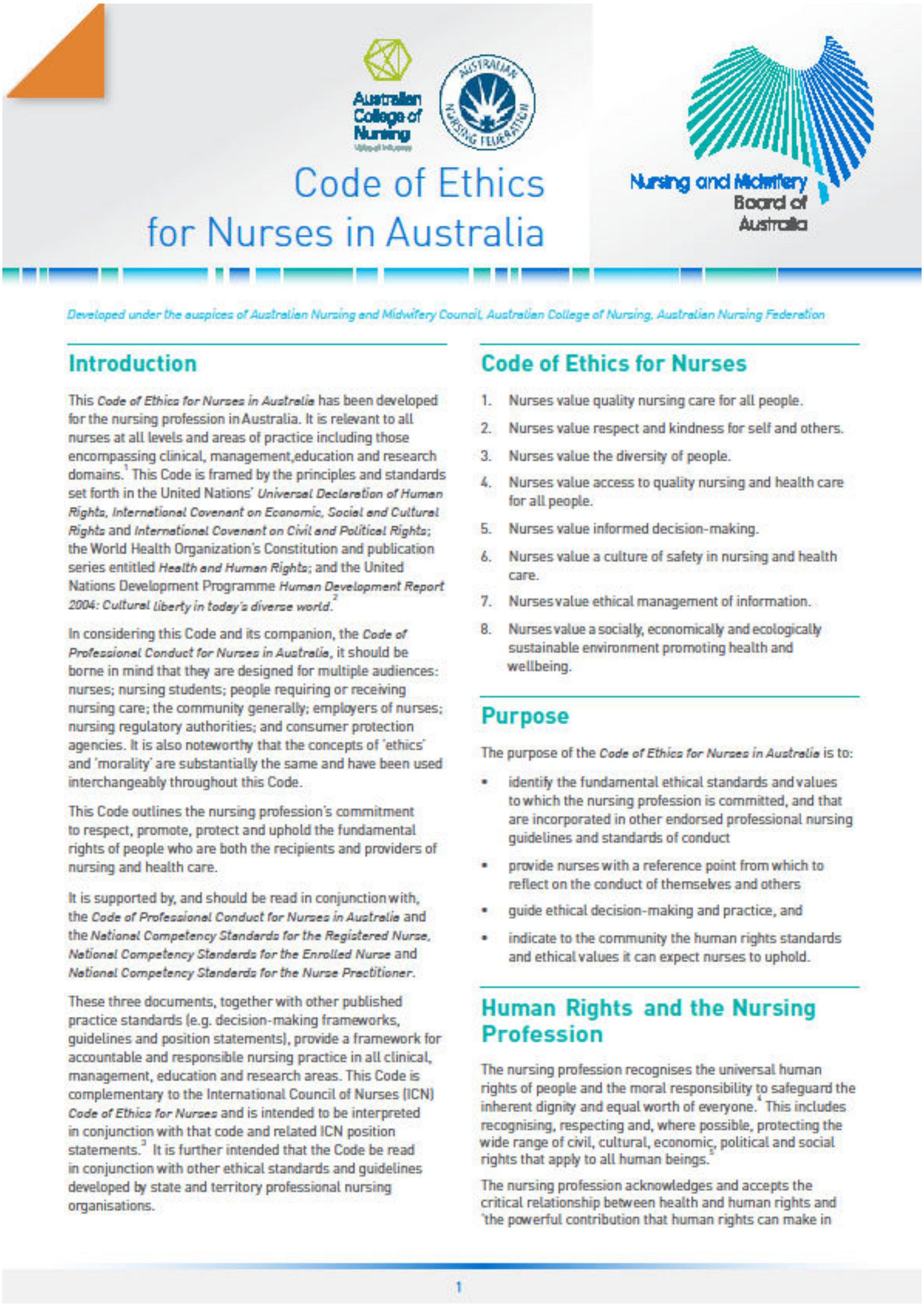
Appendix E: NMBA Code of Ethics for Nurses in Australia (2008)



Australian College of Nursing

Australian Nursing Federation

Code of Ethics for Nurses in Australia

Nursing and Midwifery Board of Australia

Developed under the auspices of Australian Nursing and Midwifery Council, Australian College of Nursing, Australian Nursing Federation

Introduction

This *Code of Ethics for Nurses in Australia* has been developed for the nursing profession in Australia. It is relevant to all nurses at all levels and areas of practice including those encompassing clinical, management,education and research domains.[1] This Code is framed by the principles and standards set forth in the United Nations' *Universal Declaration of Human Rights, International Covenant on Economic, Social and Cultural Rights* and *International Covenant on Civil and Political Rights*; the World Health Organization's Constitution and publication series entitled *Health and Human Rights*; and the United Nations Development Programme *Human Development Report 2004: Cultural liberty in today's diverse world*.[2]

In considering this Code and its companion, the *Code of Professional Conduct for Nurses in Australia*, it should be borne in mind that they are designed for multiple audiences: nurses; nursing students; people requiring or receiving nursing care; the community generally; employers of nurses; nursing regulatory authorities; and consumer protection agencies. It is also noteworthy that the concepts of 'ethics' and 'morality' are substantially the same and have been used interchangeably throughout this Code.

This Code outlines the nursing profession's commitment to respect, promote, protect and uphold the fundamental rights of people who are both the recipients and providers of nursing and health care.

It is supported by, and should be read in conjunction with, the *Code of Professional Conduct for Nurses in Australia* and the *National Competency Standards for the Registered Nurse, National Competency Standards for the Enrolled Nurse* and *National Competency Standards for the Nurse Practitioner*.

These three documents, together with other published practice standards (e.g. decision-making frameworks, guidelines and position statements), provide a framework for accountable and responsible nursing practice in all clinical, management, education and research areas. This Code is complementary to the International Council of Nurses (ICN) *Code of Ethics for Nurses* and is intended to be interpreted in conjunction with that code and related ICN position statements.[3] It is further intended that the Code be read in conjunction with other ethical standards and guidelines developed by state and territory professional nursing organisations.

Code of Ethics for Nurses

1. Nurses value quality nursing care for all people.
2. Nurses value respect and kindness for self and others.
3. Nurses value the diversity of people.
4. Nurses value access to quality nursing and health care for all people.
5. Nurses value informed decision-making.
6. Nurses value a culture of safety in nursing and health care.
7. Nurses value ethical management of information.
8. Nurses value a socially, economically and ecologically sustainable environment promoting health and wellbeing.

Purpose

The purpose of the *Code of Ethics for Nurses in Australia* is to:

- identify the fundamental ethical standards and values to which the nursing profession is committed, and that are incorporated in other endorsed professional nursing guidelines and standards of conduct
- provide nurses with a reference point from which to reflect on the conduct of themselves and others
- guide ethical decision-making and practice, and
- indicate to the community the human rights standards and ethical values it can expect nurses to uphold.

Human Rights and the Nursing Profession

The nursing profession recognises the universal human rights of people and the moral responsibility to safeguard the inherent dignity and equal worth of everyone.[4] This includes recognising, respecting and, where possible, protecting the wide range of civil, cultural, economic, political and social rights that apply to all human beings.[5]

The nursing profession acknowledges and accepts the critical relationship between health and human rights and 'the powerful contribution that human rights can make in improving health outcomes'.[6] Accordingly, the profession recognises that accepting the principles and standards of human rights in health care domains involves recognising, respecting, actively promoting and safeguarding the right of all people to the highest attainable standard of health as a fundamental human right, and that 'violations or lack of attention to human rights can have serious health consequences'.[7]

In recognising the linkages and operational relationships that exist between health and human rights, the nursing profession respects the human rights of Australia's Aboriginal and Torres Strait Islander peoples as the traditional owners of this land, who have ownership of and live a distinct and viable culture that shapes their world view and influences their daily decision-making. Nurses recognise that the process of reconciliation between Aboriginal and Torres Strait Islander and non-indigenous Australians is rightly shared and owned across the Australian community. For Aboriginal and Torres Strait Islander people, while physical, emotional, spiritual and cultural wellbeing are distinct, they also form the expected whole of the Aboriginal and Torres Strait Islander model of care.

The nursing profession also acknowledges the diversity of people constituting Australian society, including immigrants, asylum seekers, refugees and detainees, and the responsibility of nurses to provide just, compassionate, culturally competent and culturally responsive care to every person requiring or receiving nursing care.[8]

Guiding Framework

This Code contains eight value statements. Nurses and students of nursing are encouraged to use the statements as a guide when reflecting on the degree to which their clinical, managerial, educational or research practice[9] demonstrates and upholds those values.

The explanations accompanying each of the eight value statements are organised into four categories: self, person (health consumer), colleagues and community.

- **Self:** refers to the nurse, registered or enrolled, who is employed in that capacity. It also refers to students of nursing.
- **Person** (health consumer): refers to the person requiring or receiving health care, treatment, advice, information or other related services. It includes the full range of alternative terms such as client, resident and patient. This term may include the family, friends, relatives and other members of a person's nominated social network, and people who are associated with the person who is the recipient of care.[10]
- **Colleagues:** includes other nurses, students, other health care workers, staff and others lawfully involved in the care of the person.
- **Community:** refers to Australian society as a whole regardless of geographic location and any specific group the individual receiving nursing care defines as community, including those identifying as culturally connected through ethnicity, shared history, religion, gender and age.

The explanation accompanying each value statement is not intended to cover all issues that a nurse should take into account when faced with ethical problems. Ethical practice can pose challenges for nurses and may lead to conflict with colleagues and authorities. This Code does not provide a formula for the resolution of ethical issues, nor can it adequately address the definition and exploration of terms, concepts and practical issues that are part of the broader study of nursing, ethics and human rights. Nurses have a responsibility to develop their knowledge and understanding of ethics and human rights in order to clarify issues relevant to their practice and to inform their response to the issues identified. Nurses also have a responsibility to promote the *Code of Ethics for Nurses in Australia* in nursing and health care domains.

Code of Ethics

Value statement 1

Nurses value quality nursing care for all people

Explanation

Valuing quality nursing care involves nurses accepting accountability for the standard of nursing care they provide, helping to raise the standard of nursing care, and taking action when they consider, on reasonable grounds, the standard of nursing care to be unacceptable. This includes a responsibility to question and report what they consider, on reasonable grounds, to be unethical behaviour and treatment.

1. **Self:** Nurses who value quality nursing care recognise that they are accountable for the decisions they make regarding a person's care; accept their moral and legal responsibilities for ensuring they have the knowledge, skills and experience necessary to provide safe and competent nursing care; and practise within the boundaries of their professional role. Nurses who value quality nursing care ensure the professional roles they undertake are in accordance with the agreed practice standards of the profession. Nurses are also entitled to conscientiously refuse to participate in care and treatment they believe on religious or moral grounds to be unacceptable ('conscientious objection').
2. **Person** (health consumer): Nurses recognise that people are entitled to quality nursing care, and will strive to secure for them the best available nursing care. In pursuit

of this aim, nurses are entitled to participate in decisions regarding a person's nursing care and are obliged to question nursing care they regard as potentially unethical or illegal. Nurses actively participate in minimising risks for individuals.

3. **Colleagues**: Nurses take steps to ensure that not only they, but also their colleagues, provide quality nursing care. In keeping with approved reporting processes,[11] this may involve reporting, to an appropriate authority, cases of unsafe, incompetent, unethical or illegal practice. Nurses also support colleagues whom they reasonably consider are complying with this expectation.
4. **Community:** Nurses, individually and collectively, participate in creating and maintaining ethical, equitable, culturally and socially responsive, clinically appropriate and economically sustainable nursing and health care services for all people living in Australia. Nurses value their role in providing health counselling and education in the broader community. Nurses, individually and collectively, encourage professional and public participation in shaping social policies and institutions; advocate for policies and legislation that promote social justice, improved social conditions and a fair sharing of community resources; and acknowledge the role and expertise of community groups in providing care and support for people. This includes protecting cultural practices beneficial to all people, and acting to mitigate harmful cultural practices.[12]

Value Statement 2

Nurses value respect and kindness for self and others

Explanation

Valuing respect for self and others encompasses valuing the moral worth and dignity of oneself and others. It includes respecting the individual ethical values people might have in the context of health care. Kindness is the demonstration of simple acts of gentleness, consideration and care. The practise of kindness as a committed and everyday approach to care reduces the power imbalance between a person requiring or receiving care and a nurse, by placing the nurse at the person's service, which is the appropriate relationship.

1. **Self:** Respecting oneself involves recognising one's own intrinsic worth as a person and is reflected in all aspects of personal identity. Self-respect enables nurses to foster their sense of personal wellbeing and act in ways that increase their own sense of self-worth. This involves nurses maintaining their own health, acknowledging their physical and psychological strengths and limitations, and developing personal qualities that promote effective professional relationships and practices.
2. **Person** [health consumer]: Respect for people who are health consumers recognises their capacity for active and informed participation in their own health care. Nurses actively preserve the dignity of people through practised kindness and by recognising the vulnerability and powerlessness of people in their care. Significant vulnerability and powerlessness arises from the experience of illness and the need to engage with the health care system. The power relativities between a person and a nurse can be significant, particularly where the person has limited knowledge; experiences pain, illness and fear; needs assistance with personal care; or experiences an unfamiliar loss of self-determination. This vulnerability creates a power differential in the relationship between nurses and people in their care that must be recognised and managed.[13]
3. **Colleagues**: Respect for colleagues involves acknowledging and respecting their knowledge, experience, expertise and insights. It includes practising kindness and modelling consideration and care towards each other; adopting collaborative approaches to person-centred care; and, taking into account the informed views, feelings, preferences and attitudes of colleagues. Dismissiveness, indifference, manipulativeness and bullying are intrinsically disrespectful and ethically unacceptable. Nurses who respect their colleagues support them in their efforts to realise the mutual goal of providing safe and quality care to people within a positive practice environment. Nurses supporting and mentoring students provide positive role models for future practice.
4. **Community**: Respect for the community requires nurses to recognise and be responsive to the just moral claims of society and the fundamental human rights underpinning them. This involves responding to the needs and concerns of communities and responding, where possible, to relevant community initiatives aimed at promoting and protecting peoples' fundamental human rights to health and health care. It also involves nurses being responsible members of the community and fulfilling their civic responsibilities, such as participation in community affairs and in political life, and acting where possible to promote social justice.

Value Statement 3

Nurses value the diversity of people

Explanation

Valuing the diversity of people requires nurses to appreciate how different cultural backgrounds and languages may influence both the provision and receipt of nursing and health care.

1. **Self**: Valuing diversity requires acknowledgment of one's own cultural similarities to and differences from others. It involves nurses recognising and valuing their own unique identity and experiences, including thoughts, beliefs, attitudes and perceptions.
2. **Person** [health consumer]: Valuing the diversity of people involves acknowledging and responding to each person as

a unique individual, and to their culture. It requires nurses to develop cultural knowledge and awareness and greater responsiveness to the languages spoken[14] enabling them to better understand and respond effectively to the cultural and communication needs of people in their care, their families and communities during a health care encounter.

3. **Community**: Nurses recognise and accept the diversity of people constituting the Australian community and that different groups may live their lives in ways informed by different cultural values, beliefs, practices and experiences. Nurses seek to eliminate disparities in nursing and health care, especially among population groups in society that are considered most vulnerable, including Aboriginal and Torres Strait Islander populations; asylum seekers, refugees and migrants; and ethnic, religious, national and racial minorities. Nurses work to reduce the adverse effects power imbalances and prejudicial attitudes and practices have on social and institutional justice, and on the just and humane provision and delivery of nursing and health care. In particular, they work to ensure people are not disadvantaged or harmed because of their appearance, language, culture,[15] religion, age, sexuality, national or social origin, economic or political status, physical or mental disability, health status,[16] or any other characteristics that may be used by others to reduce the equal enjoyment or exercise of the right to health.
4. **Colleagues**: Nurses value and accept diversity among their colleagues and acknowledge the need for non-discriminatory interpersonal and interprofessional relationships. They respect each other's knowledge, skills and experience and regard these as a valuable resource.

Value Statement 4

Nurses value access to quality nursing and health care for all people

Explanation

Valuing nursing and health care for all people requires nurses to uphold the principles and standards of the right to nursing and health care as measured by the availability, accessibility, acceptability, quality and safety of nursing and health care services. Specifically, access refers to the extent to which a person or community can obtain health care services. This includes knowledge of when it is appropriate to seek health care, the ability to travel to and the means to pay for health care. Access does not mean the ability to provide all services imaginable for everyone, but rather the ability to reasonably and equitably provide services based on need, irrespective of geography, social standing, ethnicity, age, race, level of income, gender or sexuality.

5. **Self:** Nurses value and accept responsibility for self- care. This involves maintaining their own health, acknowledging their physical and psychological strengths and limitations, and developing personal qualities that promote effective professional relationships and practices. This includes nurses maintaining and improving their knowledge, skills and attitudes so that they can perform their professional duties effectively in the respective domains in which they may practise. When caring for one's self calls into question participation in particular practices (whether in a research, educational, managerial or clinical domain),[17] nurses act in accordance with the statements contained in this Code regarding conscientious objection.
6. **Person** (health consumer): Nurses valuing non-harmful, non-discriminatory care provide nursing care appropriate to the individual that recognises their particular needs and rights. They seek to eliminate prejudicial attitudes concerning personal characteristics such as race, ethnicity, culture, gender, sexuality, religion, spirituality, disability, age and economic, social or health status. These commitments also apply when care is extended to members of the person's family, their partners, friends and other members of a person's nominated social network.
7. **Colleagues**: Nurses value the health of colleagues and foster supportive and constructive relationships, recognising that their colleagues also have physical and psychological strengths and limitations and respecting their need for self-care.
8. **Community**: Valuing the availability, accessibility, acceptability, quality and safety of nursing and health care services for the community requires nurses to be informed and knowledgeable about the provision of ethical and culturally competent care. Nurses promote the provision of quality nursing and health care to all members of the community and oppose stigmatising or harmful discriminatory beliefs or actions. Nurses uphold and comply with policies and agreements existing in Australia regarding the ethical media representation of health consumers and health-related matters.

Value Statement 5

Nurses value informed decision-making

Explanation

Nurses value people's interests in making free and informed decisions. This includes people having the opportunity to verify the meaning and implication of information being given to them when making decisions about their nursing and health care. Nurses also recognise that making decisions is sometimes constrained by circumstances beyond individual control and that there may be circumstances where informed decision-making cannot always be fully realised.

1. **Self**: Nurses make informed decisions in relation to their practice within the constraints of their professional role and in accordance with ethical and legal requirements. Nurses are entitled to do this without undue pressure or

coercion of any kind. Nurses are responsible for ensuring their decision-making is based on contemporary, relevant and well-founded knowledge and information.

2. **Person** (health consumer): Nurses value the legal and moral right of people, including children, to participate whenever possible in decision-making concerning their nursing and health care and treatment, and assist them to determine their care on the basis of informed decision-making. This may involve ensuring people who do not speak English have access to a qualified health interpreter. Nurses recognise and respect the rights of people to engage in shared decision-making when consenting to care and treatment. Nurses also value the contribution made by persons whose decision-making may be restricted because of incapacity, disability or other factors, including legal constraints. Nurses are knowledgeable about such circumstances and in facilitating the role of family members, partners, friends and others in contributing to decision-making processes.
3. **Colleagues**: Nurses respect the rights of colleagues and members of other disciplines to participate in informed decision-making. Making these collaborative and informed decisions includes involving the person requiring or receiving nursing care (or their representative) in decisions relating to their nursing or health care, without being subject to coercion of any kind.
4. **Community**: Nurses value the contribution made by the community to nursing and health care decision-making through a range of activities, including consumer groups, advocacy and membership of health-related committees. Nurses also assist in keeping the community accurately informed on nursing and health-related issues.

Value Statement 6

Nurses value a culture of safety in nursing and health care

Explanation

Valuing a culture of safety involves nurses actively engaging in the development of shared knowledge and understanding of the crucial importance of safety in contemporary health care. Nurses who value a culture of safety appreciate that safety is everyone's responsibility. Nurses support the development of risk management processes and a practice environment designed to reduce the incidence and impact of preventable adverse events in health care. Nurses also support the open disclosure of any adverse events to any person affected during the course of their care.[18]

1. **Self**: Nurses value safe practice and a safe working environment; practise within the limitations of their knowledge and skills; and recognise and avoid situations where their ability to deliver quality care may be impaired. Nurses have a moral and legal right to practise in a safe environment, without fear for their own safety or that of others, and they seek remedies through accepted channels, including legal action, when this is not the case. Nurses value the maintenance of competence in contributing to a safe care and practice environment.
2. **Person** (health consumer): Nurses recognise that people are vulnerable to injuries and illnesses as a result of preventable human error and adverse events while in health care settings. Nurses play a key role in the detection and prevention of errors and adverse events in health care settings, and support and participate in systems to identify circumstances where people are at risk of harm. Nurses act to prevent or control such risks through prevention, monitoring, early identification and early management of adverse events. Nurses contribute to the confidential reporting of adverse events and errors, and to organisational processes for the open disclosure of these events to persons affected during the course of their care.
3. **Colleagues**: Nurses work with their colleagues to create a culture of safety. Nurses support the development of safer health care systems through non-punitive human error, adverse event management and related education. Nurses value the critical relationship between consumer safety and interprofessional competencies, including trustful communication, teamwork and situation awareness. Nurses view the detection of their own errors and risks or those of their colleagues as opportunities for achieving a safer health care system.
4. **Community**: Nurses, acting through their professional and industrial organisations and other appropriate authorities, participate in developing and improving the safety and quality of health care services for all people. This includes actively promoting the provision of equitable, just and culturally and socially responsive health care services for all people living, or seeking residence or asylum, in Australia. It also involves raising public awareness about the nature and importance of consumer safety programs in health care services.

Value Statement 7

Nurses value ethical management of information

Explanation

The generation and management of information (including health care records and other documents) are performed with professionalism and integrity. This requires the information being recorded to be accurate, non-judgemental and relevant to the health, care and treatment of a person. All health documentation is a record that cannot be changed or altered other than by the addition of further information. A notation in a record or a document used for health care communication can have a powerful positive or negative impact on the quality of care received by a person. These effects can be long-lasting, either through ensuring the provision of quality care, or through enshrining stigma, stereotyping and judgement in health care decision-making and health care provision experienced by a person.[19]

The ethical management of information involves respecting people's privacy and confidentiality without compromising health or safety. This applies to all types of data, including clinical and research data, irrespective of the medium in which the information occurs or is stored.[20] Personal information may only be shared with the consent of the individual or with lawful authorisation.

1. **Self**: Nurses are entitled to the same moral, professional and legal safeguards as any other person in relation to their personal information.[21] Nurses have a right to expect that their personal information will not be shared with another person without their approval or lawful authorisation.
2. **Person** (health consumer): Nurses are aware of, and comply with, the conditions under which information about individuals – including children, people who are incapacitated or disabled or who do not speak or read English – may or may not be shared with others. Nurses respect each person's wishes about with whom information may be shared and preserve each person's privacy to the extent this does not significantly compromise or disadvantage the health or safety of the person or others. Nurses comply with mandated reporting requirements and conform to relevant privacy and other legislation. Ethical information management also requires nurses to maintain information and records needed in order to provide quality nursing care. Nurses do not divulge information about any particular person to anyone not authorised to have that information.[22]

1. **Colleagues**: Nurses value the ethical management of information and recognise that their colleagues enjoy the same protections as other people with regard to personal information.[23] This does not override the responsibility nurses may have in reporting aspects of a colleague's professional practice giving reasonable cause for concern. Nurses ensure colleagues are given reliable information about the risks posed by people to whom they are providing or planning to provide care, subject to approved policies and relevant privacy and other legislation.
2. **Community**: Nurses comply with systems of information management meeting the standards and expectations of the community, including measures which protect the privacy and confidentiality rights, relating to the health care of all people living or seeking residency or asylum in Australia. Nurses are sensitive to, and respect, special requirements that may apply to the communication or sharing of information having cultural significance.

Value Statement 8

Nurses value a socially, economically and ecologically sustainable environment promoting health and wellbeing

Explanation

Nurses value strategies aimed at preventing, minimising and overcoming the harmful effects of economic, social or ecological factors on the health of individuals and communities. Commitment to a healthy environment involves the conservation and efficient use of resources such as energy, water and fuel, as well as clinical and other materials.

1. **Self**: Nurses use all resources efficiently and comply with strategies aimed at the sustainable use of resources (including safe re-use, recycling and conservation) in the course of their practice. Nurses may also contribute to the development, implementation and monitoring of relevant policies and procedures.
2. **Person** (health consumer): Nurses are sensitive to, and informed about, the social and environmental factors that may contribute to a person's ill health and that may play a part in their recovery. Nurses take into account the economic and domestic circumstances of people where these impact, positively or adversely, upon their needs and health.
3. **Colleagues**: Nurses help bring to the attention of their colleagues and employers the adverse effects of environmentally harmful processes and practices, and collaborate to minimise these as they occur in health care settings. Nurses work cooperatively with colleagues to improve the conservation, efficient use and safe recycling of resources in the workplace.
4. **Community**: Nurses recognise and understand the contribution economic, social and ecological factors, such as poor education, social exclusion and prejudice, crime, poverty, inadequate housing, inadequate community infrastructure and services and environmental pollution and degradation, may make to ill health in the community. Nurses value and contribute towards strategies aimed at preventing and overcoming these problems and at minimising their harmful effects.

Acknowledgments

The impetus for the development of the Code came from the Australasian Nurse Registering Authorities Conference (ANRAC) in 1990, when the research arising from the ANRAC Nursing Competencies Assessment Project indicated there was not a clear focus on the ethical standards expected and required of nurses practising in the cultural context of Australia.

The *Code of Ethics for Nurses in Australia* was first developed in 1993 under the auspices of the then Australian Nursing Council Inc. (subsequently the Australian Nursing and Midwifery Council), Royal College *of* Nursing, *Australia* (unified with The College of Nursing on 1 July 2012 to become Australian College of Nursing), and the Australian Nursing Federation. In 2000 and 2006 respectively these peak organisations agreed to undertake a joint project to review the Code. It is recognised that the Code could not have been realised without the participation of nurses and nursing organisations in Australia, whose many submissions and comments informed the revision of the Code. These contributions are acknowledged and appreciated.

When the National Registration and Accreditation Scheme commenced in Australia in 2010, this publication became a document of the Nursing and Midwifery Board of Australia, as the body responsible for the regulation of nurses and midwives. Except to update the design and names of relevant organisations, the content of the original document has not been changed unless indicated otherwise.

References

Australian Nursing and Midwifery Council (2002) *National Competency Standards for the Enrolled Nurse*, ANMC, Canberra. Available at:www.anmc.org.au. Accessed:19 March 2008.

Australian Nursing and Midwifery Council (2006) *National Competency Standards for the Nurse Practitioner*, ANMC, Canberra. Available at:www.anmc.org.au. Accessed:19 March 2008.

Australian Nursing and Midwifery Council (2006) *National Competency Standards for the Registered Nurse*, ANMC, Canberra. Available at: www.anmc.org.au. Accessed:19 March 2008.

Australian Council for Safety and Quality in Health Care and Standards Australia (2003) *Open Disclosure Standard: A national standard for open communication in public and private hospitals, following an adverse event in health care*, Commonwealth of Australia, Canberra.

Beauchamp T and Childress J (2001) *Principles of Biomedical Ethics*, Oxford University Press, New York.

Coady M and Bloch S (eds) (1996) *Code of Ethics and the Professions*, Melbourne University Press, Melbourne.

Eckermann A, Dowd T, et al. (2006) Binan Goonj: *Bridging cultures in Aboriginal health*, Churchill Livingstone/Elsevier, Marrickville, NSW.

Department of Health and Family Services (1997) *Quality and Outcome Indicators for Acute Health Services*, Commonwealth of Australia, Canberra.

Fukuda-Parr S (ed) (2004) *Human Development Report 2004: Cultural liberty in today's diverse world*, United Nations Development Programme, New York. Available at: http://hdr.undp.org. Accessed: 19 March 2008.

Fry S and Johnstone M (2008) *Ethics in Nursing Practice: A guide to ethical decision-making*, 3rd revised edition, Blackwell Science/International Council of Nurses, London/Geneva.

Holmes C, Thompson F, et al. (2007) *Review of the Code of Professional Conduct for Nurses in Australia and the Code of Ethics for Nurses in Australia; and the development of a Code of Professional Conduct for Midwives in Australia and a Code of Ethics for Midwives in Australia – Final Report*, James Cook University and RMIT University, Townsville.

International Council of Nurses (1999–2006) *Position Statements*, ICN, Geneva. Available at: www.icn.ch. Accessed: 19 March 2008.

Johnstone M (1998) *Determining and Responding Effectively to Ethical Professional Misconduct in Nursing:* A report to the Nurses Board of Victoria, RMIT University, Melbourne.

Johnstone M (in press) Bioethics: *A nursing perspective*, 5th edition, Elsevier Australia, Sydney.

Johnstone M and Kanitsaki O (2007) 'An exploration of the notion and nature of the construct of cultural safety and its applicability to the Australian health care context', *Journal of Transcultural Nursing*, 18(3), pp. 247–56.

Kerridge I, Lowe M, et al. (2005) *Ethics and Law for the Health Professions*, 2nd edition, The Federation Press, Annandale, NSW.

National Health and Medical Research Council, Australian Research Council and Australian Vice-Chancellors' Committee (2007) *National Statement on Ethical Conduct in Human Research*, Australian Government, Canberra. Available at: www.nhmrc.gov.au/publications/ synopses/_files/e72.pdf. Accessed: 19 March 2008.

NSW Department of Health (1999) *A Framework for Managing the Quality of Health Services in NSW*, NSW Department of Health, Sydney. Available at: www.health.nsw.gov.au/policies/pd/2005/PD2005_585.html. Accessed: 19 March 2008.

Reconciliation Australia (2005) 'Building relationships for change between Indigenous and non-Indigenous Australians'. Available at: www.reconciliation.org.au/i-cms.isp. Accessed: 8 November 2007.

Royal College of Nursing, *Australia* (1998) *Position Statement: Conscientious objection*, RCNA, Canberra. Available at: www.acn.edu.au. Accessed: 19 March 2008.

Royal College of Nursing, *Australia* (2006) *Position Statement: Voluntary euthanasia/assisted suicide*, RCNA, Canberra. Available at: www.acn.edu.au. Accessed: 19 March 2008.

Thomas D (2004) *Reading Doctors' Writing: Race, politics and power in Indigenous health research* 1870–1969, Aboriginal Studies Press, Canberra.

United Nations (1978) *The International Bill of Human Rights (incorporating the Universal Declaration of Human Rights; International Covenant on Economic, Social and Cultural Rights; International Covenant on Civil and Political Rights; and two Optional Protocols)*, United Nations, New York. Available at: www.un.org. Accessed: 19 March 2008.

United Nations (1948) *Universal Declaration of Human Rights*, United Nations. Available at: www.un.org. Accessed: 19 March 2008.

United Nations (1966) *International Covenant on Civil and Political Rights*, Geneva, United Nations. Available at: www.un.org. Accessed: 19 March 2008.

United Nations (1966) *International Covenant on Economic, Social and Cultural Rights*, Geneva, United Nations. Available at: www.un.org. Accessed: 19 March 2008.

World Alliance for Patient Safety (2005) *WHO Draft Guidelines for Adverse Event Reporting and Learning Systems: From information to action*, World Health Organization, Geneva. Available at: www.who.int/patientsafety/events/05/Reporting_Guidelines.pdf.

World Health Organization (1948) Constitution of the World Health Organization, WHO, Geneva. Available at: www. who.int. Accessed: 19 March 2008.

World Health Organization (2001) Health and Human Rights Publication Series: *25 questions and answers on health and human rights*, WHO Press, Geneva. Available at: www.who.int. Accessed: 19 March 2008.

World Health Organization (2005) Health and Human Rights Publication Series: *Human rights, health and poverty reduction strategies*, WHO Press, Geneva. Available at: www.who.int. Accessed: 19 March 2008.

Endnotes

1. This also includes nurses involved in other aspects of health and nursing such as planning, policy development, project management and regulatory activities.
2. United Nations 1978; World Health Organization 1948, 2001a, 2001b, 2003, 2005; Fukuda-Parr (ed.) 2004.
3. International Council of Nurses 1999–2006 (Position statements: e.g. *Nurses and human rights (2006); Cultural and linguistic competence (in press), Mental health (2002); Abuse and violence against nursing personnel (2006); Rights of children (2000); Health services for migrants, refuges and displaced persons (2006); Nurses' role in the care of detainees and prisoners (2006); Nurses' role in providing care to dying patients and their families (2006); Prevention of disability and the care of people with disabilities (2000); Torture, death penalty and participation by nurses in executions (2006); Health information: protecting patient rights (2000); Patient safety (2002); Medical waste: role of nurses and nursing (2004); Reducing environmental and lifestyle-related health hazards (1999).*
4. United Nations 1978.
5. WHO 2001b.
6. WHO 2005.
7. WHO 2001b.
8. Advice provided by a Torres Strait Islander academic.
9. This also includes nurses involved in other aspects of health and nursing such as planning, policy development, project management and regulatory activities.
10. The most appropriate term for people who are recipients of care remains controversial. The project team conducting the review of the codes found that: Arguably one of the most significant issues to emerge from the data was the use of contexts, such as 'client' in the Code and the suggestion that this term should be replaced by a more appropriate term, for example: patient; consumer; human being; person(s) and/or people. This stance was strongly supported by the Expert Panel, with one panel member pointing out that there was a trend toward reinstating the use of the term 'patient' in Australia. It is acknowledged that this trend is not universal, and the Canadian Nurses Association (2002) for example, uses the term 'people' or 'person' in its *Code of Ethics*. The use of the term 'patient' is consistent with the nomenclature used in other jurisdictions, however. For example, the UK's Nursing and Midwifery Council (2002) Code refers to both 'patient' and 'client'. The International Council of Nurses repeatedly uses the term 'patient' in its Position Statements (ICN, 2000a, 2002, 2006b), and the American Nurses Association

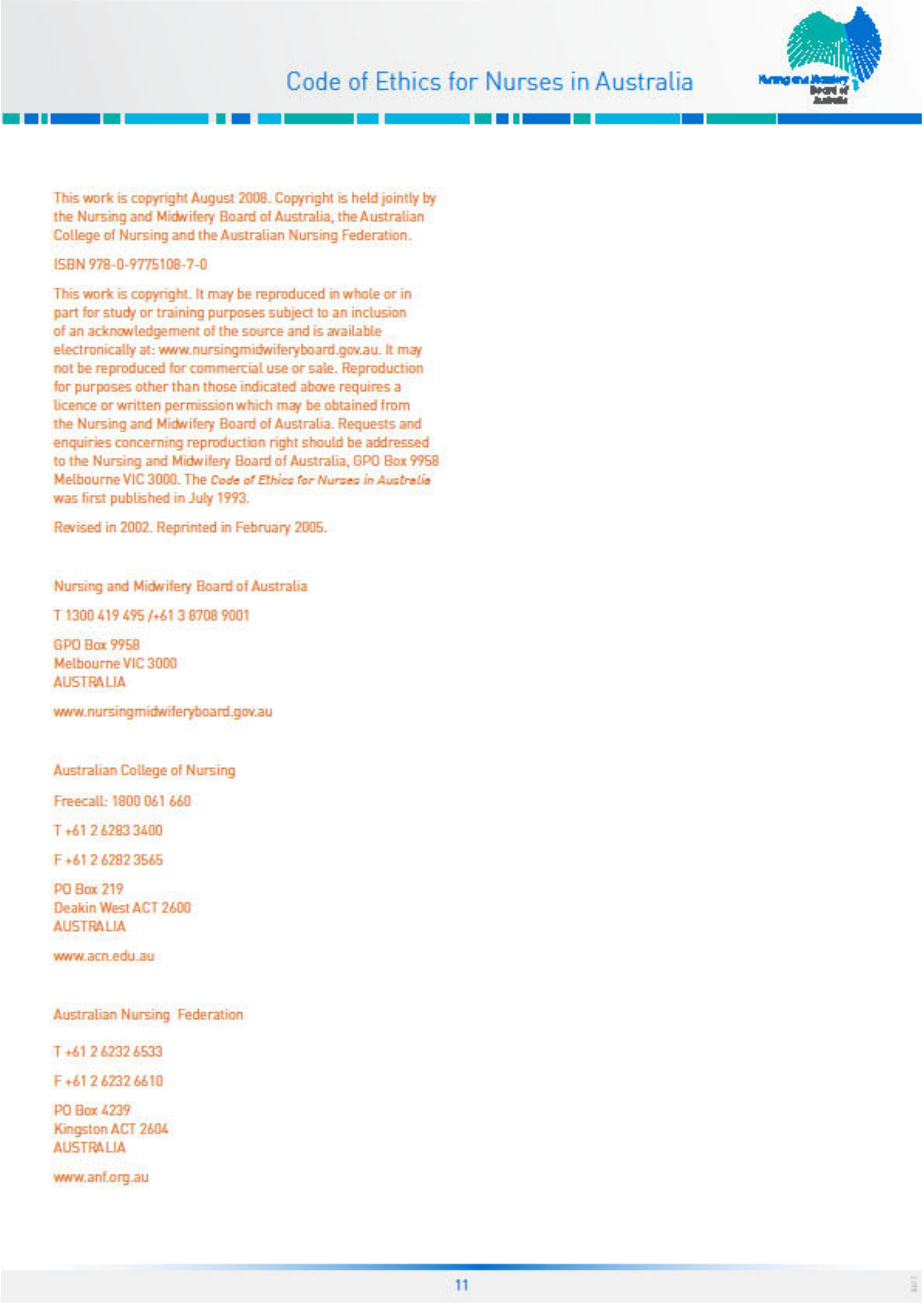
(ANA) (2001) also uses the term 'patient' in its Code of Ethics for Nurses. The term 'patient' entails a special ethical and legal relationship to the nurse or midwife, and to others in the context of professional health care, which does not apply to other 'persons', and is established in ethical discourse in phrases such as 'patient autonomy', 'patient care', 'patient advocacy' and so on. The Project Team has therefore opted for its use in the Codes of Ethics, and proposed that the term 'patient' be defined as 'the recipient of health care services – whether the recipient is an individual, a family, a group or the community'. The Project Team also believes that it is appropriate to use this terminology in the Codes because it 'makes clear that nurses care for groups as well as individuals' and because the term 'patient' can be defined as to include the full range of alternative terms that might be used in different, 'resident' and 'consumer', as well as family, friends, relatives and others associated with the patient where appropriate. Holmes, Thompson et al. (2007) ***Review of the Code of Professional Conduct for Nurses in Australia and the Code of Ethics for Nurses in Australia; and the development of a Code of Professional Conduct for Midwives in Australia and a Code of Ethics for Midwives in Australia – Final Report***, Townsville, James Cook University RMIT University. An alternative viewpoint expressed by people who are recipients of health care and health services is that the nomenclature of 'patient' is most inappropriate in 2007. If we ask the 'what are we here for' question about nursing, it is about providing high quality, safe care to people. The very word 'patient' is heavily weighted with notions of paternalism. The language that paints the context of people who are the recipients of health care abounds with terms laden with passivity, compliance, endurance, power imbalance and control. We need to be aware of just how much the language affects our views of the world. The importance of language and who controls it has been widely recognised and articulated by the feminist movement. Dale Spender talks of 'man made language' as defining and controlling the world that women live in. Nurses and midwives object strongly to the 'medicalisation' of health language. However, we could nearly identify a health service provider language as controlling a health consumer's environment. A leading national organisation for recipients of health care is the Consumer Health Forum of Australia. The language of people who have organised in any way to represent the recipients of health services and care have generally called themselves 'health consumers' and identify as 'people' or as an individual 'person'. The continuing use of 'patient' is rejected by these groups and their very strong grounds for this rejection should be respected by nurses.

11. See for example, World Alliance for Patient Safety (2005). Many organisations have guidelines relating to reporting procedures that can be followed in such circumstances. A number of jurisdictions in Australia also have legislation designed to protect people who are whistleblowers. Whistleblowing is defined as the disclosure of information to protect public interest. It is usually disclosure of information: by former or current employees of an organisation; about misconduct, illegal, unethical or illegitimate practices that are within the control of their employers; to persons or an organisation that have the authority or power to take action. The person or organisation to which the disclosure is made may be outside the normal internal reporting systems of the organisation where the person is or was employed. See the Australian Nursing Federation (and some branches') guidelines on whistleblowing.

12. According to Johnstone M (in press): A less well recognised yet equally critical core component of the right to health, is cultural liberty and the right that all people have to maintain their 'ethnic, linguistic, and religious identities' – otherwise referred to as 'cultural rights' (Fukuda-Parr 2004). Cultural rights claims entail respect for cultural difference as an active component of human rights and development (Marks 2002). Central to the notion of cultural rights is the recognition that culture is not a static process encompassing a frozen set of values, beliefs and practices. Rather it is a process that is 'constantly recreated as people question, adapt and redefine their values and practices to changing realitiesand exchanges of idea' (Fukuda-Parr 2004, 4).

13. This part of the explanatory statement also appears in the ***Code of Professional Conduct for Nurses in Australia*** and as it goes to the ethical conduct of nurses it has been included in the ***Code of Ethics*** as well. The power of nurses comes from their capacity to ration or withhold as well as provide comfort, pain relief, personal care and nurturance. People experience abusive power from nurses where they feel themselves required to plead, express gratitude or feel at the mercy of a nurse caring for them. The preceding comments and the commentary in the explanation were made in a response from the Health Consumers Council WA. It was the view of the Health Consumers' Council that kindness is irrefutably a professional quality required of nurses. It is their view that the demonstration of kindness diminishes the discrepancy in power between a nurse and a person in their care, and fosters safety and respect. Although the power relationship issue is addressed in the previous draft of the document, the Council found there was no offering to nurses on how the power differential can be managed. The Council went on to say that one of the greatest areas of complaint about nursing conduct is the absence of compassion or kindness. Conversely, people are most impressed and touched by nurses who are able to demonstrate simple acts of kindness and consideration.

14. There is a need for nurses to develop skills and capacity to respond to people speaking languages other than English, especially when they are working in health services where particular cultural groups speaking other languages are a substantial proportion of the local population.
15. According to Johnstone (in press): A less well recognised yet equally critical core component of the right to health, is cultural liberty and the right that all people have to maintain their 'ethnic, linguistic, and religious identities' otherwise referred to as 'cultural rights' (Fukuda-Parr 2004). Cultural rights claims involve respect for cultural difference as an active component of human rights and development (Marks 2002). Central to the notion of cultural rights is the recognition that culture is not a static process encompassing a frozen set of values, beliefs and practices. Rather it is a process that is 'constantly recreated as people question, adapt and redefine their values and practices to changing realities and exchanges of idea' (Fukuda-Parr 2004, 4).
16. Health status includes living with conditions such as HIV/AIDS and mental disorders.
17. This also includes nurses involved in other aspects of health and nursing such asplanning, policy development, project management and regulatory activities.
18. For example, as outlined in Australian Council for Safety and Quality in Health Care and Standards Australia (2003).
19. Response from the Health Consumers Council WA. The Council notes that it has seen some extreme and severe impacts for medical and mental health consumers from unprofessional notations in medical records. Nurses must be aware that an attempt to convey an impression about a health consumer to fellow workers during a particular episode of care can have ramifications for the consumer for many years to follow. Consumers can now access their records and can read and interpret the notes written about them. Consumers integrate their own recollections with the notes and develop a perception about the quality and professionalism of the care they received.
20. This includes oral, written, statistical, digital and computerised data and other information.
21. Including information kept in personnel files. Nurses should also uphold and comply with policies and agreements that exist in Australia regarding the ethical media representation of health consumers and health-related matters.
22. Including information kept in personnel files.



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Appendix F: NMBA Code of Conduct for Nurses (2018)

Nursing and Midwifery
Board of
Australia

Code of conduct
for nurses


9.2 Ward
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Foreword

The Nursing and Midwifery Board of Australia (NMBA) undertakes functions as set by the Health Practitioner Regulation National Law (the National Law), as in force in each state and territory. The NMBA regulates the practice of nursing and midwifery in Australia, and one of its key roles is to protect the public. The NMBA does this by developing standards, codes and guidelines that together establish the requirements for the professional and safe practice of nurses and midwives in Australia.

In developing the *Code of conduct for nurses*, and consistent with its commitment to evidence-based structures, systems and processes, the NMBA carried out a comprehensive review that was informed by research and by the profession. The research included an international and national literature review of other codes and similar publications, a comparative analysis of the predecessor code of conduct to other codes and an analysis of notifications (complaints) made about the conduct and behaviour of nurses. Input was extensively sought in the form of focus groups, workshops, an expert working group and other consultation strategies which included the profession, the public and professional organisations.

The *Code of conduct for nurses* (the code) sets out the legal requirements, professional behaviour and conduct expectations for nurses in all practice settings, in Australia. The code is written in recognition that nursing practice is not restricted to the provision of direct clinical care. Nursing practice settings extend to working in a non-clinical relationship with clients, working in management, leadership, governance, administration, education, research, advisory, regulatory, policy development roles or other roles that impact on safe, effective delivery of services in the profession and/or use of the nurse's professional skills.

The code is supported by the NMBA Standards for practice and, with the other NMBA standards, codes and guidelines, underpins the requirements and delivery of safe, kind and compassionate nursing practice.

Associate Professor Lynette Cusack RN

Chair, Nursing and Midwifery Board of Australia

Contents

Introduction

The *Code of conduct for nurses* sets out the legal requirements, professional behaviour and conduct expectations for all nurses, in all practice settings, in Australia. It describes the principles of professional behaviour that guide safe practice, and clearly outlines the conduct expected of nurses by their colleagues and the broader community.

Individual nurses have their own personal beliefs and values. However, the code outlines specific standards which all nurses are expected to adopt in their practice. The code also gives students of nursing an appreciation of the conduct and behaviours expected of nurses. Nurses have a professional responsibility to understand and abide by the code. In practice, nurses also have a duty to make the interests of people their first concern, and to practise safely and effectively.

The code is consistent with the National Law. It includes seven principles of conduct, grouped into domains, each with an explanatory value statement. Each value statement is accompanied by practical guidance to demonstrate how to apply it in practice. Underpinning the code is the expectation that nurses will exercise their professional judgement to deliver the best possible outcomes in practice.

This code applies to all nurses

The principles of the code apply to all types of nursing practice in all contexts. This includes any work where a nurse uses nursing skills and knowledge, whether paid or unpaid, clinical or non-clinical. This includes work in the areas of clinical care, clinical leadership, clinical governance responsibilities, education, research, administration, management, advisory roles, regulation or policy development. The code also applies to all settings where a nurse may engage in these activities, including face-to-face, publications, or via online or electronic means.

Using the code of conduct

The code will be used:

- to support individual nurses in the delivery of safe practice and fulfilling their professional roles
- as a guide for the public and consumers of health services about the standard of conduct and behaviour they should expect from nurses
- to help the NMBA protect the public, in setting and maintaining the standards set out in the code and to ensure safe and effective nursing practice
- when evaluating the professional conduct of nurses. If professional conduct varies significantly from the values outlined in the code, nurses should be prepared to explain and justify their decisions and actions. Serious or repeated failure to abide by this code may have consequences for nurses' registration and may be considered as unsatisfactory professional performance, unprofessional conduct or professional misconduct[1], and
- as a resource for activities which aim to enhance the culture of professionalism in the Australian health system. These include use, for example, in administration and policy development by health services and other institutions; in nursing education, in management and for the orientation, induction and supervision of nurses and students.

The code is not a substitute for requirements outlined in the National Law, other relevant legislation, or case law. Where there is any actual or perceived conflict between the code and any law, the law takes precedence. Nurses also need to understand and comply with all other NMBA standards, codes and guidelines.

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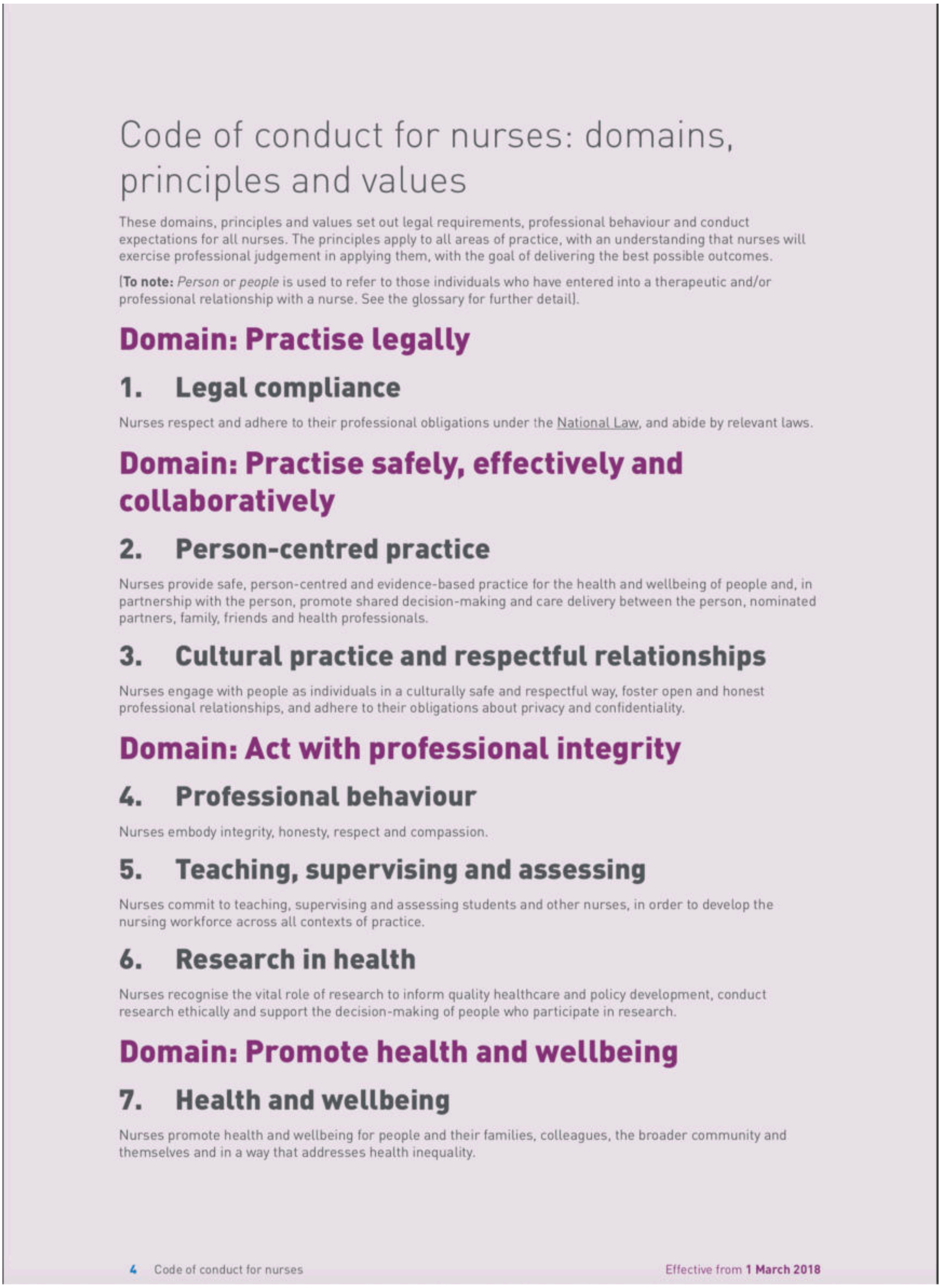
[1] As defined in the National Law, with the exception of NSW where the definitions of unsatisfactory professional conduct and professional misconduct are defined in the Health Practitioner Regulation National Law (NSW)



Code of conduct for nurses: domains, principles and values

These domains, principles and values set out legal requirements, professional behaviour and conduct expectations for all nurses. The principles apply to all areas of practice, with an understanding that nurses will exercise professional judgement in applying them, with the goal of delivering the best possible outcomes.

(**To note:** *Person* or *people* is used to refer to those individuals who have entered into a therapeutic and/or professional relationship with a nurse. See the glossary for further detail).

Domain: Practise legally

1. Legal compliance

Nurses respect and adhere to their professional obligations under the National Law, and abide by relevant laws.

Domain: Practise safely, effectively and collaboratively

2. Person-centred practice

Nurses provide safe, person-centred and evidence-based practice for the health and wellbeing of people and, in partnership with the person, promote shared decision-making and care delivery between the person, nominated partners, family, friends and health professionals.

3. Cultural practice and respectful relationships

Nurses engage with people as individuals in a culturally safe and respectful way, foster open and honest professional relationships, and adhere to their obligations about privacy and confidentiality.

Domain: Act with professional integrity

4. Professional behaviour

Nurses embody integrity, honesty, respect and compassion.

5. Teaching, supervising and assessing

Nurses commit to teaching, supervising and assessing students and other nurses, in order to develop the nursing workforce across all contexts of practice.

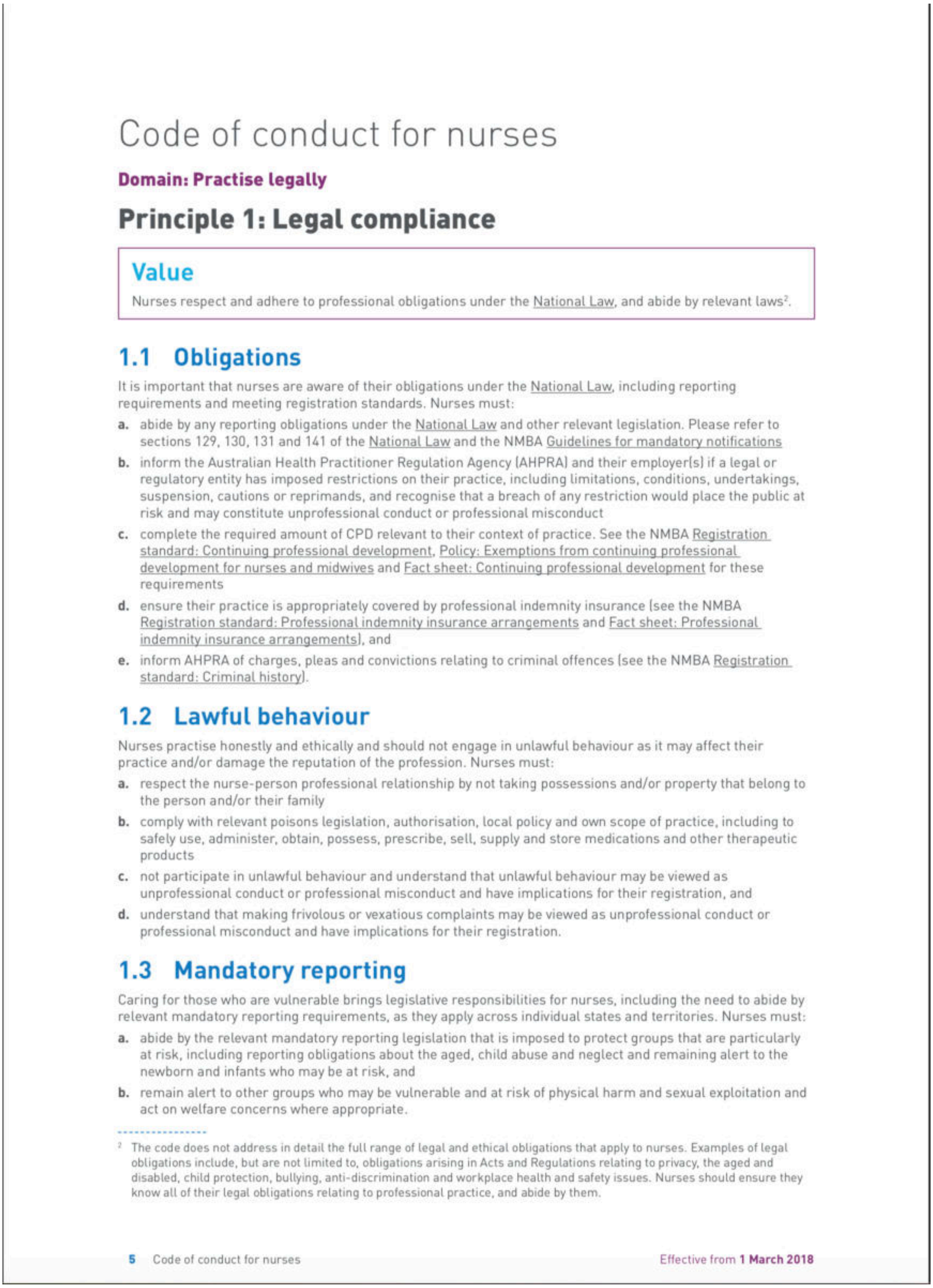
6. Research in health

Nurses recognise the vital role of research to inform quality healthcare and policy development, conduct research ethically and support the decision-making of people who participate in research.

Domain: Promote health and wellbeing

7. Health and wellbeing

Nurses promote health and wellbeing for people and their families, colleagues, the broader community and themselves and in a way that addresses health inequality.



Code of conduct for nurses

Domain: Practise legally

Principle 1: Legal compliance

Value

Nurses respect and adhere to professional obligations under the National Law, and abide by relevant laws[2].

1.1 Obligations

It is important that nurses are aware of their obligations under the National Law, including reporting requirements and meeting registration standards. Nurses must:

a. abide by any reporting obligations under the National Law and other relevant legislation. Please refer to sections 129, 130, 131 and 141 of the National Law and the NMBA Guidelines for mandatory notifications

b. inform the Australian Health Practitioner Regulation Agency (AHPRA) and their employer(s) if a legal or regulatory entity has imposed restrictions on their practice, including limitations, conditions, undertakings, suspension, cautions or reprimands, and recognise that a breach of any restriction would place the public at risk and may constitute unprofessional conduct or professional misconduct

c. complete the required amount of CPD relevant to their context of practice. See the NMBA Registration standard: Continuing professional development, Policy: Exemptions from continuing professional development for nurses and midwives and Fact sheet: Continuing professional development for these requirements

d. ensure their practice is appropriately covered by professional indemnity insurance (see the NMBA Registration standard: Professional indemnity insurance arrangements and Fact sheet: Professional indemnity insurance arrangements), and

e. inform AHPRA of charges, pleas and convictions relating to criminal offences (see the NMBA Registration standard: Criminal history).

1.2 Lawful behaviour

Nurses practise honestly and ethically and should not engage in unlawful behaviour as it may affect their practice and/or damage the reputation of the profession. Nurses must:

a. respect the nurse-person professional relationship by not taking possessions and/or property that belong to the person and/or their family

b. comply with relevant poisons legislation, authorisation, local policy and own scope of practice, including to safely use, administer, obtain, possess, prescribe, sell, supply and store medications and other therapeutic products

c. not participate in unlawful behaviour and understand that unlawful behaviour may be viewed as unprofessional conduct or professional misconduct and have implications for their registration, and

d. understand that making frivolous or vexatious complaints may be viewed as unprofessional conduct or professional misconduct and have implications for their registration.

1.3 Mandatory reporting

Caring for those who are vulnerable brings legislative responsibilities for nurses, including the need to abide by relevant mandatory reporting requirements, as they apply across individual states and territories. Nurses must:

a. abide by the relevant mandatory reporting legislation that is imposed to protect groups that are particularly at risk, including reporting obligations about the aged, child abuse and neglect and remaining alert to the newborn and infants who may be at risk, and

b. remain alert to other groups who may be vulnerable and at risk of physical harm and sexual exploitation and act on welfare concerns where appropriate.

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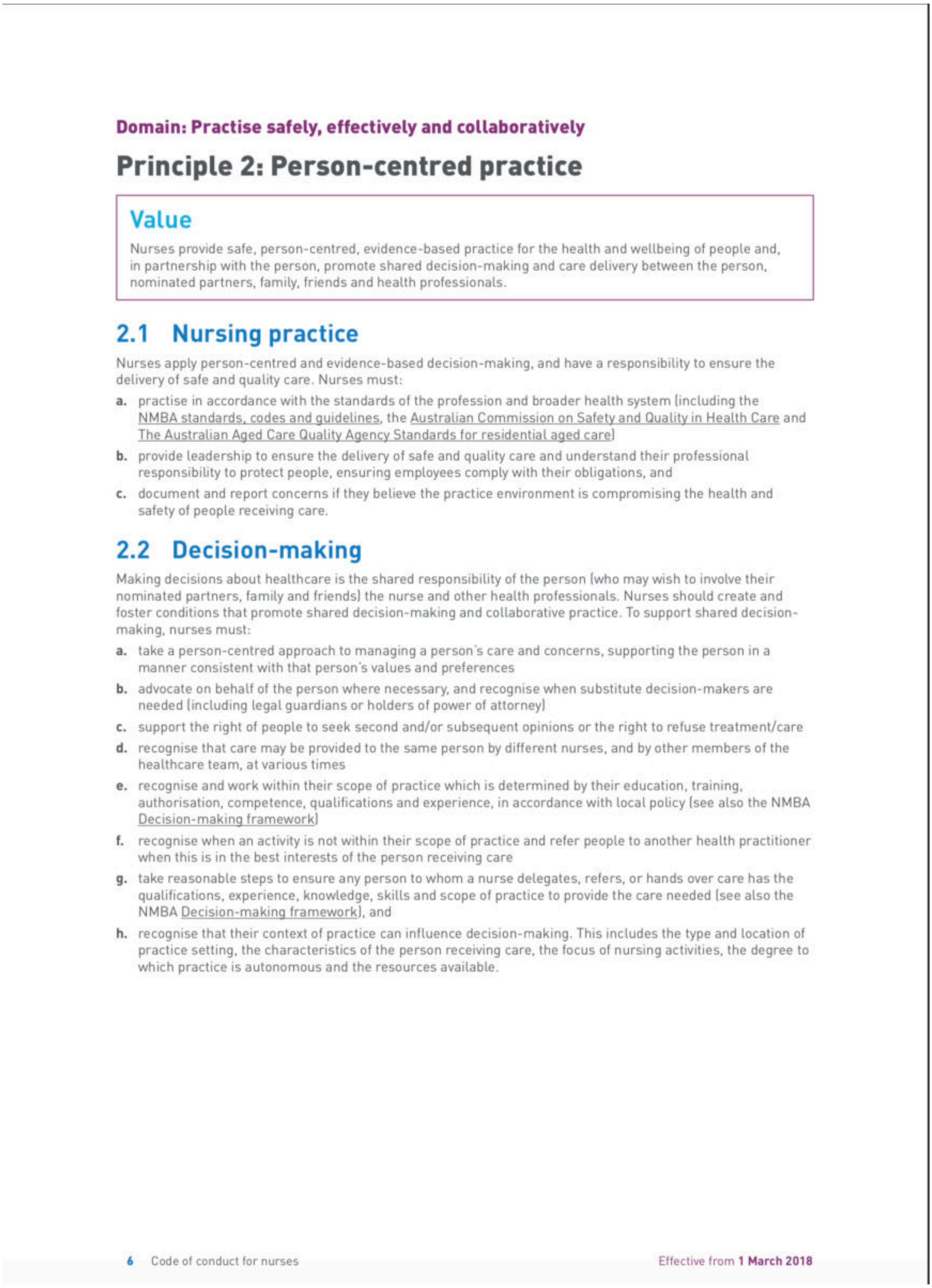
[2] The code does not address in detail the full range of legal and ethical obligations that apply to nurses. Examples of legal obligations include, but are not limited to, obligations arising in Acts and Regulations relating to privacy, the aged and disabled, child protection, bullying, anti-discrimination and workplace health and safety issues. Nurses should ensure they know all of their legal obligations relating to professional practice, and abide by them.



Domain: Practise safely, effectively and collaboratively

Principle 2: Person-centred practice

Value

Nurses provide safe, person-centred, evidence-based practice for the health and wellbeing of people and, in partnership with the person, promote shared decision-making and care delivery between the person, nominated partners, family, friends and health professionals.

2.1 Nursing practice

Nurses apply person-centred and evidence-based decision-making, and have a responsibility to ensure the delivery of safe and quality care. Nurses must:

a. practise in accordance with the standards of the profession and broader health system (including the NMBA standards, codes and guidelines, the Australian Commission on Safety and Quality in Health Care and The Australian Aged Care Quality Agency Standards for residential aged care)

b. provide leadership to ensure the delivery of safe and quality care and understand their professional responsibility to protect people, ensuring employees comply with their obligations, and

c. document and report concerns if they believe the practice environment is compromising the health and safety of people receiving care.

2.2 Decision-making

Making decisions about healthcare is the shared responsibility of the person (who may wish to involve their nominated partners, family and friends) the nurse and other health professionals. Nurses should create and foster conditions that promote shared decision-making and collaborative practice. To support shared decision-making, nurses must:

a. take a person-centred approach to managing a person's care and concerns, supporting the person in a manner consistent with that person's values and preferences

b. advocate on behalf of the person where necessary, and recognise when substitute decision-makers are needed (including legal guardians or holders of power of attorney)

c. support the right of people to seek second and/or subsequent opinions or the right to refuse treatment/care

d. recognise that care may be provided to the same person by different nurses, and by other members of the healthcare team, at various times

e. recognise and work within their scope of practice which is determined by their education, training, authorisation, competence, qualifications and experience, in accordance with local policy (see also the NMBA Decision-making framework)

f. recognise when an activity is not within their scope of practice and refer people to another health practitioner when this is in the best interests of the person receiving care

g. take reasonable steps to ensure any person to whom a nurse delegates, refers, or hands over care has the qualifications, experience, knowledge, skills and scope of practice to provide the care needed (see also the NMBA Decision-making framework), and

h. recognise that their context of practice can influence decision-making. This includes the type and location of practice setting, the characteristics of the person receiving care, the focus of nursing activities, the degree to which practice is autonomous and the resources available.

2.3 Informed consent

Informed consent is a person's voluntary agreement to healthcare, which is made with knowledge and understanding of the potential benefits and risks involved. In supporting the right to informed consent, nurses must:

a. support the provision of information to the person about their care in a way and/or in a language/dialect they can understand, through the utilisation of translating and interpreting services, when necessary. This includes information on examinations and investigations, as well as treatments

b. give the person adequate time to ask questions, make decisions and to refuse care, interventions, investigations and treatments, and proceed in accordance with the person's choice, considering local policy

c. act according to the person's capacity for decision-making and consent, including when caring for children and young people, based on their maturity and capacity to understand, and the nature of the proposed care

d. obtain informed consent or other valid authority before carrying out an examination or investigation, provide treatment (this may not be possible in an emergency), or involving people in teaching or research, and

e. inform people of the benefit, as well as associated costs or risks, if referring the person for further assessment, investigations or treatments, which they may want to clarify before proceeding.

2.4 Adverse events and open disclosure

When a person is harmed by healthcare (adverse events), nurses have responsibilities to be open and honest in communicating with the person, to review what happened, and to report the event in a timely manner, and in accordance with local policy. When something goes wrong, nurses must:

a. recognise and reflect on what happened and report the incident

b. act immediately to rectify the problem if possible, and intervene directly if it is needed to protect the person's safety. This responsibility includes escalating concerns if needed

c. abide by the principles of open disclosure and non-punitive approaches to incident management

d. identify the most appropriate healthcare team member to provide an apology and an explanation to the person, as promptly and completely as possible, that supports open disclosure principles

e. listen to the person, acknowledge any distress they experienced and provide support. In some cases it may be advisable to refer the person to another nurse or health professional

f. ensure people have access to information about how to make a complaint, and that in doing so, not allow a complaint or notification to negatively affect the care they provide, and

g. seek advice from their employer, AHPRA, their professional indemnity insurer, or other relevant bodies, if they are unsure about their obligations.

See also the Australian Commission on Safety and Quality in Health Care's publication: Australian Open Disclosure Framework.

Principle 3: Cultural practice and respectful relationships

Value

Nurses engage with people as individuals in a culturally safe and respectful way, foster open and honest professional relationships, and adhere to their obligations about privacy and confidentiality.

3.1 Aboriginal and/or Torres Strait Islander peoples' health

Australia has always been a culturally and linguistically diverse nation. Aboriginal and/or Torres Strait Islander peoples have inhabited and cared for the land as the first peoples of Australia for millennia, and their histories and cultures have uniquely shaped our nation. Understanding and acknowledging historic factors such as colonisation and its impact on Aboriginal and/or Torres Strait Islander peoples' health helps inform care. In particular, Aboriginal and/or Torres Strait Islander peoples bear the burden of gross social, cultural and health inequality. In supporting the health of Aboriginal and/or Torres Strait Islander peoples, nurses must:

a. provide care that is holistic, free of bias and racism, challenges belief based upon assumption and is culturally safe and respectful for Aboriginal and/or Torres Strait Islander peoples

b. advocate for and act to facilitate access to quality and culturally safe health services for Aboriginal and/or Torres Strait Islander peoples, and

c. recognise the importance of family, community, partnership and collaboration in the healthcare decision-making of Aboriginal and/or Torres Strait Islander peoples, for both prevention strategies and care delivery.

See the National Aboriginal and Torres Strait Islander Health Plan 2013-2023.

See also Congress of Aboriginal and Torres Strait Islander Nurses and Midwives.

3.2 Culturally safe and respectful practice

Culturally safe and respectful practice requires having knowledge of how a nurse's own culture, values, attitudes, assumptions and beliefs influence their interactions with people and families, the community and colleagues. To ensure culturally safe and respectful practice, nurses must:

a. understand that only the person and/or their family can determine whether or not care is culturally safe and respectful

b. respect diverse cultures, beliefs, gender identities, sexualities and experiences of people, including among team members

c. acknowledge the social, economic, cultural, historic and behavioural factors influencing health, both at the individual, community and population levels

d. adopt practices that respect diversity, avoid bias, discrimination and racism, and challenge belief based upon assumption (for example, based on gender, disability, race, ethnicity, religion, sexuality, age or political beliefs)

e. support an inclusive environment for the safety and security of the individual person and their family and/or significant others, and

f. create a positive, culturally safe work environment through role modelling, and supporting the rights, dignity and safety of others, including people and colleagues.

3.3 Effective communication

Positive professional relationships are built on effective communication that is respectful, kind, compassionate and honest. To communicate effectively, nurses must:

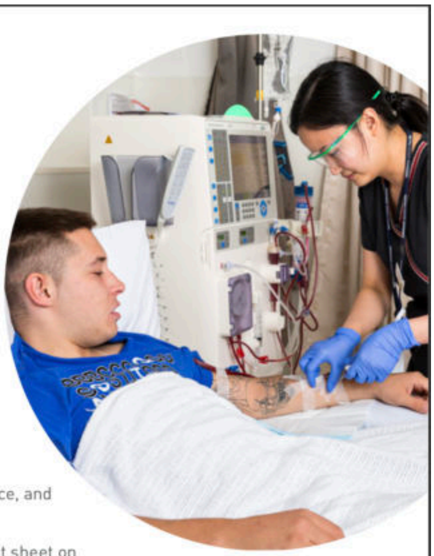
a. be aware of health literacy issues, and take health literacy into account when communicating with people

b. make arrangements, whenever possible, to meet the specific language, cultural, and communication needs of people and their families, through the utilisation of translating and interpreting services where necessary, and be aware of how these needs affect understanding

c. endeavour to confirm a person understands any information communicated to them

d. clearly and accurately communicate relevant and timely information about the person to colleagues, within the bounds of relevant privacy requirements, and

e. be non-judgemental and not refer to people in a non-professional manner verbally or in correspondence/records, including refraining from behaviour that may be interpreted as bullying or harassment and/or culturally unsafe.



3.4 Bullying and harassment

When people repeatedly and intentionally use words or actions against someone or a group of people, it causes distress and risks their wellbeing. Nurses understand that bullying and harassment relating to their practice or workplace is not acceptable or tolerated and that where it is affecting public safety it may have implications for their registration. Nurses must:

a. never engage in, ignore or excuse such behaviour

b. recognise that bullying and harassment takes many forms, including behaviours such as physical and verbal abuse, racism, discrimination, violence, aggression, humiliation, pressure in decision-making, exclusion and intimidation directed towards people or colleagues

c. understand social media is sometimes used as a mechanism to bully or harass, and that nurses should not engage in, ignore or excuse such behaviour

d. act to eliminate bullying and harassment, in all its forms, in the workplace, and

e. escalate their concerns if an appropriate response does not occur.

For additional guidance see the Australian Human Rights Commission's Fact sheet on workplace bullying

See also Nurse & Midwife Support, the national health support service for nurses, midwives and students.

3.5 Confidentiality and privacy

Nurses have ethical and legal obligations to protect the privacy of people. People have a right to expect that nurses will hold information about them in confidence, unless the release of information is needed by law, legally justifiable under public interest considerations or is required to facilitate emergency care. To protect privacy and confidentiality, nurses must:

a. respect the confidentiality and privacy of people by seeking informed consent before disclosing information, including formally documenting such consent where possible

b. provide surroundings to enable private and confidential consultations and discussions, particularly when working with multiple people at the same time, or in a shared space

c. abide by the NMBA Social media policy and relevant Standards for practice, to ensure use of social media is consistent with the nurse's ethical and legal obligations to protect privacy

d. access records only when professionally involved in the care of the person and authorised to do so

e. not transmit, share, reproduce or post any person's information or images, even if the person is not directly named or identified, without having first gained written and informed consent. See also the NMBA Social media policy and Guidelines for advertising regulated health services

f. recognise people's right to access information contained in their health records, facilitate that access and promptly facilitate the transfer of health information when requested by people, in accordance with local policy, and

g. when closing or relocating a practice, facilitating arrangements for the transfer or management of all health records in accordance with the legislation governing privacy and health records.

3.6 End-of-life care

Nurses have a vital role in helping the community to deal with the reality of death and its consequences. In providing culturally appropriate end-of-life care, nurses must:

a. understand the limits of healthcare in prolonging life, and recognise when efforts to prolong life may not be in the best interest of the person

b. accept that the person has the right to refuse treatment, or to request withdrawal of treatment, while ensuring the person receives relief from distress

c. respect diverse cultural practices and beliefs related to death and dying

d. facilitate advance care planning and provision of end-of-life care where relevant and in accordance with local policy and legislation, and

e. take reasonable steps to ensure support is provided to people, and their families, even when it is not possible to deliver the outcome they desire.

See also the Australian Commission on Safety and Quality in Health Care - End-of-Life Care.

Domain: Act with professional integrity

Principle 4: Professional behaviour

Value

Nurses embody integrity, honesty, respect and compassion.

4.1 Professional boundaries

Professional boundaries allow nurses, the person and the person's nominated partners, family and friends, to engage safely and effectively in professional relationships, including where care involves personal and/or intimate contact. In order to maintain professional boundaries, there is a start and end point to the professional relationship and it is integral to the nurse-person professional relationship. Adhering to professional boundaries promotes person-centred practice and protects both parties. To maintain professional boundaries, nurses must:

a. recognise the inherent power imbalance that exists between nurses, people in their care and significant others and establish and maintain professional boundaries

b. actively manage the person's expectations, and be clear about professional boundaries that must exist in professional relationships for objectivity in care and prepare the person for when the episode of care ends

c. avoid the potential conflicts, risks, and complexities of providing care to those with whom they have a pre-existing non-professional relationship and ensure that such relationships do not impair their judgement. This is especially relevant for those living and working in small, regional or cultural communities and/or where there is long-term professional, social and/or family engagement

d. avoid sexual relationships with persons with whom they have currently or had previously entered into a professional relationship. These relationships are inappropriate in most circumstances and could be considered unprofessional conduct or professional misconduct

e. recognise when over-involvement has occurred, and disclose this concern to an appropriate person, whether this is the person involved or a colleague

f. reflect on the circumstances surrounding any occurrence of over-involvement, document and report it, and engage in management to rectify or manage the situation

g. in cases where the professional relationship has become compromised or ineffective and ongoing care is needed, facilitate arrangements for the continuing care of the person to another health practitioner, including passing on relevant clinical information (see also 3.3 Effective communication)

h. actively address indifference, omission, disengagement/lack of care and disrespect to people that may reflect under-involvement, including escalating the issue to ensure the safety of the person if necessary

i. avoid expressing personal beliefs to people in ways that exploit the person's vulnerability, are likely to cause them unnecessary distress, or may negatively influence their autonomy in decision-making (see the NMBA Standards for practice), and

j. not participate in physical assault such as striking, unauthorised restraining and/or applying unnecessary force.

4.2 Advertising and professional representation

Nurses must be honest and transparent when describing their education, qualifications, previous occupations and registration status. This includes, but is not limited to, when nurses are involved in job applications, self-promotion, publishing of documents or web content, public appearances, or advertising or promoting goods or services. To honestly represent products and regulated health services, and themselves, nurses must:

a. comply with legal requirements about advertising outlined in the National Law (explained in the NMBA Guidelines for advertising regulated health services), as well as other relevant Australian state and territory legislation

b. provide only accurate, honest and verifiable information about their registration, experience and qualifications, including any conditions that apply to their registration (see also Principle 1: Legal compliance)

c. only use the title of nurse if they hold valid registration and/or endorsement (see also the NMBA Fact sheet: The use of health practitioner protected titles), and

d. never misrepresent, by either a false statement or an omission, their registration, experience, qualifications or position.

4.3 Legal, insurance and other assessments

Nurses may be contracted by a third party to provide an assessment of a person who is not in their care, such as for legal, insurance or other administrative purposes. When this occurs the usual nurse-person professional relationship does not exist. In this situation, nurses must:

a. explain to the person their professional area of practice, role, and the purpose, nature and extent of the assessment to be performed

b. anticipate and seek to correct any misunderstandings the person may have about the nature and purpose of the assessment and report, and

c. inform the person and/or their referring health professional of any unrecognised, serious problems that are discovered during the assessment, as a matter of duty-of-care.

4.4 Conflicts of interest

People rely on the independence and trustworthiness of nurses who provide them with advice or treatment. In nursing practice, a conflict of interest arises when a nurse has financial, professional or personal interests or relationships and/or personal beliefs that may affect the care they provide or result in personal gain.

Such conflicts may mean the nurse does not prioritise the interests of a person as they should, and may be viewed as unprofessional conduct. To prevent conflicts of interest from compromising care, nurses must:

a. act with integrity and in the best interests of people when making referrals, and when providing or arranging treatment or care

b. responsibly use their right to not provide, or participate directly in, treatments to which they have a conscientious objection. In such a situation, nurses must respectfully inform the person, their employer and other relevant colleagues, of their objection and ensure the person has alternative care options

c. proactively and openly inform the person if a nurse, or their immediate family, has a financial or commercial interest that could be perceived as influencing the care they provide

d. not offer financial, material or other rewards (inducements) to encourage others to act in ways that personally benefit the nurse, nor do anything that could be perceived as providing inducements, and

e. not allow any financial or commercial interest in any entity providing healthcare services or products to negatively affect the way people are treated.

4.5 Financial arrangements and gifts

It is necessary to be honest and transparent with people. To ensure there is no perception of actual or personal gain for the nurse, nurses must:

a. when providing or recommending services, discuss with the person all fees and charges expected to result from a course of treatment in a manner appropriate to the professional relationship, and not exploit people's vulnerability or lack of knowledge

b. only accept token gifts of minimal value that are freely offered and report the gifts in accordance with local policy

c. not accept, encourage or manipulate people to give, lend, or bequeath money or gifts that will benefit a nurse directly or indirectly

d. not become financially involved with a person who has or who will be in receipt of their care, for example through bequests, powers of attorney, loans and investment schemes, and

e. not influence people or their families to make donations, and where people seek to make a donation refer to the local policy.

Principle 5: Teaching, supervising and assessing

Value

Nurses commit to teaching, supervising and assessing students and other nurses in order to develop the nursing workforce across all contexts of practice.

5.1 Teaching and supervising

It is the responsibility of all nurses to create opportunities for nursing students and nurses under supervision to learn, as well as benefit from oversight and feedback. In their teaching and supervisor roles, nurses must:

a. seek to develop the skills, attitudes and practices of an effective teacher and/or supervisor

b. reflect on the ability, competence and learning needs of each student or nurse who they teach or supervise and plan teaching and supervision activities accordingly, and

c. avoid, where possible, any potential conflicts of interest in teaching or supervision relationships that may impair objectivity or interfere with the supervised person's learning outcomes or experience. This includes, for example, not supervising somebody with whom they have a pre-existing non-professional relationship.

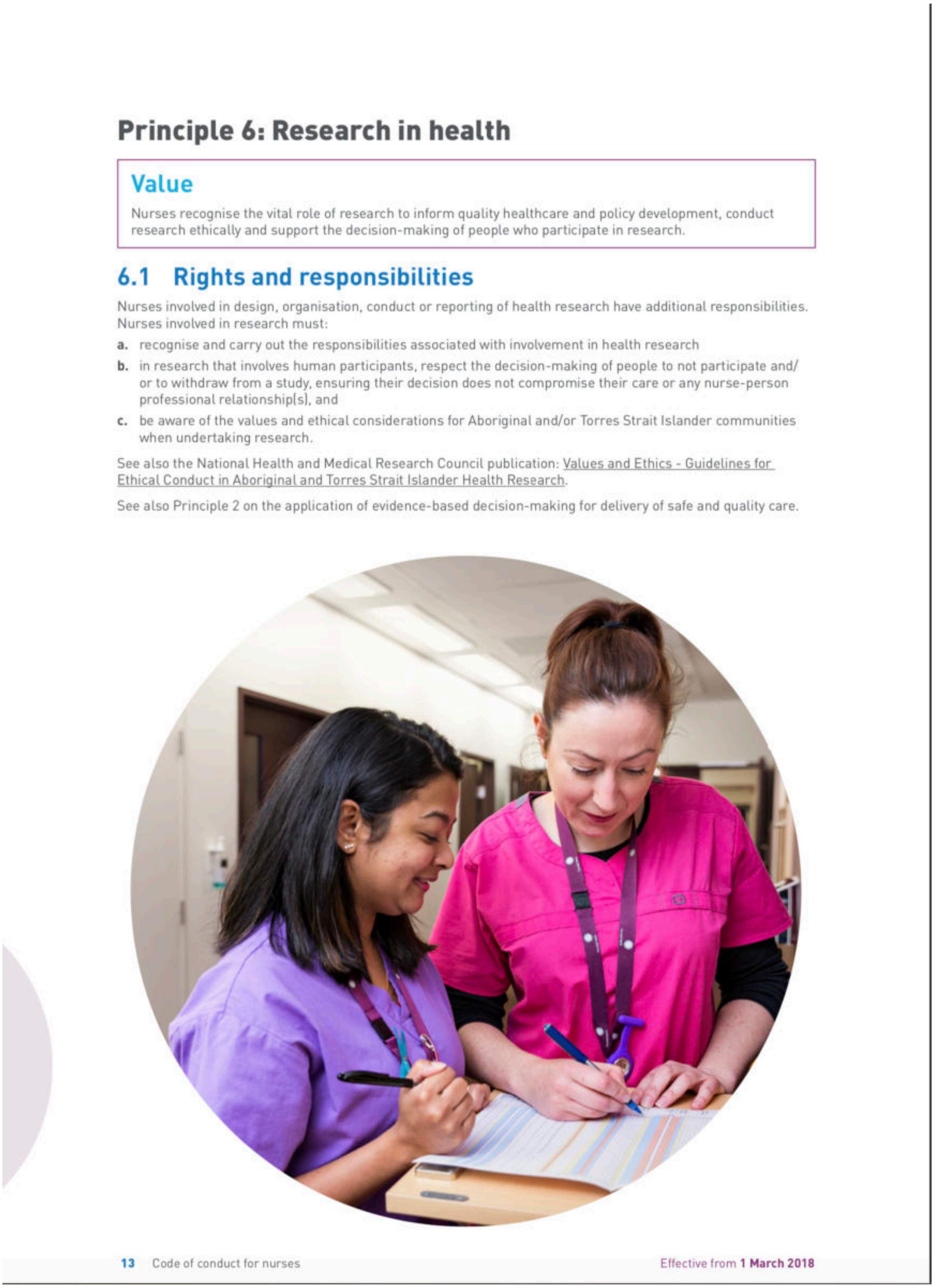
5.2 Assessing colleagues and students

Assessing colleagues and students is an important part of making sure that the highest standard of practice is achieved across the profession. In assessing the competence and performance of colleagues or students, nurses must:

a. be honest, objective, fair, without bias and constructive, and not put people at risk of harm by inaccurate and inadequate assessment, and

b. provide accurate and justifiable information promptly, and include all relevant information when giving references or writing reports about colleagues.

See also the NMBA Supervision guidelines for nursing and midwifery.



Principle 6: Research in health

Value

Nurses recognise the vital role of research to inform quality healthcare and policy development, conduct research ethically and support the decision-making of people who participate in research.

6.1 Rights and responsibilities

Nurses involved in design, organisation, conduct or reporting of health research have additional responsibilities. Nurses involved in research must:

a. recognise and carry out the responsibilities associated with involvement in health research

b. in research that involves human participants, respect the decision-making of people to not participate and/or to withdraw from a study, ensuring their decision does not compromise their care or any nurse-person professional relationship(s), and

c. be aware of the values and ethical considerations for Aboriginal and/or Torres Strait Islander communities when undertaking research.

See also the National Health and Medical Research Council publication: Values and Ethics - Guidelines for Ethical Conduct in Aboriginal and Torres Strait Islander Health Research.

See also Principle 2 on the application of evidence-based decision-making for delivery of safe and quality care.

Domain: Promote health and wellbeing

Principle 7: Health and wellbeing

Value

Nurses promote health and wellbeing for people and their families, colleagues, the broader community and themselves and in a way that addresses health inequality.

7.1 Your and your colleagues' health

Nurses have a responsibility to maintain their physical and mental health to practise safely and effectively. To promote health for nursing practice, nurses must:

a. understand and promote the principles of public health, such as health promotion activities and vaccination

b. act to reduce the effect of fatigue and stress on their health, and on their ability to provide safe care

c. encourage and support colleagues to seek help if they are concerned that their colleague's health may be affecting their ability to practise safely, utilising services such as Nurse & Midwife Support, the national health support service for nurses, midwives and students

d. seek expert, independent and objective help and advice, if they are ill or impaired in their ability to practise safely. Nurses must remain aware of the risks of self-diagnosis and self-treatment, and act to reduce these, and

e. take action, including a mandatory or voluntary notification to AHPRA, if a nurse knows or reasonably suspects that they or a colleague have a health condition or impairment that could adversely affect their ability to practise safely, or put people at risk (see Principle 1: Legal compliance).

7.2 Health advocacy

There are significant disparities in the health status of various groups in the Australian community. These disparities result from social, historic, geographic, environmental, legal, physiological and other factors. Some groups who experience health disparities include Aboriginal and/or Torres Strait Islander peoples, those with disabilities, those who are gender or sexuality diverse, and those from social, culturally and linguistically diverse backgrounds, including asylum seekers and refugees. In advocating for community and population health, nurses must:

a. use their expertise and influence to protect and advance the health and wellbeing of individuals as well as communities and populations

b. understand and apply the principles of primary and public health, including health education, health promotion, disease prevention, control and health screening using the best available evidence in making practice decisions, and

c. participate in efforts to promote the health of communities and meet their obligations with respect to disease prevention including vaccination, health screening and reporting notifiable diseases.

See also the NMBA Position statement on nurses, midwives and vaccination.

Glossary

These meanings relate to the use of terms in the *Code of conduct for nurses*.

Advance care planning is an on-going process of shared planning for current and future healthcare. It allows an individual to make known their values, beliefs and preferences to guide decision-making, even after when the individual cannot make or communicate their preferences and decisions (See Advance Care Planning Australia).

Bullying and harassment is 'when people repeatedly and intentionally use words or actions against someone or a group of people to cause distress and risk to their wellbeing. These actions are usually done by people who have more influence or power over someone else, or who want to make someone else feel less powerful or helpless'.[3]

Competence is the possession of required skills, knowledge, education and capacity.

Cultural safety concept was developed in a First Nations' context and is the preferred term for nursing and midwifery. Cultural safety is endorsed by the Congress of Aboriginal and Torres Strait Islander Nurses and Midwives (CATSINaM), who emphasise that cultural safety is as important to quality care as clinical safety. However, the "presence or absence of cultural safety is determined by the recipient of care; it is not defined by the caregiver" (CATSINaM, 2014, p. 9[4]). Cultural safety is a philosophy of practice that is about how a health professional does something, not [just] what they do. It is about how people are treated in society, not about their diversity as such, so its focus is on systemic and structural issues and on the social determinants of health. Cultural safety represents a key philosophical shift from providing care regardless of difference, to care that takes account of peoples' unique needs. It requires nurses and midwives to undertake an ongoing process of self-reflection and cultural self-awareness, and an acknowledgement of how a nurse's/midwife's personal culture impacts on care. In relation to Aboriginal and Torres Strait Islander health, cultural safety provides a de-colonising model of practice based on dialogue, communication, power sharing and negotiation, and the acknowledgment of white privilege. These actions are a means to challenge racism at personal and institutional levels, and to establish trust in healthcare encounters (CATSINaM, 2017b, p. 11[5]). In focusing on clinical interactions, particularly power inequity between patient and health professional, cultural safety calls for a genuine partnership where power is shared between the individuals and cultural groups involved in healthcare. Cultural safety is also relevant to Aboriginal and Torres Strait Islander health professionals. Non-Indigenous nurses and midwives must address how they create a culturally safe work environment that is free of racism for their Aboriginal and Torres Strait Islander colleagues (CATSINaM, 2017a[6]).

Delegation is the relationship that exists when a nurse devolves aspects of nursing practice to another person. Delegations are made to meet the person's health needs. The nurse who is delegating retains accountability for the decision to delegate. The nurse is also accountable for monitoring of the communication of the delegation to the relevant persons and for the practice outcomes. Both parties share the responsibility of making the delegation decision, which includes assessment of the competence and risks. For further details see the NMBA National framework for the development of decision-making tools for nursing and midwifery practice.

Discrimination is the unjust treatment of one or more person/s based on factors such as race, religion, sex, disability or other grounds specified in anti-discrimination legislation[7].

Handover is the process of transferring all responsibility for the care of one or more people to another health practitioner or person.

Health literacy 'is about how people understand information about health and healthcare, how they apply that information to their lives, use it to make decisions and act on it'.[8]

Local policy refers to the policies that apply to decision-making, relevant to the specific location and/or organisation where practice is being undertaken.

Mandatory notification is the requirement under the National Law for registered health practitioners, employers and education providers to report certain conduct (see Guidelines for mandatory notifications).

Mandatory reporting is a state and territory legislative requirement imposed to protect at risk groups such as the aged, children and young people.

National law means the Health Practitioner Regulation National Law that is in force in each state and territory in Australia and applies to those professions regulated under that law (see Australian Health Practitioner Regulation Agency).

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[3] Australian Human Rights Commission, *'What is bullying?'* www.humanrights.gov.au/what-bullying-violence-harassment-and-bullying-fact-sheet

[4] CATSINaM, 2014, *Towards a shared understanding of terms and concepts: strengthening nursing and midwifery care of Aboriginal and Torres Strait Islander peoples*, CATSINaM, Canberra.

[5] CATSINaM, 2017b, *The Nursing and Midwifery Aboriginal and Torres Strait Islander Health Curriculum Framework (Version 1.0)*, CATSINaM, Canberra.

[6] CATSINaM, 2017a, *Position statement: Embedding cultural safety across Australian nursing and midwifery*, CATSINaM, Canberra.

[7] Australian Human Rights Commission, *'Discrimination'* www.humanrights.gov.au/quick-guide/12030

[8] Australian Commission on Safety and Quality in Health Care, *Health literacy*: www.safetyandquality.gov.au/our-work/patient-and-consumer-centred-care/health-literacy

Nominated partners, family and friends include people in consensual relationships with the person, as identified by the person receiving care.

Nurse refers to a registered nurse, enrolled nurse or nurse practitioner. The term is reserved in Australia, under law, for a person who has completed the prescribed training, demonstrates competence to practise, and is registered as a nurse under the National Law.

Open disclosure 'is an open and honest discussion with a person about any incident(s) that caused them harm while they were receiving healthcare. It includes an apology or expression of regret (including the word 'sorry'), a factual explanation of what happened, an opportunity for the patient to describe their experience, and an explanation of the steps being taken to manage the event and prevent recurrence'[9] (Australian Commission on Safety and Quality in Health Care).

Over-involvement is when the nurse confuses their needs with the needs of the person in their care and crosses the boundary of a professional relationship. Behaviour may include favouritism, gifts, intimacy or inappropriate relationships with the partner or family member of a person in the nurse's care.

Person or people refers to those individuals who have entered into a therapeutic and/or professional relationship with a nurse. These individuals will sometimes be healthcare consumers, at other times they may be colleagues or students, this will vary depending on who is the focus of practice at the time. Therefore, the words person or people include all the patients, clients, consumers, families, carers, groups and/or communities, however named, that are within the nurse's scope and context of practice.

Person-centred practice is collaborative and respectful partnership built on mutual trust and understanding through good communication. Each person is treated as an individual with the aim of respecting people's ownership of their health information, rights and preferences while protecting their dignity and empowering choice. Person-centred practice recognises the role of family and community with respect to cultural and religious diversity.

Practice means any role, whether remunerated or not, in which the individual uses their skills and knowledge as a nurse. Practice is not restricted to the provision of direct clinical care. It also includes working in a non-clinical relationship with clients, working in management, administration, education, research, advisory, regulatory or policy development roles, and any other roles that impact on safe, effective delivery of services in the profession and/or use their professional skills.

Professional boundaries allow a nurse and a person to engage safely and effectively in a therapeutic and/or professional relationship. Professional boundaries refers to the clear separation that should exist between professional conduct aimed at meeting the health needs of people, and behaviour which serves a nurse's own personal views, feelings and relationships that are not relevant to the professional relationship.

Professional misconduct includes conduct by a health practitioner that is substantially below the expected standard and which, whether connected to practice or not, is inconsistent with being a fit and proper person to be registered in the profession.

Professional relationship is an ongoing interaction that observes a set of established boundaries or limits deemed appropriate under governing standards. The nurse is sensitive to a person's situation and purposefully engages with them using knowledge and skills with respect, compassion and kindness. In the relationship, the person's rights and dignity are recognised and respected. The professional nature of the relationship involves recognition of professional boundaries and issues of unequal power.

Referral involves a nurse sending a person to obtain an opinion or treatment from another health professional or entity. Referral usually involves the transfer (all or in part) of responsibility for the care of the person, usually for a defined time and for a particular purpose, such as care that is outside the referring practitioner's expertise or scope of practice.

Social media describes the online and mobile tools that people use to share opinions, information, experiences, images, and video or audio clips. It includes websites and applications used for social networking. Common sources of social media include, but are not limited to, social networking sites such as Facebook and LinkedIn, blogs (personal, professional and those published anonymously), WOMO, True Local, microblogs such as Twitter, content-sharing websites such as YouTube and Instagram, and discussion forums and message boards.

Substitute decision-maker is a general term for a person who is either a legally appointed decision-maker for a person, or has been nominated to make healthcare decisions on behalf of a person whose decision-making capacity is impaired.

Supervision includes managerial supervision, professional supervision and clinically focused supervision as part of delegation. For details see the NMBA Supervision guidelines for nursing and midwifery.

Therapeutic relationships are different to personal relationships. In a therapeutic relationship the nurse is sensitive to a person's situation and purposefully engages with them using knowledge and skills in respect, compassion and kindness. In the relationship the person's rights and dignity are recognised and respected. The professional nature of the relationship involves recognition of professional boundaries and issues of unequal power.

Unprofessional conduct includes conduct of a lesser standard that might reasonably be expected by the public or professional peers.

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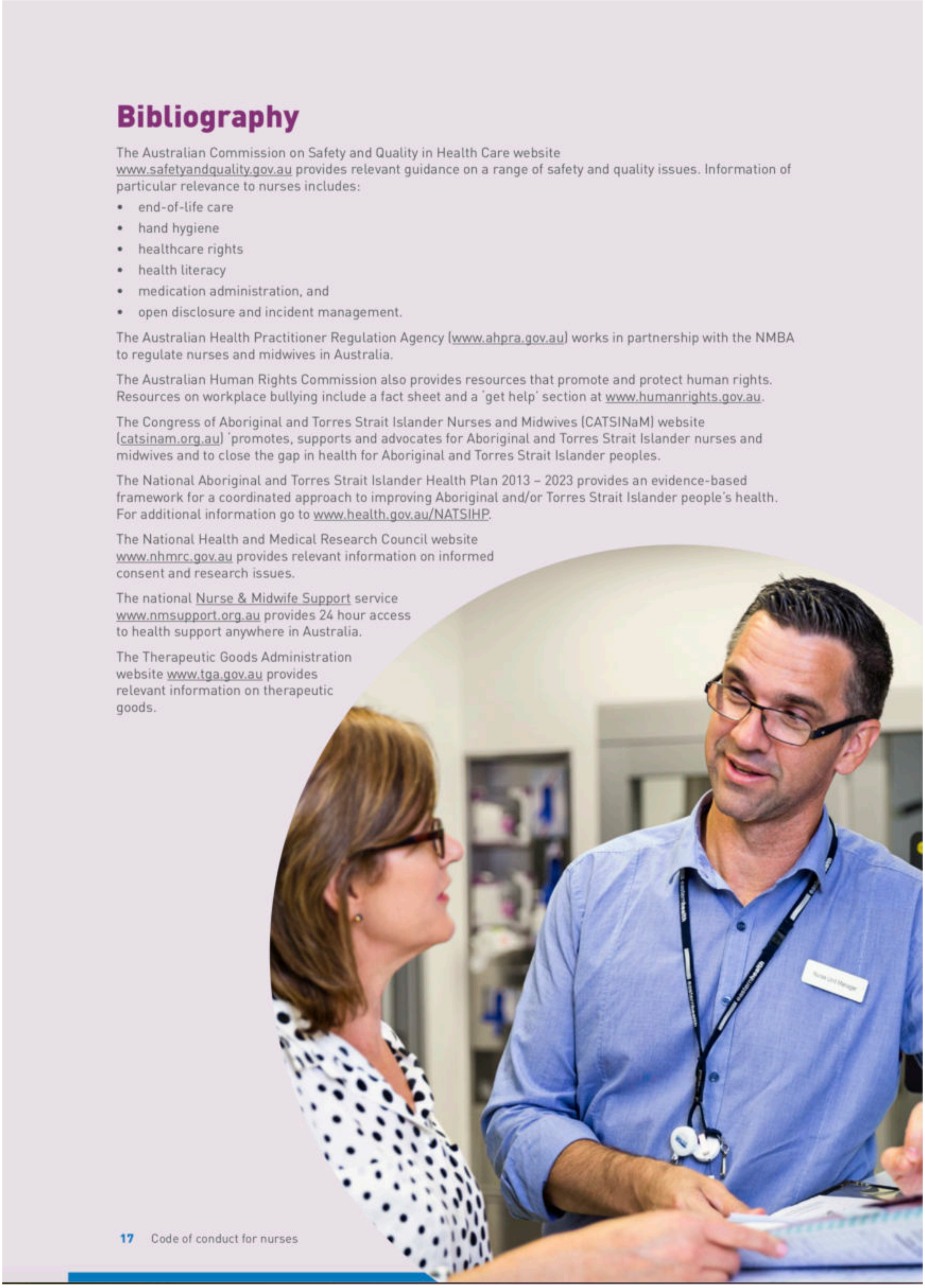
[9] Australian Commission on Safety and Quality in Health Care, *National Open Disclosure Framework*: https://www.safetyandquality.gov.au/wp-content/uploads/2013/03/Australian-Open-Disclosure-Framework-Feb-2014.pdf



Bibliography

The Australian Commission on Safety and Quality in Health Care website www.safetyandquality.gov.au provides relevant guidance on a range of safety and quality issues. Information of particular relevance to nurses includes:

- end-of-life care
- hand hygiene
- healthcare rights
- health literacy
- medication administration, and
- open disclosure and incident management.

The Australian Health Practitioner Regulation Agency (www.ahpra.gov.au) works in partnership with the NMBA to regulate nurses and midwives in Australia.

The Australian Human Rights Commission also provides resources that promote and protect human rights. Resources on workplace bullying include a fact sheet and a 'get help' section at www.humanrights.gov.au.

The Congress of Aboriginal and Torres Strait Islander Nurses and Midwives (CATSINaM) website (catsinam.org.au) 'promotes, supports and advocates for Aboriginal and Torres Strait Islander nurses and midwives and to close the gap in health for Aboriginal and Torres Strait Islander peoples.

The National Aboriginal and Torres Strait Islander Health Plan 2013 – 2023 provides an evidence-based framework for a coordinated approach to improving Aboriginal and/or Torres Strait Islander people's health. For additional information go to www.health.gov.au/NATSIHP.

The National Health and Medical Research Council website www.nhmrc.gov.au provides relevant information on informed consent and research issues.

The national Nurse & Midwife Support service www.nmsupport.org.au provides 24 hour access to health support anywhere in Australia.

The Therapeutic Goods Administration website www.tga.gov.au provides relevant information on therapeutic goods.

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Appendix G: ICN Code of Ethics for Nurses 2012

International Council of Nurses
Revised 2012

THE ICN
CODE OF ETHICS
FOR NURSES

THE ICN CODE OF ETHICS FOR NURSES

An international code of ethics for nurses was first adopted by the International Council of Nurses (ICN) in 1953. It has been revised and reaffirmed at various times since, most recently with this review and revision completed in 2012.

PREAMBLE

Nurses have four fundamental responsibilities: to promote health, to prevent illness, to restore health and to alleviate suffering. The need for nursing is universal.

Inherent in nursing is a respect for human rights, including cultural rights, the right to life and choice, to dignity and to be treated with respect. Nursing care is respectful of and unrestricted by considerations of age, colour, creed, culture, disability or illness, gender, sexual orientation, nationality, politics, race or social status.

Nurses render health services to the individual, the family and the community and coordinate their services with those of related groups.

3, place Jean-Marteau, 1201 Geneva, Switzerland

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THE ICN CODE

The *ICN Code of Ethics for Nurses* has four principal elements that outline the standards of ethical conduct.

ELEMENTS OF THE CODE

1. Nurses and people

The nurse's primary professional responsibility is to people requiring nursing care.

In providing care, the nurse promotes an environment in which the human rights, values, customs and spiritual beliefs of the individual, family and community are respected.

The nurse ensures that the individual receives accurate, sufficient and timely information in a culturally appropriate manner on which to base consent for care and related treatment.

The nurse holds in confidence personal information and uses judgement in sharing this information.

The nurse shares with society the responsibility for initiating and supporting action to meet the health and social needs of the public, in particular those of vulnerable populations.

The nurse advocates for equity and social justice in resource allocation, access to health care and other social and economic services.

The nurse demonstrates professional values such as respectfulness, responsiveness, compassion, trustworthiness and integrity.

2. Nurses and practice

The nurse carries personal responsibility and accountability for nursing practice, and for maintaining competence by continual learning.

The nurse maintains a standard of personal health such that the ability to provide care is not compromised.

The nurse uses judgement regarding individual competence when accepting and delegating responsibility.

The nurse at all times maintains standards of personal conduct which reflect well on the profession and enhance its image and public confidence.

The nurse, in providing care, ensures that use of technology and scientific advances are compatible with the safety, dignity and rights of people.

The nurse strives to foster and maintain a practice culture promoting ethical behaviour and open dialogue.

3. Nurses and the profession

The nurse assumes the major role in determining and implementing acceptable standards of clinical nursing practice, management, research and education.

The nurse is active in developing a core of research-based professional knowledge that supports evidence-based practice.

The nurse is active in developing and sustaining a core of professional values.

The nurse, acting through the professional organisation, participates in creating a positive practice environment and maintaining safe, equitable social and economic working conditions in nursing.

The nurse practices to sustain and protect the natural environment and is aware of its consequences on health.

The nurse contributes to an ethical organisational environment and challenges unethical practices and settings.

4. Nurses and co-workers

The nurse sustains a collaborative and respectful relationship with co-workers in nursing and other fields.

The nurse takes appropriate action to safeguard individuals, families and communities when their health is endangered by a co-worker or any other person.

The nurse takes appropriate action to support and guide co-workers to advance ethical conduct.

SUGGESTIONS FOR USE
of the *ICN Code of Ethics for Nurses*

The *ICN Code of Ethics for Nurses* is a guide for action based on social values and needs. It will have meaning only as a living document if applied to the realities of nursing and health care in a changing society.

To achieve its purpose the *Code* must be understood, internalised and used by nurses in all aspects of their work. It must be available to students and nurses throughout their study and work lives.

APPLYING THE ELEMENTS
of the *ICN Code of Ethics for Nurses*

The four elements of the *ICN Code of Ethics for Nurses*: nurses and people, nurses and practice, nurses and the profession, and nurses and co-workers, give a framework for the standards of conduct. The following chart will assist nurses to translate the standards into action.

Nurses and nursing students can therefore:

- Study the standards under each element of the *Code*.
- Reflect on what each standard means to you. Think about how you can apply ethics in your nursing domain: practice, education, research or management.
- Discuss the *Code* with co-workers and others.
- Use a specific example from experience to identify ethical dilemmas and standards of conduct as outlined in the *Code*. Identify how you would resolve the dilemmas.
- Work in groups to clarify ethical decision making and reach a consensus on standards of ethical conduct.
- Collaborate with your National Nurses Association, co-workers, and others in the continuous application of ethical standards in nursing practice, education, management and research.

Element of the Code # 1:

NURSES AND PEOPLE

Practitioners and Managers	**Educators and Researchers**	**National Nurses Associations**
Provide care that respects human rights and is sensitive to the values, customs and beliefs of people.	In curriculum include references to human rights, equity, justice, solidarity as the basis for access to care.	Develop position statements and guidelines that support human rights and ethical standards.
Provide continuing education in ethical issues.	Provide teaching and learning opportunities for ethical issues and decision making.	Lobby for involvement of nurses in ethics committees.
Provide sufficient information to permit informed consent to nursing and/or medical care, and the right to choose or refuse treatment.	Provide teaching/learning opportunities related to informed consent, privacy and confidentiality, beneficence and maleficence.	Provide guidelines, position statements, relevant documentation and continuing education related to informed consent to nursing and medical care.
Use recording and information management systems that ensure confidentiality.	Introduce into curriculum concepts of professional values.	Incorporate issues of confidentiality and privacy into a national code of ethics for nurses.
Develop and monitor environmental safety in the workplace.	Sensitise students to the importance of social action in current concerns.	Advocate for safe and healthy environment.

Element of the Code # 2:

NURSES AND PRACTICE

Practitioners and Managers	Educators and Researchers	National Nurses Associations
Establish standards of care and a work setting that promotes quality care.	Provide teaching/ learning opportunities that foster life long learning and competence for practice.	Provide access to continuing education, through journals, conferences, distance education, etc.
Establish systems for professional appraisal, continuing education and systematic renewal of licensure to practice.	Conduct and disseminate research that shows links between continual learning and competence to practice.	Lobby to ensure continuing education opportunities and quality care standards.
Monitor and promote the personal health of nursing staff in relation to their competence for practice.	Promote the importance of personal health and illustrate its relation to other values.	Promote healthy lifestyles for nursing professionals. Lobby for healthy workplaces and services for nurses.

Element of the Code # 3:

NURSES AND THE PROFESSION

Practitioners and Managers	Educators and Researchers	National Nurses Associations
Set standards for nursing practice, research, education and management.	Provide teaching/ learning opportunities in setting standards for nursing practice, research, education and management.	Collaborate with others to set standards for nursing education, practice, research and management.
Foster workplace support of the conduct, dissemination and utilisation of research related to nursing and health.	Conduct, disseminate and utilise research to advance the nursing profession.	Develop position statements, guidelines and standards related to nursing research.
Promote participation in national nurses' associations so as to create favourable socioeconomic conditions for nurses.	Sensitise learners to the importance of professional nursing associations.	Lobby for fair social and economic working conditions in nursing. Develop position statements and guidelines in workplace issues.

Element of the Code # 4:

NURSES AND CO-WORKERS

Practitioners and Managers	Educators and Researchers	National Nurses Associations
Create awareness of specific and overlapping functions and the potential for interdisciplinary tensions and create strategies for conflict management.	Develop understanding of the roles of other workers.	Stimulate co-operation with other related disciplines.
Develop workplace systems that support common professional ethical values and behaviour.	Communicate nursing ethics to other professions.	Develop awareness of ethical issues of other professions.
Develop mechanisms to safeguard the individual, family or community when their care is endangered by health care personnel.	Instil in learners the need to safeguard the individual, family or community when care is endangered by health care personnel.	Provide guidelines, position statements and discussion fora related to safeguarding people when their care is endangered by health care personnel.

DISSEMINATION
of the *ICN Code of Ethics for Nurses*

To be effective the *ICN Code of Ethics for Nurses* must be familiar to nurses. We encourage you to help with its dissemination to schools of nursing, practising nurses, the nursing press and other mass media. The *Code* should also be disseminated to other health professions, the general public, consumer and policy-making groups, human rights organisations and employers of nurses.

GLOSSARY OF TERMS USED
in the *ICN Code of Ethics for Nurses*

Co-worker
Other nurses and other health and non-health related workers and professionals.

Collaborative relationship
A professional relationship based on collegial and reciprocal actions and behaviour that aims to achieve certain jointly agreed goals.

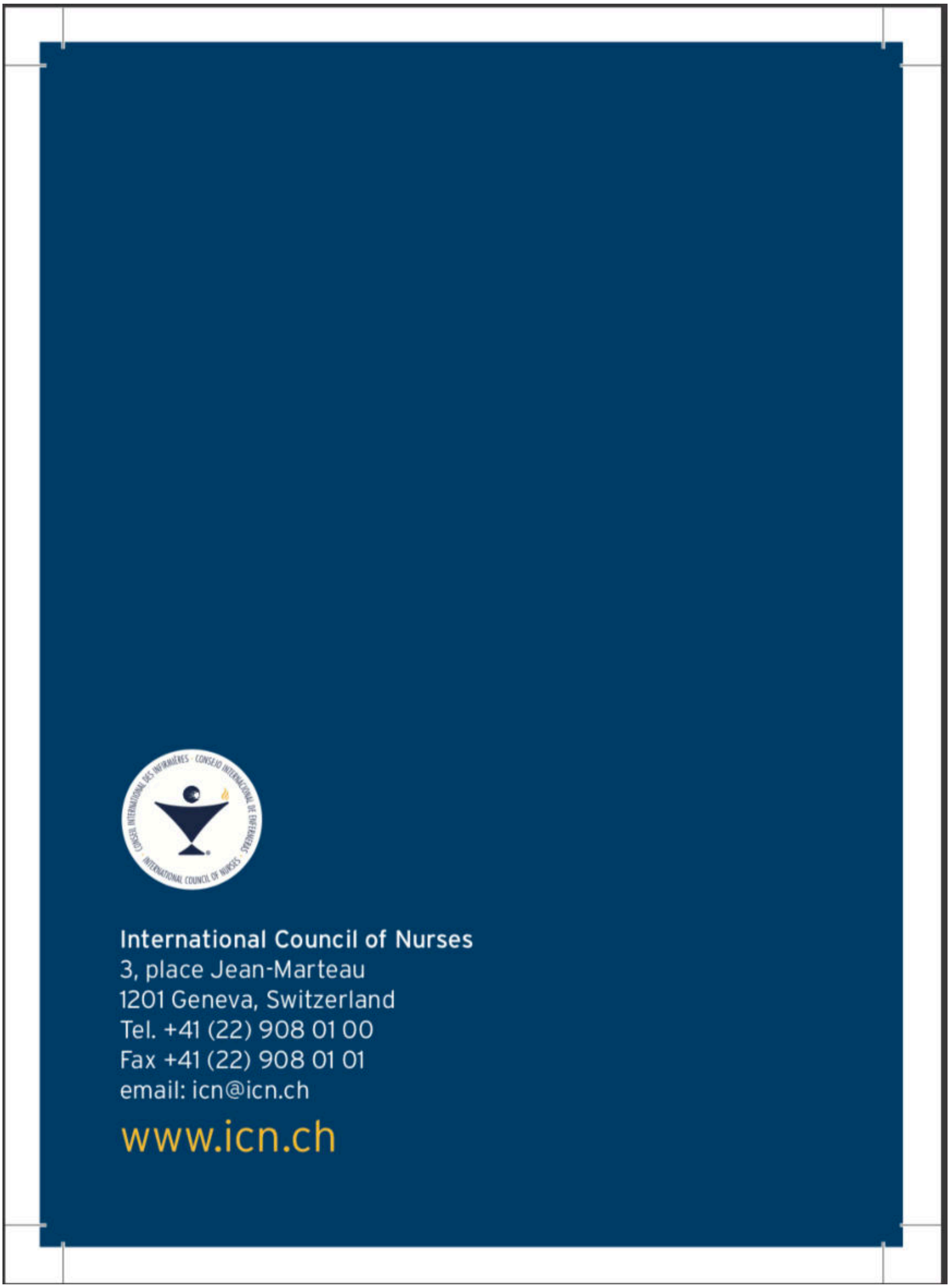
Family
A social unit composed of members connected through blood, kinship, emotional or legal relationships.

Nurse shares with society
A nurse, as a health professional and a citizen, initiates and supports appropriate action to meet the health and social needs of the public.

Personal information
Information obtained during professional contact that is private to an individual or family, and which, when disclosed, may violate the right to privacy, cause inconvenience, embarrassment, or harm to the individual or family.

Personal health
Mental, physical, social and spiritual wellbeing of the nurse.

Related groups
Other nurses, health care workers or other professionals providing service to an individual, family or community and working toward desired goals.



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Appendix H: Plain Language Information Statement

[redacted]

Plain Language Information Statement Nurses

University of Ballarat
Learn to succeed

SCHOOL OF Health Sciences (Nursing)

PROJECT TITLE:	Unpacking Advocacy in Contemporary Nursing
PRINCIPAL RESEARCHER:	Professor Sally Wellard Dr. Jane Mummery
OTHER/STUDENT RESEARCHERS:	Mrs. Clare Cole

You are invited to take part in this research project because we want to find out what advocacy is in contemporary nursing and how this role is enacted in the clinical setting. This project aims to develop an understanding of autonomy in relation to contemporary patient models of care and to develop a definition of advocacy in healthcare and explore the role of the nurse.

This plain language information statement contains detailed information about the research project. Its purpose is to explain to you as openly and clearly as possible all the procedures involved in this project before you decide whether or not to take part in it.
Please read this information carefully. Feel free to ask questions about any information in the document. You may also wish to discuss the project with a relative or friend. Feel free to do this.
Once you understand what the project is about and if you agree to take part in it, you will be asked to sign the Consent Form. By signing the consent form, you indicate that you understand the information and that you give your consent to participate in the research project.
You will be given a copy of this information and consent form to keep as a record.
This research is being undertaken as part of a PhD.

Nature and purpose of the investigation

The purpose of this project is to gain a better understanding of the concept of advocacy in contemporary healthcare. Through the literature surrounding advocacy and autonomy, and field work in the clinical setting, this project attempts to clarify the role of the nurse as an advocate in contemporary healthcare. The socially contextualised notions of health and autonomy and advocacy will be explored, and an alternative understanding of autonomy and advocacy will be developed. It is our goal that findings from the research will improve the consumer experience of healthcare delivery. A total of 30 people will participate in this project.

Advocacy is portrayed in the nursing literature as a trait essential to good nursing practice. However, advocacy is not clearly defined in relation to the role of nurses in contemporary practice. The role of nurses as advocates is highlighted in nursing codes of conduct, codes of ethics and standards of practice. Among the many definitions of advocacy, a common theme presents advocacy as a process that supports and advocates for a person or being able to plead the cause of another. In the nursing literature there is no consistent definition of advocacy or the nurses' role as an advocate. This leads to confusion around role description and has implications for patient care.

You are invited to participate in this research project because you will be able to provide us with valuable information about advocacy in contemporary healthcare. Your experiences and ideas will assist us to developed improved healthcare practices.

The results of this research will be used to help the researcher Clare Cole to obtain a degree.

Participation

Participation in this research is on a voluntary basis. Refusal to participate requires no explanation and at any time during the research participants are entitled to withdraw their consent to participate and discontinue participation at any time until data is processed without prejudice. Participants are also free to choose not to answer questions during the interview process.

Participation in this project will involve:

- You are being observed by the researcher during nurse/patient interactions
- This will mean several times a day during a defined period the research will observe the ward area for about 2 hours duration. Notes will be taken so that interactions can be described later.
- You will be invited to participate in an interview that will be at a time and place convenient to participants. This interview will take approximately 1 hour and will be arranged in a place suitable to participants. The purpose of the interview is to ask about experiences of nurses in relation to advocacy. Nurses will be asked the question "can you tell me what advocacy means to you?" The interviews will be audiotaped.

Possible Benefits

Possible benefits include the improvement of care delivery for patients by developing a common understanding of advocacy and its enactment in the clinical setting.

We cannot guarantee or promise that you will receive any benefits from this project.

Possible Risks

There are no foreseeable risks for you participating in this study. If, however you are uncomfortable with someone observing a specific interaction you are free to ask the researcher to leave the room.

Should you become upset in any way due to the discussion during the interview you can request that the researcher turn off the tape and if necessary, support will be organised through the Hospital's employee assistance program. Any data that has been collected about you will be destroyed. You may request information about the results of the study even if you withdraw.

Alternatives to Participation

You are free not to participate in this research. Regardless of your decision to participate in this study your employment will not be affected in any way.

Privacy, Confidentiality and Disclosure of Information

Your confidentiality will be maintained by using pseudonyms on the field notes and transcriptions from the interviews that are made. Any identifiable information about you will be stored separately from encoded data collected. Data will be stored in accordance with University of Ballarat guidelines for a period of 5 years and then will be destroyed. Only the research team will have access to the data.

Any information obtained in connection with this project and that can identify you will remain confidential. It will only be disclosed with your permission, except as required by law. If you give us your permission by signing the Consent Form, we plan to share the research findings through reports, publications in refereed journals and presentations at conferences

In any publication, information will be provided in such a way that you cannot be identified. This will be ensured by the use of pseudonyms and the removal of any personal information that might identify you in any way.

New Information Arising During the Project

During the research project, new information about the risks and benefits of the project may become known to the researchers. If this occurs, you will be told about this new information. This new information may mean that you can no longer participate in this research. If this occurs, the person(s) supervising the research will stop your participation.

Results of Project

The results of this project will be summarised in the form of a short report and available to you on request.

Further Information or Any Problems

If you require further information or if you have any problems concerning this project, you can contact the principal researcher Professor Sally Wellard, School of Health Sciences, University of Ballarat, phone 53279663 or email s.wellard@ballarat.edu.au

Alternatively, you can also contact:

Name: **Ms Carole Branch**

Position: **HREC Administrative Officer,** [redacted]

Telephone:03 8458 4808 or email: [redacted]

You will need to tell ***Carole*** the name of one of the researchers given in section 10 above.

Participation is Voluntary

Participation in any research project is voluntary. If you do not wish to take part, you are not obliged to. If you decide to take part and later change your mind, you are free to withdraw from the project at any stage.

Your decision whether to take part or not to take part, or to take part and then withdraw, will not affect your employment, or your relationship with the hospital.

Before you make your decision, a member of the research team will be available to answer any questions you have about the research project. You can ask for any information you want. Sign the Consent Form only after you have had a chance to ask your questions and have received satisfactory answers.

If you decide to withdraw from this project, please notify a member of the research team before you withdraw. This notice will allow that person or the research supervisor to inform you if there are any special requirements linked to withdrawing.

Ethical Guidelines

This project will be carried out according to the *National Statement on Ethical Conduct in Research Involving Humans* (2007) produced by the National Health and Medical Research Council of Australia. This statement has been developed to protect the interests of people who agree to participate in human research studies.

In accordance with the National Medical Health and Research Council guidelines, the Human Research Ethics Committee is required to conduct audits of research projects from time to time. It may therefore be possible that the Human Research Ethics Committee which has approved this research, will seek to view a copy of your signed consent form, or to contact you, to ensure that the research is being conducted according to the ethical standards required by these guidelines.

The ethical aspects of this research project have been approved by the Human Research Ethics Committee of ***Mercy Health***

Reimbursement for your costs

You will not be paid for your participation in this project however you will not be inconvenienced financially the researcher will travel to the destination designated by you for the interview.

If you have any questions, or you would like further information regarding the project titled Unpacking Advocacy in Contemporary Nursing, please contact the Principal Researcher, Professor Sally Wellard of the School of Health Sciences (Nursing):

PH: 5327 9663

EMAIL: s.wellard@ballarat.edu.au

Should you (i.e. the participant) have any concerns about the ethical conduct of this research project, please contact the University of Ballarat Ethics Officer, Research Services, University of Ballarat, PO Box 663, Mt Helen VIC 3353. Telephone: (03) 5327 9765, Email: ub.ethics@ballarat.edu.au

CRICOS Provider Number 00103D

[redacted]

Consent Form
Nurses

University of Ballarat
Learn to succeed

PROJECT TITLE:	**Unpacking Advocacy in Contemporary Nursing**
RESEARCHERS:	**Professor Sally Wellard, Dr. Jane Mummery, Mrs. Clare Cole**

<u>Consent – Please complete the following information:</u>

I, ... of . . . .
. . . .
hereby consent to participate as a subject in the above research study.

The research program in which I am being asked to participate has been explained fully to me, verbally and in writing, and any matters on which I have sought information have been answered to my satisfaction.

I understand that: all information I provide (including questionnaires) will be treated with the strictest confidence and data will be stored separately from any listing that includes my name and address. I understand and agree to the digital audio recording of interviews that take place.

I understand that

- aggregated results will be used for research purposes and may be reported in scientific and academic journals
- ***I am free to withdraw my consent at any time during the study in which event my participation in the research study will immediately cease and any information obtained from it will not be used.***
- ***once information has been aggregated it is unable to be identified, and from this point it is not possible to withdraw consent to participate***

SIGNATURE: . . . . **DATE**: . . . . . . …….. . . .. ………….

Appendix J Thematic Analysis Process Using Colaizzi

Nursing Transcript 1

Mostly it's just a voice for the [inaudible] to make sure that - making sure that they are safe and also if they aren't able to make a decision or to maybe have a voice of it if they haven't got anybody responsible they can't make it themselves. I think it's just to have someone there to be a voice, look after them yeah. (Transcript 1, pg. 1-2, 11-15)

Yeah usually with the doctors there and even with relatives even who like just before thought that would be the [lone carers] but thought that it was okay just to take her home, put her on the chair and thought, well, if she's got a chair, that'd be handy. (Transcript 1, pg. 2, 20-23)

the team feel that she's pretty much palliated, that she's not going to come out of this. (Transcript 1, pg. 2, 33-34)

but I didn't want to say too much in front of her daughter because she's not the main carer [unclear] the main carer because it can upset and I think there's a few issues there with communication so I just didn't want to say... (Transcript 1, pg. 2, 38-41)

But you need to inform them as well because they are next-of-kin as well, you know, they're the daughter but you try and tell them a lot with not saying a lot. (Transcript 1, pg. 3, 48-51)

I think family dynamics does that. I think sometimes even Allied Health does it and I think doctoring does it. I think we even do it ourselves, but I think there's a realm - you wouldn't say [that] one thing - mostly a lot of it is family dynamics, really can put up the red flag all the time. Sometimes also because of - doctors just don't see what you see and even though - and you try and see what they see and then if you try and get them to come down, then they realise it might take a day or so, but yeah and they don't often communicate with us well enough so that we go oh that's why you're doing that. We try to think about it. Sometimes they do something that they need to do, and they've been doing it but we're sometimes two days behind. (Transcript 1, pg. 3, 54-64)

I think it's all about perception. I think they perceive that we know and that they know but nobody's said anything, so it's all a bit like the doctors will assume that we know and then we assume that they know but we both all don't really know. (Transcript 1, pg. 3, 68-71

then the family say look we haven't been here, we can't get here (a) they're working, (b) they're elderly and can't get in at certain times, (c) the doctors have already done their rounds at eight o'clock and they come in every day at four o'clock and it's just those sort of barriers that I find. (Transcript 1, pg. 3-4, 72-76)

I know it's not ideal and it's all about confidentiality on the phone, you assume that they're blah, blah, but sometimes it's the only way that they're going to - both [never the twain shall meet]. (Transcript 1, pg. 4, 83-85)

I think cultural. I think English and non-English speaking backgrounds, I think a lot of that can be barriers. We don't mean to make it a barrier, but I think that can be - it would be helpful if I learnt... Transcript 1, pg. 4, 96-98)

Yeah, a lot of it I think - yeah it is it's just cultural and they understand us [unclear] - you know, if you're demented and you're from a non-English speaking background what happens? They know English but they always go back to their mother tongue, so it's very, very hard. There's a fine line of like what can we do, what we can't do and yeah, it's just - yeah, I just find that can be a bit of a... (Transcript 1, pg. 5, 103-108)

What we might not think's right's right for them. I don't know if people know that when you're nursing Maori patients you don't touch their head and you also don't put the bottle on the table... (Transcript 1, pg. 5, 111-113)

No, you don't, you put the bottle on the table, and they find it highly offensive because that's where they eat, drink, everything, so the table's very sacred. Their head is sacred because that's the part you don't touch. It's a matter of respect. You find with the Samoans they won't make eye contact because that's a matter of respect. You don't look at you in the eye. So there's lots of stuff like that that I know where I come from and with the Italian and the other Greek and Mediterranean I've actually - and Middle Eastern - even Middle Eastern we're getting more of them now and just understanding that the main person is the male figure and not the female. Yeah, it's just lots of those... (Transcript 1, pg. 5, 116-126)

Yes because they'll wait for everybody to make the decision, (b) I think sometimes if you've got some people who can't make a decision so therefore you've got this - you get that - but I think some patients feel secure if they've come from such a big family dynamic that if everybody's there and everybody knows then they're happy. Does that make sense? (Transcript 1, pg. 6, 135-140)

I think it can be a hindrance because I was always taught to stand on your own two feet in a New Zealand way, very Englishly you know, you're an adult, you're the number one, you might have thought your husband or your significant other but really in the end it's your decision. But with other cultures it's highly offensive if they said yeah, I'm fine. They can't possibly make a decision. So, it's all about how - what I think's the norm and they think's the norm. (Transcript 1, Pg. 5, 150-156)

Yeah that's right and not offending them and they're not offending you and you try to - it's really a fine balance sometimes. (Transcript 1, pg. 6, 158-159)

Sometimes mental health issues too... (Transcript 1, pg. 6, 162)

Well some girls are good at mental health - managing mental health patients, others no because they just haven't got - either you have, or you haven't. (Transcript 1, pg. 7, 164-166)

I just think sometimes we don't have enough mental health input as far as what's the norm for them or this is what we do which helps with that behaviour. (Transcript 1, pg. 7, 168-170)

I just call on what I know, you call on what you know, but it's all about - because I think that's a life thing, mental health is a life thing, so if you're not a very good communicator at home [when you're general], you're not going to communicate with someone who's probably bipolar looking distressed or someone who's in an acute phase. They get uptight - they're uptight and then of course sometimes it springs off. (Transcript 1, pg. 7, 170-176)

Yeah and maturity. You can't expect a 21-year-old to know how to handle a 45-year-old. You know how they - yeah just things like that and I even know myself. As I've got older, I can see where they're coming from and able to manage it where I used to probably not say enough, or I just wouldn't address it or go and try and get someone senior. (Transcript 1, pg. 7, 186-191)

Yeah it causes a bit of uncertainty with the patients and then they don't trust you. (Transcript 1, pg. 8, 193-194)

because if you're too vulnerable I think they then get frightened and then they start - sometimes [unclear] fear makes them feel angry so you get that behaviour of anger, where all the time it's because they don't know and they're scared. (Transcript 1, pg. 8, 198-202)

Sometimes Allied Health or doctors, even other nurses make unrealistic goals for them and I think sometimes we just have to - like sometimes you just have to say something and say look that's really not going to work and they go but why and you go this is why because you've tried four times this week and it still hasn't - yeah it's just little things like that yeah. (Transcript 1, pg. 8, 208-214)

Yeah. If you haven't got rapport and you haven't got the trust and it's almost nil, you're going to get antsy people and then people get antsy because then they feel insecure because they don't know. People that don't know get angry and it manifests as in angry or they get tearful or oh they're just being pathetic and it's not that, they just don't know. (Transcript 1, pg. 9-10, 250-255)

Well and I keep at it you mean? Yeah and I get what - yeah but that's just through experience, but it's only because I've had a background in palliative care. This man's an oncology patient so I knew what was happening and why he was awake and also had to then move on to those ends of life care because they were wanting to make - the family had no idea how unwell he really was. It was just about that sort of stuff. I just have to keep firm and stand firm and then sometimes it's just a process and then - yeah it is frustrating I have to admit because sometimes I just know what works, but then you know what I mean, you've got to also have the respect for the doctor to know because you see he was looking at me like - but I've experienced that so I've - but the [unclear] just go - or someone who was very shy or not as strong... (Transcript 1, pg. 9. 224-237)

Oh, it plays a big role yeah because if you've got a bit of an attitude it reflects... (Transcript 1, pg. 9, 243-244)

Yeah, I think we do. I think we say things that - we probably get it without even saying it, you know, like yeah and I think we do stuff without even knowing. We're got that sixth sense that we know. You can walk into a room and know there's something going on and you don't have to say it but then you come out and go I think we might [need a social worker] or I think the need a bit more information, we'll get the doctor or - yeah I think we do. We do it unknowingly yeah. (Transcript 1, pg. 10, 258-264)

Yeah it takes experience I think, that feeling yeah. I don't think you can teach gut feeling. I think some nurses never ever have that gut feeling and a lot of people will say oh but their obs are fine and you go yeah but something and you go oh I want to keep an eye on that one and they sort of look at you like are you right and then [unclear]. It's only because you just know some of the parameters aren't quite presenting. Yeah you just - I don't know if you can teach that. You might be able to say - you might be able to say it's there and maybe educate all of that, but people who don't really have much of a gut feeling, they're very - if they're very methodical they don't want to know about that. (Transcript 1, pg. 10, 269-279)

They're just like do the job, go home (Transcript 1, pg. 10, 281)

Yeah and the job is that because we've got the pressure of getting the job done and if you're seen to be getting the job done, then you're a good nurse and it's bad because not necessarily means that if the job's not being done - even jobs [being done doesn't say that] you're a good nurse and sometimes you have to wait and stop and talk and take the time otherwise it manifests itself day after day and the same problem will keep reoccurring. (Transcript 1, pg. 11, 285-291)

Nursing keeps you humble, and it will never go to plan (Transcript 1, pg. 11, 299)

they start to realise is that really important that I haven't managed to actually go and wash that patient. Right now 24 hour care does it really - unless they're continent and they're okay they just don't want it today we might think that's bad news - that's bad if the whole floor don't want it, but if that one particular person says well look I only really shower twice a week, well isn't that their normal regime. (Transcript 1, pg. 11, 302-308)

Yeah, it's what we do. We......because it's about their time management yeah... (Transcript 1, pg. 12, 316-317)

Don't and you know what sometimes in the end they get to the same goal. It does your head in, but they get there. They're still there at the end of the day, they've got all their notes done, their obs. are done, but they've just got - you know, it's just their whole management is different. (Transcript 1, pg. 12, 321-325)

I think Pastoral Care does a lot, social work and sometimes to a point even - I'll go out on a limb here - sometimes even just PSAs because they will actually come and say it. This is such and such she's not responding to me. Isn't she oh I'll just go have a look? They do it without even realising and they'll say to you - the good ones will say oh they haven't drank their drink or they haven't eaten today and you haven't had time to notice and they've taken their tray away (Transcript 1, pg. 12-13, 330-336)

Sometimes the good one, the good mentors and you can tell the ones that will take note and others that don't yeah and there again that's an experience thing and a personality thing and how they've been taught [unclear] if they've been taught to make a big tantrum, they'll have a big tantrum and they'll just pass it on, but the ones that you can see that have actually - the new age where they talk or they stop and ask the girls, ask the nurses or Allied Health, they get better results and they realise they get better results. So, it's all about results. (Transcript 1, pg. 13, 341-348)

I think it's a positive thing, if we give a toss, you know what I mean, in that sense, but I think it depends on the day. It's a day-to-day thing too. If you're feeling a bit tired, a bit hormonal, then I find sometimes that that reciprocates onto someone else's - oh well they haven't done as much today or you feel that you're not as [listened as much] or you're a bit more tired so you miss stuff that you probably - not missed but you probably don't dwell on what you would if you were a little bit more... (Transcript 1, pg. 14, 363-370)

I don't think they realise that that's just a very simple word, but it means a lot, it has a lot of off shot yeah. (Transcript 1, pg. 14, 382-383)

Yeah. It can be hit and miss sometimes yeah because the two can gel together and yeah. As I said it goes back to what I think what's right, but they've grown up thinking well it's all about perception. So, I wouldn't say it's fail proof yeah. (Transcript 1, pg. 14-15, 392-395)

I don't know, I think it has more positive than negative. I think sometimes we might do that, but I think in the same token I think we step back a lot than what we used to. Yeah, I think a lot of the time [we will be advocate] if we think that there's going to be some family, or someone just hasn't got it.

It can be - I think it has a more positive outcome than a negative and you do sometimes know you've gone a bit far or they probably need to stand on their own two feet a bit.

People play you too because they like to be that victim role. So, it's all about just working it out - the even - sometimes you get it right, sometimes you don't. (Transcript 1, pg. 15, 400-410)

Well it does. People say oh no, but it does because you've become - you've got to try and not form this opinion in your head and of course it's very difficult. It's not spot on [unclear] pleasing them, but I find that if you just do the basics and get what you can get done, you're right. It's only when you go in there and just don't - I think if you go in there and be too combative or don't do enough, I think you'll end up and just make it harder for yourself. (Transcript 1, pg. 16, 429-435)

I think sometimes we do tend to forget that - we've got to remember too that they're people. Even though we nurse them every day I think sometimes we forget that how would I feel or what I say does it make an impact on that person. (Transcript 1, pg. 16, 442-445)

Yeah, I think so. You've got to reflect on what you've said and yeah, I think it's a big thing because then sometimes you can go back and say what I mean was... (Transcript 1, pg. 16, 449-451)

...and I think sometimes we've got to do that because some personalities will just - the difficult ones if they don't have a boundary, they'll keep pushing it all the way yeah and they'll have... (Transcript 1, pg. 17, 464-466)

Yeah and that's a huge difference. If you know all the background then you know okay, they live alone - say for example, they live alone. Oh, do they have any carers come in? Yeah, I have Jane, she comes and showers me. How many times? I often find they're out in the shower because you're doing stuff and, like yourself, you know or you change them or they're just chatting to you and you might be just preparing their brekkie and you see how much they can do. (Transcript 1, pg. 18-19, 504-810)

Things like that yeah and that's how you get to know them (Transcript 1, pg. 19, 514)

Significant Statements	Formulated Meanings
Mostly it's just a voice for the [inaudible] to make sure that - making sure that they are safe and also if they aren't able to make a decision or to maybe have a voice of it if they haven't got anybody responsible they can't make it themselves. I think it's just to have someone there to be a voice, look after them yeah.	1. A voice for the patient
Yeah usually with the doctors there and even with relatives even who like just before thought that would be the [lone carers] but thought that it was okay just to take her home, put her on the chair and thought, well, if she's got a chair, that'd be handy	2. Advocate when others are there
the team feel that she's pretty much palliated, that she's not going to come out of this.	3. Team approach to care
but I didn't want to say too much in front of her daughter because she's not the main carer [unclear] the main carer because it can upset and I think there's a few issues there with communication so I just didn't want to say... (	4. Issues of family communication and family dynamics
But you need to inform them as well because they are next-of-kin as well, you know, they're the daughter but you try and tell them a lot with not saying a lot.	5. Family dynamics
I think family dynamics does that. I think sometimes even Allied Health does it and I think doctoring does it. I think we even do it ourselves but I think there's a realm - you wouldn't say [that] one thing - mostly a lot of it is family dynamics, really can put up the red flag all the time. Sometimes also because of - doctors just don't see what you see and even though - and you try and see what they see and then if you try and get them to come down, then they realise it might take a day or so, but yeah and they don't often communicate with us well enough so that we go oh that's why you're doing that. We try to think about it. Sometimes they do something that they need to do and they've been doing it but we're sometimes two days behind.	6. Communication issues

I think it's all about perception. I think they perceive that we know and that they know but nobody's said anything, so it's all a bit like the doctors will assume that we know and then we assume that they know but we both all don't really know	7. Perceptions of assumptions
then the family say look we haven't been here, we can't get here (a) they're working, (b) they're elderly and can't get in at certain times, (c) the doctors have already done their rounds at eight o'clock and they come in every day at four o'clock and it's just those sort of barriers that I find.	8. Family dynamics
I know it's not ideal and it's all about confidentiality on the phone, you assume that they're blah, blah, but sometimes it's the only way that they're going to - both [never the twain shall meet].	9. Confidentiality and family issues
I think cultural. I think English and non-English speaking backgrounds, I think a lot of that can be barriers. We don't mean to make it a barrier but I think that can be - it would be helpful if I learnt...	10. Cultural and NESB barriers
Yeah a lot of it I think - yeah it is it's just cultural and they understand us [unclear] - you know, if you're demented and you're from a non-English speaking background what happens? They know English but they always go back to their mother tongue, so it's very, very hard. There's a fine line of like what can we do, what we can't do and yeah it's just - yeah I just find that can be a bit of a...	11. Cultural and NESB barriers
What we might not think's right's right for them. I don't know if people know that when you're nursing Maori patients you don't touch their head and you also don't put the bottle on the table...	12. Cultural sensitivity
Yes because they'll wait for everybody to make the decision, (b) I think sometimes if you've got some people who can't make a decision so therefore you've got this - you get that - but I think some patients feel secure if they've come from such a big family dynamic that if everybody's there and everybody knows then they're happy. Does that make sense?	13. Extended family in decision making

I think it can be a hindrance because I was always taught to stand on your own two feet in a New Zealand way, very Englishly you know, you're an adult, you're the number one, you might have thought your husband or your significant other but really in the end it's your decision. But with other cultures it's highly offensive if they said yeah I'm fine. They can't possibly make a decision. So it's all about how - what I think's the norm and they think's the norm	14. Cultural sensitivity
Yeah that's right and not offending them and they're not offending you and you try to - it's really a fine balance sometimes	15. Cultural Sensitivity
Sometimes mental health issues too...	16. Mental health influences care
Well some girls are good at mental health - managing mental health patients, others no because they just haven't got - either you have or you haven't	17. Managing mental health
I just think sometimes we don't have enough mental health input as far as what's the norm for them or this is what we do which helps with that behaviour	18. Managing mental health
I just call on what I know, you call on what you know, but it's all about - because I think that's a life thing, mental health is a life thing, so if you're not a very good communicator at home [when you're general], you're not going to communicate with someone who's probably bipolar looking distressed or someone who's in an acute phase. They get uptight - they're uptight and then of course sometimes it springs off.	19. Experience influences healthcare
Yeah and maturity. You can't expect a 21 year old to know how to handle a 45 year old. You know how they - yeah just things like that and I even know myself. As I've got older I can see where they're coming from and able to manage it where I used to probably not say enough or I just wouldn't address it or go and try and get someone senior	20. Experience influences healthcare
Yeah it causes a bit of uncertainty with the patients and then they don't trust you	21. Rapport and trust is important

because if you're too vulnerable I think they then get frightened and then they start - sometimes [unclear] fear makes them feel angry so you get that behaviour of anger, where all the time it's because they don't know and they're scared.	22. Rapport and trust is important
Sometimes Allied Health or doctors, even other nurses make unrealistic goals for them and I think sometimes we just have to - like sometimes you just have to say something and say look that's really not going to work and they go but why and you go this is why because you've tried four times this week and it still hasn't - yeah it's just little things like that yeah.	23. Unrealistic goals of healthcare
Yeah. If you haven't got rapport and you haven't got the trust and it's almost nil you're going to get antsy people and then people get antsy because then they feel insecure because they don't know. People that don't know get angry and it manifests as in angry or they get tearful or oh they're just being pathetic and it's not that, they just don't know.	24. Rapport and trust is important 25. Information exchange is important to facilitate rapport and trust
Well and I keep at it you mean? Yeah and I get what - yeah but that's just through experience, but it's only because I've had a background in palliative care. This man's an oncology patient so I knew what was happening and why he was awake and also had to then move on to those ends of life care because they were wanting to make - the family had no idea how unwell he really was. It was just about that sort of stuff. I just have to keep firm and stand firm and then sometimes it's just a process and then - yeah it is frustrating I have to admit because sometimes I just know what works, but then you know what I mean, you've got to also have the respect for the doctor to know because you see he was looking at me like - but I've experienced that so I've - but the [unclear] just go - or someone who was very shy or not as strong...	26. Keeping firm and standing up for patients

Oh it plays a big role yeah because if you've got a bit of an attitude it reflects...(	27. Experience is important
Yeah I think we do. I think we say things that - we probably get it without even saying it, you know, like yeah and I think we do stuff without even knowing. We're got that sixth sense that we know. You can walk into a room and know there's something going on and you don't have to say it but then you come out and go I think we might [need a social worker] or I think the need a bit more information, we'll get the doctor or - yeah I think we do. We do it unknowingly yeah.	28. Intuition and 6th sense
Yeah it takes experience I think, that feeling yeah. I don't think you can teach gut feeling. I think some nurses never ever have that gut feeling and a lot of people will say oh but their obs are fine and you go yeah but something and you go oh I want to keep an eye on that one and they sort of look at you like are you right and then [unclear]. It's only because you just know some of the parameters aren't quite presenting. Yeah you just - I don't know if you can teach that. You might be able to say - you might be able to say it's there and maybe educate all of that, but people who don't really have much of a gut feeling, they're very - if they're very methodical they don't want to know about that.	29. Intuition and 6th sense
They're just like do the job, go home	30. It's just a job
Yeah and the job is that because we've got the pressure of getting the job done and if you're seen to be getting the job done, then you're a good nurse and it's bad because not necessarily means that if the job's not being done - even jobs [being done doesn't say that] you're a good nurse and sometimes you have to wait and stop and talk and take the time otherwise it manifests itself day after day and the same problem will keep reoccurring.	31. Pressures of the job
Nursing keeps you humble and it will never go to plan	32. Humility of nursing

they start to realise is that really important that I haven't managed to actually go and wash that patient. Right now 24 hour care does it really - unless they're continent and they're okay they just don't want it today we might think that's bad news - that's bad if the whole floor don't want it, but if that one particular person says well look I only really shower twice a week, well isn't that their normal regime.	33. Pressures of the job
Yeah it's what we do. We......because it's about their time management yeah...	34. Time management
Don't and you know what sometimes in the end they get to the same goal. It does your head in but they get there. They're still there at the end of the day, they've got all their notes done, their obs. are done, but they've just got - you know, it's just their whole management is different	35. Time management
I think Pastoral Care does a lot, social work and sometimes to a point even - I'll go out on a limb here - sometimes even just PSAs because they will actually come and say it. This is such and such she's not responding to me. Isn't she oh I'll just go have a look. They do it without even realising and they'll say to you - the good ones will say oh they haven't drank their drink or they haven't eaten today and you haven't had time to notice and they've taken their tray away	36. Not just the nurse
Sometimes the good one, the good mentors and you can tell the ones that will take note and others that don't yeah and there again that's an experience thing and a personality thing and how they've been taught [unclear] if they've been taught to make a big tantrum, they'll have a big tantrum and they'll just pass it on, but the ones that you can see that have actually - the new age where they talk or they stop and ask the girls, ask the nurses or Allied Health, they get better results and they realise they get better results. So it's all about results.	37. Team dynamics
I think it's a positive thing, if we give a toss, you know what I mean, in that sense, but I think it depends on the day.	38. A day to day prospect 39. It depends on the nurse

It's a day-to-day thing too. If you're feeling a bit tired, a bit hormonal, then I find sometimes that that reciprocates onto someone else's - oh well they haven't done as much today or you feel that you're not as [listened as much] or you're a bit more tired so you miss stuff that you probably - not missed but you probably don't dwell on what you would if you were a little bit more...	
I don't think they realise that that's just a very simple word but it means a lot, it has a lot of off-shot yeah.	40. What does it mean?
Yeah. It can be hit and miss sometimes yeah because the two can gel together and yeah. As I said it goes back to what I think what's right but they've grown up thinking well it's all about perception. So I wouldn't say it's fail proof yeah.	41. Not fail proof
I don't know, I think it has more positive than negative. I think sometimes we might do that, but I think in the same token I think we step back a lot than what we used to. Yeah I think a lot of the time [we will be advocate] if we think that there's going to be some family or someone just hasn't got it. It can be - I think it has a more positive outcome than a negative and you do sometimes know you've gone a bit far or they probably need to stand on their own two feet a bit. People play you too because they like to be that victim role. So it's all about just working it out - the even - sometimes	42. It can be positive 43. The Changing role of advocacy 44. The persona of the patient

you get it right, sometimes you don’t.	
Well it does. People say oh no but it does because you’ve become - you’ve got to try and not form this opinion in your head and of course it’s very difficult. It’s not spot on [unclear] pleasing them, but I find that if you just do the basics and get what you can get done you’re right. It’s only when you go in there and just don’t - I think if you go in there and be too combative or don’t do enough, I think you’ll end up and just make it harder for yourself.	45. First impressions
I think sometimes we do tend to forget that - we’ve got to remember too that they’re people. Even though we nurse them every day I think sometimes we forget that how would I feel or what I say does it make an impact on that person.	46. Remembering the person not the illness
Yeah I think so. You’ve got to reflect on what you’ve said and yeah I think it’s a big thing because then sometimes you can go back and say what I mean was...(	47. Reflection
...and I think sometimes we’ve got to do that because some personalities will just - the difficult ones if they don’t have a boundary they’ll keep pushing it all the way yeah and they’ll have...	48. Setting boundaries
Yeah and that’s a huge difference. If you know all the background then you know okay they live alone - say for example, they live alone. Oh do they have any carers come in? Yeah I have Jane, she comes and showers me. How many times? I often find they’re out in the shower because you’re doing stuff and, like yourself, you know or you change them or they’re just chatting to you and you might be just preparing their brekkie and you see how much they can do.	49. Understanding the patient’s context
Things like that yeah and that’s how you get to know them	50. Getting to know your patient

Organising formulated meanings into clusters of themes

Formulated Meanings	Cluster of Themes
1. A voice for the patient	Giving patients a voice
2. Advocate when others are there	Advocacy doesn't just have to be for those people who are alone
3. Team approach to care	There's no I in team
4. Issues of family communication and family dynamics	Family dynamics and communication influence care
5. & 8. Family dynamics	Family dynamics and communication influence care
6. Communication issues	Family dynamics and communication
7. Perceptions of assumptions	Assumptions are dangerous
9. Confidentiality and family issues	Family dynamics and communication influence care
10.&11. Cultural and NESB barriers	You have to be careful with their culture
12.&14&15. Cultural sensitivity	You have to be careful with their culture
13. Extended family in decision making	Family dynamics and communication influence care
16. Mental health influences care	It's not just about the illness
17.&18. Managing mental health	It's not just about the illness
19.&20. Experience influences healthcare	Experience, rapport and trust go hand in hand
21&22&24. Rapport and trust is important	Experience, rapport and trust go hand in hand
23. Unrealistic goals of healthcare	Realism in healthcare
25. Information exchange is important to facilitate rapport and trust	Family dynamics and communication influence care
26. Keeping firm and standing up for patients	Giving patients a voice
27. Experience is important	Experience, rapport and trust go hand in hand
28.&29. Intuition and 6th sense	Intuition in nursing
30. It's just a job	Profession vs. calling
31.&33. Pressures of the job	Job stress
32. Humility of nursing	There's no I in team
34.&35. Time management	Job stress
36. Not just the nurse	There's no I in team
37. Team dynamics	There's no I in team
38. A day to day prospect	Profession vs. calling
39. It depends on the nurse	Profession vs. calling
40. What does it mean?	The Changing role of advocacy
41. Not fail proof	The Changing role of advocacy
42. It can be positive	The Changing role of advocacy

43. The Changing role of advocacy	The Changing role of advocacy
44. The persona of the patient	It’s not just about the illness
45. First impressions	It’s not just about the illness
46. Remembering the person not the illness	It’s not just about the illness
47. Reflection	Profession vs. calling
48. Setting boundaries	It’s not just about the illness
49. Understanding the patient’s context	It’s not just about the illness
50. Getting to know your patient	It’s not just about the illness

Cluster of Themes Summarised

- Giving patients a voice
- Advocacy doesn’t just have to be for those people who are alone
- Family dynamics and communication influence care
- Assumptions are dangerous
- You have to be careful with their culture
- It’s not just about the illness
- Experience, rapport and trust go hand in hand
- There’s no I in team
- Realism in healthcare
- Intuition in nursing
- Profession vs. calling
- Job stress
- The Changing role of advocacy

Illustrating the emergence of a theme from a theme of cluster and formulated meanings

Formulated Meanings	Theme Cluster	Emergent Theme
1. A voice for the patient 26. Keeping firm and standing up for patients	Standing up and giving voice to the patients	Standing up and giving patients a heard voice
2. Advocate when others are there	Advocacy is anytime	Everybody needs an advocate
3.Team approach to care 32. Humility of nursing 36. Not just the nurse 37. Team dynamics	The team approach to care	There is no I in team
4. Issues of family communication and family dynamics 5. & 8. Family dynamics Communication issues 9. Confidentiality and family issues 13. Extended family in decision making 25. Information exchange is important to facilitate rapport and trust	Families can be a hindrance and a support but come with the patient	Families –can't live with them can't live without them
7.Perceptions of assumptions	Assumptions are perceptions that influence care	Assumptions are dangerous
10.&11. Cultural and NESB barriers 12.&14&15. Cultural sensitivity	Culture and language can be barriers to care	You have to be careful with their culture
16. Mental health influences care 17.&18. Managing mental health 44.The persona of the patient 45.First impressions 46.Remembering the person not the illness 48.Setting boundaries 49.Understanding the patient's context 50.Getting to know your patient	Illness affects the need for advocacy	The patient not the illness
19.&20. Experience influences healthcare	Rapport and trust are needed for nursing	The nurse/pt. relationships

21&22&24. Rapport and trust is important 27. Experience is important		
23. Unrealistic goals of healthcare	The expectations of the healthcare professional	Keeping it real
28.&29. Intuition and 6th sense	Using intuition as a nursing skill	6th sense
30. It's just a job 31.&33. Pressures of the job 34.&35. Time management 38. A day to day prospect 39. It depends on the nurse 47. Reflection	The process of nursing is influenced by the individual	Profession vs. a calling
40. What does it mean? 41. Not fail proof 42. It can be positive 43. The Changing role of advocacy	Advocacy is many things	What does advocacy provide in care?

Emergent Themes Summary

- Standing up and giving patients a heard voice
- Everybody needs an advocate
- There is no I in team
- Families –can't live with them can't live without them
- Assumptions are dangerous
- You have to be careful with their culture
- The patient not the illness
- The nurse/pt. relationships
- Keeping it real
- 6th sense
- Profession vs. a calling
- What does advocacy provide in care?

Nursing Transcript 2

In a case where patients are not capable of making decisions, as a nurse, to stand up for them and to make sure that they get the best care. (Transcript 2, pg. 1, 6-8)
Sometimes medically they may not understand the doctors,….and they're not sure but they will come and tell us, so in order to go and talk to the doctors and make sure they go back and explain to the patient - which has happened many times, and to talk for the patients and to make sure that they get the best care. (Transcript 2, pg. 1, 10-14)
I've noticed that the doctors will go in and talk to the patients and tell such and such is happening, and they will say okay, for some reason the patients won't ask the doctors. But as soon as they leave the room and you just happen to go there and they're like, now what is this, I don't know what's going on (Transcript 2, pg. 2, 16-21)
Imagine as a patient - I always put myself in that situation if it was me, it's a blow on you, and you just say this and walk away, and there's no family. (Transcript 2, pg. 2, 24-26)
I make sure that family is there and whether the patient is happy with that. Sometimes they don't want anyone and afterwards to sit with them and whether they really understood and if they didn’t, I'll make sure (Transcript 2, pg. 2, 28-31)
So to get them back and explain to and whether they need any pastoral care or social work intervention to make sure, which they may not ask for but as a nurse, I would make sure that they do because sometimes if you are busy you don't have the time to sit with them. (Transcript 2, pg. 2, 33-37)
As a nurse, isn't it your role? (consent) (Transcript 2, pg. 2, 45)
But I know over the years, I know who we can talk to. (Transcript 2, pg. 3, 47)
But I have documented that I have done my part, which I think I'm responsible as a nurse. So, I went, and I asked her whether you need any help at home, how you're managing and this type of help, because some of them don't know that, that you can get all this help. So, you can ask them in a nice way whether you want it (Transcript 2, pg. 3, 51-56)
So, there is a way to work. If I had gone in and said straight away that, no this is not right, I would have rubbed with her and the conversation would have ended there (Transcript 2, pg. 3, 63-65)
- I always make sure at the desk I don't confront, even if there is - I will say, okay I'll get them. (Transcript 2, pg. 3, 70-71)
I'll talk to them one to one, but I try not to in front of people and try to create - even though they may not be right. (Transcript 2, pg. 3, 72-74)
So, we can't change that, so what I told her, so I'll get speech to reassess, maybe it's changed now (Transcript 2, pg. 3, 78-79)
Maybe it's the way I talk too but I always try to get the message through somehow and they agree to it, so she still had the puree diet. (Transcript 2, pg. 4, 88-89)
Yeah but the thing is what they give we can't control. We're not here to assess it (Transcript 2, pg. 4, 98-99)
But at the same time, we have to make sure not to create - you have to handle it in a nice way (Transcript 2, pg. 4, 101-102)
. But I think it's the experience; I know when they ask certain things, what they have in their mind. As a young nurse you may not, but over the years you learn it and you know how to (Transcript 2, pg. 5, 112-115)

There might be a definition if you look, but it doesn't fit - it differs in each situation, doesn't it? (Transcript 2, pg. 5, 117-118)

Definitely, because over here we had quite a lot of issues and we get phone calls from families…. - we've had that issue, big families, not of them getting along with each other…. but the main thing is the patient. (Transcript 2, pg. 5, 132-136)

That's where I try to get - because they are more concerned with how the family will cope rather than looking at themselves whether (Transcript 2, pg. 6, 143-145)

because it's an outsider and doesn't judge, just sits there and listens. (Transcript 2, pg. 6, 146-147)

some families are very hard to deal with. It is cultural too, which over the years I've noticed. Italians they come in large numbers, but they never do anything, but they want to make sure that we provide. Indians, I've noticed, they're very needy. Just a pain, it may not be much, but for them it's the end of the world, the whole family will be pooling around them, rubbing and - so I've noticed - you know….but you need to look at that when you're dealing with (Transcript 2, pg. 6,151-158)

It's vice versa too, so we have to work to - like each you find what their needs are, and you have to, and sometimes you have to tell them to step out, in a nice way. (Transcript 2, pg. 6, 162-164)

the hospital will be liable. If you cross the road and something happens, we will be liable for it. (Transcript 2, pg. 7, 174-175)

We want to make sure while she's in our care that we do the best for her. (Transcript 2, pg. 7, 177-178)

So sometimes it's how you approach it (Transcript 2, pg. 7, 181)

So, it's a situation you have to look at the - it's hard to say, each one is different. (Transcript 2, Pg. 7, 192-193)

. I just say I'm one of the other nurses because I don't like to come across like, I'm better, I'm in charge. (Transcript 2, pg. 7, 199-201)

I keep one foot ready to……because I'm busy, and that always is taken as a negativity, that you don't have the time for - but the experience as I'm talking, it clicks in me what I'm doing so I quickly go in. Because I've noticed that in the past I didn't - and that itself rubs off, oh she doesn't have the time for me. So, you have to make sure, even though you're busy, you take the time to sit and talk to them. (Transcript 2, pg. 8, 208-215)

Definitely, it's the whole lot…..Yeah, the body language, which I've done many times but I always watch the doctors, like the surgeons, and I do feel - the patient was lying and he stood right in front of her, and the leg was on the side rail. I thought, oh my goodness, if it was me, the patient, you would feel - so that incident is always in my mind. (Transcript 2, pg. 8, 217-223)

so, when I'm talking, I never stand. If the patient is in the bed, I always make sure that I either am sitting in her level - because I think that standing it's overpowering. (Transcript 2, pg. 8, 224-226)

So there is quite a lot, and in the tone of your voice, you have to make sure that you do care because it does - when you listen to a conversation, you can see some people - because you're doing - it's not they really mean it, it's just because of too many things happening that you will be doing something and you talk to - all that, you have to be careful, especially if it's a sensitive - and to make sure the curtains are… (Transcript 2, pg. 8, 228-234)

Language can be, and I think you have to put yourself in that situation, which I do a lot. (Transcript 2, pg. 9, 239-240)

You can't judge and you've never been in that situation and many times I've said - and patients have said that to me - I've said, it's going to be okay, or, it's alright. I really did mean it when I said that and then the patient will tell me back, it's not alright. (Transcript 2, pg. 9, 241-244)

you have to think yourself, in that position, which we don't, we sometimes think ourselves as health care workers, you're just there to look after and sometimes it might be something at home (Transcript 2, pg. 9, 245-248)

You can be judgemental, emotional and the other thing is, if you have something going on, you can't be teary, (Transcript 2, pg. 9, 252-253)

Because we are there with the patients 24 hours. (Transcript 2, pg. 9, 259)

Imagine if we are not there, …. we are the ones who are by the bedside and who knows the patient (Transcript 2, pg. 9, 263-266)

then I know because otherwise you're in charge and you don't come across in contact. So, I do a round in the morning and I talk to them, so I know what's going on, what their needs are, and I think because we are there 24 hours (Transcript 2, pg. 10, 268-271)

So those kinds of things, I think we are the ones because we are there 24 hours, but it also depends the type of nurses. Not everyone can pick that, but many - especially the younger generation - it's just a job for them. (Transcript 2, pg. 10, 278-281)

So, it's not for everyone, but you can still take it as a job. I see it in some of the nurses for them it's a job. (Transcript 2, pg. 11, 306-307)

So, it can be like that, but I think you - in order, all this extra to come, you have to be really caring and compassionate (Transcript 2, pg. 11, 309-310)

I don't believe in just nurses because sometimes we might not catch up but while she's walking, she might talk (Transcript 2, pg. 11, 318-320)

If it's done in the right way……Where we don't take in control of the situation, and get emotionally attached (Transcript 2, pg. 12, 327-330)

Significant Statements	Formulated Meanings
In a case where patients are not capable of making decisions, as a nurse, to stand up for them and to make sure that they get the best care	1. Standing up for patient who are not competent 2. Best care is about standing up for the patient
Sometimes medically they may not understand the doctors,….and they're not sure but they will come and tell us, so in order to go and talk to the doctors and make sure they go back and explain to the patient - which has happened many times, and to talk for the patients and to make sure that they get the best care	3. Ensuring communication is complete and understood
I've noticed that the doctors will go in and talk to the patients and tell such and such is happening and they will say okay, for some reason the patients won't ask the doctors. But as soon as they leave the room and you just happen to go there and they're like, now what is this, I don't know what's going on	4. Nurses fill in the gaps
Imagine as a patient - I always put myself in that situation if it was me, it's a blow on you, and you just say this and walk away, and there's no family	5. The capacity for empathy is important
I make sure that family is there and whether the patient is happy with that. Sometimes they don't want anyone and afterwards to sit with them and whether they really understood and if they didn't I'll make sure	6. Making sure that the patient has support available
So to get them back and explain to and whether they need any pastoral care or social work intervention to make sure, which they may not ask for but as a nurse, I would make sure that they do because sometimes if you are busy you don't have the time to sit with them	7. The nurse knows best
As a nurse, isn't it your role? (consent)	8. It is our role
But I know over the years, I know who we can talk to.	9. Experience facilitates communication
But I have documented that I have done my part, which I think I'm responsible as a nurse. So I went and I asked her whether you need any help at home, how you're managing and this type of help, because some of them don't know that, that you can get all this help. So you can ask them in a nice way whether you want it	10. The litigious nature of healthcare

So there is a way to work. If I had gone in and said straight away that, no this is not right, I would have rubbed with her and the conversation would have ended there	11. Experience facilitates communication
- I always make sure at the desk I don't confront, even it there is - I will say, okay I'll get them.	12. Trying to avoid confrontation where it is inappropriate
I'll talk to them one to one, but I try not to in front of people and try to create - even though they may not be right	1. Trying to avoid confrontation where it is inappropriate
So we can't change that, so what I told her, so I'll get speech to reassess, maybe it's changed now	2. Being the peace maker
Maybe it's the way I talk too but I always try to get the message through somehow and they agree to it, so she still had the puree diet	3. Ensuring effective communication
Yeah but the thing is what they give we can't control. We're not here to assess it	4. People are not controllable – they will do what they want to regardless
But at the same time we have to make sure not to create - you have to handle it in a nice way	5. Being the peace maker
. But I think it's the experience; I know when they ask certain things, what they have in their mind. As a young nurse you may not, but over the years you learn it and you know how to	6. Experience plays a role in the healthcare politics
There might be a definition if you look, but it doesn't fit - it differs in each situation, doesn't it?	7. The healthcare environment and care is contextually based
Definitely, because over here we had quite a lot of issues and we get phone calls from families….- we've had that issue, big families, not of them getting along with each other…..but the main thing is the patient.	8. Families are secondary to the needs of the patient
That's where I try to get - because they are more concerned with how the family will cope rather than looking at themselves whether	9. Patients should come first
because it's an outsider and doesn't judge, just sits there and listens.	10. Providing extra support
some families are very hard to deal with. It is cultural too, which over the years I've noticed. Italians they come in large numbers, but they never do anything, but they want to make sure that we provide. Indians, I've noticed, they're very needy. Just a pain, it may not be much, but for them it's the end of the world, the whole	11. Cultural influences care provided

family will be pooling around them, rubbing and - so I've noticed - you know….but you need to look at that when you're dealing with	
It's vice versa too, so we have to work to - like each you find what their needs are and you have to, and sometimes you have to tell them to step out, in a nice way	12. You need to be aware of different cultural expectations of healthcare
the hospital will be liable. If you cross the road and something happens, we will be liable for it.	13. The litigious nature of healthcare
We want to make sure while she's in our care that we do the best for her	14. The Litigious nature of healthcare
So sometimes it's how you approach it	15. Your approach towards the patient will influence your outcomes
So it's a situation you have to look at the - it's hard to say, each one is different	16. You have to consider the context of situation
. I just say I'm one of the other nurses because I don't like to come across like, I'm better, I'm in charge	17. Putting yourself on the same level as the patient
I keep one foot ready to……because I'm busy, and that always is taken as a negativity, that you don't have the time for - but the experience as I'm talking, it clicks in me what I'm doing so I quickly go in. Because I've noticed that in the past I didn't - and that itself rubs off, oh she doesn't have the time for me. So you have to make sure, even though you're busy, you take the time to sit and talk to them	18. First impressions are important in shaping the nurse/patient relationship
Definitely, it's the whole lot…..Yeah, the body language, which I've done many times but I always watch the doctors, like the surgeons, and I do feel - the patient was lying and he stood right in front of her, and the leg was on the side rail. I thought, oh my goodness, if it was me, the patient, you would feel - so that incident is always in my mind.	19. It's not just what you say but how you say it
so when I'm talking I never stand. If the patient is in the bed, I always make sure that I either am sitting in her level - because I think that standing it's overpowering.	20. Consider the role of perception in power relationships
So there is quite a lot, and in the tone of your voice, you have to make sure that you do care because it does - when you listen to a conversation, you can see some people - because you're doing - it's not they really mean it, it's just because of too	21. It's not just what you say but how you say it

many things happening that you will be doing something and you talk to - all that, you have to be careful, especially if it's a sensitive - and to make sure the curtains are…	
Language can be, and I think you have to put yourself in that situation, which I do a lot.	22. Put yourself in their shoes
You can't judge and you've never been in that situation and many times I've said - and patients have said that to me - I've said, it's going to be okay, or, it's alright. I really did mean it when I said that and then the patient will tell me back, it's not alright.	23. It's important to stick to the facts as patients will pick you up on lies
you have to think yourself, in that position, which we don't, we sometimes think ourselves as health care workers, you're just there to look after and sometimes it might be something at home	24. Put yourself in their shoes
You can be judgemental, emotional and the other thing is, if you have something going on, you can't be teary	25. Separation of professional and personal is important
Because we are there with the patients 24 hours	26. The ever presence of the nurse
Imagine if we are not there, ….we are the ones who are by the bedside and who knows the patient	27. Nurses are the only ones who know the patient
then I know because otherwise you're in charge and you don't come across in contact. So I do a round in the morning and I talk to them, so I know what's going on, what their needs are and I think because we are there 24 hours	28. Making yourself visible to others while in charge
So those kind of things, I think we are the ones because we are there 24 hours, but it also depends the type of nurses. Not everyone can pick that, but many - especially the younger generation - it's just a job for them	29. Personality of the nurse influences how they approach the job and therefore advocacy
So it's not for everyone, but you can still take it as a job. I see it in some of the nurses for them it's a job.	30. It's just a job
So it can be like that, but I think you - in order, all this extra to come, you have to be really caring and compassionate	31. Empathy and compassion are essential skills
I don't believe in just nurses because sometimes we might not catch up but while she's walking she might talk	32. Other people can act as advocates for patients

If it's done in the right way……Where we don't take in control of the situation, and get emotionally attached	33. Letting the patients make decisions and not getting too involved

Organising formulated meanings into clusters of themes

Formulated Meanings	Cluster of Themes
1. Standing up for patient who are not competent	Standing up for patients
2. Best care is about standing up for the patient	Standing up for patients
3. Ensuring communication is complete and understood	Communication and information exchange is essential
4. Nurses fill in the gaps	Communication and information exchange is essential
5. The capacity for empathy is important	Empathy and caring
6. Making sure that the patient has support available	Standing up for patients
7. The nurse knows best	Professional idealisation of nursing
8. It is our role	Professional idealisation of nursing
9. Experience facilitates communication	Communication and information exchange is essential
10. The litigious nature of healthcare	The litigious nature of healthcare
11. Experience facilitates communication	Communication and information exchange is essential
12. Trying to avoid confrontation where it is inappropriate	Power and knowledge mismatch
13. Trying to avoid confrontation where it is inappropriate	Power and knowledge mismatch
14. Being the peace maker	Power and knowledge mismatch
15. Ensuring effective communication	Communication and information exchange is essential
16. People are not controllable – they will do what they want to regardless	Power and knowledge mismatch
17. Being the peace maker	Power and knowledge mismatch
18. Experience plays a role in the healthcare politics	Experience counts
19. The healthcare environment and care is contextually based	Contextualisation of healthcare
20. Families are secondary to the needs of the patient	Standing up for patients
21. Patients should come first	Standing up for patients
22. Providing extra support	Standing up for patients
23. Cultural influences care provided	Cultural diversity
24. You need to be aware of different cultural expectations of healthcare	Cultural diversity
25. The litigious nature of healthcare	The litigious nature of healthcare
26. The Litigious nature of healthcare	The litigious nature of healthcare
27. Your approach towards the patient will influence your outcomes	It’s not just what you say but how you say it
28. You have to consider the context of situation	Contextualisation of healthcare
29. Putting yourself on the same level as the patient	Power and knowledge mismatch

30. First impressions are important in shaping the nurse/patient relationship	It's not just what you say but how you say it
31. It's not just what you say but how you say it	It's not just what you say but how you say it
32. Consider the role of perception in power relationships	Power and knowledge mismatch
33. It's not just what you say but how you say it	It's not just what you say but how you say it
34. Put yourself in their shoes	Empathy and caring
35. It's important to stick to the facts as patients will pick you up on lies	Veracity and the truth
36. Put yourself in their shoes	Empathy and caring
37. Separation of professional and personal is important	Professional idealisation of nursing
38. The ever presence of the nurse	Professional idealisation of nursing
39. Nurses are the only ones who know the patient	Professional idealisation of nursing
40. Making yourself visible to others while in charge	Power and knowledge mismatch
41. Personality of the nurse influences how they approach the job and therefore advocacy	Empathy and caring
42. It's just a job	Professional idealisation of nursing
43. Empathy and compassion are essential skills	Empathy and caring
44. Letting the patients make decisions and not getting too involved	Allowing patients to have a say
45. Other people can act as advocates for patients	It's not just the role of the nurse

Cluster of Themes Summarised

- Standing up for patients
- Communication and information exchange is essential
- Empathy and caring
- Professional idealisation of nursing
- Communication and information exchange is essential
- The litigious nature of healthcare
- Power and knowledge mismatch
- Experience counts
- Contextualisation of healthcare
- Cultural diversity
- It's not just what you say but how you say it
- Veracity and the truth
- Allowing patients to have a say
- It's not just the role of the nurse

Illustrating the emergence of a theme from a theme cluster and formulated meanings

Formulated Meanings	Theme Cluster	Emergent Theme
1.Standing up for patient who are not competent 2.Best care is about standing up for the patient 6.Making sure that the patient has support available 20.Families are secondary to the needs of the patient 21.Patients should come first 22.Providing extra support	Supporting the patient and providing best care	Standing up for the patient
3.Ensuring communication is complete and understood 4.Nurses fill in the gaps 9.Experience facilitates communication 15.Ensuring effective communication	Communication is essential to nursing practice	Without communication what do we have?
5.The capacity for empathy is important 34.&36.Put yourself in their shoes 41.Personality of the nurse influences how they approach the job and therefore advocacy 43.Empathy and compassion are essential skills	The capacity for empathy and providing care are essential skills	Empathy and Caring in nursing
7.The nurse knows best 8.It is our role 37.Separation of professional and personal is important 38.The ever presence of the nurse 39.Nurses are the only ones who know the patient 42.It's just a job	Idealisation of the role of the nurse in healthcare	The Consummate Professional
10.&25&26.The litigious nature of healthcare	The legal aspects of healthcare	The litigious nature of healthcare
12 & 13.Trying to avoid confrontation where it is inappropriate 14.Being the peace maker	Power and knowledge are influential in the delivery of healthcare	Power and knowledge are not created equal

16.People are not controllable – they will do what they want to regardless 17.Being the peace maker 32.Consider the role of perception in power relationships 29.Putting yourself on the same level as the patient 40.Making yourself visible to others while in charge		
18.Experience plays a role in the healthcare politics	The role of politics within nursing care	The nurse as a politician
19.The healthcare environment and care is contextually based 28.You have to consider the context of situation	Healthcare is strongly contextually based and therefore is not one size fits all.	Contexts of care
23.Cultural influences care provided 24.You need to be aware of different cultural expectations of healthcare	Cultural and language differences influence care	You have to be careful with culture
27.Your approach towards the patient will influence your outcomes 31.&33.It's not just what you say but how you say it 30.First impressions are important in shaping the nurse/patient relationship	The nurse/patient relationship influences care	The nurse/patient relationship façade
35.It's important to stick to the facts as patients will pick you up on lies	Tell the truth to the patient	Veracity and Truth
44.Letting the patients make decisions and not getting too involved	Patients becoming active participant in their healthcare	Autonomy within healthcare
45.Other people can act as advocates for patients	Team factors influencing advocacy	It's not just about the nurse

Emergent Themes Summary

- Standing up for the patient
- Without communication what do we have?
- Empathy and Caring in nursing
- The Consummate Professional
- The litigious nature of healthcare
- Power and knowledge are not created equal
- The nurse as a politician

- Contexts of care
- You have to be careful with culture
- The nurse/patient relationship façade
- Veracity and Truth
- Autonomy within healthcare
- It’s not just about the nurse

Nursing Transcript 3

it's their responsibility to themselves and to their own health. So, their willingness to get up and get better, and try and do things for themselves. (Transcript 3, pg. 1, 5-7)

I think our role is to encourage as much as we can. To make sure that we're doing the right things to - or that we're taking the right steps to help them help themselves (Transcript 3, pg. 1,10-12)

I try and talk to them. Tell them that they've got to try and get up on their feet or - especially if they can and they are afraid or feel the need that they don't need to do it. So, I just try and speak to them and say oh okay, so maybe today we'll try and see how we go. (Transcript 3, pg. 2, 19-23)

But I think that if you approach them in the right way, it tends to happen. They tend to be a lot better about it and are willing to try. (Transcript 3, pg. 2,24-26)

So, approach them with good manner. If you ask politely and - or some people don't like a direct oh, you're going to get up today. You're going to use the frame today - that type of approach. So, if you know you can build rapport with your patients and know how they are, you know which - in what way you should try and approach them with the - make the move. (Transcript 3, pg. 2,28-33)

Well the patient has the right to refuse any type of care. So, if they don't want to be washed and if they don't want any medications and they blatantly refuse. You can try and reason with them or talk to them about why they don't want to do it? Or explain to them the benefits of doing it and then usually that does help (Transcript 3, pg. 2, 36-40)

But if that doesn't work, they have the right to refuse. (Transcript 3, pg. 2, 42-43)

I think that the demand - the workload and the demand makes nurses really busy. At times, we are so in the routine of doing things that we just do it for them, because we know that it's going to be quicker. It saves us time. It saves them time and it just gets done. In the end, that's what - I guess as long as you do your work, it's the most important thing for most. But at the same time, it's not helping that situation. So, if a patient needs a lot of encouragement to do something and it takes them a while, we tend to take over that - a lot of the time, it's because we don't have the time. (Transcript 3, pg. 3, 48-56)

They usually - if I explain to them and I ask, they do it for me. But yeah, I think just the workload and the time issue is a big barrier to us being advocates (Transcript 3, pg. 3, 59-61)

the right amount of time to spend with someone to help them in that type of way. (Transcript 3, pg. 3, 71-72)

Just depends on the type of patients you have. (Transcript 3, pg. 3, 75-76)

If they're really full on patients, if they're all full nursing care, then really the time that you have is minimal. If depending on how many drugs they have and things like that. So, everything just adds onto the workload. (Transcript 3, pg. 4, 77-80)

well when you get handover, if they say full nursing care, most of the time you go into the room expecting for that patient to be in full need of your care. Sometimes you find out, when you go into the room and you speak to them, that they can do most things themselves. They just require set up. That's a little bit different as well. So, it just depends. (Transcript 3, pg. 4, 96-101)

You do get a lot of information just through the way that you speak to them or… (Transcript 3, pg. 4, 105-106)

There's a lot of things that we do that's a lot - visual assessment is a big thing. I'll probably ask one or two questions and the rest I just get from how they are really. How - the way that I see them. (Transcript 3, pg. 5, 126-128)

The patient is a big one. I think that the patients, or most of the patients, are under this false impression that because they're in hospital and they're sick, that they can't do anything for themselves. Or they just rely on us to do everything for them. I know that sounds really mean (Transcript 3, pg. 5, 134-138)

...it is true, yeah. I think that if they have their mindset like that already, it's really difficult for me to turn around and be like can you get out of your chair? Or try and guide them to do anything really. (Transcript 3, pg. 6, 140-142)

. It's - that's hard, because even trying to explain to them, if they've got that mindset and they're really dead set on that, it's really hard to sway them the other way. Or try and convince them to help themselves. (Transcript 3, pg. 6, 145-148)

, I always just had this thing in the back of my head that I've got to encourage my patients to try and do things for themselves. (Transcript 3, pg. 6, 163-165)

Whereas I think with a lot of the older nurses, when they're hospital trained, they're so used to doing things for their patients, that maybe some of them don't even bother to ask. Or they just do it, because it's their job. That's the way that they were trained. (Transcript 3, pg. 6, 166-169)

But in terms of advocacy, I always hear the older nurses say oh, if they can do it for themselves, let them do it sort of thing. But [unclear] I've seen a lot of the - they just do it, sort of thing. (Transcript 3, pg. 7, 180-183)

I think that it's because a lot of people have different ways in communicating. It's a big thing. If I ask a patient a certain way to do something and they do it for me, but they won't do it for the next person, what happened between them that the patient's refusing? Or maybe they just didn't approach it the right - in the right way. Or maybe they didn't even ask. Just things like that (Transcript 3, pg. 8, 203-208)

. Everybody's got different personalities. (Transcript 3, pg. 8, 222-223)

Just people are different. Personalities are different and that plays a - has a lot to do with the way that you talk to someone. Things that you can get done as well, depending on how you talk to someone (Transcript 3, pg. 9, 239-241)

. I always get - the girls are always like to me, don't ask. Because if you ask, he's going to say no (Transcript 3, pg. 9, 243-245)

I think it can be a little bit of both. I think - I always ask, because I think it's polite to ask. That's just how I always am. I have to ask someone. If then they refuse, I will keep going (Transcript 3, pg. 9, 251-253)

. If you explain it to them, most people will say yes to you anyway, even if they don't want to have it.

But it can be seen in both ways. I can see that as manipulative at one - on one side. On the other, I can see how it benefits (Transcript 3, pg. 9, 256-259)

But if you're straight up, they tend to listen to you a lot more. (Transcript 3, pg. 9, 263)

in nursing, they always say that we are responsible for our patients and their care. We have a duty of care to the patient. Everyone has to look at it in a way that as long as it's not going to hurt them or hurt themselves. Then you make a decision. I find it hard to - it's a very, very fine line. (Transcript 3, pg. 10, 267-270)

I like to treat people the way that I'd want to be treated if I was the patient. I wouldn't force anyone to do anything that they didn't want to do. Because if they came in and I was like no, I wouldn't want them pestering me about doing something or taking something. But if a patient has dementia or a mental illness, it brings so much more on the plate that it's hard to draw that line (Transcript 3, pg. 10, 274-279) but I don't feel comfortable doing things, if the patient doesn't know about it. Unless that's the technique that they've been using beforehand, say in the nursing home. If that's the way that they're getting their medications in the nursing home. The family's aware, then I'm happy to do it, if that's the way that they've always had it done. (Transcript 3, pg. 10-11, 294-299)

. For someone that's worked in rehab for a long time, they would have the best experience in doing that type of thing because that's the job that they would do every day. But if you worked in ICU and your patient required full nursing care, or they were intubated or something, and you've been doing everything for them. The moment that they come to and try to do things for themselves and couldn't, would you sit there and argue with them, as to whether they should do it or not? (Transcript 3, pg. 12, 329-336)

But it just depends on the clinical setting that you're in. With medical patients, it's good to have advocacy and to be an advocate for your patients, because it's an acute medical ward. Everyone's going to go home eventually. When they do get that discharge planning going with the patients, you've got to have - they've got to be ready to go home. (Transcript 3, pg. 12, 338-342)

I think because, as a human, people have the right to know things. (Transcript 3, pg. 13, 359)

I think that everyone should not hide things. (Transcript 3, pg. 13, 361)

? If you go against the family, they execute you for it. Then if you go against the patient - obviously they don't know, but they're your patient. I don't know. I feel that the patient should always be told the truth. The more that they know, the better they are at doing things for themselves. (Transcript 3, pg. 13, 363-367)

sometimes I go into a room and I'm doing something for someone. They ask me why I'm doing it? Or even without them asking, I'll explain what I'm doing. That way, they understand why we're doing what we're doing. (Transcript 3, pg. 13, 368-371)

They were really appreciative, because I explained what I was doing and why I was doing it. So, they finally understood as to why we do the things that we do. They were more accepting of the fact that we were doing these things. (Transcript 3, pg. 13, 373-377)

I think the biggest reason is because most of the times we're running around like crazy. We don't have the time to do it. We're just like bang, bang, bang. We do the things that we need to do. We forget to tell them why we're doing it. I mean yes and no. Yeah. (Transcript 3, pg. 13, 380-384)

The patient has the right for you to be confidential with their medical records (Transcript 3, pg. 14, 403-404)

I don't think that it should be our responsibility to deal with things like that. But then again, people are people and people have families. (Transcript 3, pg. 16, 460-461)

. If the patient has the right mindset as to the fact that they want to get home. They want to get better, then that helps too. But [I guess just] - I don't know. You just have to assess the situation and know when to encourage and when it's inappropriate to encourage. (Transcript 3, pg. 16, 467-471)

But I think that handing over, especially with little things like that makes a big difference, in advocacy obviously. Sometimes you forget to hand over things like that though. But yeah, I think it's just the way that you approach things, would be the best way to facilitate… (Transcript 3, pg. 16, 474-477)

No, we're not the only ones. The doctors definitely play a big role in that. I think that sometimes the mentality of a patient is they do whatever the doctor tells them to do. When we tell them things, they tend not to listen. Whereas when the doctor tells them things, they're more than happy to do it. (Transcript 3, pg. 17, 484-488)

But definitely, there's a lot of people that can advocate that. (Transcript 3, pg. 17, 498)

Allied Health play a big part in advocacy for patients, because they are the ones that organise for a patient to get home. That's usually what we use them for. (Transcript 3, pg. 17, 499-501)

Yes, I think that we are dismissed at times, because of the way that patients look at our role. Because only we know our role. We are aware of what we do and how we do it. (Transcript 3, pg. 18, 515-517)

So, a lot of the time, patients come in and they see us as a person that just does things for them. (Transcript 3, pg. 18, 519-520)

But I think that when I talk to a lot of people, they are generally more grateful for the things that we do for them, because we're always around. (Transcript 3, pg. 18, 522-524)

I think that you can use that to encourage them to do things. Because you are looking after them all the time or you do see them a lot. That helps definitely in them - obviously you're building rapport with your patients. The more you see them, the more that they get accustomed to you and work with you, to do the things that they need to do. (Transcript 3, pg. 18, 526-530)

When I used to go into the room, she used to be like oh, we have the best nurse in the room. It was because I had spent so much time with her and I - obviously we had a chat. I spoke to her. Half the time, I'd encourage her to go to the toilet without using her oxygen. But she wouldn't do it for anyone else, because she - I guess she grew a liking to me. But because - it must have been the way that I treated her. We got to know each other. (Transcript 3, pg. 18, 532-538)

I'm not afraid to share a little bit of my life with my patients, if it helps me build rapport or relate to someone on a personal level. (Transcript 3, pg. 18, 539-540)

. Most of the time, in this hospital and in every hospital, we're - there is such a big push for beds that you're constantly just trying to get people out the door. (Transcript 3, pg. 19, 550-553)

we still do spend a lot of time with our patients. So, there's never a time where you can't be an advocate. Unless you're really busy or something - you had a code or something happened, where you couldn't physically be there to spend a little bit of time. To just say oh, why don't (Transcript 3, pg. 19-20, 568-573)

Significant Statements	Formulated Meanings
it's their responsibility to themselves and to their own health. So their willingness to get up and get better, and try and do things for themselves	1. Patient responsibility
I think our role is to encourage as much as we can. To make sure that we're doing the right things to - or that we're taking the right steps to help them help themselves	2. Encouragement role
I try and talk to them. Tell them that they've got to try and get up on their feet or - especially if they can and they are afraid or feel the need that they don't need to do it. So I just try and speak to them and say oh okay, so maybe today we'll try and see how we go	3. Talking to patients
But I think that if you approach them in the right way, it tends to happen. They tend to be a lot better about it and are willing to try	4. All about the approach
So approach them with good manner. If you ask politely and - or some people don't like a direct oh, you're going to get up today. You're going to use the frame today - that type of approach. So if you know you can build rapport with your patients and know how they are, you know which - in what way you should try and approach them with the - make the move	5. Facilitating rapport
Well the patient has the right to refuse any type of care. So if they don't want to be washed and if they don't want any medications and they blatantly refuse. You can try and reason with them or talk to them about why they don't want to do it? Or explain to them the benefits of doing it and then usually that does help	6. Patients rights
But if that doesn't work, they have the right to refuse	7. Patients rights
I think that the demand - the workload and the demand makes nurses really busy. At times, we are so in the routine of doing things that we just do it for them, because we know that it's going to be quicker. It saves us time. It saves them time and it just gets done. In the end, that's what - I guess as long as you	8. Workload pressures

do your work, it's the most important thing for most. But at the same time, it's not helping that situation. So if a patient needs a lot of encouragement to do something and it takes them a while, we tend to take over that - a lot of the time, it's because we don't have the time.	
They usually - if I explain to them and I ask, they do it for me. But yeah, I think just the workload and the time issue is a big barrier to us being advocates	9. Time barriers
the right amount of time to spend with someone to help them in that type of way.	10. Time barriers
Just depends on the type of patients you have.	11. Personality
If they're really full on patients, if they're all full nursing care, then really the time that you have is minimal. If depending on how many drugs they have and things like that. So everything just adds onto the workload	12. Acuity of patients
well when you get handover, if they say full nursing care, most of the time you go into the room expecting for that patient to be in full need of your care. Sometimes you find out, when you go into the room and you speak to them, that they can do most things themselves. They just require set up. That's a little bit different as well. So it just depends	13. Miscommunication
You do get a lot of information just through the way that you speak to them or	14. Communicating with patients
There's a lot of things that we do that's a lot - visual assessment is a big thing. I'll probably ask one or two questions and the rest I just get from how they are really. How - the way that I see them	15. Visual assessment
The patient is a big one. I think that the patients, or most of the patients, are under this false impression that because they're in hospital and they're sick, that they can't do anything for themselves. Or they just rely on us to do everything for them. I know that sounds really mean	16. Persona of the patient
...it is true, yeah. I think that if they have their mindset like that already, it's really difficult for me to turn around and be	17. Persona of the patient

like can you get out of your chair? Or try and guide them to do anything really.	
. It's - that's hard, because even trying to explain to them, if they've got that mindset and they're really dead set on that, it's really hard to sway them the other way. Or try and convince them to help themselves.	18. Made up their minds
, I always just had this thing in the back of my head that I've got to encourage my patients to try and do things for themselves.	19. Encouragement of patients
Whereas I think with a lot of the older nurses, when they're hospital trained, they're so used to doing things for their patients, that maybe some of them don't even bother to ask. Or they just do it, because it's their job. That's the way that they were trained	20. That's the job
But in terms of advocacy, I always hear the older nurses say oh, if they can do it for themselves, let them do it sort of thing. But [unclear] I've seen a lot of the - they just do it, sort of thing.	21. Doing rather than encouraging
I think that it's because a lot of people have different ways in communicating. It's a big thing. If I ask a patient a certain way to do something and they do it for me, but they won't do it for the next person, what happened between them that the patient's refusing? Or maybe they just didn't approach it the right - in the right way. Or maybe they didn't even ask. Just things like that	22. Style of communication
. Everybody's got different personalities	23. Personality
Just people are different. Personalities are different and that plays a - has a lot to do with the way that you talk to someone. Things that you can get done as well, depending on how you talk to someone	24. Personality
. I always get - the girls are always like to me, don't ask. Because if you ask, he's going to say no	25. Don't give an option
I think it can be a little bit of both. I think - I always ask, because I think it's polite to ask. That's just how I always am. I have to ask someone. If then they refuse, I will keep going	26. Keep going

. If you explain it to them, most people will say yes to you anyway, even if they don't want to have it. But it can be seen in both ways. I can see that as manipulative at one - on one side. On the other, I can see how it benefits	27. Manipulation
But if you're straight up, they tend to listen to you a lot more	28. Honest is the best policy
in nursing, they always say that we are responsible for our patients and their care. We have a duty of care to the patient. Everyone has to look at it in a way that as long as it's not going to hurt them or hurt themselves. Then you make a decision. I find it hard to - it's a very, very fine line	29. Duty of care
I like to treat people the way that I'd want to be treated if I was the patient. I wouldn't force anyone to do anything that they didn't want to do. Because if they came in and I was like no, I wouldn't want them pestering me about doing something or taking something. But if a patient has dementia or a mental illness, it brings so much more on the plate that it's hard to draw that line	30. Treat me as you would like to be treated as long as you see me as competent
but I don't feel comfortable doing things, if the patient doesn't know about it. Unless that's the technique that they've been using beforehand, say in the nursing home. If that's the way that they're getting their medications in the nursing home. The family's aware, then I'm happy to do it, if that's the way that they've always had it done	31. It's all about perceptions of competency
. For someone that's worked in rehab for a long time, they would have the best experience in doing that type of thing because that's the job that they would do everyday. But if you worked in ICU and your patient required full nursing care, or they were intubated or something, and you've been doing everything for them. The moment that they come to and try to do things for themselves and couldn't, would you sit there and argue with them, as to whether they should do it or not?	32. Experience of the nurse

But it just depends on the clinical setting that you're in. With medical patients, it's good to have advocacy and to be an advocate for your patients, because it's an acute medical ward. Everyone's going to go home eventually. When they do get that discharge planning going with the patients, you've got to have - they've got to be ready to go home	33. Context of care
I think because, as a human, people have the right to know things.	34. Rights of patient
I think that everyone should not hide things	35. Telling the truth
? If you go against the family, they execute you for it. Then if you go against the patient - obviously they don't know, but they're your patient. I don't know. I feel that the patient should always be told the truth. The more that they know, the better they are at doing things for themselves	36. Confidentiality and the family
sometimes I go into a room and I'm doing something for someone. They ask me why I'm doing it? Or even without them asking, I'll explain what I'm doing. That way, they understand why we're doing what we're doing	37. Explaining care to patients
They were really appreciative, because I explained what I was doing and why I was doing it. So they finally understood as to why we do the things that we do. They were more accepting of the fact that we were doing these things	38. Explaining care to patients
I think the biggest reason is because most of the times we're running around like crazy. We don't have the time to do it. We're just like bang, bang, bang. We do the things that we need to do. We forget to tell them why we're doing it. I mean yes and no. Yeah	39. Time constraints
The patient has the right for you to be confidential with their medical records	40. Patient rights
I don't think that it should be our responsibility to deal with things like that. But then again, people are people and people have families.	41. Families and patients

. If the patient has the right mindset as to the fact that they want to get home. They want to get better, then that helps too. But [I guess just] - I don't know. You just have to assess the situation, and know when to encourage and when it's inappropriate to encourage	42. Experience of the nurse 43. Persona of the patient
But I think that handing over, especially with little things like that makes a big difference, in advocacy obviously. Sometimes you forget to hand over things like that though. But yeah, I think it's just the way that you approach things, would be the best way to facilitate…	44. Communication is important
No, we're not the only ones. The doctors definitely play a big role in that. I think that sometimes the mentality of a patient is they do whatever the doctor tells them to do. When we tell them things, they tend not to listen. Whereas when the doctor tells them things, they're more than happy to do it.	45. Not the only ones
But definitely, there's a lot of people that can advocate that.	46. Not the only ones
Allied Health play a big part in advocacy for patients, because they are the ones that organise for a patient to get home. That's usually what we use them for	47. Not the only ones
Yes, I think that we are dismissed at times, because of the way that patients look at our role. Because only we know our role. We are aware of what we do and how we do it.	48. The nurses role misunderstood
So a lot of the time, patients come in and they see us as a person that just does things for them.	49. The nurses role misunderstood
But I think that when I talk to a lot of people, they are generally more grateful for the things that we do for them, because we're always around.	50. The nurses role misunderstood
I think that you can use that to encourage them to do things. Because you are looking after them all the time or you do see them a lot. That helps definitely in them - obviously you're building rapport with your patients. The more you see them, the more that they get accustomed to you and work with you, to do the things that they need to do	51. Time spent investing in rapport

When I used to go into the room, she used to be like oh, we have the best nurse in the room. It was because I had spent so much time with her and I - obviously we had a chat. I spoke to her. Half the time, I'd encourage her to go to the toilet without using her oxygen. But she wouldn't do it for anyone else, because she - I guess she grew a liking to me. But because - it must have been the way that I treated her. We got to know each other	52. The way you treat patients
I'm not afraid to share a little bit of my life with my patients, if it helps me build rapport or relate to someone on a personal level.	53. Relating on a personal level
. Most of the time, in this hospital and in every hospital, we're - there is such a big push for beds that you're constantly just trying to get people out the door	54. Push for beds
we still do spend a lot of time with our patients. So there's never a time where you can't be an advocate. Unless you're really busy or something - you had a code or something happened, where you couldn't physically be there to spend a little bit of time. To just say oh, why don't	55. Never a time where you can't be an advocate

Organising formulated meanings into clusters of themes

Formulated Meanings	Cluster of Themes
1. Patient responsibility	Patient responsibility for their health and care
2. Encouragement role	Role of the nurse
3. Talking to patients	Communication
4. All about the approach	Role of the nurse
5. Facilitating rapport	Role of the nurse
6. Patients rights	Patient's rights
7. Patients rights	Patient's rights
8. Workload pressures	Pressures of the job
9. Time barriers	Pressures of the job
10. Time barriers	Pressures of the job
11. Personality	Patient responsibility for their health and care
12. Acuity of patients	Pressures of the job
13. Miscommunication	Communication
14. Communicating with patients	Communication

15. Visual assessment	Role of the nurse
16. Persona of the patient	Patient responsibility for their health and care
17. Persona of the patient	Patient responsibility for their health and care
18. Made up their minds	Patient responsibility for their health and care
19. Encouragement of patients	Role of the nurse
20. That's the job	Pressures of the job
21. Doing rather than encouraging	Role of the nurse
22. Style of communication	Communication
23. Personality	Patient responsibility for their health and care
24. Personality	Patient responsibility for their health and care
25. Don't give an option	Competency and perceptions
26. Keep going	Competency and perceptions
27. Manipulation	Role of the nurse
28. Honest is the best policy	Communication
29. Duty of care	Role of the nurse
30. Treat me as you would like to be treated as long as you see me as competent	Competency and perceptions
31. It's all about perceptions of competency	Competency and perceptions
32. Experience of the nurse	Facilitation of care
33. Context of care	Facilitation of care
34. Rights of patient	Patient's rights
35. Telling the truth	Role of the nurse
36. Confidentiality and the family	Patient's rights
37. Explaining care to patients	Role of the nurse
38. Explaining care to patients	Role of the nurse
39. Time constraints	Pressures of the job
40. Patient rights	Patient's rights
41. Families and patients	Communication
42. Experience of the nurse	Facilitation of care
43. Persona of the patient	Patient responsibility for their health and care
44. Communication is important	Communication
45. Not the only ones	Role of the nurse
46. Not the only ones	Role of the nurse

47. Not the only ones	Role of the nurse
48. The nurses role misunderstood	Role of the nurse
49. The nurses role misunderstood	Role of the nurse
50. The nurses role misunderstood	Role of the nurse
51. Time spent investing in rapport	Role of the nurse
52. The way you treat patients	Role of the nurse
53. Relating on a personal level	Role of the nurse
54. Push for beds	Pressures of the job
55. Never a time where you can't be an advocate	Role of the nurse

Cluster of Themes Summarised

Patient responsibility for their health and care
Role of the nurse
Communication
Patient's rights
Pressures of the job

Competency and perceptions
Facilitation of care
Patient's rights
Facilitation of care

Illustrating the emergence of a theme from a theme of cluster and formulated meanings

Formulated Meanings	Theme Cluster	Emergent Theme
1. Patient responsibility 11. Personality 16.Persona of the patient 17.Persona of the patient 18.Made up their minds 23.Personality 24.Personality 43.Persona of the patient	Patient's influence care	Persona of the patient
2.Encouragement role 4.All about the approach 5.Facilitating rapport 15.Visual assessment 19.Encouragement of patients 27.Manipulation 29.Duty of care 35.Telling the truth 37.Explaining care to patients 38.Explaining care to patients 45.Not the only ones 46.Not the only ones 47.Not the only ones 48.The nurses role misunderstood 49.The nurses role misunderstood 50.The nurses role misunderstood 51.Time spent investing in rapport 52.The way you treat patients 53.Relating on a personal level 55.Never a time where you can't be an advocate	The all-encompassing role of the nurse	Influential aspects of the nursing role
3.Talking to patients 13.Miscommunication 14.Communicating with patients 22.Style of communication 28.Honesty is the best policy 41.Families and patients	Communication is important	The role of Communication

44.Communication is important		
6.Patients' rights 7.Patients' rights 34.Rights of patient 36.Confidentiality and the family 40.Patient rights	The rights of patients in care	Patient rights
8.Workload pressures 9.Time barriers 10.Time barriers 12.Acuity of patients 20.That's the job 21.Doing rather than encouraging 39.Time constraints 54.Push for beds	Working pressures	Pressures of the job
25.Don't give an option 26.Keep going 30.Treat me as you would like to be treated as long as you see me as competent 31.It's all about perceptions of competency	The way we treat patients	Issues of competency and perception
32.Experience of the nurse 33.Context of care 42.Experience of the nurse	Context and experience influence care	Context and experience

Emergent Themes Summary

- Persona of the patient
- Influential aspects of the nursing role
- The role of Communication
- Patient rights
- Pressures of the job
- Issues of competency and perception
- Context and experience

Nursing Transcript 4

I think it's just probably looking out for the patient. So, as a nurse, you know, when the doctor's, perhaps, just come in and reviewed them very quickly and then there may be points that they haven't sort of covered, so you sort of go back in there and assist the patient best you can and support them. (Transcript 4, pg. 2, 16-20)

So being next to the patient and helping them. (Transcript 4, pg. 2, 23)

I suppose, through experience, you can be able to do that, too. Sort of step up for the patient and say what you want done. (Transcript 4, pg. 2, 33-35)

Yeah, because you can see down the track what can happen and what bad results could happen if things aren't put in place. (Transcript 4, pg. 2, 38-40)

Even though you've got your criteria there for your MET call, sometimes that doesn't even mean anything because then you call them and they look at you as if to say, well, why did you call them? (Transcript 4, pg. 3, 45-48)

You just get stronger in being able to voice what you want to say, whereas if I was a graduate, there's no way I would fight the doctor and say, no, I want this done. (Transcript 4, pg. 2, 50-52)

Sort of everyone's got this mentality that the doctors are right, and the doctors have done the further training so they should know what they're doing and it's not always... (Transcript 4, pg. 3, 57-60)

Well, no one does. You sort of just take it on yourself and - well, I think what I do is I put myself in their shoes. How would I feel if someone came in and just told me all this jargon and no one sort of stuck up for me? So, I guess you just - well, no one gives you consent. You just go ahead and do it. (Transcript 4, pg. 3-4, 71-75)

Yeah, I think you just do because you've got that caring nature and although it's a holistic approach, you know, you're looking at their wellbeing and the whole package. (Transcript 4, pg. 4, 78-80)

Well, their diagnosis, their mental health, their physical health, the whole package (Transcript 4, pg. 4, 82-83)

Well, certain doctors' attitudes. Like, some are brilliant and happy to take on board what you have to say but some - yeah, some think, well, you're just the nurse and I'm the [DE] kind of thing so then you've sort of really got to push your way. (Transcript 4, pg. 4, 87-90)

I guess if the patient doesn't want to hear what you've got to say, either, that would be a barrier or if they're adamant that they're going to discharge themselves or things like that, then their attitude. If they've totally put a wall up to - then you can't get - you can't get past that. (Transcript 4, pg. 4, 91-95)

You know, you really don't want to go back to what you've - how sick you were when you first came in, which he was very sick. I still don't think he realises the danger he's putting himself in by drinking and going home and discharging himself today without education (Transcript 4, pg. 5, 103-107)

Think about how sick you were when you came in and do you really want to do that again? He sort of said, no, I'm never going to do that again, but looking at his history, he has done this before. So, you can only try so much. You can give them the warnings and the - you know, this is how you should do it, and that's why we do the Diabetic Educator referral and putting everything in place that, hopefully, he does take something on board. (Transcript 4, pg. 5, 110-117)

Yeah, I guess, for me, I get really frustrated when they come in so sick, fix them up - and with him in particular, I've had him the last few days - so we've done full-on nursing care with him, medicine-wise, electrolyte replacement, the whole bit. To find then he's just going to go back and, you know, be probably back in again - so it is, to me, it's really frustrating but you kind of have to put that aside and still plod on and hope that you maybe make a difference somehow by telling him, you know. (Transcript 4, pg. 5-6, 129-136)

There's certainly a lot of patients that we've had that give you the attitude and the language and so forth. Sometimes you get hardened to that and you think, well, you know what, you're going to go home so here's the form. You know what I mean? You get so tired of that sometimes. Like I said, with him not so much because he's not too bad but some just treat you so poorly that you think, well, you know what, do whatever. (Transcript 4, pg. 6, 139-145)

Yeah, you do find it difficult. Sometimes you give up because you think, I can't do this anymore. (Transcript 4, pg. 6, 150-151)

It's certainly a lot harder because you know they're going to do what - the opposite to what you're going to do. (Transcript 4, pg. 6, 152-154)

I guess if you're flat out busy. (Transcript 4, pg. 6, 157)

You know, you don't have the time to go back and - like you would want to go back. (Transcript 4, pg. 6, 159-160)

Yeah, well, yeah, because you're busy. Yeah, look, you still - I still try and get it in there even though you might be flat out. But, yeah, it does still impact because if you've got longer time - if you've got more time to spend with the patient, you can sit down and say, well, look, this is what you should be doing, or just having a chat with them sometimes is enough. When you are flat out and acuity is there, you're too busy putting up your electrolyte replacements and that's all the clinical side of it, without actually looking at the patient. (Transcript 4, pg. 7, 169-176)

So sometimes, you know, when you're perhaps putting up their electrolyte replacement or doing an hourly sugar or whatever, you try and fit in that little bit of a conversation there because that's your only opportunity that you can. So, while you're putting up the bag of fluid or whatever, you'll explain what you're doing. Well, you try to, even though you are so flat out. Sometimes you've got to stop and think, well, this is a patient in a bed (Transcript 4, pg. 7, 185-192)

When you're handing over, you know. The [by-pat] patient or the DKA patient and, yeah, sometimes you've just got to stop and think, well, they are a patient in that bed. (Transcript 4, pg. 8, 196-198)

It's not until sometimes, you know, they might sit and have a look on their face of fear or whatever it might be, and you think, oh, yeah, I'd better go back and explain myself. (Transcript 4, pg. 8, 200-202)

Sometimes, if maybe you've had your own experience or you know of somebody that's gone through that same thing, that helps. If you're an empathetic person, I think you just - you can put yourself in their shoes and think, well, how would I feel if that was me so - yeah. (Transcript 4, pg. 8, 214-217)

Only like just the more experience, again. You know the more patients that you've had. You might have had a previous patient with that same condition, and they felt a certain way, so you think, oh, well, maybe this person feels the same, yeah. (Transcript 4, pg. 8, 219-222)

Yeah. More so than doctors because they're only in and out a lot of the time…. our Social Worker is so involved with our patients... ...and our Physio. She's not just a physio. She gets in there (Transcript 4, pg. 9, 230-233)

So, I think we're as a team - you know, like a lot of the allied health and the nurses take on that role, all of us. (Transcript 4, pg. 9, 235-236)

Yeah, I think it's a huge part, just for the wellbeing and understanding. If you explain everything that's going on and tell them what they're going to go home with and so forth and what their condition is sometimes, then you'd hope that they'd be more compliant at home, too, so that they understand. Rather than just telling them all this jargon, if you explain things to them, then, hopefully, they'll take it on board and change their habits at home. (Transcript 4, pg. 9, 242-248)

Just language that the lay person out there that doesn’t know the terminology that we're so used to. (Transcript 4, Pg. 9, 251-252)

There’s a barrier for non-English-speaking people. (Transcript 4, pg. 10, 256-257)

No, communication's massive and even with family when they come in, you explain to them as well, so everyone then knows where they're standing (Transcript 4, pg. 10, 259-261)

Yeah, I think it's huge, especially when they're sort of getting up in their years and they're relying on daughters, sons, to perhaps add to their care at home. I think it's very important. (Transcript 4, pg. 10, 263-265)

Because sometimes they are so sick and they need to see their family or their family need to see them, even if it's just for 10 minutes, to come in and check that they're okay and then they can go home. (Transcript 4, pg. 10, 271-273)

You know, it's worse still if the patient's in the bed worrying about a family member at home so it's a huge part. (Transcript 4, pg. 10, 275-276)

So family is a massive part of - because then, ultimately, you're going to send them home so where are you sending them home to? (Transcript 4, Pg. 10, 280-282)

So, you're forever doing an assessment on them in different tasks. (Transcript 4, pg. 11, 288-289)

The bigger picture just - the jigsaw puzzle, I suppose, comes into place and you can see what... (Transcript 4, pg. 11, 291-292)

So, I suppose, again, experience with the different cultures. (Transcript 4, pg. 11, 299)

They'll come here and so many different nationalities and it's a big eye-opener because, as you say, their health care, the way they treat their health and the cultural differences is huge. Over the years then, I've got to know how they sort of each deal with different things so then you give them that respect for their different cultural attitudes. (Transcript 4, pg. 11, 303-307)

I guess you just want to be there to explain the parts that they perhaps haven't understood from the doctor so that they know exactly - so that you can see whether they've fully understood the condition or the diagnosis. (Transcript 4, pg. 12, 315-318)

If someone - which has happened in the past - they question, why did you do a Code Blue on someone who's in their 80s or whatever she was and doesn't want to be saved? Again legally, you don't have the documentation, so you have to (Transcript 4, pg. 12, 333-337)

I think I just put myself in their shoes and how would I feel or if it was my mother or my relative? Then that's how I would like to be treated and I'd like to know everything that's going on and be informed. (Transcript 4, pg. 13, 358-361)

Again, his personality allows you to just maybe try one more time whereas someone who's just got their hand in your face and, you know, I'm not going to have anything more, and getting verbally aggressive and you can see that this is going to escalate - [I just wouldn't even bother]. (Transcript 4, pg. 14, 382-386)

Yeah, we are, actually, when you say it like that. (manipulative) (Transcript 4, pg. 14, 390)

Yeah, we do and that comes with experience, once again, and confidence, you have the confidence to say, well, no, you're going to do it my way, and that's how it is. (Transcript 4, pg. 14, 399-401)

Well yeah, if they're feeling intimidated [laughs]. (Transcript 4, pg. 14, 404)

It depends on how, you know, you come across (Transcript 4, pg. 15, 406)

the doctors come in, come out so there has to be somebody - and because we're the ones that are with the patient for the eight hours and doing their showers with them, we're doing the whole sort of process through, if it's not us, then who would it be? (Transcript 4, pg. 15, 433-136)

I think we just sort of come along and pick up the pieces, yeah. (Transcript 4, pg. 16, 439-440)

Put the jigsaw puzzle together. (Transcript 4, pg. 16, 442)

Significant Statements	**Formulated Meanings**
I think it's just probably looking out for the patient. So, as a nurse, you know, when the doctor's, perhaps, just come in and reviewed them very quickly and then there may be points that they haven't sort of covered, so you sort of go back in there and assist the patient best you can and support them.	1. Looking out for the patient 2. Supporting the patient
So being next to the patient and helping them.	3. Helping the patient
I suppose, through experience, you can be able to do that, too. Sort of step up for the patient and say what you want done.	4. Stepping up for the patient 5. Experience plays a role
Yeah, because you can see down the track what can happen and what bad results could happen if things aren't put in place	6. Insight and experience help to predict what may happen
Even though you've got your criteria there for your MET call, sometimes that doesn't even mean anything because	7. Decision-making questioned

then you call them and they look at you as if to say, well, why did you call them?	
You just get stronger in being able to voice what you want to say, whereas if I was a graduate, there's no way I would fight the doctor and say, no, I want this done.	8. Feeling confident in your decisions
Sort of everyone's got this mentality that the doctors are right and the doctors have done the further training so they should know what they're doing and it's not always...	9. Dr's know best
Well, no one does. You sort of just take it on yourself and - well, I think what I do is I put myself in their shoes. How would I feel if someone came in and just told me all this jargon and no one sort of stuck up for me? So I guess you just - well, no one gives you consent. You just go ahead and do it.	10. Putting yourself in their shoes and being empathetic
Yeah, I think you just do because you've got that caring nature and although it's a holistic approach, you know, you're looking at their wellbeing and the whole package.	11. Caring nature of nurses
Well, their diagnosis, their mental health, their physical health, the whole package	12. Holistic care
Well, certain doctors' attitudes. Like, some are brilliant and happy to take on board what you have to say but some - yeah, some think, well, you're just the nurse and I'm the [DE] kind of thing so then you've sort of really got to push your way.	13. Standing up to the Dr's
I guess if the patient doesn't want to hear what you've got to say, either, that would be a barrier or if they're adamant that they're going to discharge themselves or things like that, then their attitude. If they've totally put a wall up to - then you can't get - you can't get past that.	14. Patient's can be obstructive
You know, you really don't want to go back to what you've - how sick you were when you first came in, which he was very sick. I still don't think he realises the danger he's putting himself in by drinking and going home and	15. Patients don't always know best

discharging himself today without education	
Think about how sick you were when you came in and do you really want to do that again? He sort of said, no, I'm never going to do that again, but looking at his history, he has done this before. So you can only try so much. You can give them the warnings and the - you know, this is how you should do it, and that's why we do the Diabetic Educator referral and putting everything in place that, hopefully, he does take something on board	16. History repeats itself 17. You can only try so much
Yeah, I guess, for me, I get really frustrated when they come in so sick, fix them up - and with him in particular, I've had him the last few days - so we've done full-on nursing care with him, medicine-wise, electrolyte replacement, the whole bit. To find then he's just going to go back and, you know, be probably back in again - so it is, to me, it's really frustrating but you kind of have to put that aside and still plod on and hope that you maybe make a difference somehow by telling him, you know.	18. Patient's can be frustrating
There's certainly a lot of patients that we've had that give you the attitude and the language and so forth. Sometimes you get hardened to that and you think, well, you know what, you're going to go home so here's the form. You know what I mean? You get so tired of that sometimes. Like I said, with him not so much because he's not too bad but some just treat you so poorly that you think, well, you know what, do whatever.	19. You can only do so much
Yeah, you do find it difficult. Sometimes you give up because you think, I can't do this anymore.	20. Giving up
It's certainly a lot harder because you know they're going to do what - the opposite to what you're going to do.	21. Opposites attract
I guess if you're flat out busy	22. Time constraints
You know, you don't have the time to go back and - like you would want to go back	23. You don't always have the time

Yeah, well, yeah, because you're busy. Yeah, look, you still - I still try and get it in there even though you might be flat out. But, yeah, it does still impact because if you've got longer time - if you've got more time to spend with the patient, you can sit down and say, well, look, this is what you should be doing, or just having a chat with them sometimes is enough. When you are flat out and acuity is there, you're too busy putting up your electrolyte replacements and that's all the clinical side of it, without actually looking at the patient.	24. Time and higher acuity influences patient care
So sometimes, you know, when you're perhaps putting up their electrolyte replacement or doing an hourly sugar or whatever, you try and fit in that little bit of a conversation there because that's your only opportunity that you can. So while you're putting up the bag of fluid or whatever, you'll explain what you're doing. Well, you try to, even though you are so flat out. Sometimes you've got to stop and think, well, this is a patient in a bed	25. Making time 26. Remembering they are a person
When you're handing over, you know. The [by-pat] patient or the DKA patient and, yeah, sometimes you've just got to stop and think, well, they are a patient in that bed.	27. A person not a condition
It's not until sometimes, you know, they might sit and have a look on their face of fear or whatever it might be and you think, oh, yeah, I'd better go back and explain myself	28. Trying to explain
Sometimes, if maybe you've had your own experience or you know of somebody that's gone through that same thing, that helps. If you're an empathetic person, I think you just - you can put yourself in their shoes and think, well, how would I feel if that was me so - yeah	29. Personal experience can help you empathise with patients
Only like just the more experience, again. You know the more patients that you've had. You might have had a previous patient with that same condition and they felt a certain way so	30. Experience can influence care

you think, oh, well, maybe this person feels the same, yeah.	
Yeah. More so than doctors because they're only in and out a lot of the time….our Social Worker is so involved with our patients... ...and our Physio. She's not just a physio. She gets in there	31. everybody can support patients
So I think we're as a team - you know, like a lot of the allied health and the nurses take on that role, all of us.	32. Teamwork facilitates patient care
Yeah, I think it's a huge part, just for the wellbeing and understanding. If you explain everything that's going on and tell them what they're going to go home with and so forth and what their condition is sometimes, then you'd hope that they'd be more compliant at home, too, so that they understand. Rather than just telling them all this jargon, if you explain things to them, then, hopefully, they'll take it on board and change their habits at home.	33. Communication and explanation facilitates compliance
Just language that the lay person out there that doesn't know the terminology that we're so used to.	34. Jargon is second nature
There's a barrier for non-English-speaking people.	35. NESB is a barrier
No, communication's massive and even with family when they come in, you explain to them as well so everyone then knows where they're standing	36. Communication has to involve the family
Yeah, I think it's huge, especially when they're sort of getting up in their years and they're relying on daughters, sons, to perhaps add to their care at home. I think it's very important	37. Family matters
Because sometimes they are so sick and they need to see their family or their family need to see them, even if it's just for 10 minutes, to come in and check that they're okay and then they can go home.	38. The importance of family as support
You know, it's worse still if the patient's in the bed worrying about a family member at home so it's a huge part	39. Patients benefit form family involvement
So family is a massive part of - because then, ultimately, you're going to send them home so where are you sending them home to?	40. Knowing what you are sending them home to is important

So you're forever doing an assessment on them in different tasks.	41. Continual assessment
The bigger picture just - the jigsaw puzzle, I suppose, comes into place and you can see what...	42. The jigsaw of health
So I suppose, again, experience with the different cultures.	43. Cultural experience helps
They'll come here and so many different nationalities and it's a big eye-opener because, as you say, their health care, the way they treat their health and the cultural differences is huge. Over the years then, I've got to know how they sort of each deal with different things so then you give them that respect for their different cultural attitudes.	44. Culture influences care
I guess you just want to be there to explain the parts that they perhaps haven't understood from the doctor so that they know exactly - so that you can see whether they've fully understood the condition or the diagnosis	45. Communication extends care
If someone - which has happened in the past - they question, why did you do a Code Blue on someone who's in their 80s or whatever she was and doesn’t want to be saved? Again legally, you don't have the documentation so you have to	46. Legalities of healthcare
I think I just put myself in their shoes and how would I feel or if it was my mother or my relative? Then that's how I would like to be treated and I'd like to know everything that's going on and be informed	47. Putting yourself in their shoes
Again, his personality allows you to just maybe try one more time whereas someone who's just got their hand in your face and, you know, I'm not going to have anything more, and getting verbally aggressive and you can see that this is going to escalate - [I just wouldn’t even bother].	48. Patient personality influences care
Yeah, we are, actually, when you say it like that. (manipulative)	49. Manipulation of patients
Yeah, we do and that comes with experience, once again, and confidence, you have the confidence to say, well, no, you're going to do it my way, and that's how it is	50. Confidence and experience as a nurse

Well yeah, if they're feeling intimidated [laughs].	51. Patient’s feelings
It depends on how, you know, you come across	52. Interpretation of actions
the doctors come in, come out so there has to be somebody - and because we're the ones that are with the patient for the eight hours and doing their showers with them, we're doing the whole sort of process through, if it's not us, then who would it be?	53. Nurses are always constant and assisting with care 54. If it’s not nurses who else would it be?
I think we just sort of come along and pick up the pieces, yeah I think we just sort of come along and pick up the pieces, yeah	55. Picking up the pieces
Put the jigsaw puzzle together.	56. Fitting pieces together

Organising formulated meanings into clusters of themes

Formulated Meanings	Cluster of Themes
1. Looking out for the patient	Supporting Patients
2. Supporting the patient	Supporting Patients
3. Helping the patient	Supporting Patients
4. Stepping up for the patient	Supporting Patients
5. Experience plays a role	Experience of the nurse
6. Insight and experience help to predict what may happen	Experience of the nurse
7. Decision-making questioned	Experience of the nurse
8. Feeling confident in your decisions	Experience of the nurse
9. Dr's know best	Are the Dr's always right?
10. Putting yourself in their shoes and being empathetic	Empathy and caring
11. Caring nature of nurses	Empathy and caring
12. Holistic care	Empathy and caring
13. Standing up to the Dr's	Power and knowledge mismatch
14. Patient's can be obstructive	Patients influence the ability for care
15. Patients don't always know best	Patients influence the ability for care
16. History repeats itself	Patients influence the ability for care
17. You can only try so much	Patients influence the ability for care
18. Patient's can be frustrating	Patients influence the ability for care
19. You can only do so much	Patients influence the ability for care
20. Giving up	Patients influence the ability for care
21. Opposites attract	Patients influence the ability for care
22. Time constraints	Just too busy
23. You don't always have the time	Just too busy
24. Time and higher acuity influences patient care	Just too busy
25. Making time	Just too busy
26. Remembering they are a person	The person not the condition
27. A person not a condition	The person not the condition
28. Trying to explain	Supporting the patient
29. Personal experience can help you empathise with patients	Empathy and caring
30. Experience can influence care	Experience of the nurse
31. everybody can support patients	Supporting patients is about teamwork
32. Teamwork facilitates patient care	Supporting patients is about teamwork
33. Communication and explanation facilitates compliance	Communication is important
34. Jargon is second nature	Choosing the language
35. NESB is a barrier	Barriers to care
36. Communication has to involve the family	Communication is important
37. Family matters	Family has to be involved
38. The importance of family as support	Family has to be involved
39. Patients benefit form family involvement	Family has to be involved

40. Knowing what you are sending them home to is important	Putting the pieces together
41. Continual assessment	Putting the pieces together
42. The jigsaw of health	Putting the pieces together
43. Cultural experience helps	Cultural diversity
44. Culture influences care	Cultural diversity
45. Communication extends care	Communication is important
46. Legalities of healthcare	Legal aspects of care
47. Putting yourself in their shoes	Empathy and caring
48. Patient personality influences care	Patients influence the ability for care
49. Manipulation of patients	Manipulation of patients
50. Confidence and experience as a nurse	Experience of the nurse
51. Patient's feelings	Patients influence the ability for care
52. Interpretation of actions	First impressions
53. Nurses are always constant and assisting with care	Nurses are always there
54. If it's not nurses who else would it be?	Nurses are always there
55. Picking up the pieces	Putting the pieces together
56. Fitting pieces together	Putting the pieces together

Cluster of Themes Summarised

- Supporting Patients
- Experience of the nurse
- Are the Dr's, always right?
- Empathy and caring
- Power and knowledge mismatch
- Patients influence the ability for care
- Just too busy
- The person not the condition
- Supporting patients is about teamwork
- Communication is important
- Choosing the language
- Barriers to care
- Family has to be involved
- Putting the pieces together
- Cultural diversity
- Legal aspects of care
- Patients influence the ability for care
- Manipulation of patients
- First impressions
- Nurses are always there

Illustrating the emergence of a theme from a theme of cluster and formulated meanings

Formulated Meanings	Theme Cluster	Emergent Theme
1. Looking out for the patient 2. Supporting the patient 3. Helping the patient 4. Stepping up for the patient 28. Trying to explain	Supporting and helping the patient	Supporting the patient
5. Experience plays a role 6. Insight and experience help to predict what may happen 7. Decision-making questioned 8. Feeling confident in your decisions 30. Experience can influence care 50. Confidence and experience as a nurse	Experience and confidence of the nurse	Experience and confidence of the nurse
10. Putting yourself in their shoes and being empathetic 11. Caring nature of nurses 12. Holistic care 29. Personal experience can help you empathise with patients 47. Putting yourself in their shoes	The capacity for empathy and care	Empathy and caring for holistic care
13. Standing up to the Dr's 14. Patient's can be obstructive 15. Patients don't always know best 16. History repeats itself 17. You can only try so much 18. Patient's can be frustrating 19. You can only do so much 20. Giving up 21. Opposites attract 48. Patient personality influences care 49. Manipulation of patients 51. Patient's feelings	You can't take the patient out of the equation	The baggage of patients

52. Interpretation of actions		
22. Time constraints 23. You don't always have the time 24. Time and higher acuity influences patient care 25. Making time	Time constraints and the acuity of patients in healthcare	Finding the time
26. Remembering they are a person 27. A person not a condition	The person beyond the condition	The person behind the illness
31. everybody can support patients 32. Teamwork facilitates patient care	Teamwork	It's not just about the nurse
33. Communication and explanation facilitates compliance 36. Communication has to involve the family 45. Communication extends care	Communication in providing care	Communication is essential
34. Jargon is second nature	Terminology of healthcare	Jargon
35. NESB is a barrier	Language barriers	NESB
37. Family matters 38. The importance of family as support 39. Patients benefit form family involvement	The importance of family	Family in healthcare
40. Knowing what you are sending them home to is important 41. Continual assessment 42. The jigsaw of health 55. Picking up the pieces 56. Fitting pieces together	The complexities of the puzzle of health and illness	The puzzle makers
43. Cultural experience helps 44. Culture influences care	Cultural influences	You have to be careful with their culture
46. Legalities of healthcare	Legal aspects of health	Legal aspects of health
53. Nurses are always constant and assisting with care 54. If it's not nurses who else would it be?	Constant presence of nurses	The ever presence of nurses

Emergent Themes Summary

- Supporting the patient
- Experience and confidence of the nurse

- Empathy and caring for holistic care
- The baggage of patients
- Finding the time
- The person behind the illness
- It’s not just about the nurse
- Communication is essential
- Jargon
- NESB
- Family in healthcare
- The puzzle makers
- You have to be careful with their culture
- Legal aspects of health
- The ever presence of nurses

Significant Statements Nurse 5

advocacy is a big thing…..kind of a patient advocate in relating to their health…..the end of the day they have the rights and - to decide for their health care……you have to inform them that these are the plans and this is the doctor's plan and this is plan……at the end of the day you have to decide what would you like for your health care from us and from the doctors. (Transcript 5, Page 2, lines 16-22)

Sometimes their health, it's compromised because they're not too well. Then we will get someone, like ring the family or if they don't have family, we get social worker or some people from level of the government to decide for themselves. (Transcript 5, Page 2, lines 25-28)

They have the right to choose about their health care because there are rights. (Transcript 5, Page 2, Lines 30-31)

I rang the doctor and want them to explain more about what the decision of the patient is, because he is well enough to decide anyway. He's not confused or anything. (Transcript 5, Page 3, Lines 45-48)

But where it's just up to me though, just like ringing them and say, look, he's not decided and we know that you have explained the risk and stuff like that, but they still are not sure (Transcript 5, Page 3, Lines 58-60)

So that's all we can do, we can just give them the options and give a complete information so they can decide which is which. (Transcript 5, page 3, lines 62-64)

We are the first line. We are the first line of what - we speak for them. We are 24 hours with - we spend more of our time with them than the doctors for like 24 hours with them so, we - yeah, we are the first line of advocacy, (Transcript 5, page 3, 67-70)

You know in our nursing ethics, it doesn't say that we are advocate, but we feel - that's what I feel, I feel that we are the advocate. We speak for themselves. (Transcript 5, page 4, lines 77-79)

I think I can advocate for things like that, for their comfort. (Transcript 5, page 4, 82)

In that way I am advocating for the patient, things like that. The decisions then - and then you talk to the patient, these are the options I will get the doctor to review, maybe he might increase your medications and what do you think and say, yeah, that will be good. (Transcript 5, page 4, 86-89)

Yeah, their care, because I am the one that is first online and the one that's watching them, giving them shower and stuff like that and you always have ask what is more comfortable for you. You don't have to say this is better, I want you to do this, because this for me, I think is more comfortable because we're all different (Transcript 5, page 4, 93-97)

So, what do you think is more comfortable for you, you have a choice, but this is what we can do?

(Transcript 5, page 4, 98-99)

Yes, I guess - for me if it's explained well, they wouldn't be thinking of going somewhere else or whatever, if it's explained well, unless they're not happy with the - like public hospital or whatever (Transcript 5, page 4, line 103-105)

You can have your shower when you're ready for a shower, but I would prefer you to have a shower at this time, like between 9 and 10. (Transcript 5, pg. 5, 110-111)

I always tell them what I am up to and then what is expected of me and for them, you know. (Transcript 5, pg. 5, 114-115)

Yeah, for me, once you have informed them, you get the trust and yeah, there will be a very good patient relationship, yeah. (Transcript 5, page 5, 120-121)

Sometimes people are different, like different views and just have to respect that because you are all different, like diverse, you know, like this is good for me, but may not be good for you. (Transcript 5, page 5, 126-128)

First thing is the language barrier, which we can organise with interpreter; their culture, you have to be very, very careful with their culture (Transcript 5, pg. 5, 131-133)

So that is the culture; diversity and yeah, with a woman especially, (Transcript 5, pg. 5, 137-138)

Sometimes also men if they like, I want to go home, you know, but they are - because I am the head of the family I have to be home, but sir, you're sick, what about these options, you know (Transcript 5, pg. 6, 139-141)

Because sometimes they really don't know the degree of their illness and we still have duty of care to tell them that this is what's happening and this is what's going to happen if you don't stay for another 24 hours (Transcript 5, pg. 6, 142-145)

Sometimes others have some attitudes, just personality. Personalities that is another thing that's very big. (Transcript 5, pg., 6, 153-154)

Yeah, especially when I was new, I'm still kind of learning the Australian culture. It is so different. But now I'm an Aussie now and I get - I can talk to them, you know, with any conversation, I can still, you know. (Transcript 5, pg. 6, 160-163)

With the advocacy, we're always kind of a bit pushy. Like this would be - this will benefit you, you know, if you have this operation, this will benefit you (Transcript 5, pg. 7, 170-172)

So many factors, like I will just go with medication because we don't have much money and stuff like that. (Transcript 5, pg., 7, 172-174)

I can speak for my four patients right now to you because I know what's going on (Transcript 5, pg. 7, 183-184)

It's for the benefits of the patients really and then you can liaise with other services in the hospital and it makes easier for everyone, you know. If you are advocating for this patient, you know, you speak for - and you know exactly what their problem - I mean, you know what their concerns are, they'll tell you. (Transcript 5, pg. 8, 205-209)

So, you are really the first line of help actually and for that I am very, you know, I feel fulfilled and I feel that I'm an advocate (Transcript 5, pg. 8, 210-211)

Yes, hundred percent. Because I guess I - what you're doing, and you know what you're talking about and you feel for them. I always put myself into theirs, just like if I am the person. This is what I want to do. (Transcript 5, pg. 8, 223-226)

Because when I become a patient, I want to be treated the way I treat my patients. (Transcript 5, pg. 8, 227-228)

Number one for me (communication). (Transcript 5, pg. 9, 249)

They don't know what do you do, you just have to keep an eye on them and do whatever you can make them comfortable or they need some - something to calm them down (Transcript 5, pg. 9-10, 258-260)

I think probably the social worker, yeah, the physios, yeah there are - allied help, I think they are really great as well. (Transcript 5, pg. 10, 271-272)

We work as a team…. but as I said, we're the first line……as soon as the patient comes, we can see that (Transcript 5, pg. 10, 274-276)

So, it's like it's having my time to sit down for - it's not more informal rather than like say, so do you live with your husband. (Transcript 5, pg. 10, 280-282)

I collect data straight away when they come (Transcript 5, pg. 10, 283)

Then it's like there's a rapport happening because you're - and it's not like obvious at all, I think. (Transcript 5, pg. 10, 287-288)

when I learn about your lingo, I become a bit more talkative and I get out of my shell and I can, you know, yeah so I... (Transcript 5, pg. 11, 300-301)

I reckon it supports, yeah, it supports - not against, I would go for - it's support. I think it support their needs really. (Transcript 5, pg. 11, 305-306)

Yeah, I don't think it will - I don't feel - I don't know it will disempower them if you explain them well…. but you always give them the options. You have to be clear with the options that you give them, so I don't know; I don't think it disempowers them. (Transcript 5, pg. 11, 310-313)

Some people are like, they have a closed mind and like no – (Transcript 5, pg. 11, 315-316)

if you are informed, I don't think there will be a big problem, because you know what is happening. This is the worst thing that when people come and said, nobody has told us, now we're in the dark and nobody has told us what's happening, you know. (Transcript 5, pg. 12, 323-327)

I don't know, that's the communication for me anyway. If that communication doesn't work there is some issues with like their family or social or maybe even psych problem, but if you cannot reason out with them, I think - and people know if the nurses will pick that out, you cannot reason well with them, and then during time, I'm not the only one that felt that, everyone felt the same. (Transcript 5, pg. 12, 332-337)

Yeah, yeah. I do agree with that, because you will - let's say you are handing over, you handed over and tell them that a patient is difficult. I don't know, when I get there, it's a different story. (Transcript 5, pg. 12, 343-345)

It is fair to say just watch, she's had a bit of this attitude, and then see how you go, but don't label them as difficult and aggressive and stuff like that. Let yourself find out by how you deal with them, because it's different. (Transcript 5, pg. 13, 352-355)

That time maybe the patient is really in pain and you did not address that well as when I came maybe there's no pain anymore and so he's different…. It is hard to judge people really. (Transcript 5, pg. 13, 358-362)

Yes, I always - it will always fall on my - because we're the first line of care, people that care for them. (Transcript 5, pg. 13, 367-368)

Significant Statements	Formulated Meanings
advocacy is a big thing…..kind of a patient advocate in relating to their health…..the end of the day they have the rights and - to decide for their health care……you have to inform them that these are the plans and this is the doctor's plan and this is plan……at the end of the day you have to decide what would you like for your health care from us and from the doctors.	1. The rights of patients within healthcare to make their own decisions 2. Informing patients about their rights and choices in healthcare
Sometimes their health, it's compromised because they're not too well. Then we will get someone, like ring the family or if they don't have family we get social worker or some people from level of the government to decide for themselves.	3. Illness and poor health may influence the need for an advocate or significant assistance in healthcare
They have the right to choose about their health care because there are rights.	4. The rights of patients within healthcare to make their own decisions
I rang the doctor and want them to explain more about what the decision of the patient is, because he is well enough to decide anyway. He's not confused or anything.	5. Issues around competency and capacity influence the nurses decisions and actions
But where it's just up to me though, just like ringing them and say, look, he's not decided and we know that you have explained the risk and stuff like that, but they still are not sure	6. Nurses upholding the rights of the patient to be able to make autonomous decision
So that's all we can do, we can just give them the options and give a complete information so they can decide which is which	7. The role of the nurse as an advocate is heavily influenced by communication and informing patients
We are the first line. We are the first line of what - we speak for them. We are 24 hours with - we spend more of our time with them than the doctors for like 24 hours with them so, we - yeah, we are the first line of advocacy	8. The nurses are ideally placed to advocate as they spend more time with the patient 9. Speaking on behalf of the patient
You know in our nursing ethics, it doesn't say that we are advocate, but we feel - that's what I feel, I feel that we are the advocate. We speak for themself	10. Speaking for/on behalf of the patient
In that way I am advocating for the patient, things like that. The decisions then - and then you talk to the patient, these are the options I will get the doctor to review, maybe he might increase your medications and what do you think and say, yeah, that will be good	11. Giving the patients options in relation to choices in healthcare decisions

Yeah, their care, because I am the one that is first on line and the one that's watching them, giving them shower and stuff like that and you always have ask what is more comfortable for you. You don't have to say this is better, I want you to do this, because this for me, I think is more comfortable because we're all different	12. Highlighting the choice that patients have available to them in the healthcare setting 13. Highlights that the nurses are part of the first line of care for patients
So what do you think is more comfortable for you, you have a choice, but this is what we can do.	
Yes, I guess - for me if it's explained well, they wouldn't be thinking of going somewhere else or whatever, if it's explained well, unless they're not happy with the - like public hospital or whatever	14. Informing patients and communicating patients about their choices and treatment
You can have your shower when you're ready for a shower, but I would prefer you to have a shower at this time, like between 9 and 10	15. Giving patients choices which are already limited in their nature – therefore a façade of choice
I always tell them what I am up to and then what is expected of me and for them, you know.	16. Setting out the boundaries of the nurse patient relationship
Yeah, for me, once you have informed them, you get the trust and yeah, there will be a very good patient relationship, yeah.	17. Nurse patient relationships are built on trust and rapport
sometimes people are different, like different views and just have to respect that because you are all different, like diverse, you know, like this is good for me, but may not be good for you	18. Diversity in healthcare influences the choices people make
first thing is the language barrier, which we can organise with interpreter; their culture, you have to be very, very careful with their culture	19. Culture and language differences are important to recognise and understand in healthcare
Sometimes also men if they like, I want to go home, you know, but they are - because I am the head of the family I have to be home, but sir, you're sick, what about these options, you know	20. The role of gender is also underestimated in terms of healthcare options and outcomes
Because sometimes they really don't know the degree of their illness and we still have duty of care to tell them that this is what's happening and this is what's going to happen if you don't stay for another 24 hours	21. Trying to educate and communicate with patients about their illness and possible outcomes

Sometimes others have some attitudes, just personality. Personalities that is another thing that's very big.	22. Personality influences the patient nurse relationship
Yeah, especially when I was new, I'm still kind of learning the Australian culture. It is so different. But now I'm an Aussie now and I get - I can talk to them, you know, with any conversation, I can still, you know.	23. The culture of the nurse can also influence their role in the healthcare setting
With the advocacy, we're always kind of a bit pushy. Like this would be - this will benefit you, you know, if you have this operation, this will benefit you	24. Talking about different cultural contexts of advocacy
So many factors, like I will just go with medication because we don't have much money and stuff like that.	25. Limitations of the patient to engage with healthcare options due to socio-economic factors
I can speak for my four patients right now to you because I know what's going on	26. Importance of understanding your patients so as to give them voice/ speak on their behalf
It's for the benefits of the patients really and then you can liaise with other services in the hospital and it makes easier for everyone, you know. If you are advocating for this patient, you know, you speak for - and you know exactly what their problem - I mean, you know what their concerns are, they'll tell you	27. Speaking for the patient and on behalf of the patient
So you are really the first line of help actually and for that I am very, you know, I feel fulfilled and I feel that I'm an advocate	28. Being an advocate is fulfilling
Yes, hundred percent. Because I guess I - what you're doing and you know what you're talking about and you feel for them. I always put myself into theirs, just like if I am the person. This is what I want to do.	29. Having empathy for the patient facilitates advocacy
because when I become a patient, I want to be treated the way I treat my patients	30. Reciprocity if the nurse becomes a patient
Number one for me (communication).	31. Communication is essential for advocacy
they don't know what do you do, you just have to keep an eye on them and do whatever you can make them comfortable or they need some - something to calm them down	32. Insider knowledge is a disadvantage for the patient
I think probably the social worker, yeah the physios, yeah there are - allied help, I think they are really great as well.	33. Teamwork and the team environment facilitates patient care
we work as a team…..but as I said, we're the first line……as soon as the patient comes we can see that	34. Although we work as a team the nurse is the first to assist with patients

so it’s like it’s having my time to sit down for - it’s not more informal rather than like say, so do you live with your husband.	35. Much of the information elicited from patients occurs within an informal context
I collect data straight away when they come	36. Data is asking the patient about their personal situation
Then it’s like there’s a rapport happening because you’re - and it’s not like obvious at all, I think.	37. Rapport is important in the nurse patient relationship
when I learn about your lingo, I become a bit more talkative and I get out of my shell and I can, you know, yeah so I...	38. Language barriers influence the ability of the nurse to advocate successfully
I reckon it supports, yeah, it supports - not against, I would go for - it’s support. I think it support their needs really	39. Advocacy has a supportive function within patient healthcare
Yeah, I don’t think it will - I don’t feel - I don’t know it will disempower them if you explain them well….but you always give them the options. You have to be clear with the options that you give them so I don’t know, I don’t think it disempowers them	40. Disempowering of patients only occurs if patients aren’t given information or options to have a choice. 41. The role of the advocate is to stop the disempowering of patients
some people are like, they have a closed mind and like no	42. Personal characteristics influence nursing care and the ability to advocate
if you are informed I don’t think there will be a big problem, because you know what is happening. This is the worst thing that when people come and said, nobody has told us, now we’re in the dark and nobody has told us what's happening, you know.	43. Informing patients and families about outcomes and treatments is essential to nursing practice
I don’t know, that's the communication for me anyway. If that communication doesn't work there is some issues with like their family or social or maybe even psych problem, but if you cannot reason out with them, I think - and people know if the nurses will pick that out, you cannot reason well with them, and then during time, I'm not the only one that felt that, everyone felt the same.	44. Communication is essential
Yeah, yeah. I do agree with that, because you will - let’s say you are handing over, you handed over and tell them that a	45. Handover can be influential in the development of the labelling of

patient is difficult. I don't know, when I get there, it's a different story.	patients and therefore the need for advocacy
It is fair to say just watch, she's had a bit of this attitude, and then see how you go, but don't label them as difficult and aggressive and stuff like that. Let yourself find out by how you deal with them, because it's different.	46. Important not to label patients
That time maybe the patient is really in pain and you did not address that well as when I came maybe there's no pain anymore and so he's different….It is hard to judge people really	47. There are other factors that influence patient's behaviours
Yes, I always - it will always fall on my - because we're the first line of care, people that care for them.	48. It is ultimately the nurses responsibility as we are the first line of care

Organising formulated meanings into clusters of themes

Formulated Meanings	Cluster of Themes
1. The rights of patients within healthcare to make their own decisions	Patients have rights
2. Informing patients about their rights and choices in healthcare	Communication and information exchange is essential
3. Illness and poor health may influence the need for an advocate or significant assistance in healthcare	Are they able/or should they be allowed to make a decision?
4. The rights of patients within healthcare to make their own decisions	Patients have rights
5. Issues around competency and capacity influence the nurses decisions and actions	Are they able/or should they be allowed to make a decision?
6. Nurses upholding the rights of the patient to be able to make autonomous decision	Patients have rights
7. The role of the nurse as an advocate is heavily influenced by communication and informing patients	Communication and information exchange is essential
8. The nurses are ideally placed to advocate as they spend more time with the patient	Professional Idealisation of advocacy and the role of the nurse
9. Speaking on behalf of the patient	Speaking for/ on behalf of the patient
10. Speaking for/on behalf of the patient	Speaking for/ on behalf of the patient
11. Giving the patients options in relation to choices in healthcare decisions	Patients have rights
12. Highlighting the choice that patients have available to them in the healthcare setting	Patients have rights
13. Highlights that the nurses are part of the first line of care for patients	Professional Idealisation of advocacy and the role of the nurse

14. Informing patients and communicating patients about their choices and treatment	Patients have rights
15. Giving patients choices which are already limited in their nature – therefore a façade of choice	The nurse/ patient relationship façade
16. Setting out the boundaries of the nurse patient relationship	The nurse/ patient relationship façade
17. Nurse patient relationships are built on trust and rapport	The nurse/ patient relationship façade
18. Diversity in healthcare influences the choices people make	Cultural diversity
19. Culture and language differences are important to recognise and understand in healthcare	Cultural diversity
20. The role of gender is also underestimated in terms of healthcare options and outcomes	Patient factors that influence advocacy
21. Trying to educate and communicate with patients about their illness and possible outcomes	Communication and information exchange is essential
22. Personality influences the patient nurse relationship	The nurse/ patient relationship façade
23. The culture of the nurse can also influence their role in the healthcare setting	Cultural diversity
24. Talking about different cultural contexts of advocacy	Cultural diversity
25. Limitations of the patient to engage with healthcare options due to socio-economic factors	Patient factors that influence advocacy
26. Importance of understanding your patients so as to give them voice/ speak on their behalf	Speaking for/ on behalf of the patient
27. Speaking for the patient and on behalf of the patient	Speaking for/ on behalf of the patient
28. Being an advocate is fulfilling	Professional Idealisation of advocacy and the role of the nurse
29. Having empathy for the patient facilitates advocacy	The nurse/ patient relationship façade
30. Reciprocity if the nurse becomes a patient	
31. Communication is essential for advocacy	Communication and information exchange is essential
32. Insider knowledge is a disadvantage for the patient	The nurse/ patient relationship façade
33. Teamwork and the team environment facilitates patient care	It's not just about nurses/or nurses are not the only ones
34. Although we work as a team the nurse is the first to assist with patients	It's not just about nurses/or nurses are not the only ones
35. Much of the information elicited from patients occurs within an informal context	Communication and information exchange is essential
36. Data is asking the patient about their personal situation	Communication and information exchange is essential

37. Rapport is important in the nurse patient relationship	The nurse/ patient relationship façade
38. Language barriers influence the ability of the nurse to advocate successfully	Cultural diversity
39. Advocacy has a supportive function within patient healthcare	The nurse/ patient relationship façade
40. Disempowering of patients only occurs if patients aren't given information or options to have a choice.	Communication and information exchange is essential
41. The role of the advocate is to stop the disempowering of patients	The nurse/ patient relationship façade
42. Personal characteristics influence nursing care and the ability to advocate	Cultural diversity
43. Informing patients and families about outcomes and treatments is essential to nursing practice	Communication and information exchange is essential
44. Communication is essential	Communication and information exchange is essential
45. Handover can be influential in the development of the labelling of patients and therefore the need for advocacy	Communication and information exchange is essential
46. Important not to label patients	The nurse/ patient relationship façade
47. There are other factors that influence patient's behaviours	Cultural diversity
48. It is ultimately the nurses responsibility as we are the first line of care	Professional Idealisation of advocacy and the role of the nurse

Cluster of Themes Summarised
Speaking for/ on behalf of the patient
Patients have rights
Communication and information exchange is essential
The nurse/ patient relationship façade
Professional Idealisation of advocacy and the role of the nurse
Are they able/or should they be allowed to make a decision?
It's not just about nurses/or nurses are not the only ones
Cultural diversity
Patient factors that influence advocacy

Illustrating the emergence of a theme from a theme cluster and formulated meanings

Formulated Meanings	Theme Cluster	Emergent Theme
(1)The rights of patients within healthcare to make their own decisions (4) The rights of patients within healthcare to make their own decisions (6)Nurses upholding the rights of the patient to be able to make autonomous decision (11)Giving the patients options in relation to choices in healthcare decisions (12)Highlighting the choice that patients have available to them in the healthcare setting (14) Informing patients and communicating patients about their choices and treatment	The right of the patient to be able to make their own decisions regarding healthcare choices	Autonomy within healthcare
1. Informing patients about their rights and choices in healthcare 7.The role of the nurse as an advocate is heavily influenced by communication and informing patients 21.Trying to educate and communicate with patients about their illness and possible outcomes 31. Communication is essential for advocacy 35.Much of the information elicited from patients occurs within an informal context 36. Data is asking the patient about their personal situation 40. Disempowering of patients only occurs if patients aren't given information or options to have a choice. 43.Informing patients and families about outcomes	Information exchange and communication skills are essential to facilitate advocacy in practice	Without communication what do we have?

and treatments is essential to nursing practice 45.Handover can be influential in the development of the labelling of patients and therefore the need for advocacy 44. Communication is essential		
9. Speaking on behalf of the patient 10.Speaking for/on behalf of the patient 26. Importance of understanding your patients so as to give them voice/ speak on their behalf 27. Speaking for the patient and on behalf of the patient	Speaking on or for the patient	Speaking on or for the patient
15.Giving patients choices which are already limited in their nature – therefore a façade of choice 16. Setting out the boundaries of the nurse patient relationship 17.Nurse patient relationships are built on trust and rapport 22.Personality influences the patient nurse relationship 29.Having empathy for the patient facilitates advocacy 32.Insider knowledge is a disadvantage for the patient 37.Rapport is important in the nurse patient relationship 39.Advocacy has a supportive function within patient healthcare 41. The role of the advocate is to stop the disempowering of patients 46.Important not to label patients	The role of the nurse/patient relationship	The nurse/patient relationship façade
8.The nurses are ideally placed to advocate as they spend more time with the patient	Idealisation of the nurses role in the process of advocacy and provided care to patients	The boy who cried wolf – idealisation of advocacy in nursing

13. Highlights that the nurses are part of the first line of care for patients 28. Being an advocate is fulfilling 48. It is ultimately the nurses responsibility as we are the first line of care		
3. Illness and poor health may influence the need for an advocate or significant assistance in healthcare 5.Issues around competency and capacity influence the nurses decisions and actions	Influencing factors of patients that may indicate the need for an advocate	Vulnerability
33.Teamwork and the team environment facilitates patient care 34. Although we work as a team the nurse is the first to assist with patients	Advocacy and the team	It’s not just about me – nurses perspectives on ‘team’
18.Diversity in healthcare influences the choices people make 19.Culture and language differences are important to recognise and understand in healthcare 23.The culture of the nurse can also influence their role in the healthcare setting 24.Talking about different cultural contexts of advocacy 38.Language barriers influence the ability of the nurse to advocate successfully 42. Personal characteristics influence nursing care and the ability to advocate	Cultural and language differences influence the care provided	You have to be careful with culture
20.The role of gender is also underestimated in terms of healthcare options and outcomes 25.Limitations of the patient to engage with healthcare options due to socio-economic factors	Influencing factors that change the scope of healthcare	Patients have baggage

Emergent Themes Summary
Autonomy within healthcare
Without communication what do we have?
Speaking on or for the patient
The nurse/patient relationship façade
The boy who cried wolf – idealisation of advocacy in nursing
Vulnerability
It's not just about me – nurses' perspectives on 'team'
You have to be careful with culture
Patients have baggage

Theme Cluster	Emergent Theme
Participant 5	
Informing patients' about their rights Supporting decision making Speaking on behalf of the patient Understanding patient's	Understanding your patients so as to give them a voice/speak for them
Cultural and language differences Culture of the nurse Language Barriers	You have to be careful with culture
Boundaries of the nurse/pt. r/s Trust and rapport First line of care Spending more time with the pt. Teamwork Nurse is first with patient	First line of care
Illness and poor health SES factors Gender	Vulnerability
Competency and capacity	Power and knowledge
Participant 4	
Looking out for the patient Supporting the patient Stepping up for the patient Explanation and communication Jargon NESB	Stepping up for the patient
Family matters/family support Culture influences care	You have to be careful with culture
Higher acuity patients Remembering the person not the condition	Vulnerability
Empathy Caring Putting yourself in their shoes Jigsaw of health Holistic Picking up the pieces Nurses are constant	First line of care (or if it's not nurses who else would it be?)
Experience Insight Confidence You can only do so much Giving up Manipulation of patients	???????
Obstructive patients History repeats itself Pt. personality	
Time constraints	You don't always have the time
Participant 3	
Personality of the patient	

Persona of the patient	
Encouragement role Duty of care	First line of care
Competency issues Don’t give an option	Perceptions of competency
Rapport Relating on a personal level	Relating on a personal level
Explaining care Telling the truth	Honesty is the best policy (or telling the truth)
Nurses role misunderstood Not only the nurse	??????
Communication is important	??????
Rights of the patient Confidentiality	??????
Time constraints Push for beds	Pressures of the job
Experience of the nurse	?????
Context of care	??????
Participant 2	
Standing up for the patient – best care Supporting the patient Patients should come first Peacemaker Letting patient’s make the decisions	Patients should come first
Nurses are the only ones who know the patient	Nurses are the only ones who know the patient
People are not controllable Perception Putting yourself on the same level as patient Making yourself visible	Power and knowledge (or people are not controllable they will do what they want)
Veracity and truth telling	It’s important to stick to the facts
It’s not just what you say but how you say it Communication is complete and understood	It’s not just what you say but how you say it
First impression shapes nurse/pt. r/s Empathy/compassion Put yourself in their shoes	First line of care
Experience	??????
Nurses fill in the gaps	Nurses fill in the gaps
Healthcare environment and care is contextually based	You have to consider the context of the situation
Culture influences expectations Culture influences care	You have to be careful with culture
Participant 1	
Voice for the patient Standing up for patients	
Perceptions and assumptions	Power and knowledge

Team approach to nursing Not just the nurse	Not just the nurse
Getting to know your patient Remembering the person not the illness Mental health influences care	Remembering the person not the illness
Setting boundaries	Setting boundaries
Family in decision making Cultural and NESB barriers Cultural sensitivity	You have to be careful with culture
Understanding the patient's context	?????
Experience Intuition 6th sense	?????
Rapport and trust	?????
Time management Pressures of the job It's just a job	Pressures of the job

Common Threads	
Experience of the nurse *Insight* *Confidence* *You can only do so much* *Giving up* *Manipulation of patients* *Intuition* *6th Sense* *Experience*	4,3,2,1
You have to be careful with culture *Cultural and language differences* *Culture of the nurse* *Language barriers* *Family matters/support* *Culture influences care* *Culture influences expectations* *Family in decision making* *NESB barriers* *Cultural sensitivity*	5,4,2,1
Vulnerability *Illness and poor health* *SES factors* *Gender* *Higher acuity patients* *Remembering the person not the condition* *Getting to know your patient* *Mental health influences care*	5,4,
Power and Knowledge *Boundaries of the nurse/pt. r/s* *Setting boundaries* *Jargon* *Manipulation of patients* *Don't give an option* *People are not controllable* *Perception and assumptions* *Putting yourself on the same level as the patient* *Making yourself visible* *First impression shapes nurse/pt./ r/s* *Competency and Capacity* *Peacemaker*	5,4,3,2,1
Pressures of the job *Time constraints* *Push for beds* *It's just a job* *Misunderstood nurses role*	5,4,3,1
You have to consider the context of the situation	3,2,1,4

Healthcare environment and care is contextually based *Context of care* *Understanding the patient's context* *Obstructive patients* *History repeats itself* *Nurses are constant* *Jigsaw of health* *Nurses are first with the patient* *First line of care*	
Relating on a personal level *Rapport* *Trust* *Put yourself in their shoes* *Empathy/compassion* *First impressions shape the nurse/pt. r/s* *Veracity and truth telling* *Duty of care* *Encouragement role* *Picking up the pieces* *Holistic*	1,2,3
Not just the nurse *Team approach to nursing*	1,3,5
Understanding your patients so as to give them a voice/speak for them *Voice for the patient* *Standing up for the patient – best care* *Nurses fill in the gaps* *It's not just what you say but how you say it* *Communication is complete and understood* *Explaining care* *Patient's should come first* *Letting patient's make the decisions* *Supporting the patient* *Rights of the patient* *Confidentiality* *Personality/persona of the patient* *Looking out for the patient* *Stepping up for the patient* *Explanation and communication* *Informing patients' about their rights*	1, 2, 3, 4,5
Outliers Nurses are the only ones who know the patient	2

Themes – all titles are representative of the participant’s words

You have to be careful with culture *Cultural and language differences* *Culture of the nurse* *Language barriers* *Family matters/support* *Culture influences care* *Culture influences expectations* *Family in decision making* *NESB barriers* *Cultural sensitivity*	5,4,2,1
Understanding your patients so as to give them a voice/speak for them (formerly Communication) *Voice for the patient* *Standing up for the patient – best care* *Nurses fill in the gaps* *It’s not just what you say but how you say it* *Communication is complete and understood* *Explaining care* *Patient’s should come first* *Letting patient’s make the decisions* *Supporting the patient* *Rights of the patient* *Confidentiality* *Personality/persona of the patient* *Looking out for the patient* *Stepping up for the patient* *Explanation and communication* *Informing patients’ about their rights*	1, 2, 3, 4,5
People are not controllable (formerly power/knowledge) *Boundaries of the nurse/pt. r/s* *Setting boundaries* *Jargon* *Manipulation of patients* *Don’t give an option* *People are not controllable* *Perception and assumptions* *Putting yourself on the same level as the patient* *Making yourself visible* *First impression shapes nurse/pt./ r/s* *Competency and Capacity* *Peacemaker*	5,4,3,2,1
Relating on a personal level *Rapport* *Trust*	1,2,3

Put yourself in their shoes *Empathy/compassion* *First impressions shape the nurse/pt. r/s* *Veracity and truth telling* *Duty of care* *Encouragement role* *Picking up the pieces* *Holistic*	
Remembering the person not the condition **(formerly vulnerability)** *Illness and poor health* *SES factors* *Gender* *Higher acuity patients* *Remembering the person not the condition* *Getting to know your patient* *Mental health influences care*	5,4,
You have to consider the context of the situation *Healthcare environment and care is contextually based* *Context of care* *Understanding the patient's context* *Obstructive patients* *History repeats itself* *Nurses are constant* *Jigsaw of health* *Nurses are first with the patient* *First line of care*	3,2,1,4
Experience of the nurse *Insight* *Confidence* *You can only do so much* *Giving up* *Manipulation of patients* *Intuition* *6th Sense* *Experience*	4,3,2,1
Pressures of the job *Time constraints* *Push for beds* *It's just a job* *Misunderstood nurses role*	5,4,3,1
Not just the nurse *Team approach to nursing*	1,3,5
Outliers Nurses are the only ones who know the patient	2

Finalised 6 themes

You have to be careful with culture *Cultural and language differences* *Culture of the nurse* *Language barriers* *Family matters/support* *Culture influences care* *Culture influences expectations* *Family in decision making* *NESB barriers* *Cultural sensitivity*	5,4,2,1
Understanding your patients so as to give them a voice/speak for them (formerly Communication) *Voice for the patient* *Standing up for the patient – best care* *Nurses fill in the gaps* *It's not just what you say but how you say it* *Communication is complete and understood* *Explaining care* *Patient's should come first* *Letting patient's make the decisions* *Supporting the patient* *Rights of the patient* *Confidentiality* *Personality/persona of the patient* *Looking out for the patient* *Stepping up for the patient* *Explanation and communication* *Informing patients' about their rights*	1, 2, 3, 4,5
People are not controllable (formerly power/knowledge) *Boundaries of the nurse/pt. r/s* *Setting boundaries* *Jargon* *Manipulation of patients* *Don't give an option* *People are not controllable* *Perception and assumptions* *Putting yourself on the same level as the patient* *Making yourself visible* *First impression shapes nurse/pt./ r/s* *Competency and Capacity* *Peacemaker*	5,4,3,2,1

Remembering the person not the condition (formerly vulnerability) *Illness and poor health* *SES factors* *Gender* *Higher acuity patients* *Remembering the person not the condition* *Getting to know your patient* *Mental health influences care*	5,4,
You have to consider the context of the situation *Healthcare environment and care is contextually based* *Context of care* *Understanding the patient's context* *Obstructive patients* *History repeats itself* *Nurses are constant* *Jigsaw of health* *Nurses are first with the patient* *First line of care*	3,2,1,4
Pressures of the job *Time constraints* *Push for beds* *It's just a job* *Misunderstood nurses role*	5,4,3,1
Not just the nurse *Team approach to nursing*	1,3,5
Relating on a personal level *Rapport* *Trust* *Put yourself in their shoes* *Empathy/compassion* *First impressions shape the nurse/pt. r/s* *Veracity and truth telling* *Duty of care* *Encouragement role* *Picking up the pieces* *Holistic*	1,2,3
Experience of the nurse *Insight* *Confidence* *You can only do so much* *Giving up* *Manipulation of patients* *Intuition* *6th Sense* *Experience*	4,3,2,1
	2

Nurses are the only ones who know the patient	

Appendix K: Final Ethics Report

1) Project Details:

Project No:	A12-153
Project Name:	Unpacking Advocacy in Contemporary Nursing

2) Principal Researcher Details:

Full Name:	Dr. Jane Mummery
School/Section:	SEAS
Phone:	53279627
Fax:	
Email:	j.mummery@federation.edu.au

3) Project Status:

Please indicate the current status of the project:	
☒ Data collection complete **Completion date: 31/12/2013**	☐ Abandoned **Please give reason:**

4) Special Conditions:

If this project was approved subject to conditions, were these met?		
☐ N/A	☒ Yes	☐ No *** NB: If 'no', please provide an explanation:**

5) Changes to project:

Were any amendments made to the originally approved project?	
☒ No	☐ Yes *** NB: Please provide details:**

6) Storage of Data:

Please indicate where the data collected during the course of this project is stored:
Storage of data is via password protected electronic files with the student researcher being the only person with access to this password.

7) Research Participants:

Were there any events that had an adverse effect on the research participants?

☒ No	☐ Yes *** NB: Please provide details:**

8) Summary of Results:

8.1. Please provide a short summary of the results of the project (no attachments please):
Results of the project shows that there are differences in the theoretical understanding of advocacy compared to the practical application within contemporary nursing practice. It has also demonstrated the competing discourses that influence the practical application of advocacy within nursing practice. There will be more concrete findings and conclusions once the second phase of data analysis has been completed.

8.2. Were the aims of the project (as stated in the application for approval) achieved? Please provide details.
Yes – the aims were to develop an understanding of the role of advocacy in clinical practice and also to develop an understanding of the influencing factors in healthcare that affect the conceptualisation and enactment of advocacy in clinical nursing practice. I believe that both these aims have been addressed through the project to date. It is clear that there are many influential factors that affect how advocacy is perceived and therefore enacted by nurses in contemporary nursing practice.

9) Feedback:

The HREC welcomes any feedback on: • **Difficulties experienced with carrying out the research project; or** • **Appropriate suggestions which might lead to improvements in ethical clearance and monitoring of research.**
Nil comments or suggestions.

10) Signature/s:

Principal Researcher:	…………………………….. Print name: Jane Mummery	**Date:**	24/3/2015
Other/Student Researchers:	………… ………………….. Print name: Clare Cole	**Date:**	24/03/2015
	……………………………. Print name:	**Date:**	

Please return to the Ethics Officer, at either the Gippsland or Mt. Helen campus, as soon as possible.

References

Abdelhadi, N. & Drach-Zahavy, A. (2011). Promoting patient care: work engagement as a mediator between ward service climate and patient-centered care. *Journal of Advanced Nursing*, 68(6), 1276-1287.

Abrams, K. (1999). From autonomy to agency: feminist perspectives on self-direction. *William and Mary Law Review*, 40(3), 805-846.

Adibi, H. (2014). mHealth: Its Implications within the Biomedical and Social Models of Health–a Critical Review. *Multidiscip Journals Sci Technol J Sel Areas Heal Informatics*, *4*(2), 16-23.

Agarwal, V. (2018). Re-conceptualising pain through patient-centered care in the complementary and alternative medicine therapeutic relationship. *JAN*, 74, 2406-2415.

Agledahl, K., Forde, R. & Wifstad, A. (2011). Choice is not the issue. The misrepresentation of healthcare in bioethical discourse. *Journal of Medical Ethics*, 37(4), 212-215.

Ahonen, P., Tienari, J., Merilainen, S. & Pullen, A. (2014). Hidden contexts and invisible power relations: A Foucaultian reading of diversity research. *Human Relations*, 67(3), 263-286.

Alicea-Planas, J. (2016). Listening to the narratives of our patients as part of holistic nursing care. *Journal of Holistic Nursing*, 34(2), 162-166.

Allen, D. (2004). Ethnomethodological insights into insider-outsider relationships in nursing ethnographies of healthcare settings. *Nursing Inquiry*, 11(1), 14-24.

Alvehus, J. & Crevani, L. (2018). Micro-ethnography and closed vignettes. Eight propositions for fieldwork and write-work in multimodal leadership studies. *Co-Lead Workshops,* p. 1-18.

Anderson, P. (2003). Autonomy, Vulnerability and Gender. *Feminist Theory*, 4(2), 149-164.

Andrews, T. (2012). What is social constructionism? *The Grounded Theory Review*, 11(1), 39-46.

Andreychik, M. & Migliacio, N. (2015). Empathizing with others' pain versus empathizing with others' joy: examining the separability of positive and negative empathy and their relation to different types of social behaviours and social emotions. *Basic and Applied Social Psychology*, 37(5), 274-291.

Andriessen, H., Kluin, M., Van Gulijk, C. & Ale, B. (2012, June). *Participant observation in risk problems.* Paper presented at the 11th International Probabilistic Safety Assessment and Management Conference and the Annual European Safety and Reliability Conference, Helsinki, Finland.

Annells, M. (1996). Grounded theory method: Philosophical perspectives, paradigm of inquiry, and postmodernism. *Qualitative Health Research*, 6(3), 379-393.

Anney, V. (2014). Ensuring the Quality of the Findings of Qualitative Research: Looking at Trustworthiness Criteria. *Journal of Emerging Trends in Educational Research and Policy Studies*, 5(2), 272-281.

Aronson, J. (2007). Compliance, Concordance, Adherence. *Br J Clin Pharmacol,* 63(4), 383-384.

Arras, J. (1994). Principles and particularity: the role of cases in bioethics. *Indiana Law Journal*, 69(4), 983-1014.

Arslanian-Engoren, C. (2002). Feminist poststructuralism: a methodological paradigm for examining clinical decision-making. *Journal of Advanced Nursing*, 37(6), 512-517.

Asimakopoulou, K., Gupta, A. & Scambler, S. (2014). Patient-centered care: barriers and opportunities in the dental surgery. *Community Dentistry & Oral Epidemiology*, 42(6), 603-610.

Asselin, M. (2003). Insider research: Issues to consider when doing qualitative research in your own setting. *Journal for Nurses in Staff Development*, *19(2), 99-103.*

Atinga, R., Bawole, J. & Nang-Beifubah, A. (2016). Some patients are more equal than others: patient-centered care differential in two-tier inpatient ward hospitals. *Patient Educ Couns,* 99(3), 370-377.

Atkins, K. (2006). Autonomy and autonomy competencies: a practical relational approach. *Nursing Philosophy*, 7(4), 205-215.

Atkinson, P. & Coffey, A. (2003). Revisiting the relationship between participant observation and interviewing. In J. Holstein & J. Gubrium (Eds.), *Inside Interviewing: new lenses, new concerns* (pp. 415-428). Thousand Oaks, CA: SAGE Publications.

Atkinson, P. & Hammersley, M. (2004). Ethnography and participant observation. In N. Denzin & Y. Lincoln (Eds.), *Strategies of Qualitative Inquiry* (2nd Ed). (pp. 134-164). Thousand Oaks, CA: Sage.

Australia. Australian Commission on Safety and Quality in Healthcare (2017). *National Safety and Quality Health Service Standards.* (2nd Edition). Retrieved on October 25, 2018, from https://www.safetyandquality.gov.au/our-work/assessment-to-the-nsqhs-standards/

Australian Healthcare Practitioner Regulation Agency [AHPRA] (n.d.). Retrieved from http://www. Ahpra.gov.au/About-AHPRA/Who-WE-Are.aspx

Australian Nursing and Midwifery Accreditation Council [ANMAC](n.d.). Retrieved from www.anmac.org.au/about-anmac/about

Austin Health. (2016). Austin Health Annual Report 2016-2017. Retrieved from http://www.austin.org.au/Assets/Files/Austin%20Health%20Annual%20Report%202016-17.pdf

Baker, L. (2006). Observation: A complex research method. *Library Trends*, 55(1),171-189.

Ballantyne, H. (2016). Developing nursing care plan. *Nursing Standard*, 30(26), 51-60.

Ballinger, C. (2008). Over Rapport. In L. Given (Ed.), *The SAGE Encyclopedia of Qualitative Research Methods.* (pp. 590-604). Thousand Oaks, California: SAGE Publications.

Banner, D. (2010). Qualitative Interviewing: Preparation for Practice. *Canadian Journal of Cardiovascular Nursing*, 20(3), 27-30.

Barbaro, B., Opoczynska, M., Rostworowska, M., Drozdzowicz, L. & Golanski, M. (2008). Changes in the patient's identity in the context of a psychiatric system – an empirical study. *Journal of Family Therapy*, 30(4), 438-449.

Baumbusch, J. (2011). Conducting critical ethnography in long-term residential care: experiences of a novice researcher in the field. *Journal of Advanced Nursing*, 67(1), 184-192.

Baylis, F., Kenny, N. & Sherwin, S. (2008). A relational account of public health ethics. *Public Health Ethics*, 1(3), 196-209.

Bear, R., & Stockie, S. (2015). Patient engagement and patient-centered care in the management of advanced chronic kidney disease and chronic kidney failure. *Canadian Journal of Kidney Health and Disease*, 1(24),1-8.

Beauchamp, T. (1994). Principals and other emerging paradigms in bioethics. *Indiana Law Journal*, 69(4), 955-971.

Beauchamp, T. (2005). Who deserves autonomy, and whose autonomy deserves respect? In J. Taylor (Ed.), *Personal Autonomy: new essays on personal autonomy and its role in contemporary healthcare* (pp. 310-329). Cambridge, UK: Cambridge University Press.

Beauchamp, T (2007). The 'Four Principles' Approach to Health Care Ethics (2nd ed.). In R. Ashcroft, A. Dawson, H. Draper, & J. McMillan (Eds.), *Principles of Health Care Ethics* (pp.3-10). Chichester, UK: John Wiley & Sons Ltd.

Beauchamp, T. & Childress, J. (2013). *Principles of Biomedical Ethics* (7th ed). Oxford, UK: Oxford University Press.

Benner, P. (1982). From novice to expert. *The American Journal of Nursing,* 82(3), 402-407.

Benner, P. (2003). Enhancing patient advocacy and social ethics. *American Journal of Critical Care*, 12(4), 374-375.

Benner, P. (2004). The tradition & Skill of Interpretive Phenomenology in Studying Health, Illness & Caring Practices. In P. Benner (Ed.), *Interpretive Phenomenology: embodiment, caring & ethics in Health & Illness.* (pp. 99-128). Thousand Oaks, CA: SAGE Publications.

Bergman, M. (2018). Police Shootings and Race in the United States: Why the Perpetrator Predation Perspective Is Essential to I-O Psychology's Role in Ending This Crisis. *Industrial & Organisational Psychology*, 11(1), 1-6.

Berk, M., Berk, L., Dodd, S., Fitzgerald, P., de Castella, A., Filia, S., …Stafford, L. (2013). The sick role, illness cognitions and outcomes in bipolar disorder. *Journal of Affective Disorders*, 146(1), 146-149.

Bernabeo, E.C., & Holmboe, E. (2013). Patients, providers, and systems need to acquire a specific set of competencies to achieve truly patient-centered care. *Health affairs*, 32(2), 250-8.

Bernal, E. (1992). The nurse as patient advocate. *Hastings Centre Report*, 22(4), 18-30.

Best, S. & Kellner, D. (1991). *Postmodern Theory: critical interrogations.* Hampshire, UK: MacMillan Publishing.

Bikker, A., Atherton, H., Brant, H., Porqueddu, T., Campbell, J., Gibson, A., McKinstry, B., Salisbury, C & Ziebland, S. (2017). Conducting a team-based multi-sited focused ethnography in primary care. *BMC Medical Research Methodology.* 17, Open Access. Retrieved from https://bmcmedresmethodolo.biomedcentral.com/articles/10.1186/s12874-017-0422-5

Bird, A. (1994). Enhancing patient well-being: advocacy or negotiation? *Journal of Medical Ethics*, 20(3), 152-156.

Bishop, A. & Scudder, J. (2003). Gadow's contribution to our philosophical interpretation of nursing. *Nursing Philosophy*, 4(2), 104-110.

Blackmore, R. (2001). Advocacy in Nursing: Perceptions of learning disability nurses. *Journal of Intellectual Disabilities*, 5(3), 221-234.

Blair, W. & Smith, B. (2012). Nursing Documentation: Frameworks and barriers. *Contemporary Nurse,* 41(2), 160-168.

Boell, S. & Cecez-Kecmanovic, D. (2010). Literature Reviews and the Hermeneutic Circle. *Australian Academic and Research Libraries*, 41(2), 129-144.

Booth, T., McConnell, D. & Booth, W. (2006). Temporal discrimination and parents with learning difficulties in the child protection system. *The British Journal of Social Work,* 36(6), 997-1015.

Borrell-Carrio, F., Suchman, A. & Epstein, R. (2004). The Biopsychosocial Model 25 Years Later: Principles, Practice, and Scientific Inquiry. *Annals of Family Medicine*, 2(6), 576-582.

Borrett, D. (2013). Heidegger, Gestell and rehabilitation of the Biomedical model. *Journal of Evaluation in Clinical Practice*, 19(3), 497-500.

Bradbury-Jones, C., Sambrook, S. & Irvine, F. (2008). Power and empowerment in nursing: a fourth theoretical approach. *Journal of Advanced Nursing*, 62(2), 258-266.

Bradshaw, A. (2011). Compassion: What History Teaches Us. *Nursing Times*, 107(19/20), 12-14.

Bramlett, M., Gueldner, S. & Sowell, R. (1990). Consumer-centric advocacy: its connection to nursing frameworks. *Nursing Science Quarterly*, 3(4), 156-161.

Brannick, T. & Coghlan, D. (2007). In defence of being “native”: The case for insider Academic Research. *Organisational Research Methods*, 10(1), 59-74.

Brashers, D., Haas, S. & Neidig, J. (1999). The patient self-advocacy scale: measuring patient involvement in health care decision-making interactions. *Health Communication*, 11(2), 97-121

Braun, V. & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology,* 3(2), 77-101.

Braun, V. & Clarke, V. (2013). Teaching thematic analysis: over-coming and developing strategies for effective learning. *The Psychologist*, 26(2), 120-123.

Braun, M., Gurrera, R., Kavel, M., Armesta, J. & Moye, J. (2009). Are clinicians ever biased in their judgments of capacity of older adults to make medical decisions? *Journal of the American Society on Aging,* 33(1), 78-81.

Braun, A., Skene, L. & Merry, A. (2010). Informed consent for anaesthesia in Australia and New Zealand. *Anaesthesia and Intensive Care*, 38(5), 809-822.

Brayboy, B. & Deyhle, D. (2000). Insider-Outsider: Researchers in American Indian Communities. *Theory into Practice*, 39(3), 163-169.

Breeding, J. & Turner, D. (2002). Registered Nurses' lived experience of advocacy within a critical care unit: a phenomenological study. *Australian Critical Care*, 15(3), 110-117.

Breier-Mackie, S. (2001). Patient autonomy and medical paternity: can nurses help doctors to listen to patients? *Nursing Ethics*, 8(6), 510-521.

Brison, S. (2000). Relational Autonomy and Freedom of Expression. In C. MacKenzie, & N. Stoljar (Eds.), *Relational Autonomy: feminist perspectives on Autonomy, Agency and The Social Self* (pp.280-299). Oxford, UK: Oxford University Press.

Brockling, U., Krasmann, S., & Lemke, T. (2010). From Foucault's Lectures at the College de France to Studies of Governmentality: An Introduction. In U. Brockling, S. Krasmann, & T. Lemke (Eds.), *Governmentality: current Issues and Future Challenges* (pp. 1-33). Hoboken, NY: Taylor and Francis.

Brondari, M., Alan, R. & Donnelly, L. (2017). Stigma of addiction and mental illness in healthcare: the case of patients' experiences in dental settings. *PLOS One,* 12(5), 1-13.

Brown, A. (2000). *On Foucault: a critical introduction*. Chicago, USA: Wadsworth.

Brown, N. (2012). Negotiating the Insider/Outsider Status: Black Feminist Ethnography and Legislative Studies. *Journal of Feminist Scholarship,* 3(3), 19-34.

Bruera, E., Neumann, C., Mazzocato, C., Stiefel, F. & Sala, R. (2000). Attitudes and beliefs of palliative care physicians regarding communication with terminally ill cancer patients. *Palliative Medicine,* 14(4), 287-298.

Brunero, S., Lamont, S. & Coates, M. (2010). A review of empathy education in nursing. *Nursing Inquiry,* 17(1), 65-74.

Bu, X. & Jezewski, M. (2007). Developing a mid-range theory of patient advocacy through concept analysis. *Journal of Advanced Nursing,* 57(1), 101-110.

Burnham, J. (2014). Why sociologists abandoned the sick role concept. *History of the Human Sciences,* 27(1), 70-87.

Burns, E., Fenwick, J., Schmied, V. & Sheehan, A. (2012). Reflexivity in midwifery research: The insider/outsider debate. *Midwifery,* 28(1), 52-60.

Butcher, H., Holkup, P., Park, M. & Maas, M. (2001). Thematic Analysis of the Experience of Making a Decision to Place a Family Member with Alzheimer's Disease in a Special Care Unit. *Research in Nursing & Health,* 24(6), 470-480.

Caelli, K., Ray, L. & Mill, J. (2003). 'Clear as mud': Toward greater clarity in generic qualitative research. *International Journal of Qualitative Methods,* 2(2),1-13.

Candlin, C. N., & Candlin, S. (2002). Discourse, expertise, and the management of risk in health care settings. *Research on Language and Social Interaction*, *35*(2), 115-137.

Cassell, C. & Symon, G. (1994). *Qualitative methods in organisational research: A practical guide.* London, UK: SAGE publications.

Cawley, R. & Chaloupka, W. (1997). America Governmentality: Michel Foucault and Public Administration. *American Behavioural Scientist,* 41(1), 28-42.

Chaboyer, W., McMurray, A., Wallis, M. & Chang, H.Y. (2008) Standard Operating Protocol for Implementing Bedside Handover in Nursing, Griffith University, Australia https://www.safetyandquality.gov.au/wp-content/uploads/2012/02/SOP-Bedside-Handover.pdf

Cheek, J. (2004). At the margins? Discourse Analysis and Qualitative Research. *Qualitative Health Research.* 14(8): 1140-1150.

Childress, J. (2009). A principle-Based Approach. In H. Kuhse & P. Singer, P. (Eds.), *A Companion to Bioethics.* (2nd Ed.) (pp.67-76). Chichester, UK: Blackwell Publishing.

Chrisp, T., Tabberer, S. & Thomas, B. (2012). Bounded autonomy in deciding to seek medical help: carer role, the sick role and the case of dementia. *Journal of Health Psychology,* 18(2), 272-281.

Christman, J. & Anderson, J. (2005). Introduction. In J. Christman & J. Anderson (Eds.), *Autonomy and the challenges to liberalism: new essays.* (pp. 1-26). Cambridge, UK: Cambridge University Press.

Christman, J. (2004). Relational Autonomy, Liberal Individualism, and the Social Constitution of Selves. *Philosophical Studies,* 117(1/2), 143-164.

Christman, J. (2005). Autonomy, Self-Knowledge, and Liberal Legitimacy. In Christman, J. & Anderson, J. (Eds.). *Autonomy and the challenges to liberalism: new essays.* Cambridge University Press: Cambridge. Pp. 330-358.

Christopoulos, K. (2001). The sick role in literature and society. *JAMA,* 285(1), 93.

Churchill, L., Fanning, J. & Schenck, D. (2013). *What patients teach: the everyday ethics of healthcare.* Oxford, UK: Oxford University Press.

Chiong, W. (2001). Diagnosing and defining disease. *JAMA,* 286 (1), 89.

Clayton, H. (2006). The alienating language of healthcare. *Journal of the Royal Society of Medicine,* 99(10), 484.

Clouser, K. & Gert, B. (1994). Morality vs. Principlism. In R. Gillon (Ed.), *Principles of Health Care Ethics.* (pp. 251-266). Chichester, UK: John Wiley & Sons Ltd.

Cockerham, W. (2007). *Social Causes of Health and Disease.* Cambridge, UK: Polity.

Cody, M. (2006). *The Knowledge and Practice of Health Visitors in North* (Doctoral dissertation). University of Wales, UK.

Coffey, A. (1999). *The ethnographic self: fieldwork and the representation of identity.* London, UK: SAGE Publications.

Colaizzi, P. (1978). Psychological research as the phenomenologist views it. In R. Valle & M. King (Eds.), *Existential Phenomenological Alternatives for Psychology.* (pp. 6). New York, NY: Oxford University Press.

Cole, C. (2012). Implied consent and nursing practice: Ethical or Convenient? *Nursing Ethics,* 19(4), 550-557.

Cole, C., Wellard, S. & Mummery, J. (2014). Problematising autonomy and advocacy in nursing. *Nursing Ethics,* 21(5), 576-582.

Collins, L., Schrimmer, A., Diamond, J. & Burke, J. (2011). Evaluating verbal and non-verbal communication skills, in an ethnogeriatric OSCE. *Patient Education and Counselling,* 83(2),158-162.

Connelly, L. (2010). What is Phenomenology. *MedSurg Nursing,* 19(2), 127-128.

Constantino, R., Burroughs, J. & Hwang, J. (2014). ELSI: Ethical, Legal and Sociocultural Issues in Nursing viewed through a complex synergistic system lens. *Journal of Nursing Care,* 3(1), 145-151.

Cooper, D. (1994). Productive, relational and everywhere? Conceptualising power and resistance within Foucaultian Feminism. *Sociology,* 28(2), 435-454.

Corrigan, O. (2003). Empty ethics: the problem with informed consent. *Sociology of Health & Illness,* 25(7), 768-792.

Coyle, A. (2007). Discourse Analysis. In E. Lyons & A. Coyle (Eds.), *Analysing Qualitative Data in Psychology.* (pp. 98-116). Los Angeles, LA: SAGE Publications.

Craigie, J. (2011). Competence, practical rationality and what a patient value. *Bioethics,* 25(6), 326-333.

Crawford, R. (2019). Using focused Ethnography in Nursing Research. *Kai Tiaki Nursing Research.* 10(1), 63-67.

Crean, M. (2018). Minority Scholars and Insider-Outsider Researcher Status: Challenges along a Personal, Professional and Political Continuum. *Forum: Qualitative Social Research,* 19(1), 1-16.

Cremonesi, L., Irrera, O., Lorenzini, D. & Tazziloi, M. (2016). Foucault and the Making of Subjects: Rethinking autonomy between subjection and subjectivation. In L. Cremonesi, O. Irrera, D. Lorenzini, M. & Tazziloi (Eds.), *Foucault and The Making of Subjects.* (pp. 1-10). London, UK: Rowman & Littlefield International.

Crist, J. & Tanner, C. (2003). Interpretation/Analysis Methods in Hermeneutic Interpretive Phenomenology. *Nursing Research,* 52(3), 202-205.

Crowther, J., Wilson, K., Horton, S. & Lloyd-Williams, M. (2013). Compassion in healthcare- lessons from a qualitative study of the end of life care of people with dementia. *Journal of the Royal Society of Medicine,* 106(12), 492-497.

Cunico, L., Sartori, R., Marognolli, O. & Meneghini, A. (2012). Developing empathy in nursing students: a cohort longitudinal study. *Journal of Clinical Nursing,* 21(13-14), 2016-2025.

Curtin, L. (1979). The Nurse as Advocate: A Philosophical foundation for Nursing. *ANS/Ethics and Values,* 1(3), 1-10.

Curtis, K. (2014). Learning the requirements for compassionate practice: Student vulnerability and courage. *Nursing Ethics,* 21(2), 210-223.

Curtis-Tyler, K. (2010). Levers and barriers to patient-centered care with children: findings from a synthesis of studies of the experiences of children living with type 1 diabetes or asthma. *Child: care, health and development,* 37(4), 540-550.

Cypress, B. (2017). Rigor or reliability and validity in qualitative research: Perspectives, strategies, reconceptualisation, and recommendations. *Dimensions of Critical Care Nursing,* 36(4), 253-263.

Dahm, M. & Wadensten, B. (2008). Nurses' experiences of and opinions about using standardises care plans in electronic health records – a questionnaire study. *J Clin Nurs,* 17(16), 2137-2145.

Daniels, H. (2010). An approach to notions of subject position and discourse in activity theory. In C. Kanes. (Ed.), *Elaborating Professionalism, Innovation and Change in Professional Education.* (pp. 167-182). London, UK: Springer Publishing.

Darwall, S. (2006). The value of autonomy and autonomy of the will. *Ethics,* 116(2), 263-284.

Davies, M. & Elwyn, G. (2008). Advocating mandatory patient 'autonomy' in healthcare: adverse reactions and side effects. *Health Care Anal,* 16(4), 315-328.

Davis, A., Konishi, E. & Tashiro, M. (2003). A pilot study of selected Japanese nurses' ideas on patient advocacy. *Nursing Ethics,* 10(4), 404-413.

DeAlmeida, J. & Schramm, F. (1999). Paradigm shift, metamorphosis of medical ethics, and the rise of bioethics. *Cad. Saude Publica,* 15(1), 15-25.

DeGrazia, D. (1992). Moving Forward in bioethical theory: theories, cases, and specified principlism. *The Journal of Medicine and Philosophy,* 17(5), 511-539.

De Oliveria, A. & Da Silva, M. (2010). Autonomy in palliative care: concepts and perceptions of health teamwork. *Acta Paul Enferm,* 23(2), 212-217.

DeSantis, L. & Ugarriza, D. (2000). The Concept of Theme as Used in Qualitative Nursing Research. *Western Journal of Nursing Research,* 22(3), 351- 372.

DeWalt, K. & DeWalt, B. (2011). *Participant observation: A guide for fieldworkers*. (2nd ed.). Lanham, USA: Rowman Altamira Press.

De Wet, J. & Erasmus, Z. (2005). Towards rigour in qualitative analysis. *Qualitative Research Journal,* 5(1), 27-40.

Decety, J. & Jackson, P. (2004). The functional architecture of human empathy. *Behavioural and cognitive Neuroscience Reviews*. 3(2), 71-100.

Delaney, L. (2018). Patient-centered care as an approach to improving health care in Australia. *Collegian,* 25(1), 119-123.

Deligiorgi, K. (2016). Autonomy in Bioethics. *Sympsoion,* 3(2), 177-190.

Dennehy, L. & White, S. (2012). Consent, assent, and the importance of risk stratification. *British Journal of Anaesthesia,* 109(1), 40-46.

Denscombe, M. (2008). Communities of Practice: A Research Paradigm for the Mixed Methods Approach. *Journal of Mixed Methods Research,* 2(3),270-283.

Denzin, N. & Lincoln, Y. (2005) Introduction: The Discipline and Practice of Qualitative Research. In N. Denzin & Y. Lincoln (Eds.), *Handbook of Qualitative Research*. (3rd ed.) (pp. 1-32). Thousand Oaks, CA: Sage.

Denzin, N. & Lincoln, Y. (2017). *The SAGE Handbook of Qualitative Research* (5th ed.). Los Angeles, LA: SAGE Publications.

Descartes, R. (1996/1641). *Meditations on First Philosophy.* Cambridge, UK: Cambridge University Press.

Descartes, R. (2000/1637). Philosophical Essays and Correspondence. In R. Ariew (Ed.), *Philosophical Essays and Correspondence*. (pp. 46-73). Indianapolis, IN: Hackett Publishing Company

Detel, W. & Pippin, R. (2005). *Foucault and Classical Antiquity: Power, Ethics and Knowledge.* Cambridge, UK: Cambridge University Press.

Deveaux, M. (1994). Feminism and Empowerment: A Critical Reading of Foucault. *Feminist Studies,* 20(2), 223-247.

Devisch, I. (2010). Oughtonomy in healthcare. A deconstructive reading of Kantian autonomy. *Medical Health Care and Philosophy,* 13(4), 303-312.

DiCuccio, M., Colbert, A., Triolo, P., Schreiber, J. & Dean, B. (2020). Cracking the Code for Quality: The interrelationships of culture, nurse demographics, advocacy, and patient outcomes. *The Journal of Nursing Administration,* 50(3), p. 152-158.

Dickinson, T. & Hurley, M. (2011). Exploring the antipathy of nursing staff who work within secure healthcare facilities across the United Kingdom to young people who self-harm. *Journal of Advanced Nursing,* 68(1),147-158.

Dinc, L. & Gastmans, C. (2013). Trust in nurse-patient relationships: a literature review. *Nursing Ethics,* 20(5), 501-516.

Dodds, S. (2000). *Choice and Control in Feminist Bioethics.* In C. MacKenzie & N. Stoljar (Eds.), *Relational Autonomy: feminist perspectives on Autonomy, Agency and The Social Self.* (pp. 213-235). Oxford, UK: Oxford University Press.

Donnelly, M. (2010). *Healthcare Decision-Making and the Law: autonomy, capacity and the limits of liberalism*. Leiden, Netherlands: Cambridge University Press.

Drach-Zahavy, A. (2009). Patient-centered care and nurses' health: the role of nurses' caring orientation. *Journal of Advanced Nursing,* 65(7), 1463-1474.

Dreyfus, H. & Rabinow, P. (1982). *Michel Foucault: Beyond Structuralism and Hermeneutics.* (2nd Ed.) Chicago, USA: The University of Chicago Press.

Driver, F. (1994). Bodies in Space: Foucault's account of disciplinary power. In C. Jones, & R. Porter (Eds.), *Reassessing Foucault: Power, Medicine and the Body.* (pp. 113-131). London, UK: Routledge.

Dudzinski, D. & Shannon, S. (2006). Competent patients' refusal of nursing care. *Nursing Ethics,* 13(6), 608-621.

Duncan, C. & Diamond, M. (2011, July). One foot in, one foot out: The paradox of participant-observation. In *6th International Conference on Interdisciplinary*

Social Sciences, Harry Truman School of Public Affairs, University of Missouri (pp. 11-13).

Durose, C. (2011). Revisiting Lipsky: front-line work in UK local governance. *Political Studies,* 59(4), 978-995.

Dworkin, R. (1993). Medical Law and Ethics in the Post-Autonomy Age. *Indiana Law Journal,* 68(3), 727-742.

Dwyer, S. & Buckle, J. (2009). The Space Between: On Being an Insider-Outsider in Qualitative Research. *International Journal of Qualitative Method,* 8(1), 54-63.

Ebbesen, M. & Pedersen, B. (2007). Empirical investigation of the ethical reasoning of physicians and molecular biologists – the importance of the four principles of Biomedical ethics. *Philosophy, Ethics and Humanities in Medicine,* 25(2), 23-39.

Edkins, J. & Pin-Fat, V. (2005). Through the wire: relations of power and relations of violence. *Journal of International Studies,* 34(1), 1-24.

Edwards, R. & Holland, J. (2013). *What is Qualitative Interviewing?* London, UK: Bloomsbury Publishing.

Edwards, K. & Welch, T. (2011). The extension of Colaizzi's method of phenomenological enquiry. *Contemporary Nurse,* 39(2), 163-171.

Eisenberg, M. (1990). The Duty of Care of Corporate Directors and Officers. *HeinOnline,* 51, 945-972.

Emanuel, L., Berwick, D., Conway, J., Combes, J., Hatlie, M., Leape, L., ... & Walton, M. (2008). What exactly is patient safety? In *Advances in patient safety: new directions and alternative approaches (Vol. 1: Assessment)*. Agency for Healthcare Research and Quality.

Elliott, A. (2001). Health care ethics: cultural relativity of autonomy. *Journal of Transcultural Nursing,* 12(4), 326-330.

Ells, C. (2003). Foucault, Feminism, and Informed Choice. *Journal of Medical*

Humanities, 24(3/4), 213-228.

Ells, C., Hunt, M. & Chambers-Evans, J. (2011). Relational autonomy as an essential component of patient-centered care. *International Journal of Feminist Approaches to Bioethics,* 4(2), 79-101.

Ellul, J. (1965). *Propaganda: the formation of men's attitudes.* New York, NY: Vintage.

Emmett, C., Poole, M., Bond, J. & Hughes, J. (2013). Homeward bound or bound for a home? Assessing the capacity of dementia patients to make decisions about hospital discharge: Comparing practice with legal standards. *International Journal of Law and Psychiatry,* 36(1), 73-82.

Engel, G. (1977). The need for a new medical model: A challenge for biomedicine. *Science,* 196(4286), 129-136.

Epstein, C. (2011). Who Speaks? Discourse, the subject and the study of identity in international politics. *European Journal of International Relations,* 17(2), 327-350.

Ergun, A. & Erdemir, A. (2012). Negotiating Insider and outsider Identities in the Field: "Insider" in a Foreign Land; "Outsider" in One's Own Land. *Field Methods,* 22(1),16-38.

Eyler, J. (2001). The changing assessments of John Snow's and William Farr's Cholera Studies. *Sozial- und Präventivmedizin*. 46(4), 225–232.

Fagan, A. (2004). Challenging the bioethical application of the autonomy principle within multicultural societies. *Journal of Applied Philosophy,* 21(1), 15-31.

Fairclough, N. (1992). Discourse and Text: Linguistic and Intertextual Analysis within Discourse Analysis. *Discourse & Society*, *3*(2), 193–217.

Fan, R. (1997). Self-determination vs. family-determination: two incommensurable principles of autonomy. *Bioethics,* 11(3&4), 309-322.

Faulkner, M. & Aveyard, B. (2002). Is the hospital sick role a barrier to patient participation? *Nursing Times,* 98(24), 35-39.

Faust, H. (2009). Kindness, not compassion, in healthcare. *Cambridge Quarterly of Healthcare Ethics,* 18(3), 287-299.

Fee, E. & Krieger, N. (1993). Understanding AIDS: Historical Interpretations and the Limits of Biomedical Individualism. *American Journal of Public Health,* 83(10), 1477-1486.

Fejes, A. (2008). Governing nursing through reflection: a discourse analysis of reflective practices. *Journal of Advanced Nursing,* 64(3), 243-250.

Fereday, J. & Muir-Cochrane, E. (2006). Demonstrating Rigor Using Thematic Analysis: A Hybrid Approach of Inductive and Deductive Coding and Theme Development. *International Journal of Qualitative Methods,* 5(1), 80-92.

Ferguson, L., Ward, H., Card, S., Sheppard, S. & McMurtry, J. (2013). Putting the 'patient' back into patient-centered care: An education perspective. *Nurse Education in Practice*, 13(4), 283-287.

Ferraris, M. (1996). *History of hermeneutics*. New York, NY: Humanities Press.

Ferreira-Neto, J. (2018) Michel Foucault and Qualitative Research in Human and Social Sciences. *Forum Qualitative Social Research,* 19(3), 23-40.

Fisher, C. (2011). Addiction research ethics and the Belmont principles: do drug users have a different moral voice? *Substance Use & Misuse,* 46(6), 728-741.

Fix, G., Lukas, C., Bolton, R., Hill, J., Mueller, N., LaVela, S., & Bokhour, B. (2018). Patient-centered care is a way of doing things: How healthcare employees conceptualise patient-centered care. *Health Expectations*, 21(1), 300-307.

Flick, U. (2008). *Managing Quality in Qualitative Research.* Los Angeles, LA: SAGE Publications.

Flood, A. (2010). Understanding phenomenology. *Nurse Researcher,* 17(2), 7-15.

Frank, A. (2013). From sick role to practices of health and illness. *Medical Education,* 47(1), 18-25.

Fredericks, S., Lapum, J. & Hul, G. (2015). Applying patient-centered care to surgical intervention. *British Journal of Cardiac Nursing,* 10(4), 170-174.

Friedman, M. (2000). Feminism in ethics: Conceptions of autonomy. In M. Fricker& J. Hornsby (Eds.), *The Cambridge Companion to Feminism in Philosophy.* (pp. 205-224). Cambridge, UK: Cambridge University Press.

Friedman, M. (2003). *Autonomy, Gender, Politics.* New York, NY: Oxford University Press.

Fontana, A. (2002). Postmodern Trends in Interviewing. In J. Gubrium & J Holstein (2001). *Handbook of Interview Research: Context & Method.* (pp. 161-176). Thousand Oaks, California: SAGE Publications.

Fossey, E., Harvey, C., McDermott, F. & Davidson, L. (2002). Understanding and evaluating qualitative research. *Australian and New Zealand Journal of Psychiatry,* 36(6), 717-732.

Foucault, M. (1965). *Madness & Civilisation: A History of Insanity in the Age of Reason.* New York, NY: Vintage Books.

Foucault, M. (1973). *The Birth of the Clinic: An archaeology of medical perception.* London, UK: Tavistock.

Foucault, M. (1977). *Discipline and Punish: the birth of the prison.* London, UK: Penguin Books.

Foucault, M. (1980/1972a). Truth and Power. In C. Gordon (Ed.), *Power/Knowledge: Selected Interviews and other writings 1972-1977.* (pp. 109-133). New York, NY: Pantheon Books.

Foucault, M. (1980/1972b). Two Lectures. In C. Gordon (Ed.), *Power/Knowledge: Selected Interviews and other writings 1972-1977.* (pp. 78-108). New York, NY: Pantheon Books.

Foucault, M. (1982). The subject and power. *Critical Inquiry,* 8(4), 777-795.

Foucault, M. (1984). Truth and Power. In P. Rabinow (Ed.), *The Foucault Reader: an introduction to Foucault's thought.* (pp. 51-75). London, UK: Penguin Books.

Foucault, M. (1988/1965). *Madness & Civilization: a history of insanity in the age of reason.* New York, NY: Vintage Books.

Foucault, M. (1998/1984) Foucault. In J Faubion (Ed.) *Essential works of Michel Foucault, Vol 2: Aesthetics, method, epistemology.* (pp. 459-463). New York, NY: The New Press.

Foucault, M. (1990/1978). *The History of Sexuality. Volume 1: An introduction.* New York, NY: Vintage Books.

Foucault, M. (1991/1978). Governmentality. In G. Burchell, C. Gordon, & P. Miller (Eds.), *The Foucault Effect: studies in governmentality with two lectures by and an interview with Michel Foucault.* (pp. 87-104). Chicago, USA: The University of Chicago Press.

Foucault, M. (1994/1970). *The Order of Things: an archaeology of the human sciences.* New York, NY: Vintage Books.

Foucault, M. (2002/1969). *The Archaeology of Knowledge.* London, UK: Routledge Classics.

Foucault, M. (2002/1994a). The subject and power. In J. Faubion (Ed.), *Michel Foucault Power: essential works of Foucault 1954-198.* (Volume 3) (pp.326-348). London, UK: Penguin Books.

Foucault, M. (2002/1994b). Truth and Power. In J. Faubion (Ed.), *Michel Foucault Power: essential works of Foucault 1954-198.*volume 3. (pp. 111-133). London, UK: Penguin Books.

Fox, N. (1999). Power, control and resistance in the timing of health and care. *Social Science and Medicine,* 48(10), 1307-1319.

Frank, A. (2013). From sick role to practices of health and illness. *Medical Education,* 47(1), 18-25.

Frequent Flyer (2012). *Frequent Flyer*. Retrieved from https://medical-dictionary.thefreedictionary.com/frequent+flyer

Friedman, M. (2000). Feminism in ethics Conceptions of Autonomy. In M. Fricker & J. Hornsby (Eds.), *The Cambridge companion to feminism in Philosophy.* (pp. 205-224). Cambridge, UK: Cambridge University Press.

Friedman, M. (2003). *Autonomy, Gender & Politics.* New York, NY: Oxford University Press.

Gabe, J., Bury, M. & Elston, M. (2004). *Key concepts in medical sociology.* London, UK: SAGE.

Gadamer, H. (2004/1976). Truth and Method. (2nd Ed.) London, UK: Sheed and Ward Stagbooks.

Gadow, S. (1980). *Existential advocacy: Philosophical foundations of Nursing.* Washington DC, USA: NLN Publications.

Gallagher, M. (2008). Foucault, Power and Participation. *International Journal of Children's Rights,* 16(3), 395-406

Galletta, A. (2013). *Mastering the semi-structured interview and beyond: from researcher design to analysis.* New York, NY: NYU Press.

Gambrill, E. (2010). Evidence-Informed Practice: Antidote to Propaganda in the Helping Professions? *Research on Social Work Practice*, *20*(3), 302–320.

Garcia, E., Duberstein, P., Paterniti, D., Cipri, C., Kravitz, R. & Epstein, R. (2012). Feeling labelled, judged, lecture, and rejected by family and friends over depression: Cautionary results for primary care clinicians from a multi-centered, qualitative study. *BMC Family Practice,* 13(1), 64- 73.

Garrett, P.M. (2003). 'Swimming with Dolphins: The Assessment Framework, New Labour and New Tools for Social Work with Children and Families'. *British Journal* of *Social Work,* 33(4), 441 - 463.

Gastaldo, D. & Holmes, D. (1999). Foucault and Nursing: a history of the present. *Nursing Inquiry,* 6(4), 231-240.

Gaylord, N. & Grace, P. (1995). Nursing Advocacy: an ethic of practice. *Nursing Ethics,* 2(1), 11-18.

Geist, R. & Opler, S. (2010). A guide for healthcare practitioners in the assessment of young people’s capacity to consent to treatment. *Clinical Paediatrics,* 49(9), 834-839.

Gerrits, T., Reis, R., Braat, D., Kremer, J. & Hardon, A. (2013). Bioethics in practice: addressing ethically sensitive requests in a Dutch fertility clinic. *Social Science & Medicine,* 98, 30-339.

Gerson, E. (1976). The social character of illness: deviance or politics? *Social Science & Medicine,* 10(5), 219-224.

Ghatak, S. & Abel, A. (2013). Power/Faith: Governmentality, religion, and post-secular societies. *Int J Polit Cult Soc,* 26(3), 217-235.

Giacomini, M. & Cook, D. (2000). Users' guide to the medical literature: XXIII Qualitative research in health care are the results of the study valid? *JAMA,* 284(3), 37-362.

Gilbert, T. (2001). Reflective practice and clinical supervision: meticulous rituals of the confessional. *Journal of Advanced Nursing,* 36(2), 199-205.

Gillon, R. (1996). Preface: Medical Ethics and the Four Principles. In R. Gillon (Ed.), *Principles of Health Care Ethics.* (pp. xxi-xxxi). Chichester, UK: John Wiley & Sons: Chichester.

Gillon, R. (1997). *Philosophical Medical Ethics.* Chichester, UK: John Wiley & Sons.

Gilbert, T. (2001). Reflective practice and clinical supervision: meticulous rituals of the confessional. *Journal of Advanced Nursing.* 36(2): 199-205.

Gill, R. (2014). "If you're struggling to survive day-to-day": Class optimism and contradiction in entrepreneurial discourse. *Organisation,* 21(1), 50-67.

Gill, S., Dunning, T., McKinnon, F., Cook, D. & Bourke, J. (2013). Understanding the experience of inpatient rehabilitation: insights into patient-centered care from patients and family members. *Scandinavian Journal of Caring Sciences*, 28(2), 264-272.

Gillespie, R. (2002). Archietecture and power: a family planning clinic as a case study. *Health and Place, 8*(3), 211-220.

Giordano, J. & Duffy, J. (2010). Practical Considerations for Determining Patient Capacity and Consent. *American Family Physician,* 81(9), 1090-1092.

Glenton, C. (2003). Chronic back pain sufferers – striving for the sick role. *Social Science & Medicine,* 57(11), 2243-2254.

Gluyas, H. (2015). Patient-centered care: improving healthcare outcomes. *Nursing Standard*, 30(4), 50-57.

Goering, S. (2009). Postnatal reproductive autonomy: promoting relational autonomy and self-trust in new parents. *Bioethics,* 23(1), 9-19.

Goodman, B. & East, L. (2014). The 'sustainability lens': A framework for nurse education that is 'fit for the future'. *Nurse Education Today,* 34(1), 100-103.

Goodrich, J., & Cornwell, J. (2008). Seeing the person in the patient: the point of care review paper. London, UK: The King's Fund. 1-63.

Gordon, C. (2000). Introduction. In J. Faubion (Ed.), *Michel Foucault Power: essential works of Foucault 1954-198.* (Volume 3) (pp. xi-xliii). London, UK: Penguin Books.

Graham, L. (2011). The product of text and 'other' statements: discourse analysis and the critical use of Foucault. *Educational Philosophy and Theory,* 43(6), 663-674.

Grbich, C. (2007). *Qualitative Data Analysis: an introduction.* London, UK: SAGE Publications.

Gronnerod, J. (2004). On the meanings and uses of laughter in research interviews. *Young,* 12(1), 31-49.

Guta, A., Strike, C., Flicker, S., Murray, S., Upshur, R. & Myers, T. (2014). Governing through community-based research: Lessons from the Canadian HIV research sector. *Social Science & Medicine,* 123, 250-261.

Habibis, D., Hookway, N. & Vreugdenhil, A. (2016). Kindness in Australia: an empirical critique of moral decline sociology. *The British Journal of Sociology,* 67(3), 395-413.

Hanks, R. (2005). Sphere of nursing advocacy model. *Nursing Forum,* 40(3), 75-78.

Hanks, R. (2007). Barriers to Nursing Advocacy: A concept analysis. *Nursing Forum,* 42(4), 171-177.

Hanks, R. (2010). Development and testing of an instrument to measure protective nursing advocacy. *Nursing Ethics,* 17(2), 255-267.

Harkin, M., & Melby, V. (2014). Comparing burnout in emergency nurses and medical nurses. *Clinical nursing studies*, *2*(3), 152-163.

Harnett, P. & Greaney, A. (2008). Operationalizing autonomy: solutions for mental health nursing practice. *Journal of Psychiatric and Mental Health Nursing,* 15(1), 2-9.

Haylett, W. (2009). Ethical Considerations in Paediatric Oncology Phase I Clinical Trials According to The Belmont Report. *Journal of Paediatric Oncology Nursing,* 26(2), 107-112.

Heale, R. &Twycross, A. (2015). Validity and Reliability in quantitative studies. *Evid Based Nurs,* 18(3), 66-67.

Heidegger, M. (1962). *Being and Time.* Oxford, UK: Blackwell Publishing.

Heidegger, M. (1972). *On Time and Being.* New York, NY: Harper & Row.

Hendricks, A. (2009). Personal autonomy, good care, informed consent and human dignity – some reflections form a European perspective. *Medicine and Law,* 28(3), 469-477.

Henneman, E. (1995). Nurse-physician collaboration: a poststructuralist view. *Journal of advanced nursing,* 22(2), 359-363.

Herzlich, C. & Pierret, J. (1985). The social construction of the patient: patients and illnesses in other ages. *Social Science & Medicine,* 20(2), 145-151.

Hewitt, J. (2002). A critical review of the arguments debating the role of the nurse advocate. *Journal of Advanced Nursing,* 37(5), 439-445.

Hewitt, J. (2007). Ethical Component of Researcher-Researched Relationships in Qualitative Interviewing. *Qualitative Health Research,* 17(8), 1149-1159.

Hodge, S. & Harris, R. (2012). Discipline, governmentality and 25 years of competency-based training. *Studies in the Education of Adults,* 44(2), 155-170.

Hofmeyr, B. (2006). The power not to be (what we are): the politics and ethics of self-creation in Foucault. *Journal of Moral Philosophy, 3*(2), 215-230.

Hofmeyer, A., Toffoli, L., Vernon, R., Taylor, R., Klopper, H. C., Coetzee, S. K. & Fontaine, D. (2018). Teaching compassionate care to nursing students in a digital learning and teaching environment. *Collegian*, *25*(3), 307-312.

Holloway, S. (2001). The experience of higher education from the perspective of disabled students. *Disability & Society,* 16(4), 597-615.

Holloway, I. & Wheeler, S. (1996) *Qualitative Research for Nurses,* Oxford, UK: Blackwell Science.

Holmes, D. (2002). Police and pastoral power: governmentality and correctional forensic psychiatric nursing. *Nursing Inquiry*, 9(2), 84-92.

Holmes, D. & Gastaldo, D. (2002). Nursing as means of governmentality. *Journal of Advanced Nursing,* 38(6), 557-565.

Holmes, D. & O'Byrne, P. (2006). The art of public health nursing: using confession techne in the sexual health domain. *Nursing and Healthcare Management and Policy*, 56(4), 430-437.

Holroyd, J. (2009). Relational Autonomy and Paternalistic Interventions. *Res Publica,* 15(4), 321-336.

Hoyle, L. (2014). I mean, obviously you're using your discretion: Nurses use of discretion in policy implementation. *Social Policy and Society,* 13(2), 189-202.

Hooks, R. (2016). Patient-centered care. *Nursing Standard*, 30(20), 61-62.

Hufford, D. (2009). The misunderstood God. Newburg Park, CA: Windblown Media.

Human Rights Principles (2005). Retrieved from http://www.unfpa.org/resources/human-rights-principles

Humphreys, M. & Smallwood, A. (2004). An exploration of the ethical dimension pertinent to gaining consent for thrombolysis. *Nursing in Critical Care,* 9(6), 264-270.

Hunt, G. (1997). The Human Condition of the Professional: discretion and accountability. *Nursing Ethics,* 4(6), 519-526.

Husserl, E. (1931). *Cartesian Meditations: An Introduction to Phenomenology*. The Hague, Germany: Martinus Nijhoff Publishers.

Hyland, D. (2002). An exploration of the relationship between patient autonomy and patient advocacy: Implications for nursing practice. *Nursing Ethics,* 9(5), 472-482.

Ikonomidis, S. & Singer, P. (1999). Autonomy. Liberalism and advance care planning. *Journal of Medical Ethics,* 25(6), 522-527.

Iltis, A. (2000). Bioethics as methodological case resolution: specifications, specified principlism and casuistry. *Journal of Medicine and Philosophy,* 25(3), 271-284.

Image of Professions Survey. (2017) Roy *Morgan Image of Professions Survey 2017: Nurses still easily most highly regarded – followed by Doctors, Pharmacists & Engineers.* Retrieved from http://www.roymorgan.com/findings/6797-image-of-professions-2017-201605110031

International Council of Nurses. (2012). *The ICN Code of Ethics for Nurses.* Retrieved from www.**icn**.ch/who-we-are/**code-of-ethics**-for-nurses/

Jardine, D. (1992). Immanuel Kant, Jean Piaget and the rage for order: Ecological hints of the colonial spirit in pedagogy. *Educational Philosophy and Theory,* 23(1), 28-43.

Jensen, C. (2008). Power, Technology and Social studies of health care: an infrastructural inversion. *Health Care Anal,* 16(4), 355-374.

Jerofke-Owen, T., & Bull, M. (2018). Nurses' Experiences Empowering Hospitalised Patients. *Western Journal of Nursing Research*, 40(7), 961-975.

Jo, K., Doorenbos, A., Sung, K., Hong, E., Rue, T. & Coenen, A. (2011). Nursing interventions to promote dignified dying in South Korea. *International Journal of Palliative Nursing,* 17(8), 392-397.

Johnson, R., Rogers, Y., van der Lunden. & Bianchi-Berthouze, N. (2012). Being in the Thick of in-the wild studies: The challenges and insights of researcher participation. *CHI,* May 5-10, 1135-1144 (Conference Proceedings).

Jones, C. & Porter, R. (1998). Introduction. In C. Jones & R. Porter (Eds.), *Reassessing Foucault: power medicine, and the body.* (pp. 1-16). London, UK: Routledge Publishing.

Jones, J. & Smith, J. (2017). Ethnography: Challenges and opportunities. *Evidence Based Nursing*, 20(4), 98-100.

Jugessur, T. & Iles, I. (2009). Advocacy in mental health nursing: an integrative review of the literature. *Journal of Psychiatric and Mental Health Nursing,* 16(2), 187-195.

Jutel, A. (2009). Sociology of diagnosis: a preliminary review. *Sociology of Health & Illness*, 31(2), 278-299.

Kafle, N. (2011). Hermeneutic phenomenological research method simplified. *Bodhi: An Interdisciplinary Journal,* 5(1), 181-200.

Kagan, S. (2016). Embracing our own vulnerability for more effective and compassionate care. *Geriatric Nursing,* 37(5), 401-403.

Kanuha, V. (2000). "Being" native versus "going native": Conducting social work research as an insider. *Social Work, 45(5), 439-447.*

Kant, I. (2010/1785). Transition from popular moral philosophy to a metaphysics of morals. In T. Hill Jr. & A. Zweig (Eds.), *Kant: Groundwork for the metaphysics of morals* (pp. 208-245). Oxford, UK: Oxford University Press.

Kaplan, D., de Blois, M., Dominguez, V. & Walsh, M. (2016). Studying the teaching of kindness: A conceptual model for evaluating kindness education programs in Schools. *Evaluation and Program Planning,* 58, 160-170.

Karel, M., Gurrera, R., Hicken, B. & Moye, J. (2010). Reasoning in the capacity to make medical decisions: the consideration of values. *Journal of Clinical Ethics,* 21(1), 58-71.

Kelly, J. (2010). Battlefield conditions: different environment but the same duty of care. *Nursing Ethics,* 17(5), 636-645.

Kim-Godwin, Y. S., Alexander, J. W., Felton, G., Mackey, M. C. & Kasakoff, A. (2006). Prerequisites to providing culturally competent care to Mexican migrant farmworkers: A Delphi study. Journal of Cultural Diversity, 13(1), 27-33.

Kleinsinger, F. (2003). Understanding noncompliant behaviour: Definitions and Causes. *Perm J,* 7(4), 18-21.

Kohnke, M. (1980). Advocacy: risk and reality. London, UK: Mosby.

Komrad, M. (1983). A defence of medical paternalism: maximising patients' autonomy. *Journal of Medical Ethics,* 9(1), 38-44.

Kopecky, D. (2011). Foucault, Governmentality, Neoliberalism and Adult education – perspective on the normalisation of social risks. *JoP,* 2(2), 246-262.

Kornhaber, R., Walsh, K., Duff, J. & Walker, K. (2016). Enhancing adult therapeutic interpersonal relationships in the acute health care setting: an integrative review. *Journal of Multidisciplinary Healthcare,* 14(9), 537-546.

Korstjens, I. & Moser, A. (2018). Series: Practical guidance to qualitative research. Part 4: Trustworthiness and publishing. *European Journal of General Practice,* 24(1), 120-124.

Kotarba, J. & Seidel, J. (1984). Managing the problem pain patient: compliance or social control? *Social Science & Medicine,* 19(12),1393-1400.

Kramer, M., Bauer, W., Dikcer, D., Durusus-Tanriover, M., Ferreira, F., Rigby, S., Roux, X., Schumm-Draeger, P., Weidanz, F. & van Hulsteijn, J. (2014). The changing face of internal medicine: Patient centered care. *European Journal of Internal Medicine*, 25(2),125-127.

Kubsch, S., Sternard, M., Hovarter, R. & Matzke, V. (2004). A holistic model of advocacy: factors that influence its use. *Complementary therapies in nursing and midwifery,* 10(1), 37-45.

Kuiper, R., Pesut, D. & Kautz, D. (2009). Promoting the self-regulation of clinical reasoning skills in nursing students. *The Open Nursing Journal,* 3, 76-85.

Kukla, A. (2000). *Social Constructivism and the Philosophy of Science.* London, UK: Routledge.

Kukla, R. (2005). Conscientious Autonomy: displacing decision in health care. *Hastings Centre Report,* 35(2), 34-44.

Kvale, S. (1996). *InterViews: An Introduction to Qualitative Research Interviewing.* California, CA: SAGE Publications.

La Guardia, J. & Ryan, R. (2007). Why identities fluctuate: variability in traits as a function of situational variations in autonomy support. *Journal of Personality,* 75(6), 1205-1228.

Labaree, R. (2002). The risk of 'going observationalist': negotiating the hidden dilemmas of being an insider participant observer. *Qualitative Research,* 2(1), 97-122.

Lamber, V., Glakcen, M., & McCarron, M. (2011). Employing an ethnographic approach: Key characteristics. *Nurse Researcher,* 19(1), 17-23.

Lawler, J. (2006). *Behind the Screens: nursing somology, and the problems of the body.* Sydney, NSW: Sydney University Press.

Lawlor, L (2004). Eschatology and Positivism: The Critique of Phenomenology in Derrida and Foucault. *Bulletin de la Société Américaine de Philosophie de Langue Française*, 14(1), 22-42.

Laurier, E. (2010). Participant Observation. In N. Clifford, S. French, & G. Valentine (Eds.), *Research Methods in Human and Physical Geography* (2nd Ed)(pp. 116-130).London, UK: Sage.

Laverty, S. (2003). Hermeneutic Phenomenology and Phenomenology: A Comparison of Historical and Methodological Considerations. *International Journal of Qualitative Methods,* 2(3), 21-35.

Lavis, V. (2010). Multiple Researcher Identities: Highlighting tensions and implications for ethical practice in Qualitative Interviewing. *Qualitative Research in Psychology,* 7(4), 316-331.

Leary, A. (2014). Kindness does cost. *Nursing Standard,* 28(41), 26-2.

Lemke, T. (2010). Beyond Foucault: from biopolitics to the government of life. In U. Brockling, S. Krasmann & T. Lemke (Eds.), *Governmentality: current Issues and Future Challenges.* (pp. 165-184). Hoboken, NY: Taylor and Francis.

Lincoln, Y. & Guba, E. (1985). *Naturalistic inquiry.* Beverly Hills, CA: SAGE.

Lincoln, Y. & Guba, E. (1989). *Fourth Generation Evaluation.* Newbury Park, USA: SAGE Publications.

Lincoln, Y. & Guba, E. (2000). Paradigmatic controversies, contradictions, and emerging confluences. In N. Denzin, & Y. Lincoln (Eds.), *The handbook of qualitative research* (2nd ed.) (pp.1065-1122). Thousand Oaks, CA: Sage Publications.

Litaker, D., Koroukian, S. & Love, T. (2005). Context and healthcare access: looking beyond the individual. *Medical Care,* 43(6), 531-540.

Loh, J. (2013). Inquiry into Issues of Trustworthiness and Quality into Narrative Studies: A Perspective. *The Qualitative Report,* 18(33), 1-15.

Longino, H. (1997). Feminist Epistemology as a Local Epistemology. *The Aristotelian Society*, 71(1), 19-36.

Lopez, K. & Willis, D. (2004). Descriptive versus interpretive phenomenology: Their contributions to nursing knowledge. *Qualitative health research,* 14(5), 726-735.

Low, J. (2019). A pragmatic definition of the concept of theoretical saturation. *Sociological Focus,* 52(2), 131-139.

Luborsky, M. (1994). The Identification and Analysis of Themes and Patterns. In J. Gubrium & A. Sankar (Eds.), *Qualitative Methods in Aging Research*. (pp. 189-210). Thousand Oaks, California: SAGE Publications.

Lukes, S. (2004). *Power: A Radical View.* (2nd Ed.) Basingstoke, UK: Palgrave Macmillan Ltd.

Lupton, D. (1997). Foucault and the medicalisation critique. In A. Peterson & R. Bunton (Eds.), *Foucault, Health and Medicine*. (pp. 94-110). London, UK: Routledge.

Lysaught, M. (2004). Respect: Or, how respect for persons became respect for autonomy. *Journal of Medicine and Philosophy,* 29(6), 665-680.

McCance, T., Gribben, B., McCormack, B. and Mitchell, E. (2010) *Improving the Patient Experience by Exploring Person-centered Care in Practice. Final Programme Report*. Belfast: Belfast Health and Social Care Trust.

McCarthy, J. (2003). Principlism or narrative ethics: must we choose between them? *Medical Humanities,* 29(2), 65-71.

McCarthy, A. (2005). *A rebellious distemper: A Foucaultian history of breast cancer to 1900* (Doctoral dissertation, Queensland University of Technology).

McClimans, L., Dunn, M. & Slowther, A. (2011). Health policy, patient-centered care and clinical ethics. *Journal of Evaluation in Clinical Practice*, 17(5), 913-919.

McGowen, R. (1994). Power and Humanity, or Foucault among the historians. In C. Jones & R. Porter (Eds.), *Reassessing Foucault: Power, Medicine and the Body.* (pp. 91-112). London, UK: Routledge.

McGrath, P., Holewa, H. & McGrath, Z. (2006). Nursing Advocacy in an Australian multidisciplinary context: findings on medico-centrism. *Scand J. Caring Sci.* 20: 394-402.

McHoul, A. & Grace, W. (1993). *A Foucault Primer: discourse, power and the subject.* Melbourne, Victoria: Melbourne University Press.

McIlwraith, J. & Madden, B. (2006). *Health Care & The Law.* (6th Ed.) Pyrmont, NSW: Lawbook Co.

McGrath, P., Holewa, H. & McGrath, Z. (2006). Nursing advocacy in an Australian multidisciplinary context: findings on medico-centrism. *Scandinavian Journal of Caring Sciences,* 20(4), 394-402.

McGrath, C., Palmgren, P., Liljedahl, M. (2018). Twelve tips for conducting qualitative research interviews. *Medical Teacher.* DOI: 10.1080/0142159X.2018.1497149

McKeown, M., Ridley, J., Newbigging, K., Machin, K., Poursanidou, K. & Cruse, K. (2014). A conflict of roles, a conflict of ideas? The unsettled relations between care team staff and independent mental health advocates. *International Journal of Mental Health Nursing*, 23(5), 398-408.

McKinlay, A., Carter, C. & Pezet, E. (2012). Governmentality, Power and organisation. *Management & Organisational History,* 7(1), 3-15.

McKinlay, A. & Taylor, P. (2014). *Foucault, Governmentality, and Organisation: inside the factory of the future.* Hoboken, NY: Taylor and Francis.

McLeod, C. and Sherwin, S. (2000). *Relational Autonomy, self-trust and health care for patients who are oppressed.* In C. MacKenzie & N. Stoljar (Eds.), *Relational Autonomy: feminist perspective on autonomy, agency and the social self.* (pp. 259-279). Oxford, UK: Oxford University Press.

McNay, L. (1994). *Foucault: a critical introduction.* Cambridge, UK: Polity Press.

McNay, L. (2009). Self as enterprise: dilemma of control and resistance in Foucault's the birth of Biopolitics. *Theory, Culture & Society,* 26(6), 55-77.

McSteen, K. & Peden-McAlpine, C. (2006). The role of the nurse as advocate in ethically difficult care situations with dying patients. *Journal of Hospice and Palliative Nursing,* 8(5), 259-269.

MacDonald, C. (2002a). Nurse Autonomy as Relational. *Nursing Ethics,* 9(2), 194-201.

MacDonald, C. (2002b). Relational Professional Autonomy. *Cambridge Quarterly of Healthcare Ethics,* 11(3), 282-289.

MacDonald, F. (2006, June). *Relational group autonomy: ensuring agency and accountability in the group rights paradigm.* Paper presented at the Annual Meeting of the Canadian Political Science Association, British Columbia, Canada.

MacDonald, H. (2007). Relational ethics and advocacy in nursing: literature review. *Journal of Advanced Nursing,* 57(2), 119-126.

Macdonald, L. M. (2016). Expertise in Everyday Nurse–Patient Conversations: The Importance of Small Talk. *Global Qualitative Nursing Research*. https://doi.org/10.1177/2333393616643201

Mackenzie, C. (2008). Relational Autonomy, normative authority, and perfectionism. *Journal of Social Philosophy,* 39(4), 512-533.

MacKenzie, C., McDowell, C. & Pittaway, E. (2007). Beyond 'Do No Harm': the challenge of constructing ethical relationships in refugee research. *Journal of Refugee Studies,* 20(2), 299-319.

MacKenzie, C., & Stoljar, N. (2000). *Autonomy Refigured.* In C. MacKenzie, & N. Stoljar, (Eds.), *Relational Autonomy: feminist perspectives on autonomy, agency, and the social self.* (pp. 3-31). Oxford, UK: Oxford University Press.

MacLean, A. (2006). Autonomy, Consent and Persuasion. *European Journal of Health Law,* 13(4), 321-338.

Mace, K. (2012). Creating a culture of kindness. *Journal of Christian Nursing,* 29(4), 228-230.

Macklin, R. (1999). *Against Relativism: Cultural Diversity & the Search of Ethical Universals in Medicine.* New York, NY: Oxford University Press.

Magid, C. (2001). Developing tolerance for ambiguity. *JAMA,* 286(1), 88.

Mahlin, M. (2010). Individual patient advocacy, collective responsibility, and activism within professional nursing associations. *Nursing Ethics,* 17(2), 247-254.

Mallik, M. (1997a). Advocacy in nursing – a review of the literature. *Journal of Advanced Nursing,* 25(1), 130-138.

Mallik, M. (1997b). Advocacy in nursing – perceptions of practising nurses. *Journal of Clinical Nursing,* 6(4), 303-313.

Mallik, M. (1998). Advocacy in nursing: perceptions and attitudes of the nursing elite in the United Kingdom. *Journal of Advanced Nursing,* 28(5), 1001-1011.

Malterud, K. (1999). The (Gendered) construction of diagnosis interpretation of medical signs in women patients. *Theoretical Medicine and Bioethics,* 20(3), 275-286.

Marcinowicz, L., Konstantynowicz, J. & Godlewski, C. (2010). Patients’ perceptions of GP non-verbal communication: a qualitative study. *British Journal of General Practice,* 60(571), 83-87.

Marsella, A. (1987). Health, Public Policy, and Culture: the issue of ethnocentricity. In R. Draper, P. Leaf, & L Levin (Eds.), *Yale Symposium on Health Public Policy.* New Haven, CT: Yale University Press.

Marshall, A., Kitson, A. & Zeitz, K. (2012). Patients’ views of patient-centered care: a phenomenological case study in one surgical unit. *Journal of Advanced Nursing*, 68(12), 2664-2673.

Martin, G., Leslie, M., Minion, J., Willars, J. & Dixon-Woods, M. (2013). Between surveillance and subjectification: professionals and the governance of quality and patient safety in English hospitals. *Social Science & Medicine,* 99, 80-88.

Mascaro, J., Darcher, A., Negi, L. & Raison, C. (2015). The neural mediators of kindness-based meditation: a theoretical model. *Frontiers in Psychology,* 6(109), 1-12.

Matic, J., Davidson, P. & Salamonson, Y. (2010). Review: bringing patient safety to the forefront through structured computerisation during clinical handover. *Journal of Clinical Nursing,* 20(1), 184-189.

May, T. (2005). The concept of autonomy in bioethics: an unwarranted fall from grace. In J. Taylor (Ed.), *Personal Autonomy: new essays on personal autonomy and its role in contemporary healthcare.* (pp. 299-309). Cambridge, UK: Cambridge University Press.

Mays, N. & Pope, C. (1995a). Observational methods in health care settings. *BMJ,* 311(6998), 182-184.

Mays, N. & Pope, C. (1995b). Rigour and qualitative research. *BMJ,* 311(6997), 109-112.

Mercer, J. (2007). The challenges of insider research in educational institutions wielding a double-edged sword and resolving delicate dilemmas. *Oxford Review of Education,* 33(1), 1-17.

Meyers, D. (1989). *Self, Society and Personal Choice.* New York, NY: Columbia University Press.

Mik-Meyer, N. & Obling, A. (2012). The negotiation of the sick role: general practitioners' classification of patients with medically unexplained symptoms. *Sociology of Health & illness*, 34 (7), 1025-1038.

Mill, J. (2010/1859). *On Liberty.* USA: Megalodon Entertainment LLC.

Mills, S. (2013). *Michel Foucault.* Hoboken, NY: Taylor and Francis.

Mitsi, A., Kourakos, M., Poulimenakou, G., Latsou, D. & Sarris, M. (2018). Therapeutic Relationship and Quality of Life in Chronic Diseases. *American Journal of Nursing Science,* 7(3-1), 103-108.

Mol, A. (2008). *The logic of care: Health and the problem of patient choice.* New York, NY: Routledge.

Moore, L., Britten, N., Lydahl., Naldemirci, O., Elam, M., Wolf, A. (2017). Barriers and facilitators to the implementation of person-centered care in different healthcare contexts. *Scandinavian Journal of Caring Sciences*, 31(4), 662-673

Moran, D. (2000). *Introduction to Phenomenology*. New York, NY: Routledge Taylor & Francis Group.

Moran, L., Skeggs, B., Tyrer, P. & Corteen, K. (2002). Safety talk, violence and laughter: methodological implications and reflections on focus groups in violence researcher. In R. Lee & E. Stanko (Eds.) *Researching Violence: Methodology and Measurement.* (pp. 107-125). London, UK: Routledge.

Morra, M. (2000). New opportunities for nurses as patient advocates. *Seminars in Oncology Nursing,* 16(1), 57-64.

Morrissey, J. (2013). Governing the academic subject: Foucault, governmentality and the performing University. *Oxford Review of Education,* 39(6), 797-810.

Morrow, S. (2005). Quality and Trustworthiness in Qualitative Research in Counselling Psychology. *Journal of Counselling Psychology,* 52(2), 250-260.

Morse, J., Barrett, M., Mayan, M., Olson, K. & Spiers, J. (2002). Verification strategies for establishing reliability and validity in qualitative research. *International Journal of Qualitative Methods,* 1(2), 13-22.

Moye, J., Gurrera, R., Karel, M., Edelstein, B. & O'Connell, C. (2006). Empirical advances in the assessment of the capacity to consent to medical treatment: clinical implications and research needs. *Clinical Psychology Review,* 26(8), 1054-1077.

Moyle, W. (2002). Unstructured interviews: challenges when participants have a major depressive illness. *Journal of Advanced Nursing,* 39(3), 266-273.

Murphy, N. & Aquino-Russell, C. (2008). Nurses practice beyond simple advocacy to engage in relational narratives: expanding opportunities for persons to influence the public sphere. *The Open Nursing Journal,* 2(1), 40-47.

Murray, T. (2003). *Blending qualitative and quantitative research methods in theses and dissertations.* Thousand Oaks, CA: Corwin Press.

Naik, A., Teal, C., Dyer, C., Kunik, M. & McCullough, L. (2008). Patient autonomy for the management of chronic conditions: a two-component re-conceptualisation. *The American Journal of Bioethics,* 9(2), 23-30.

Naples, N. (1996). A feminist revisiting of the insider/outsider debate: The "outsider phenomenon" in rural Iowa. *Qualitative Sociology,* 19(1), 83-106.

National Commission for the protection of human subjects of Biomedical and behavioural research (1979). *The Belmont Report.* Retrieved from www.hhs.gov/ohrp/humansubjects/guidance/**belmont**.html

National Institute for Health and Care Excellence [NICE] (n.d.). Retrieved from http://www.nice.org.uk/about

Nedelsky, J. (1989). Reconceiving Autonomy: Sources, Thoughts, and Possibilities. *Yale Journal of Law and Feminism,* 1(7), 7-36.

Negarandeh, R., Oskouie, F., Ahmadi, F., Nikravesh, M. & Hallberg, I. (2006). Patient advocacy: barriers and facilitators. *BMC Nursing,* 5(3), 1472-1480.

Negarandeh, R., Oskouie, F., Ahmadi, F. & Nikravesh, M. (2008). The meaning of patient advocacy for Iranian nurses. *Nursing Ethics,* 15(4), 457-467.

Nursing and Midwifery Board of Australia [NMBA] (n.d.). Retrieved from www.nursingmidwiferyboard.gov.au/About.aspx

Nursing and Midwifery Board of Australia [NMBA] (2008a) *Code of Ethics for Nurses.* Retrieved from http://www.nursingmidwiferyboard.gov.au/Codes-Guidelines-Statements/Professional-standards.aspx

Nursing and Midwifery Board of Australia [NMBA] (2008b) *Code of Professional Conduct for Nurses* Retrieved from http://www.nursingmidwiferyboard.gov.au/Codes-Guidelines-Statements/Professional-standards.aspx

Nursing and Midwifery Board of Australia. (2006). *National Competency standards for the Registered Nurse*. Retrieved from http://www.nursingmidwiferyboard.gov.au/Codes-Guidelines-Statements/Professional-standards.aspx

Nursing and Midwifery Board of Australia [NMBA] (2010) *Professional Boundaries for Nurses* Retrieved from http://www.nursingmidwiferyboard.gov.au/Codes-and-Guidelines--/Professional-boundaries-for-nurses--February-2010.pdf

Nursing and Midwifery Board of Australia [NMBA] (2016). *Registered Nurse Standards for Practice.* Retrieved from http://www.nursingmidwiferyboard.gov.au/Codes-Guidelines-Statements/Professional-standards.aspx

Nursing and Midwifery Board of Australia [NMBA] (2018) *Code of Conduct for Nurses* Retrieved from http://www.nursingmidwiferyboard.gov.au/Codes-Guidelines-Statements/Professional-standards.aspx

O'Connor, T. & Kelly, B. (2005). Bridging the gap: a study of general nurses' perceptions of patient advocacy in Ireland. *Nursing Ethics,* 12(5), 453-467.

O'Malley, P. (1996). Risk and responsibility. In A. Barry, T. Osborne, & N. Rose (Eds.), *Foucault and political reason: Liberalism, neoliberalism and rationalities of government*. (pp. 189-208). London, UK: UCL Press.

O'Reilly, M. & Parker, N. (2012). Unsatisfactory Saturation: a critical exploration of the notion of saturated sample sizes in qualitative research. *Qualitative Research,* 13(2), 190-197.

Office of the public advocate. (2019). *Health practitioners seeking a decision by OPA.* Retrieved from www.publicadvocate.vic.gov.au

Ojakangas, M. (2012). Michel Foucault and the enigmatic origins of bio-politics and governmentality. *History of the Human Sciences,* 25(1), 1-14.

Oksala, J. (2013). From Biopower to Governmentality. In C. Falzon, T. O'Leary & J. Sawicki (Eds.), *A companion to Foucault.* (pp. 320-336). Chichester, UK: Wiley-Blackwell.

Olson, T. (2002). From clinician to client: The lived experience of mental illness. *Issues in Mental Health Nursing*, *23*(5), 435-444.

Orr, P. (2000). Influenza vaccination for health care workers: A duty of care. *Can J Infect Dis,* 11(5), 225-226.

Osborne, T. (1993). On liberalism, neo-liberalism and the 'liberal' profession of medicine. *Economy and Society,* 22(2), 345-356.

Oxelmark, L., Ulin, K., Caboyer, W., Bucknall, T., & Ringdal, M. (2018). Registered Nurses' experiences of patient participation in hospital care: supporting and hindering factors patient participation in care. *Scand J Caring Sci,* 32(2), 612-621.

Pacquiao, D. (2008). Nursing care of vulnerable populations using a framework of cultural competence, social justice and human rights. *Contemporary Nurse*, *28*(1-2), 189-197.

Paley, J. (2014). Heidegger, Lived experience and Method. *JAN,* 70(7), 1520-1531.

Parsons, T. (1951). *The social System.* Glencoe, IL: Free Press.

Patton, M. (2002). *Qualitative Research and Education Methods.* California, CA: SAGE Publications.

Pearce, S. & Pickard, H. (2010). Finding the will to recover: philosophical perspectives on agency and the sick role. *Journal of Medical Ethics,* 36(12), 831-833.

Peerson, A. & Yong, V. (2003). Reflexivity in nursing: where is the patient? Where is the nurse? *Australian Journal of Holistic Nursing,* 10(1), 30-45.

Pelzang, R. (2010). Time to learn: understanding patient-centered care. *British Journal of Nursing*, 19(14), 912-917.

Pentzopoulou-Valalas T. (1990) Experience and Causal Explanation in Medical Empiricism. In P. Nicolacopoulos (eds.), *Greek Studies in the Philosophy and History of Science*. Boston Studies in the Philosophy of Science (Vol 121) (pp. 91-108). Dordrecht, Germany: Springer.

Perron, A. (2013). Nursing as ‘disobedient’ practice: care of the nurse’s self, parrhesia, and the dismantling of a baseless paradox. *Nursing Philosophy*, 14(3), 154-167.

Perron, A., Fluet, C. & Holmes, D. (2005). Agents of care and agents of the state: bio-power and nursing practice. *Journal of Advanced Nursing,* 50(5), 536-544.

Perry, B. (2011). The Labelling Paradox: Stigma, the Sick Role, and Social Networks in Mental Illness. *Journal of Health and Social Behaviour,* 52(4), 460-477.

Petersen, A. (2013). From bioethics to a sociology of bio-knowledge. *Social Science & Medicine,* 98, 264-270.

Phoenix, C. & Orr, N. (2017). Analysing exceptions within qualitative data: promoting analytical diversity to advance knowledge of ageing and physical activity. *Qualitative Research in Sport, Exercise and Health,* 9(3), 271-284

Phutela, D. (2015). The importance of non-verbal communication. *IUP Journal of Soft Skills,* 9(4), 43-49.

Pope, C., Van Royen, P. & Baker, R. (2002). Qualitative methods in research on healthcare quality. *Qual Saf Health Care,* 11(2), 148-152.

Porter, S. (1996). Contra-Foucault: Soldiers, Nurses and Power. *Sociology,* 30(1), 59-78.

Powell, J. & Gilbert, T. (2010). Power and Social Work in the United Kingdom. *The Journal of Social Work,* 10(1), 3-24.

Prior, K. & Bond, M. (2008). The measurement of abnormal illness behaviour: toward a new research agenda for the illness behaviour questionnaire. *Journal of Psychosomatic Research,* 64(3), 245-253.

Rabinow, P. (1984). *The Foucault Readers: an introduction to Foucault’s thought.* London, UK: Penguin Books.

Rademakers, J., Delnoij, D., Nijman, J. & de Boer, D. (2012). Educational inequalities in patient-centered care: patients' preferences and experiences. *BioMed Central*, 12(1), 261-269.

Rafii, F., Fatemi, N., Danielson, E., Johansson, C. & Modanloo, M. (2014). Compliance to treatment in patients with chronic illness: A concept exploration. *Iranian Journal of Nursing and Midwifery Research,* 19(2), 159-167.

Rajtar, M. (2013). Bioethics and religious bodies: refusal of blood transfusions in Germany. *Social Science & Medicine,* 98, 271-277.

Ranieri, P. (n.d.) *Partnering with consumers and the community.* Retrieved from https://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/clinical+resources/safety+and+quality/partnering+with+consumers+and++the+community/patient+and+consumer+centered+care

Rathert, C., Williams, E., McCaughey, D. & Ishqaidef, G. (2012). Patient perceptions of patient-centered care: empirical test of a theoretical model. *Health Expectations,* 18(2),199-209.

Reid, L. (2005). Diminishing returns? Risk and the duty to care in the sars epidemic. *Bioethics,* 19(4), 348-361.

Reinharz, S. (1997). 'Who am I: the need for a variety of selves in the field'. In R. Hertz (Ed). *Reflexivity and voice.* (pp. 3-20). Thousand Oaks, CA: SAGE.

Regan, P. (2012). Hans-Georg Gadamer's philosophical hermeneutics: concepts of reading, understanding and interpretation. *Meta: Research in Hermeneutic, Phenomenology, and Practical Philosophy,* IV (2), 286-303.

Rendtorff, J. (2007). The Limitation and accomplishments of autonomy as a basic principle in bioethics and Biolaw. In D. Weisstub & G. Diaz-Pintos (2007).

Autonomy and Human Rights in Health Care: an international perspective. (pp. 75-87). Dordrecht, Germany: Springer.

Rendtorff, J. & Kemp, P. (2000). *Autonomy, dignity, integrity and vulnerability, Volume 1 of basic ethical principles in European bioethics and Biolaw: Report to the European commission of the BIOMED-II project.* Copenhagen: Danish Centre for Ethics and Law.

Richards, T., Coulter, A. & Wicks, P. (2015). Time to deliver patient centered care. *BMJ,* 10(350), 530.

Rigby, D. (2014). Patient-centered care. *The Australian Journal of Pharmacy*, 95, 72-76.

Riley, R. & Manias, E. (2006). Governance in operating room nursing: Nurses' knowledge of individual surgeons. *Social Science & Medicine*, 62(6), 1541-1551.

Ritchie, J., Lewis, J. & Elam, G. (2003). Designing and Selecting Samples. In J. Ritchie & J. Lewis (2003). *Qualitative Research Practice: a guide for social science students and researchers.* (pp. 77-108). London, UK: SAGE Publications.

Robson, C. (2002) *Real World Research.* (2nd ed.). Oxford, UK: Blackwell Publishing

Rolfe, G. & Gardner, L. (2006). 'Do not ask who I am…': confession, emancipation and (self)-management through reflection. *Journal of Nursing Management*, 14(8), 593-600.

Rose, N. (1994). Identity, genealogy, history. In S. Hall & P. Du Gay (Eds.), Questions of cultural identity (pp. 128-150). London, UK: Sage.

Roulston, K. (2010). Considering quality in qualitative interviewing. *Qualitative Research,* 10(2), 199-228.

Rundell, J. (1995) Gadamer and the circles of hermeneutics. In D. Roberts (Eds.), *Reconstructing Theory: Gadamer, Habermas and Lubman*. (pp. 10-38). Melbourne, VIC: Melbourne University Press.

Rutherford, P., Lee, B. & Greiner, A. (2004). *Transforming care at the bedside*. Cambridge, Ma: Institute for Healthcare Innovations.

Ryan, R. & Deci, E. (2006). Self-regulation and the problem of human autonomy: does psychology need choice, self-determination, and will? *Journal of Personality,* 74(6), 1557-1585.

Saari, C. (2001). Counteracting the effects of Invisibility in Work with Lesbian Patients. *Psychotherapy in Practice,* 57(5), 645-654.

Saharso, S. (2003). Feminist ethics, autonomy, and the politics of multiculturalism. *Feminist Theory,* 4(2), 199-215.

Santana, M., Manalili, K., Jolley, R., Zelinsky, S., Quan, H., & Lu, M. (2017). How to practice person-centered care: A conceptual framework. *Health Expectations*, 21(2), 429-440.

Santana, M., Manalili, K., Jolley, R., Zelinsky, S., Quan, H. & Lu, M. (2018). How to practice person-centered care: A Conceptual Framework. *Health Expectations,* 21(2), 429-440.

Saunders, B., Sim, J., Kingstone, T., Baker, T., Waterfield, J., Bartlam, B., Burroughs, H. & Jinks, C. (2018). Saturation in qualitative research: exploring its conceptualisation and operationalisation. *Qual Quant,* 52(4), 1893-1907.

Savvides, N., Al-Youssef, J., Colin, M. & Garrido, C. (2014). Journeys into Inner/Outer Space: Reflections on the Methodological Challenges of Negotiating Insider/Outsider Status in International Educational Research. *Research in Comparative and International Education,* 9(4), 412-425.

Scambler, S., Gupta, A. & Asimakopoulou, K. (2014). Patient-centered care – what is it and how is it practised in the dental surgery? *Health Expectations*, 18(6), 2549-2558.

Scambler, S., Newton, P. & Asimakopoulou, K. (2014). The context of empowerment and self-care within the field of diabetes. *Health,* 18(6), 545-560.

Scanlan, C. & Kerridge, I. (2009). Autonomy and chronic illness: not two components but many. *The American Journal of Bioethics,* 9(2), 40-42.

Scanlon, A. & Lee, G. (2007). The use of the term vulnerability in acute care: why does it differ and what does it mean? *Australian Journal of Advanced Nursing,* 24(3), 54-59.

Schwan, A. & Shapiro, S. (2011). *How to read Foucault's discipline and punish.* London, UK: Pluto Press.

Schwandt, T. (1998). Constructivist, Interpretivist Approaches. In N. Denzin & Y. Lincoln (Eds.), *The Landscape of Qualitative Research: Theories and Issues*. (pp. 118-137). Thousand Oaks, CA: Sage Publications.

Schwartz, L. (2002). Is there an advocate in the house? The role of healthcare professionals in patient advocacy. *Journal of Medical Ethics,* 28(1), 37-40.

Scully, J., Banks, S. & Shakespeare, T. (2006). Chance, choice and control: lay debate on prenatal social sex selection. *Social Science and Medicine,* 63, 21-31.

Seale, C. (1999). Quality in Qualitative Research. *Qualitative Inquiry,* 5(4), 465-478.

Seidel, B. (2016, January 18). I specialise in patients, not consumers, clients or users [Blog Post]. Retrieved from http://medicalrepublic.com.au/i-specialise-in-patients-not-consumers-clients-or-users/1550

Seidman, I. (2006). *Interviewing as Qualitative Research: A guide for researchers in Education and the Social Sciences.* (3rd Ed.). New York, NY: Teachers College Press.

Sellin, S. (1995). Out on a limb: a qualitative study of patient advocacy in institutional nursing. *Nursing Ethics,* 2(1), 19-29.

Sellman, D. (2005). Towards an understanding of nursing as a response to human vulnerability. *Nursing Philosophy,* 6(1), 2-10.

Shah, A. (2004). The researcher/interviewer in intercultural context: a social intruder! *British Educational Research Journal,* 30(4), 549-575.

Sherwin, S. (1992). *No longer patient: Feminist ethics and Health care Philadelphia.* Philadelphia, PA: Temple University Press.

Shirley, J. (2009). Limits of autonomy in nursing's moral discourse. *Advances in Nursing Science,* 30(1), 14-25.

Shore, N. (2006). Re-conceptualising the Belmont Report. *Journal of community Practice,* 14(4), 5-26.

Simmonds, A. (2008). Autonomy and Advocacy in Perinatal Nursing Practice. *Nursing Ethics,* 15(3), 360-370.

Simons, J. (2013). Power, Resistance, and Freedom. In C. Falzon, T. O'Leary & J. Sawicki (Eds.), *A companion to Foucault.* (pp. 301-319). Chichester, UK: Wiley-Blackwell.

Sims, J. (2010). A brief review of the Belmont Report. *Dimens Crit Care Nurs,* 29(54), 173-174.

Simpson, C. (2010). Decision-making capacity and informed consent to participate in research by cognitively impaired individuals. *Applied Nursing Research,* 23(4), 221-226.

Smart, C. (1995). Law, Crime and Sexuality: Essays in Feminism. London, UK: SAGE Publications.

Smith, J. & Firth, J. (2011). Qualitative data analysis: the framework approach. *Nurse Researcher,* 18(2), 52-62.

Smith, J. & Osborn, M. (2007). Pain as an assault on the self: An interpretative phenomenological analysis of the psychological impact of chronic benign low back pain. *Psychology & Health,* 22(5), 517-534.

Spenceley, S., Reutter, L. & Allen, M. (2006). The road less travelled: nursing advocacy at the policy level. *Policy Politics Nursing Practice,* 7(3), 180-194.

Spradley, J. (1980). *Participant Observation.* New York, NY: Holt, Rinehart and Winston.

St-Pierre, I. & Holmes, D. (2008). Managing nurses through disciplinary power: a Foucaultian analysis of workplace violence. *Journal of Nursing Management,* 16(3), 352-359.

Stasiak, D. B. (2001). Culture Care theory with Mexican-Americans in an urban context. In M. Leininger (Ed.), *Culture Care Diversity and Universality: A theory of nursing* (pp. 179-201). Boston, USA: Jones & Bartlett.

Stepanikova, I., Zhang, Q., Wieland, D., Eleazer, P. & Stewart, T. (2011). Non-verbal communication between primary care physicians and older patients: how does race matter? *Journal of General Internal Medicine,* 27(5), 576-581.

Stevenson, F., Cox, K., Britten, N. & Dundar, Y. (2004). A systematic review of the research on communication between patients and healthcare professionals about medicines: the consequences for concordance. *Health Expectations,* 7(3), 235-245.

Stickley, T. (2011). From SOLER to SURETY for effective non-verbal communication. *Nurse Education in Practice,* 11(6), 395-8.

Stiggelbout, A., Molewijk, A., Otten, W., Timmermans, D., van Bockel, J. & Kievit, J. (2004). Ideals of patient autonomy in clinical decision-making: a study on the development of a scale to assess patients' and physicians' views. *Journal of Medical Ethics,* 30(3), 368-274.

Stimson, G. (1974). Obeying Doctor's Orders: A view from the other side. *Social Science and Medicine,* 8(2), 97-104.

Stoljar, N. (2011). Informed Consent and Relational Conceptions of Autonomy. *Journal of Medicine and Philosophy,* 36(4), 375-384.

Storni, C. (2015). Patients' lay expertise in chronic self-care: a case study in type 1 diabetes. *Health Expectations*, *18*(5), 1439-1450.

Straughair, C. (2012a). Exploring compassion: implications for contemporary nursing. Part 1. *British Journal of Nursing,* 21(3),160-164.

Straughair, C. (2012b). Exploring compassion: implications for contemporary nursing. Part 2. *British Journal of Nursing,* 21(4), 239-244.

Streeck, J. & Mehus, S. (2005) Microethnography: The study of Practices. In Fitch, K. & Sanders, R. (Eds.). *Handbook of Language and Social Interaction,* Lawrence Erlbaum Associates Publishers, London, pp. 381-406.

Stuifbergen, M. & Van Delden, J. (2011). Filial obligations to elderly parents: a duty to care? *Med Health Care and Philos,* 14(1), 63-71.

Sumner, J. & Townsend-Rocchiccioli, J. (2003). Why are nurses leaving Nursing? *Nursing Admin Q,* 27(2), 164-171.

Tai, M. & Lin, C. (2001). Developing culturally relevant bioethics for Asian people. *Journal of Medical Ethics,* 27(1), 51-54.

Tarber, C., Frosthol, L. & Rehfeld, E. (2016). Talking at cross purposes: negotiation of the sick role with a MUS patient as a real time social process. *Tidsskrift for Forskning I Sygdom og Samfund*, 13(24), 61-88.

Tauber, A. (2003). Sick Autonomy. *Perspectives in biology and medicine,* 46(4), 484-495.

Taylor, J. (2011). The intimate insider: negotiating the ethics of friendship when doing insider research. *Qualitative Research,* 11(1), 3-22.

Taylor, I. & Kelly, J. (2006). Professionals, discretion and public sector reform in the UK: re-visiting Lipsky. *International Journal of Public Sector Management,* 19(7), 629-642.

Thacker, K. (2008). Nurses' advocacy behaviours in end-of-life nursing care. *Nursing Ethics,* 15(2), 174-185.

Thistlethwaite, J. (2013). Practice-based learning across and between the health professions: a conceptual exploration of definitions and diversity and their impact on interprofessional education. *PBLH,* 1(1), 15-28.

Thomas, A., Menon, A., Boruff, J., Rodriguez, A. & Ahmed, S. (2014). Applications of social constructivist learning theories in knowledge translation for healthcare professionals: a scoping review. *Implementation Science,* 9(1), 54-74.

Thomas, J.& Harden, A. (2008). Methods for the thematic synthesis of qualitative research in systematic reviews. *BMC Medical Research Methodology,* 8(1), 45-55.

Thomas, E. & Magilvy, J. (2011). Qualitative Rigor or Research Validity in Qualitative Research. *Journal for Specialists in Paediatric Nursing,* 16(2),151-155.

Thwaites, R. (2017). (re)Examining the feminist interview: Rapport, Gender "matching", and emotional labour. *Frontiers in Sociology,* 2(18), 1-8.

Tobin, G. & Begley, C. (2004). Methodological rigour within a qualitative framework. *Journal of Advanced Nursing,* 48(4), 388-396.

Tomlinson, J. (2012). We must join forces with our patients. *The BMJ,* 345, e7047.

Tsai, D. (1999). Ancient Chinese medical ethics and the four principles of Biomedical ethics. *Journal of Medical Ethics,* 25(4), 315-321.

Usher, R. & Edwards, R. (2003). *Postmodernism and Education.* London, UK: Routledge.

Van Der Eijk, M., Nijhuis, F., Faber, M. & Bloem, B. (2013). Moving from physician-centered care towards patient-centered care for Parkinson's disease patients. *Parkinsonism Relat Disord,* 19(11), 923-927.

Van Manen, M. (2007). Phenomenology of Practice. *Phenomenology & Practice,* 1(1), 11-30.

Van Maanen, J. (2011). *Tales of the field on writing ethnography.* (2nd Ed.). Chicago, USA: University of Chicago Press.

Van Rensburg, A., Rau, A., Fourie, P. & Bracke, P. (2016). Power and integrated healthcare: shifting from governance to governmentality. *Integrated Journal of Integrated Care,* 16(3),1-11.

Varul, M. (2010). Talcott Parsons, the sick Role and Chronic Illness. *Body & Society*, 16(2), 72-94.

Vaismoradi, M., Turunen, H. & Bondas, T. (2013). Content Analysis and thematic analysis: Implications for conducting a qualitative descriptive study. *Nursing and Health Sciences,* 15(3), 398-405.

Veatch, R. & Spicer, C. (1994). Against paternalism in the patient-physician relationship. In R. Gillon (Ed.), *Principles of Health Care Ethics.* (pp. 409-419). London, UK: John Wiley & Sons Ltd.

Vighi, F. & Feldner, H. (2007). *Zizek: Beyond Foucault.* Hampshire, USA: Palgrave McMillan.

Vinson, A. (2016). 'Constrained collaboration': Patient empowerment discourse as resources for countervailing power. *Sociology of Health & Illness,* 38(8), 1364-1378.

Vintges, K. (2012). Muslim women in the western media: Foucault, agency, governmentality and ethics. *European Journal of Women's Studies,* 19(3), 283-298.

Vollmer, S. & Howard, G. (2010). Statistical power, the Belmont report, and the ethics of clinical trials. *Sci Eng Ethics,* 16(4), 675-691.

Voshaar, M., Van De Laar, M. & Van Den Bemt, B. (2015). Patient-centered care in established rheumatoid arthritis. *Best Practice & Research Clinical Rheumatology*, 29(4-5): 643-663.

Walker, C. (2015). Social Constructionism and Qualitative Research. *The Journal of Theory Construction and Testing,* 19(2), 37-38.

Walters. A. (1995). The phenomenological movement: implications for nursing research. *Journal of Advanced Nursing,* 22(4), 791-799.

Ward, J., Cody, J., Schaal, M. & Hojat, M. (2012). The empathy enigma: an empirical study of decline in empathy among undergraduate nursing students. *Journal of Professional Nursing,* 28(1), 34-40.

Warda, M. R. (2000). Mexican Americans' perceptions of culturally competent care. *Western Journal of Nursing Research*, 22(2), 203-224.

Watt, R. (2007). From victim blaming to upstream action: tackling the social determinants of oral health inequalities. *Community Dent Oral Epidemiol,* 35, 1-11.

Watts, J. (2008). Emotion, empathy and exit: reflections on doing ethnographic qualitative research on sensitive topics. *Medical Sociology Online,* 3(2), 3-14.

Watts, J. (2010). Ethical and practical challenges of participant observation in sensitive health research. *International Journal of Social Research Methodology,* 14(4), 301-312.

Weatherall, M. (1996). Drug treatment and the rise in pharmacology. In R. Porter (Ed.), *The Cambridge Illustrated History of Medicine,* (pp. 246-277). Cambridge, UK: Cambridge University Press.

Weaver, R. (2015). Reconciling evidence-based medicine and patient-centered care: defining evidence-based inputs to patient-centered decisions. *Journal of Evaluation in Clinical Practice*, 21(6), 1076-1080.

Weinsheimer, J. (1985). *Gadamer's Hermeneutics a Reading of Truth and Method.* New York, NY: Yale University Press.

Welford, C., Murphy, K. & Casey, D. (2012). Demystifying nursing research terminology: Part 2. *Nurse Researcher,* 19(2), 29.

Wellard, S. (1998). Construction of chronic illness. *International Journal of Nursing Studies,* 35, 49-55.

West, C., Stewart, L., Foster, K. & Usher, K. (2013). Accidental insider: Living the PhD study. *Collegian,* 20(1),61-65.

White, I. D., Faithfull, S. & Allan, H. (2013). The re-construction of women's sexual lives after pelvic radiotherapy: A critique of social constructionist and Biomedical perspectives on the study of female sexuality after cancer treatment. *Soc Sci Med,* 76(1), 188-196.

White, S. & Seery, J. (2008). Consent: the law and ethical considerations. *Anaesthesia and Intensive Care Medicine,* 10(3), 111-114.

Whitehead, T. (1999). Autonomy and Competency – self-determination in the lives of adults with developmental disabilities. *Bioethics Forum,* 15(2), 19-30.

Whitehead, C., Kuper, A., Freeman, R., Grundland, B. & Webster, F. (2014). *Medical Education,* 48(6), 632-643.

Willard, C. (1996). The nurse's role as patient advocate: obligation or imposition? *Journal of Advanced Nursing,* 24(1), 60-66.

Wilson-Barnett, J. (1994). The Nurse-Patient Relationship. In R. Gillon (Ed.), *Principles of Health Care Ethics.* (pp. 367-376). London, UK: John Wiley & Sons Ltd.

Wojnar, D. & Swanson, K. (2007). Phenomenology: an exploration. *Journal of Holistic Nursing,* 25(3), 172-180.

Wray, S. & Deery, R. (2008). The Medicalisation of Body Size and Women's Healthcare. *Health Care for Women International*, 29(3),227-243.

Ybema, S. & Kamsteeg, F. (2009). Making the familiar strange: A case for disengaged organisational ethnography. In S. Ybema, D. Yanow, H. Wels & F. Kamsteeg (Eds.), *Organisational Ethnography: studying the Complexities of Everyday Life.* (pp. 101-119). London, UK: SAGE Publications.

Young, A. (2009). Review: the legal duty of care for nurses and other health professionals. *Journal of Clinical Nursing,* 18(22), 3071-3078.

Zhang, D., Yu, Z. & Chin, C. (2005). Context-aware infrastructure for personalised healthcare. *Personalised Health Management Systems,* 117: 154-163.

Zulueta, P. (2013). Compassion in 21st century medicine: Is it sustainable? *Clinical Ethics,* 8(4), 119-128.