

**The dialectic of control:
A critical ethnography of renal
nurses' decision-making**

Thesis submitted by

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In March 2004

**for the degree of Doctor of Philosophy
in the School of Nursing Sciences
James Cook University**

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STATEMENT ON THE CONTRIBUTION OF OTHERS

This thesis has been made possible through the support of many people as follows:

Supervisors:

Primary Supervisor: Associate Professor Kim Usher,
School of Nursing Sciences, James Cook University

Secondary Supervisor: Professor Colin Holmes,
School of Nursing Sciences, James Cook University

Financial assistance:

School of Nursing Sciences Scholarship: \$15,000 per annum

Queensland Nursing Council Scholarship: \$ 5000 (awarded 2002)

Editorial assistance:

Mrs Pauline Taylor: Senior secretary/assistant to Head of School,
School of Nursing Sciences, James Cook University

Peer Reviewers

Mrs Jane Williams: PhD Nursing Student, Nursing Sciences
School of Nursing Sciences, James Cook University

Dr. Narelle Biedermann: Lecturer
School of Nursing Sciences, James Cook University

Mrs Anne Blong: Clinical Nurse, Renal Unit,
Townsville District Health Services

ACKNOWLEDGEMENTS

There are a number of people, colleagues and friends, who have contributed in some way in the development and completion of this thesis through their gift of time, advice, encouragement and support.

I am indebted to Professors Kim Usher and Colin Holmes for their patience, careful supervision and encouragement throughout the years of my candidature. This appreciation is also extended to Doctor Irmgard Bauer who contributed in a supervisory role in the first year of candidature.

My sincere appreciation is also extended to the hospital and renal unit where this study was conducted. This was only made possible by the nursing support and participants. The Nurse Managers always had supportive words, especially, during my loneliest times as a researcher, away from my clinical role. This appreciation is extended to the renal nursing staff that acknowledged, and tolerated my presence, in the unit as a researcher investigating daily practice.

I would like to express my deep and sincere appreciation to all the key participants who assisted with the study, unselfishly sharing their time, thoughts and ideas about decision-making, that make up so much of this thesis.

Finally, I would like to thank my family, friends and work colleagues for their unending tolerance, encouragement and support over the years of my candidature, in particular, my parents for their financial assistance, my fellow PhD student, Jane Williams, who shared both the laughter and the tears, renal nurse colleagues Heather Gibbs, Wendy Washington, and Kate Kendell who listened and critiqued my ideas passionately and, Pauline Greenland for her guidance in writing the recommendations. Finally, but not least, my dear partner, John, who spent many a restless night with me and still believed in me.

Thank you.

KEY TO TRANSCRIPTS AND FIELD NOTES

In the presentation of the research findings (Chapter 5, 6 and 7), where excerpts from the participants are included, the following abbreviations and font styles have been used:

Long quotes: All the names used within this thesis are pseudonyms (refer to appendix 2 for further information). Pseudonym name, date and paragraph or sentence (#) identifies excerpts from participant interviews.

E.G. I felt that this was not the case but the other nurse did not seem to pay any attention (Julie, 26/10, # 16).

Short quotes: When a few words, or word, have been applied within a sentence in the main text, this is specified through the use of italics.

E.G. It was not unusual for the nurses to speak *about being in control* and *autonomous* in their practice as they went about their day.

Field notes (FN): Field notes are signified as FN, and are structured in the same manner, with exception to the font style of italics. Regular font refers to researcher comment. Comments made by nurses that have been captured as fieldnotes are indicated by speech marks and are not verbatim.

E.G. *Julie held the cup in her hand and proceeded to the door.* [I watched from a distance but close enough to see her facial expression] *She listened tentatively to what the doctor was saying but seemed doubtful of the diagnosis as she raised her eyes in an upward motion, later adding that “nothing changes!”* (FN, 23/7, # 5).

... Indicates that the researcher has edited the material

ABSTRACT

Renal disease in Australia is increasing at an alarming rate. Many of the patients presenting with renal failure are from rural and remote areas where renal and other health care services are minimal. What services are available tend to be predominantly managed by nurses because of the way that renal services are organised in regional areas. Consequently, there is an assumption that renal nurses are autonomous in their practice and accountable for the decisions they make. The purpose of this study was to explore these assumptions within the bounds and context of a regional renal unit. The aim of the study was to increase nurses' awareness about their responsibility when taking on expanded nursing roles in terms of their decision-making ability, and capacity, and what this means in terms of accountability.

Critical ethnography was adopted as the methodology to explore the nature of decision-making in the renal unit context. Particular emphasis was placed on how nurses used their knowledge during daily routine practice. Carspecken's (1996) five-stage method of critical ethnography incorporated periods of prolonged participant-observation, structured and unstructured interviews and documentation review. Concepts from Giddens' (1984) structuration theory provided a theoretical framework that sensitised the researcher to certain 'aspects of nursing practice' to guide data collection and analysis. These, in turn, provided major chapter headings for the thesis: decision-making across time-space encounters (Contextuality), the rules and resources (Social Structures) available for decision-makers and the nurses' ability and skills (Knowledgeability). In addition, Giddens (1984) 'Dialectic of Control' was threaded throughout the finding chapters as a major theme that addressed the nurses' capacity (power and control) to make and implement decisions. Collectively the researcher and participants gained new insights about decision-making practices, during reflection and dialogue, one learning from the other. It was assumed that if, and when, decision-making concerns were recognised, the nurses themselves could possibly make changes to their practice with the aim of enhancing patient outcomes.

Time-space played an important factor in controlling nurses' decision-making, but this was often in complex and subtle ways. Encounters across time-space often

controlled who made decisions and when. This alternating decision-making behaviour caused conflict and confusion that, at times, undermined some nurses' authority and overall responsibility as decision makers. Even though many nurses spoke about being autonomous decision makers, most unknowingly followed established routines and practices that was not always conducive to best-practice principles. Social structures, the rules and resources, could enable and constrain decision-making within this context. The rules that nurses ascribed to were not always known at a discursive level, therefore, rationale could not always be given for the decisions they made. When rules could be spoken about, not all the nurses followed them. Reasons for breaching unit rules varied such as out-dated rules or policies, limited resources that required 'short-cuts' and, at times, no recognition that rules were being broken. Knowing the rules and prescribing to routine practices provided a sense of safety as the nurses made decisions. This did not necessarily mean that best decisions were being made but gave a presentation that the decisions being made were satisfactory. Knowledgeability about the rules and resources available to nurses, and decision-making encounters across time-space, appeared to be a key feature that enabled the nurses to exercise their dialectic of control. When a nurse had, or perceived to have, control over the decisions they made, this, in turn, facilitated a sense of "being autonomous". Despite this shared perception of being in control, several nurses remained frustrated and constrained by bureaucratic policies and hierarchical structures. However, the nurses, too, could create these constraints, knowingly or unknowingly, as they went about their day.

Recommendations resulting from these findings include that further research is required on certain aspects of decision-making such as the role emotions play when making decisions, how ethical issues embedded in routine practice are recognised, and how risk and uncertainty are acknowledged and then managed. When nurses do not question their decision-making roles, they can become constrained in their decision-making capacity and ability. Without deliberate reflection aspects that control nurses' decision-making may never be exposed, thus changed. The implications of this study are central for both patient outcomes and the professional development of nursing.

Table of contents

THESIS SUBMITTED BY	I
STATEMENT OF ACCESS	II
ELECTRONIC COPY	III
STATEMENT OF SOURCES	IV
STATEMENT ON THE CONTRIBUTION OF OTHERS	V
ACKNOWLEDGEMENTS	VI
KEY TO TRANSCRIPTS AND FIELD NOTES	VII
ABSTRACT	VIII
CHAPTER ONE: SETTING THE SCENE.....	1
INTRODUCTION TO THE STUDY	1
<i>Finding the research question</i>	2
<i>Positioning myself as a nurse and researcher</i>	3
DECISION-MAKING IN THE STUDY UNIT	4
RENAL HEALTH CARE IN AUSTRALIA	5
<i>Renal nursing shortages - local and global</i>	6
<i>The birth of nephrology nursing</i>	7
<i>Dialysis in Australia</i>	7
THE ROLE OF RENAL NURSES IN AUSTRALIA	9
<i>Consequences of renal technology – dilemmas and opportunities</i>	10
<i>Autonomous practitioners?</i>	10
Giddens’ concept of power and control	11
<i>Standards of practice</i>	13
SIGNIFICANCE OF CLINICAL DECISION-MAKING FOR RENAL NURSES	14
THE HIGHS AND LOWS OF CRITICAL RESEARCH APPROACH	15
<i>Structuration theory</i>	16
STRUCTURE AND OUTLINE OF THE THESIS	19
CHAPTER TWO: THE DECISION-MAKING LITERATURE.....	22
INTRODUCTION	22
<i>The evolution of nurses’ decision-making research</i>	23
THEORETICAL APPROACHES TO DECISION-MAKING.....	24
<i>Prescriptive and normative decision-making models</i>	25
<i>Descriptive decision-making models</i>	26
Information processing	27
NURSING KNOWLEDGE THAT INFORMS DECISIONS	27
Bounded rationality.....	28
Skills acquisition and the role of intuition.....	29
<i>Novice-expert decision-making</i>	31
Intuition, analytical or both?	32

Queuing theory.....	33
<i>Personal performance in decision-making: nature versus nurture?</i>	34
EMOTIONS AND DECISION-MAKING	35
<i>Ethical concerns for nurses making, or not making, decisions</i>	37
THE CONTEXT OF DECISION-MAKING	39
<i>Australian decision-making studies</i>	40
THE HEALTH CARE SYSTEM AS AN ORGANISATION.....	44
<i>Bureaucracy - a tool of power and control</i>	45
<i>Bureaucracy and power</i>	46
<i>Power and decision-making</i>	48
PROFESSIONAL IDEOLOGY AND CONTROL	50
Hegemonic structures at play	53
<i>Nursing's power</i>	54
KNOWLEDGE, POWER AND NURSING	55
COLLABORATIVE DECISION-MAKING	58
<i>Group and team decision-making theory</i>	59
Uncertainty and risk	62
Resistance	64
<i>Nursing's professional accountability and responsibility in practice</i>	65
SUMMARY.....	67
CHAPTER THREE: CRITICAL ETHNOGRAPHY AND GIDDENS' THEORETICAL FRAMEWORK OF STRUCTURATION	69
INTRODUCTION	69
ETHNOGRAPHY	69
<i>Getting 'critical' in ethnography</i>	71
THE DEVELOPMENT OF CRITICAL THEORY.....	71
<i>Why critical theory?</i>	73
<i>Critical theory's worldview</i>	74
Reflexivity	75
Dialectic	75
<i>The double hermeneutic loop - a dialectic approach</i>	76
CRITICAL ETHNOGRAPHY.....	77
<i>Conditions associated with critical ethnography</i>	78
<i>Structuration theory's 'weakness' as a critical theory</i>	80
STRUCTURATION THEORY - REDEFINING AGENCY AND STRUCTURE.....	81
<i>An eclectic theory</i>	82
SELECTED STRUCTURATION CONCEPTS USED IN THIS STUDY	84
Contextuality	84
<i>Social structures: rules and resources</i>	84
Knowledgeability.....	86

<i>The dialectic of control</i>	87
CONCLUSION	88
CHAPTER FOUR: THE STUDY'S RESEARCH METHODS.....	90
INTRODUCTION	90
<i>The research setting</i>	90
THE RESEARCH DESIGN AND RIGOUR OF THE STUDY	92
<i>The role of the researcher and participants</i>	95
Insider or outsider?.....	96
<i>Investigator responsiveness</i>	97
<i>Appropriate sampling: participant selection</i>	98
HOW STRUCTURATION THEORY WAS USED IN THE STUDY	101
Stage 1: Building a primary record- the etic perspective.....	102
Stage 2: Preliminary re-constructive analysis	102
Stage 3: Dialogical data generation.....	103
<i>Triangulation as a research strategy</i>	104
<i>Journaling and self-reflection</i>	104
<i>Individual and group member checking</i>	105
Stages 4 and 5: Conducting system analysis	106
<i>Pulling the loose ends together</i>	107
ETHICAL CONSIDERATIONS	107
<i>Informed consent</i>	108
<i>Anonymity and confidentiality</i>	109
CHAPTER FIVE: CONTEXTUALITY	111
AN INTRODUCTION TO CONTEXTUALITY	111
TIME	112
LIFE-SPAN TIME: NOVICE TO EXPERT	113
<i>Learning the ropes - the novice</i>	114
The learning culture- a matter of trial and error	119
<i>When in Rome. . . new to the unit</i>	121
<i>When the ropes were known - the experts</i>	123
Passing the buck or maintaining the mark?.....	125
Seeking approval.....	126
REVERSIBLE TIME - THE DURÉE OF ACTIVITY AND LONGUE DURÉE OF INSTITUTIONS	128
<i>Routines and social practice</i>	129
Get them on!	131
<i>Decision-making reliance across time</i>	133
Doing much the same.....	135
DIVIDING AND ALLOCATING TIME.....	136
<i>Unintentional loss of time control</i>	138

DECIDING TREATMENT TIME.....	139
<i>Ethical decision-making: awkward decisions</i>	140
<i>Saving nursing time</i>	143
SPACE	144
<i>The nurses' station</i>	146
<i>Front and back regions of decision-making</i>	147
TIME-SPACE AND DECISION-MAKING	148
<i>Positioning-self</i>	148
ENCOUNTERS: PRESENCE AND CO-PRESENCE	150
<i>Patient-nurse decision-making encounters</i>	150
Low and high presence availability.....	153
<i>Nurse-nurse decision-making encounters</i>	154
Sharing decision-making space.....	155
<i>Doctor-nurse decision-making encounters</i>	158
DECISION-MAKING OUTSIDE THE RENAL UNIT LOCALE	161
CHAPTER SUMMARY	162
CHAPTER SIX: SOCIAL STRUCTURES.....	164
INTRODUCTION	164
RULES	165
<i>Rules across time-space</i>	166
NORMATIVE RULES IN DECISION-MAKING.....	168
<i>Makers and followers of rules</i>	169
Prescriptive rules of practice.....	171
<i>Breaking rules</i>	172
Don't forget the phosphate binders	173
Always two on the floor.....	174
POLICIES AND PROCEDURES	175
<i>Watching you, watching me</i>	179
<i>Rules of thumb</i>	180
ACCIDENTAL OR INTENTIONAL BREAKING OF RULES: WHICH IS WHICH?.....	183
<i>Dangerous liaisons - deciding how much fluid to remove</i>	185
When is an error an error?.....	190
TAILORING PRACTICE RULES.....	191
<i>Work rules and nursing autonomy</i>	192
<i>Knowledge rules of practice</i>	194
<i>New and old rules</i>	195
RULES OF SIGNIFICATION	196
<i>Rules of treatment (non)compliance</i>	200
<i>Rules of signification extending space</i>	202
RULES CONTROLLING THE DIALECTIC OF CONTROL - A SUMMARY	203

RESOURCES - STRUCTURES OF DOMINATION	204
ALLOCATIVE MATERIALS IN THE UNIT	204
<i>Fluffy-duffy 'non-clinical' decisions</i>	205
<i>Just another resource!</i>	207
<i>The new dialyser</i>	208
<i>Who informs whom?</i>	209
<i>When abnormal becomes normal</i>	210
AUTHORITATIVE RESOURCES	211
<i>Official decision-making authority within the organisation</i>	212
<i>Intermediate Nurses - not novices, nor experts</i>	214
<i>Deciding who is in-charge</i>	214
<i>When things go wrong</i>	217
CHAPTER SUMMARY	220
CHAPTER SEVEN: KNOWLEDGEABILITY.....	221
INTRODUCTION	221
<i>The autonomy-dependence continuum of decision-making</i>	222
NURSES' ABILITY AND CAPACITY AS DECISION MAKERS	222
<i>Acquiring decision-making ability</i>	225
<i>Routines: enabling and constraining</i>	227
INFORMING DECISIONS: WAYS OF KNOWING	230
<i>Windows of opportunity</i>	230
<i>The 'evidence' informing decision-making</i>	233
EXPERT SYSTEMS AND SPECIALISATION.....	235
<i>Technology - advances and dilemmas</i>	236
<i>Appearing not to make decisions</i>	239
RISK, UNCERTAINTY AND DECISION-MAKING.....	240
<i>Day-to-day practice minimising risk</i>	241
<i>Nurses' over and under-confidence as decision makers</i>	243
TRUST AND COLLABORATION	245
EMOTIONS AND DECISION-MAKING	248
<i>Unspoken concerns</i>	252
EVALUATING OUTCOMES	255
<i>Comparing us with them</i>	256
Internal evaluation of decision outcomes	257
THE HIDDEN SIDE OF NURSES' DECISION-MAKING - UNSUNG HEROES	258
QUESTIONING AUTONOMY - CAN OR CAN'T DO?	260
CHAPTER SUMMARY	262

CHAPTER EIGHT: CRITICAL REFLECTIONS	264
INTRODUCTION	264
REVISITING THE QUESTIONS.....	265
REVISITING DECISION-MAKING THEORY	269
<i>Individual decision-making</i>	271
<i>Group decision-making</i>	274
APPLICATION OF STRUCTURATION THEORY – FRIEND AND FOE.....	276
ENSURING TRUSTWORTHINESS THROUGHOUT THE STUDY	276
<i>Investigator responsiveness</i>	277
<i>Asking the right questions, looking in the right places</i>	278
<i>A Participatory approach</i>	278
<i>Increasing awareness: actors are inherently reflexive</i>	279
<i>Other concerns</i>	281
RECOMMENDATIONS AND POTENTIAL OPPORTUNITIES	282
<i>Findings and recommendations in nursing practice and education</i>	283
FUTURE RESEARCH.....	291
FINAL REFLECTION	292
REFERENCES	293
APPENDICES.....	321
APPENDIX 1: RIGOUR IN QUALITATIVE STUDIES.....	321
APPENDIX 2: PROFILE OF NURSE PARTICIPANTS AND ALLOCATED PSEUDONYM	322
APPENDIX 3: CONSENT TO OBSERVE PRACTICE (PARTICIPANT)	323
APPENDIX 4: CONSENT TO BE INTERVIEWED (INFORMANT)	324
APPENDIX 5: THE KEY PARTICIPANT CONSENT FORM.....	325
APPENDIX 6: GLOSSARY OF TERMS	326
APPENDIX 7: THE RENAL UNIT’S NURSING ORGANISATIONAL CHART.....	329
LIST OF TABLES	
TABLE 4.1: Level of nurse participant involvement.....	98
TABLE 4.2: Brainstorming potential issues for preliminary research plan.....	99
TABLE 4.3: Carspecken’s 5 stages of critical ethnography aligned with Giddens’ social and system integration.....	100

LIST OF FIGURES

FIGURE 3.1: Agency-structure duality82

FIGURE 8.1: Concepts adopted from Giddens (1984) structuration theory.....266

FIGURE 8.2: The agency-structure duality and its affect on the dialectic of control.....267

FIGURE 8.3: The interface between the cognitive continuum and the dialectic of control.....270

FIGURE 8.4: Opinion-autonomy position.....272

FIGURE 8.5: Methodical-autonomy position273

FIGURE 8.6: Opinion-dependence position.....274

FIGURE 8.7: The nurses' collective decision-making position and control.....275