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

Thesis submitted by

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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.

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