A STUDY OF MEDICAL, NURSING, AND INSTITUTIONAL NOT-FOR-RESUSCITATION (NFR) DISCOURSES

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ABSTRACT

This study investigates the way that medical, nursing and institutional discourses construct knowledge in the specific context of Not-for-resuscitation (NFR) in a New Zealand general hospital where NFR guidelines are available in the wards and from the regional ethics committee. The thesis argues that there are ranges of techniques that staff use to construct NFR knowledge, enacted through various forms of speech and silence, which result in orderly and disorderly experiences for patients nearing death. The study was conducted through a critical analysis of the talk of health professionals and the Chairperson of the Regional Ethics Committee. Critical discourse analysis, a methodology that is primarily concerned with a critical analysis of the use of language and the reproduction of dominant ideologies or belief systems in discourse, was employed. The researcher examined the transcribed, audiotaped talk of eleven professional staff members of a large metropolitan general hospital, and the Regional Ethics Committee Chairperson.

The results of the analysis indicate that medical discourses do not dominate the construction of NFR knowledge within the institution. Nor do the institutional or ethics committee discourses, written as NFR policy documents, dominate by instilling order into NFR practices with patients. Rather, a range of discourse practices within the disciplines of nursing, medicine, management and policy advice work to determine what happens to patients in the context of NFR and, unexpectedly, cardio-pulmonary resuscitation. NFR discourses designed by the institution to influence and standardise practice at the bedside are resisted by professional discourses through the techniques of keeping quiet and keeping secrets, forcing others to keep quiet, delays in speaking up, through to speaking up against opposition. These techniques of speech and silence constitute a divergence between institutional discourses and professional discourses, and divergence within nursing and medical discourses. Both medical and nursing discourses underplay the degree of influence their professional power had over NFR events.

This research is potentially significant at two levels; firstly because of what it reveals about the way in which health professionals and policy advisors construct NFR knowledge and secondly, because of the relationship between NFR practices in the health sector and societal ideas about control of death at the beginning of the twenty-first century. These findings will have particular relevance for the shaping of future health care policies. The outcomes of this study also point to the need for further research, both into NFR and into cardio-pulmonary resuscitation events particularly with regard to the implications of the policies for patients and their families.

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CHAPTER ONE
NOT-FOR-RESUSCITATION DISCOURSES: AN OVERVIEW

Introduction

This study investigates the way that medical, nursing and institutional discourses construct knowledge in the specific context of Not-For-Resuscitation (NFR) in a New Zealand general hospital. The thesis argues that there is a range of techniques that staff use to construct an NFR reality, enacted through various forms of talk and silence, which determine what happens to patients nearing death. The study was conducted through a critical analysis of the talk of twelve nurses, doctors, managers, policy advisors and the Chairperson of the Regional Ethics Committee. Critical discourse analysis, a methodology that is primarily concerned with a critical analysis of the use of language and the reproduction of dominant ideologies or belief systems in discourse, was employed. Also part of the investigation was a consideration of the way in which the talk of individual professionals and a lay ethics committee chairperson might serve certain ideological interests in society regarding decision-making about NFR and death. Chapter One is aimed at providing the reader with an overview of the thesis.

Background

Positioning resuscitation

Attempting to revive people who appear to be dead is a practice that goes back to ancient history. The earliest reference to resuscitation is thought to be the Bible where the prophet Elisha used mouth-to-mouth breathing to revive an apparently dead child (Nolan, 1998). The word 'resuscitation' has been in common use in the English language since the sixteenth century (Onions, 1964) and is derived from the Latin verb *suscitare* to raise. To resuscitate means to restore to life. The Shorter Oxford Dictionary (1964) definition of resuscitation is restoration of life or consciousness in one almost or apparently drowned or dead (Onions, 1964). Resuscitation, in the context of this thesis, is taken to mean an event whereby trained staff attempt to revive a patient in a general hospital after a cardiac or pulmonary arrest. They may do so by attempting to stimulate the restarting of a regular heartbeat by manual, electrical or pharmaceutical means. It is a long established and accepted aspect of care and treatment in acute general hospitals in New Zealand and other Western health care facilities. If there is a chance of revival it is of paramount importance to start cardio-pulmonary resuscitation (CPR) immediately in order to supply the brain with sufficient oxygen to keep functioning and prevent irreversible damage. The key to successful resuscitation is believed to be defibrillation. The time taken from arrest to beginning defibrillation is the major determinant of outcome, not just for survival but also for neurological function (Eastwick-Field, 1996). Eighty six percent of hospital patients who suffer a cardio-pulmonary arrest are unable to be resuscitated, in spite of immediate intervention (Lo, 1991; Wagg, Kinirons & Stewart, 1995).

Positioning Not-For-Resuscitation

In the 1970's, in cases where it was judged that the patient would not achieve any quality of life even if resuscitation were successful, the practice of excluding the patient from the possibility of cardio-pulmonary resuscitation treatment began to emerge. This decision was expected to be recorded in the notes so that all staff understood what action was required in the event of a cardiac arrest (Youngner, 1987). In this thesis, Not-For-Resuscitation indicates a situation in which a patient in a general hospital is deliberately excluded from the possibility of resuscitation as a treatment. It is a practice whereby a patient assessed for absence of breathing and heartbeat would not be subjected to manual, electronic or pharmaceutical cardiac stimulation or respiratory assistance. Rather, the patient would need to be assessed only to ascertain whether death had occurred or not (Charlton, 1996).

Not-for-Resuscitation (NFR), also known as Not-for-Cardio-Pulmonary Resuscitation (No-CPR), or Do-Not-Resuscitate (DNR) or Do-Not-Attempt-to-Resuscitate (DNAR), is the policy and practice of deliberately foregoing any attempt to revive a person whose heart has stopped beating. The term, which gives the thesis its title, is 'Not-For-Resuscitation' or 'NFR' and in the study will be taken to mean Not-For-Cardio-Pulmonary Resuscitation. This term has been selected because it narrows the exclusion from resuscitation to immediate interventions to revive the cardiopulmonary function: those designed specifically to revive the functions of the heart and lungs at the time a cardiac arrest is discovered and intervention commences. Resuscitation in general has come to mean an increasingly wide range of measures to revive someone, for example, blood transfusion, respiratory assistance and antibiotics and other drugs given over an extended length of time (Ardagh, 1997). Not-For-Resuscitation (NFR), Do-Not-Resuscitate (DNR) and Do-Not-Attempt-Resuscitation (DNAR) all remain significant terms as the body of the thesis indicates.

Positioning NFR practices

Health professionals in New Zealand are concerned with problems in NFR practice. A report of a small unpublished phenomenological study on ethical dilemmas of resuscitation conducted in Dunedin concluded:

> Many difficulties arose with inadequate communication between medical staff and nurses and medical staff and patients/families... we frequently found there to be difficulties with documentation of a DNR (Do-Not-Resuscitate) order or lack of communication in regard to making a decision and/or documenting it. (Arthur, Dorne, McHugh, Theewis & Welsh, 1994, p. 30)

These findings were echoed by other New Zealand nursing and medical writers and researchers (McLachlan, 1994; Niles, 1996; Schroyen, 1997; Taylor, Ramsay, Parker & Peart, 1996). Their concerns are also raised in overseas studies (Aarons & Beeching, 1991; Miles & Burke, 1996; Steinberg, Najman, Cartwright, McDonald & Williams, 1997). The above quotation refers to one element of DNR or NFR practice, that of a written DNR order (Arthur et al., 1994). Difficulties arose for the nurses in that study, when a DNR decision was not communicated effectively, either because the order was not written down or because it was not communicated effectively some other way. This raises the question of whose influence is the greatest in the decision made not to resuscitate. Does one person or more make the decision? How is the decision communicated to others? What impact does that have on all staff's actions? Furthermore, what impact do NFR events have on the practice of health professionals throughout the hospital in which they work?

Positioning NFR policies

NFR policy development and dissemination processes are of interest because of their stated purpose of standardisation (Jezewski, 1996). There has been a proliferation of research which documents the difficulties in NFR practices and itemises problems and barriers to the smooth, transparent implementation of NFR policies (Ardagh, 1999; Asplund & Britton, 1990; Bedell, Pelle, Maher & Cleary, 1986; Gleeson & Wise, 1990). There are a number of calls for unambiguous, standardised regulatory practices to 'fix things' (Hancock, 1997; Hayward, 1999).

Policy statements may reflect whether the practices generally match the moral belief systems of those involved (van der Arend, 1997; Mello & Jenkinson, 1998). Professionals may be guided in NFR practices by standards and guidelines set by their profession or by the health care providing organisation

(Langslow, 1995; Komesaroff, 1997). It is possible that those who are in less powerful positions influence those in more senior positions to make particular decisions (Porter, 1996; Robinson, 1990; Wicks, 1999). Relevant questions are: Do NFR policies and guidelines make decision-making and communication any easier? Do they help to standardise practice? Do they make a difference to the quality of care a patient receives?

The clinical world in a public general hospital is part of a larger world in which rules, regulations, policies and laws, both written and unwritten, are enacted. The social and public policy world is made up of public bodies and the policies they create, disseminate and evaluate. Their sphere of influence includes policy making in ethics committees, strategic planning in such state agencies as the Ministry of Health, use of the legal process in the judicial system and the passage of legislation through the Parliamentary system. The extent to which the clinical world and policy world interact is ably expressed by Taylor (1985a, 1985b), cited by Frankford (1997) in a paper on professional power: "our talk, our discourse, of power is inexorably allied with numerous private and public policy interventions" (p. 189). This suggests that hospitals are not isolated from community and public policy influences.

There are ongoing debates in policy, medical, nursing and pharmaceutical literature about cost-savings, illusory or otherwise, at the end of life (Felder, 1997; Maksoud, Jahnigen, & Skibinski, 1993; Mechanic, 1994; Scitovsky, 1994; Sulmasy, 1995; Temkin-Greener, Meiners, Petty, & Szydlowski, 1992). Health services management research discourses have started to argue that such issues as euthanasia, advance directives, NFR and futile care withdrawal deserve the attention of economists (Ward, 1997). The combination of old age and poverty may represent further pressure to decline health care in the interests of cost containment and cost shifting to provide health care for other needy groups in the population (Burstin, Lipsitz & Brennan, 1992). Such pressure is resisted by the argument that rationing based simply on age is unlikely to achieve a significant reduction in costs because age is not a good discriminator for disability, quality of life or life expectancy (Scharf, Flamer & Christophidis, 1997). Nevertheless, of relevance to this thesis, is the possibility that old, poor hospital patients may be more likely to be designated NFR than others whose clinical outlook may be the same. A related possibility is that, if patients pay for their own care, then every means to prolong life, regardless of the potential success of these measures, must be employed. NFR therefore needs to be understood as a wider policy event as well as a clinical event.

Positioning the public policy context: The New Zealand health service

New Zealand has a population of fewer than four million people; significant both in terms of the size of the health service and the national economy that generates the funding for all public social services. Since 1984, social and economic reforms in New Zealand have brought major changes in social and political relations (Boston, Dalziel & St John, 1999; Kelsey, 1995; 1997), leading to questions regarding NFR in a context of public policy. Health reform developments in New Zealand sometimes preceded, and were sometimes preceded by, developments in other countries, especially those within the Organisation for Economic Cooperation and Development (Laugesen & Salmond, 1994). The aims of the controversial reforms in the health system were to increase efficiency and effectiveness in a climate of diminishing financial resources (Salmond, Mooney & Laugesen, 1994). The forces behind the changes included the belief that public expenditure needed to be contained (Upton, 1991). There was also a general ideological shift to the right and a drive towards commercialisation and privatisation (Easton, 1992; 1997). These forces have had a major impact on the health sector.

Prior to 1991, fourteen Area Health Boards, consisting of a combination of elected and appointed members, had managed publicly provided health care in New Zealand. They were abolished virtually overnight in 1991 (Upton, 1991) and the structures set up to replace them included four Regional Health Authorities whose business it was to fund service providers on a contestable basis; a system of managed competition. Twenty-three Crown Health Enterprises were established to provide public hospital and related services, each with a Board of Directors, appointed by the Government and charged with acting as successful and efficient businesses (Companies Act 1993; Health and Disability Services Act 1993). The Department of Health retained some residual functions and attempted to play a role in the monitoring and evaluation of health services (Ministry of Health, 1996). Further change was introduced in 1996 with an agreement between the two parties in the Coalition Government, resulting in Crown Health Enterprises being replaced by Regional Hospitals and Health Services. The competitive profit focus was removed, and replaced with a direction to be business-like (Steering Group to Oversee Health and Disability Changes to the Minister of Health and the Associate Minister of Health, 1997). The four Regional Health Authorities were re-structured into one national Health Funding Authority (Gauld, 1999). The Government continued to state that it accepted responsibility for the funding of services provided in the public sector (Gauld, 2000). Yet critics of the reforms claim that covert political and economic agendas were the privatisation of the health service through the carefully orchestrated under-funding of publicly provided services. They argued that the outcome of such measures is the shift of risk from the State to individuals, demonstrated through increased enrolment in health insurance schemes and increased use of private facilities (Coalition for Public Health, 1998).

The theoretical underpinnings of the changes prior to 1999 can be analysed in relation to language expressing the dominant values of public choice theory, agency theory and managerialism. All three theoretical approaches to public sector policy and service provision are closely linked to values inherent in neo-classical economics; the primacy of market forces, individualism, freedom of opportunity, self-reliance and consumer sovereignty (Boston, 1991; Boston, Martin, Pallot & Walsh, 1996; Boston, Dalziel & St John, 1999). The health sector, like the public sector as a whole, was affected by the growing influence of the managerialist approach to social relations. This approach places value on managerial skills over professional skills. It focuses on outputs, rather than inputs or process, and promotes systems of financial accountability. In the interests of financial accountability, this approach to public sector practices values short-term labour contracts, a corporate image and monetary incentives rather than non-monetary incentives like professional ethics (Boston, et al., 1996). Another feature of managerialism is the devolution of organisations into smaller semi-autonomous units, leading to such things as unit budget holding, the aim being to achieve greater financial accountability. This aim justifies major changes in the public sector, according to a prominent critic of the reforms (Kelsey, 1997). Regardless of claims of increasing privatisation, public hospitals in New Zealand, like those in other Western countries, continue to consume the major portion of the health budget, and function as the nucleus of the health system (Gauld, 2000). A new Government in 1999 brought further change (King, 2000).

The most significant change has been the introduction of twenty-one District Health Boards consisting of a mixture of appointed and elected members (Public Health and Disability Act, 2000). It is each Board's responsibility to manage the funding allocated by the Government and also to provide health services for their district. The full effect of the latest round of changes cannot yet be gauged but Blank's (2000) words on the changes of the previous decade serve as a warning against even more change: "There was, in the rush to restructure the health system, a failure to ensure that adequate analyses of the problem and formulation of policy options and objectives were carried out" (Blank, in Davis & Ashton, 2000, p. 156). The question arises: What impact might all of these major changes have on the practice of NFR?

Positioning ethics committees

While Area Health Boards were in existence, and in response to the findings of the Cartwright Inquiry into cervical cancer and its treatment at National Women's Hospital (Cartwright, 1988) regional ethics committees had been set up throughout New Zealand. They were set up to fulfill such objectives as to:

> safeguard the rights of health and disability consumers;
>
> support service consumers and participants in research and to protect them from harm;
>
> facilitate health and disability related research for the well being of society. (Manawatu/Wanganui Ethics Committee, 1994)

There was also a National Advisory Ethics Committee, which received some support from Ministry of Health staff (Gillett, 1995). This committee was short-lived but did produce a national standard for ethics committees (National Advisory Committee on Health and Disability Services Ethics, 1996). Through the transition period between the 'old' and 'new' health services from 1991 to 1994 it was unclear how ethics committees were to operate but they eventually established themselves in the Health Funding Authority structure (St John, 1998). In the most recent legislative changes, the National Ethics Committee has been re-established (Public Health and Disability Act, 2000).

Some Regional Ethics Committees have been involved in developing guidelines for NFR orders (Carroll, personal communication, 1994; Gillett, 1995; Kirk, personal communication, 1994; Perrott, personal communication, 1994). In other parts of New Zealand, Ethics Committees do not see such matters as their responsibility at all (Scott, personal communication, 1994). Committees may spend a good proportion of their time reviewing research proposals. Additionally, some hospitals have ethics committees, for example Auckland Health Care, as do research funding organisations, for example, the Health Research Council of New Zealand, and educational institutions involved with research projects such as polytechnics and universities (see, e.g., Research Policy Office, Victoria University of Wellington, 2000). Those ethics committees that might be interested in developing a policy on exclusion from cardio-pulmonary resuscitation are likely to refer to both local and overseas writing and research findings to inform them (Carroll, personal communication, 1994; Perrott, personal communication, 1994).

Positioning the Treaty of Waitangi

Among many unique characteristics of New Zealand, is the Treaty of Waitangi, signed in 1840 in an agreement between Maori (the indigenous inhabitants of New Zealand or tangata whenua) and British Crown representatives. The second half of the twentieth century saw an increased awareness of the Treaty and its fundamental position in New Zealand society. "While the Treaty of Waitangi can be analysed article by article for its health implications it is necessary to recall that one of its main intentions was to protect the well being of the tangata whenua" (Reid, 1999). In spite of this intention, there is ongoing discrepancy in the health standards of Maori and non- Maori (Pomare & de Boer, 1988; National Health Committee, 1998). In the last decade, numerous attempts have been made by the health system to address these discrepancies.

Most of these have been in the primary care sector (Cunningham & Durie, 1999).

In the hospital sector, innovative practices have been introduced into the mental health inpatient service and in other initiatives like the Maori-nurse-provided Te Puna Ora service at Tauranga Hospital where Maori patients can choose which type of service they have; the ordinary hospital service or the Maori-provided one within the hospital. Most hospitals and associated services now provide a Maori advisory service, providing Maori inpatients with assistance, and staff with advice and support regarding such activities as research and patient service (Ramsden, personal communication, 2000). It is possible that this service might be used to clarify issues for Maori patients and their families regarding NFR. Guidelines have also been published for researchers on health research involving Maori (Health Research Council of New Zealand (HRC), 1998). These guidelines were written by the Maori Health Committee of the HRC for researchers applying for funding from the Health Research Council. Past practices of non-Maori researchers have resulted in Maori being very suspicious of researchers. The Guidelines focus on consultation as a vital step in ensuring that the Maori community as well as the researcher will benefit from a health research project. Treaty of Waitangi issues relevant to this thesis, are addressed in Chapter Four and Chapter Ten.

Positioning the people who use the health service

Given that CPR and NFR have been part of the health service for at least thirty years it would be reasonable to suppose that members of the public might have a basic understanding of the two procedures. Nevertheless, the question of whether people who require health care understand the process of resuscitation or what it means to refuse it or to be denied it without consultation is a pertinent one. Those who do not wish to be resuscitated in the event of a cardiac arrest may be influenced by their perceptions of dying, death and beyond. They may be fearful of the procedure itself or be sceptical of their ability to survive with any discernible quality of life (Bruce-Jones, Roberts, Bowker & Cooney, 1996). They may also be influenced by their own previous experience of resuscitation processes or by media representations (Stewart, 1995). Some television images of the efficacy of CPR are unrealistically positive, according to an American study (Diem, Lantos, & Tulsky, 1996). One study showed that health professionals, too, have unrealistically positive views of the success rate of resuscitation attempts (Wagg, Kinirons & Stewart, 1995). Hence, it is understandable that members of the public may have an unrealistically positive view of the likelihood of themselves or family members being revived should they arrest. The media plays a part in influencing health policy development (Gauld, 2000). It is, therefore, possible that media portrayals of NFR could influence NFR policy development and practice.

What may also influence people's view of CPR and NFR is how they see themselves in relation to the power of the health professional. Members of the public who enter hospital for treatment and care, are generally known as patients (see Appendices A, B and E). The term 'patient' and the place it has in the power relations of the health service has been the focus of much research interest (Bloor & McIntosh, 1990; Lupton, 1992; Silverman, 1987; Waitzkin, 1984). Silverman (1987) argues, with regard to the power relationship between patients and doctors, that the person or patient who is terminally ill is accorded more power than others because of their proximity to death. Other patients accorded some power, according to Silverman (1987), include chronically ill patients who know what is going on and those who can pay for their treatment. It is this last group who have been reconstituted as consumers, arising from the movement towards consumerism which can be described as "a lifestyle characterised by the acquisition and consumption of goods and services produced in the market economy" (Eckersley 2001, p. 57). The emergence of the term 'consumer' is an example of how the person who uses the health service has been constituted or discursively constructed. While the term 'patient' suggests passivity and resignation, the term 'consumer' is constituted as suggesting that someone with an illness has a place in the market and therefore choice about what health services can be purchased. There is also a relationship between consumerism and the espousal of autonomy, a concept which is discussed in more detail below. These constructions may be of significance in a study of NFR policies and practices. They may mean that patients (or consumers) may want a say in whether they should be offered CPR in the case of an arrest, or not.

Indeed, the question of consultation between patients and their families and health professionals, regarding NFR status, is a feature of research publications (Asplund & Britton, 1990; Bruce-Jones, Roberts, Bowker & Cooney, 1996; Eckburg, 1998; Lowe & Kerridge, 1997; Pang, 1999). Numerous medical and ethics researchers have solicited the views of patients on decisions about NFR (Bruce-Jones, Roberts, Bowker & Cooney, 1996; Mead & Turnbull, 1995; Robertson, 1993; Schade & Muslin, 1989; Stewart, 1995; Watson, Wilkinson, Sainsbury & Kidd, 1997). A New Zealand study, which involved an audit of a formal Do-Not-Resuscitate policy at Dunedin hospital, showed that only in a small proportion of cases studied was there no record of a discussion involving the patient or family. In addition, eighty-five percent of staff that responded to the questionnaire issued as part of the audit thought that patients should be given information regarding the hospital's resuscitation policy and DNR option at admission (Taylor, Ramsay, Parker & Peart, 1996). These findings suggest that it is a responsibility of health professionals to provide the information to patients and their families.

The increased use of expensive technology was used as one of the justifications for changes in the health sector in the 1990's in New Zealand. Self-reliance and self-interest were being promoted through public sector policies (Boston et al., 1996; Scott, 1994). In keeping with these ideas, writers in medical and ethics research publications, most obviously from the United States, argue for the increasing espousal of individual autonomy and consumer choice (see, e.g., Deber, Kraetschmer & Irvine, 1996; McClung & Kamer, 1990; Pollack 1996; Tong 1995, in Johnstone, 1999). They suggest that the decision about medical treatment itself, whether it should be continued, and whether it should be provided at all, lies with the individual patient. This points to an argument that the decision about whether a patient should be resuscitated or not should lie with the competent patient and/or family (American Medical Association, 1992; Annas & Glantz, 1986; Boyd, Teres, Rapoport & Lemeshow, 1996, Higgs 1995). In contrast, other medical commentary argues that such decisions are the responsibility of the medical practitioner (Koch, Meyers & Sandroni, 1992; Savulescu, 1995).

Positioning nursing vis a vis medicine

A prominent nurse researcher (Zerwekh, 1994) argues that nurses represent themselves as the truth tellers and information providers to the people in their care as they approach death, at least in the hospice setting. Nurses, the argument continues, are the most highly skilled professionals in helping the patient come to terms with their death. Nurses do this through talk or through companionable silence (Zerwekh, 1994). To help patients deal with the death, it would follow, nurses need to be well informed about the patient's diagnosis and prognosis. Yet, May's (1993) study of a group of experienced staff nurses in a general hospital revealed nurses' frustration at not being included when doctors disclosed to patients that they were terminally ill. "Where nurses are excluded from decision-making processes about disclosure, their intimate knowledge of the patient is rendered useless" (May, p. 1367). The author goes on to report that the respondents' accounts focused not on the ethical problems which are associated with disclosure but on the practical difficulties which are associated with the everyday exigencies of relationships between professional groups (May, 1993).

Unlike the nurses in Zerwekh's (1994) research, Armstrong (1987), a medical sociologist, in a paper on death and dying, asserts that truth and silence are not necessarily in opposition. Rather, he makes the point that the very nature of truth about death and dying has changed. He comments:

> The secret of death and the truth of life no longer resided with such assuredness in the depths of the body; the court of judgment demanded less the body as evidence and more the person as witness. Thus the new discipline of medical ethics took over the medical analysis of death and required the confession of the physician while the new discourse on dying encouraged the dying *qua* subject to speak. (Armstrong, 1987, p. 656)

This analysis of death and dying places social relations in the context of power and the contestability of discourses. The physician is seen to confess the truth of the impending death, the dying person is seen to be required to speak of his or her own death, and the ethicist is seen to set the rules about what should be said or not said. There is no direct acknowledgment here of the nurse as any sort of truth teller unless her work is subsumed into the confessional activities of the physician. Nursing publications tend to portray nurses as powerless but at the same time responsible for being effective patient advocates (Fryer, 1996; Johnstone, 1999; Konishi, 1998; Kuuppelomaki, 1993).

Conflict appears to be almost a taken-for-granted element among professional disciplines, particularly nursing. In the context of NFR decision-making such conflict is concerned with whether the patient and family should be consulted (Barnes, 1997; Glick, 2000; Lake, 1996: Levine & Zuckerman, 2000); to which patients NFR might be relevant (Daly, Gorecki, Sadowski, Rudy, Montenegro, Song & Dyer, 1996; Godkin & Toth, 1994; Manias, 1998; Miller, Gorbien, Simbartl & Jahnigen, 1993); the way in which NFR orders are communicated (Aarons & Beeching, 1991; Lipton, 1986; Miles & Burke, 1996); situations where nurses believe they have to act against their conscience (Johnstone, 1999) and when a doctor ignores a patient's wish not to receive resuscitation (Aarons & Beeching, 1991; Mead & Turnbull, 1995). There may be conflict within the nursing and medical professions about NFR (Doyal & Wilsher, 1994; Henry, 1993; Lessey, 1996; Marsh & Staver, 1991) or between clinical staff members and managers (Arnott & Warner, 1995; Birtwhistle & Nielsen, 1998; Davenport, 2000; Degeling, 2000; Hackler & Hiller, 1990).

Research, including ethics research, supports Armstrong's (1987) contention that the physician or doctor is the primary player in NFR decisions and actions. Ethics studies on NFR tend to portray medical practitioners as key decision-makers but also propose the involvement of patients and their families (Baggs & Schmidt, 2000; Koch, Meyers & Sandroni, 1992; Kuhse, Singer, Baume, Clark & Rickard, 1997; Stewart, 1995; Youngner, Lewandowski, McClish, Juknialis, Coulton & Bartlett, 1985). A common thread running through these studies appears to be that NFR decisions and actions are fraught with problems: problems of communication and authority, especially in relation to nursing and medicine, but also involving members of other health professional disciplines, patients and families.

Positioning the researcher

In my clinical experience as a nurse my involvement in CPR was limited. In every CPR attempt that I assisted in, my colleagues and I were not able to restart cardio-pulmonary activity even after extended and totally committed effort. I had no experience that I can recall, of involvement in discussions about impending NFR decisions. I was aware of some of the social practices operating in health care facilities, for example, the use of codes to denote that a patient would not receive cardio-pulmonary resuscitation if their heart were to stop. More recently, as a nurse, professional advisor and academic, I have listened to many stories from New Zealand nurses recalling their experiences of resuscitation attempts and instances where there has been conflict between medical and nursing staff about whether a patient should be resuscitated or not. In one story the nurses made an agreement with a patient that, if she arrested she would be provided with support and comfort and allowed to die in peace. This was explicitly against the orders of the doctor who considered the patient to be for resuscitation. When an arrest did occur and the patient died, the nurses upheld the agreement and told the doctor that the arrest was discovered too late to contemplate resuscitation procedures. In response to that story, questions that came to my to mind included:

- What did the patient want?
- Were family members involved at all?
- What was the view of the doctor?
- Did the doctor believe the nurses?
- Why were some things talked about and not others?
- What forces framed the discussion and the subsequent subterfuge?
- What prevented the nurses from talking to the doctor?
- On what basis, do health professionals make decisions about whether patients will receive cardio-pulmonary resuscitation or not?
- And last, but not least, what was the patient's experience in these circumstances?

My experience suggests that there exists a lot of misunderstanding and misinformation about NFR orders and practice. The nurse ethicist Johnstone (1999), in raising the question of the acceptability of NFR, warns nurses that, "a whole range of important moral, legal and professional considerations must be taken into account" (p. 372).

Positioning the study

This study is set against a background of changing hospital practices where CPR remains largely unsuccessful in returning people to a reasonable quality of life, yet is standard practice in Western hospitals (Zoch, Desbiens, DeStefano, Stueland & Layde, 2000). NFR has been practised since the 1970's in cases where it was considered, with some deliberation, that CPR was not likely to result in the successful resuscitation of the patient. Hospital nurses are considered to be morally and clinically responsible enough to make the decision to initiate CPR but are not usually seen to be primary decision-makers regarding the NFR status of patients. That responsibility lies with the medical profession although nurses, patients, families and others may be part of the decision-making process. Since the 1970's there have been calls to set up hospital-wide NFR policies, based on the assumption that every relevant staff member would then be able to carry out the appropriate care for patients. The research indicates that the existence of a policy or protocol is no guarantee that this will happen. In New Zealand a number of public health care providers set up NFR policies in the early 1990's and one hospital conducted an audit of its policy (Taylor, Ramsay, Parker & Peart, 1996). It seemed useful to research another New Zealand health care provider organisation which had an NFR policy but where no such audit or research had been carried out. The relevant Regional Ethics Committee had also produced guidelines for NFR for use in the hospitals in the region. An investigation might reveal whether the hospital and

Ethics Committee NFR policies were known, whether they were effective in guiding practice and whether health professionals found them helpful.

A preliminary survey of the nursing, medical, bioethics and sociology literature brought home to me the extent to which NFR was problematised by the research already conducted. A picture was created of NFR policies and practices where conflict and distress, ineffective ways of communicating between health professionals, uncertainty and ambiguity were apparent. On the edge of all this hovered the patients and their families, sometimes being included in decision-making, sometimes not. It was possible that the problems identified in the research studies may have had negative effects on patients and their families.

I have already referred to changing hospital practices, informed by the importation to New Zealand of ideas about CPR and NFR practices. Another thread of change came from the radical reforms in the New Zealand health and public sectors, especially those introduced through the Health and Disability Services Act 1993. The notions of individual autonomy and self-reliance, and the extent to which patients might play a part in making decisions about their NFR status, as well as the self-determination and partnerships aspects of the Treaty of Waitangi, were political and ideological background features.

My primary interest was in investigating NFR events in a New Zealand public hospital in an ordinary medical ward setting. What intrigued me most of all was the supposition that medical and nursing professionals have different views and understandings of their positions on NFR; that there appear to be barriers in communicating these differences effectively, and that authority regarding NFR appears diffused and problematic. What was needed was a research approach that could uncover something of what really went on at the bedside and also in the health care institution at large regarding the decision-making involved in the development and implementation of NFR policies. The studies referred to previously, employ a range of methods, including an approach that assumed that reality could be apprehended by capturing the individual's point of view (subjectivity) and that qualitative researchers can directly represent this lived experience in language (Crowe, 1998, p. 339). An alternative approach might assume that subjectivity and the language people use when they talk and write about NFR are socially and politically constructed and that they occur in a socio-political and historical context. This post-structural position views knowledge as an effect of power and constituted in language (Crowe, 1998).

A point of curiosity is the possibility that staff involved in NFR decisions use talk or withhold talk and conversation as a technique of professional power. By that I mean that members of professional disciplines will seek to exert influence over NFR events through language. Published research suggests that medical discourse dominates the NFR decision-making process. If there is a lot of conflict in the clinical setting, it is possible that it is because the dominant discourse on NFR is under pressure from other discourses. Perhaps new and novel discourses are exerting their influence on NFR discourses. If these are identified through a study of everyday practices, NFR events, and their effect on patients, might be better understood.

Much of the existing commentary suggests that language and talk around NFR and around patients nearing the end of their lives, is significant. Questions raised, include whether to talk to patients and their families about NFR, which clinician should do this, and the frequency of practices that involve one professional group keeping information secret from another group on the basis that the patient will benefit. There are assertions that professional knowledge is the rationale for withholding information from patients or other staff regarding NFR. Conversely, nurses claim that they are silenced by being excluded from decision-making altogether, in spite of knowing the patient better than medical professionals do.

The physiological aspects of the end of life are intriguing, changing and worthy of further study (Charlton, 1996). As a social scientist I am interested in the social construction of death. "The court of judgment demanded less the body as evidence and more the person as witness" (Armstrong, 1987, p. 651). This late twentieth century assertion signals a shift away from the acceptance of death as a natural and inevitable physical event. What becomes more significant is medical expert judgment about whether a death will occur and in what circumstances. My focus of interest is on the professional person as a witness to and judge of a particular kind of socially constructed death in a hospital, NFR. Out of these considerations, a research project evolved. What follows are explanatory statements of the aims of the study, key concepts and the overall approach taken. In later chapters, these elements are explored in more detail and the approach to the research justified more substantially.

The aim of the study

The overall aim of the research is to make more evident the social practices of the construction and implementation of NFR policies through a critical analysis of the language used by those working at clinical and institutional level. The primary question is: What NFR disciplinary discourses are uncovered by a critical analysis of the talk of those involved in the social practices in the ward? The secondary question is: What NFR disciplinary discourses are uncovered by a critical analysis of the talk and texts of those involved in the social practices across the health care institution? Also of interest is the identification of a possible relationship between practice and institutional understandings and the wider socio-political context.

Research approach

The investigation aims to contribute to knowledge through a rich engagement with the particular and specific, rather than with the general and comprehensive. It is with this goal in mind that I undertook to investigate the NFR policies and practices regarding NFR in one large, metropolitan general hospital in New Zealand during the period when Crown Health Enterprises were being transformed into Hospital and Health Services (1996 - 1997). It was important to understand policy and practice from the perspective and position of a range of speakers. To this end, I included conversations with direct providers of medical and nursing care in one ward. I also had conversations with the Service Manager and Charge Nurse of that same ward, and three policy-making consultants at Crown Health Enterprise level (two with nursing backgrounds, and one from a medical background) of which the ward was a part. I also talked with the Chairperson of the Regional Health Authority Ethics Committee whose area of jurisdiction included the Crown Health Enterprise where the other interviews were carried out. As a previously practising and currently academic nurse I brought to the research process and to the institution in which the research was conducted, a particular position and relationship. This situation exerted an influence on the quality and content of conversations.

The point of focusing on NFR events was that this approach was based on the understanding that it is these moments that are likely to reveal realities that may not otherwise be exposed. The research is not aimed at improving policies and practices per se. No patients were included in the research. The extent to which the participants represent themselves as speaking on behalf of patients is a feature to be examined more specifically in the data analysis chapters of the thesis.

The conversations involved starter questions to encourage participants to talk about NFR; an invitation to talk about times of crisis and conflict and to engage in a discussion about NFR policy texts. The transcribed texts were examined for evidence of the way in which each participant represented him- or herself and their disciplines in relation to everyday NFR policies and practices, moments of NFR crisis and institutional NFR practices. The data were also examined for evidence of wider socio-political influences. The research was given ethical approval from Massey University Human Ethics Committee and the relevant Regional Health Authority Ethics Committee. Management approval from the Crown Health Enterprise was also given without problems.

The structure of the thesis

Chapter One aims to provide the reader with an overview of the study. It backgrounds the topic of NFR and the socio-political context in which the research was conducted. It positions the study in the social sciences, and asserts that NFR is a social reality and justifies the research approach of critical discourse analysis. Chapter One addresses the project's overall aim, which is to reveal how NFR power is exercised, through a critical analysis of the talk of eleven health professionals in a hospital setting and of the lay Chairperson of the Regional Ethics Committee.

Chapter Two positions language, disciplinary discourses and ideology in the research project. An explication of discourse theory is presented with a view to justifying the social science foundations of discourse analysis and explains the critical elements of the research approach. The contributions of Karl Marx, Michel Foucault and Norman Fairclough as social theorists are acknowledged and argued along with those of their contemporaries and successors in order to clarify the development of ideas relevant to a study of the language of NFR. Chapter Two concludes with an examination of the contribution that particular theorists have made to the design and conduct of this research investigation

Chapter Three contains a critique of the published commentary regarding NFR discourses. In this chapter, NFR discourses are examined in order to surface influential NFR discourses as well as to consider the possibility of an alternative and more effective approach to NFR talking and writing. The language of NFR is highlighted. The way that different disciplines position themselves is revealed. Commentary from the disciplines of sociology, medicine, nursing, public policy, the law, bioethics and economics is examined to ascertain the way in which the exponents of disciplines construct NFR knowledge.

Chapter Four discusses critical discourse analysis as the methodology selected for the study and identifies some of the problems associated with discourse analysis. Chapter Four also describes how the data collection process was developed in order to generate new NFR texts. Ethical considerations and the relevant approval processes are detailed. The practicalities of conducting the research are covered and commentary on their implementation is included.

Chapter Five is the first of the four data analysis chapters and is aimed at making explicit the social relations that existed between the participants and the researcher. This approach is based on the assumption, that the nature of those relations determined how, and to some extent what research texts would be generated. The social practice of the researcher in the process of conducting the interviews with the participant is examined. The texts are first examined for individual words or phrases that are distinctive and that indicate how the researcher organised the texts to achieve a particular effect. Secondly, texts are read for evidence of the dominance of the researcher discourse and finally, they are read for evidence of ideological positioning in the wider social context. A discussion of the analysis concludes the chapter.

Chapter Six reports the analysis of everyday NFR social practices of the research participants who worked as health professionals on the wards with patients. The analysis is organised around three main features of NFR talk: individual words and phrases, disciplinary discourses and wider ideological interests. The first task was to read the transcripts for the presence of distinctive words and phrases. The second task was to identify any distinctive disciplinary discourses generated in the talk of participants. Finally, transcripts were read in order to surface any wider ideological interests, for example, ideas about death or old age. Everyday practice is defined as NFR talk that was represented as taking place in a non-crisis situation where there was the possibility of deliberation. The aim of this chapter is to provide evidence that NFR knowledge is constructed in ways that, to some extent, resist and reshape traditional notions of disciplinary power and authority.

Chapter Seven is organised in a similar way to Chapter Six except that the focus is on talk about crisis NFR practices. These are practices where health professionals had to act immediately without an opportunity for deliberation or where there was overt conflict or stand off between two positions. The excerpts provided are examined to ascertain whether these moments of heightened ambiguity, uncertainty and conflict, more extensively rearrange NFR discourses and therefore expose new ways of constructing NFR knowledge, relative to the outcomes of everyday NFR practices.

Chapter Eight focuses on NFR talk occurring at institutional level. The three levels of analysis alluded to above, are applied. Three distinct discourses are identified: a pro-NFR policy discourse, an anti-NFR policy discourse, and a silent discourse generated by those who do not know of the existence of one or all three NFR policies relevant to the research. The NFR policy rhetoric of standardisation of practice throughout the institution is disrupted by the second and third discourses. The competing policy discourses revealed by this analysis help explain the wide variety of patient experiences revealed in NFR social practice.

Chapter Nine contains a discussion of the significance of the previous three chapters. Chapter Nine explores the NFR talk generated in the research as a collage of speech and silence, which works to assert power/authority and resistance. This power is exercised as a collage of NFR silence and speech: nursing, medical, interdisciplinary, institutional, patient and family. The disorderly CPR/NFR event is identified as a rupture of speech and silence, which tends to replay the traditional constructions of NFR knowledge. These observations are measured against the backdrop of late modern and postmodern theoretical understandings of death in the context of professional power. The implications of a socially constructed death for patients and the possibility of greater influence of a patient/consumer or family NFR discourses are considered.

Chapter Ten reports the research conclusions, and focuses on a critique of the methodology and of the research project as a whole. It records the possible implications of the research findings and makes clear the way in which the study speaks to patients, families, researchers, nurses, doctors, policy advisors, managers and health ethics committees. Included are suggestions for further research.

Summary

The aim of Chapter One is to provide an overview of the research account. It provides a background to the research project, including the development of the research ideas, and the socio-political context. The aim of the thesis and the two research questions are stated. The chapter also identifies my position as a researcher and sets out the research approach. Language and critical discourse are fundamental to the research process. Chapter Two will consider the centrality of these ideas to the purpose of, and the approach taken to, the research.

CHAPTER TWO

THEORETICAL FOUNDATIONS OF CRITICAL DISCOURSE ANALYSIS

Introduction

The aim of the chapter is to position language, disciplinary discourses and ideology in this study. The main argument of the study is that a range of language techniques used by health professionals creates a particular construction of NFR knowledge. The method employed to examine the language techniques is a critical discourse analysis involving three levels of data: individual words and phrases, competing disciplinary discourses and ideological positions. Foucault's (1973; 1977) ideas regarding language, power, the contestability of medical discourses, and the potential for their disruption by other discourses make a major contribution to the theoretical underpinning of the first two levels of analysis. However, Foucault eschewed the notion of ideology and so it is from critical social science and Western Marxist ideas of social theory that the 'critical' aspect of discourse analysis derives. This critical aspect has been developed by the social linguist Fairclough (1992; 1995) and Fairclough and Wodak (1997). The project brings together these ideas and applies them to the arena of research into NFR in a health care setting.

This chapter consists of four sections. To begin with, some preliminary understandings of discourse, discourse theory, ideology and research are offered. The contribution that Foucault has made to language and discourse, particularly his positioning on technical or disciplinary discourses, and ideology, is then discussed. The third section addresses the critical thread in the development of discourse theory, the contributions of twentieth century Western Marxists. The fourth section focuses on the way that the contributions discussed in the two preceding sections combine to forge a path to the use of critical discourse analysis as the selected method for this study. Chapter Four provides more detail on the application of this method.

Discourse

Discourse theory: Fundamentals

Mainstream social scientists have tended to see the *content* of linguistic data as their primary concern. Language itself has been seen as transparent or self-evident. The study of language was considered to be the preserve of the discipline of linguistics. But there has been a linguistic turn in social theory, which has resulted in language being accorded a more central role within social phenomena (Fairclough, 1992). Foucault is responsible to some extent for that 'turn' through the enormous influence of his argument regarding the primacy of language and its powerful place in the systematisation *from the outset* of people's thoughts and understandings of the discourses they participate in (Foucault, 1973).

With this in mind, and as a starting point for discussion, some general understandings of the concept of discourse have been selected. To begin with:

> In any given historical period we can write, speak or think about a given social object or practice (madness, for example) only in certain specific ways and not others. 'A discourse' would then be *whatever* constrains - but also enables - writing, speaking and thinking within such specific historical limits. (McHoul & Grace, 1993, p. 31)

This statement identifies some principal features of the significance of language and its power to enable some things to be spoken about and others not. McHoul and Grace's (1993) definition of discourse allows for the assertion that at the beginning of the twenty-first century certain ways of talking, thinking and acting about NFR events will predominate over others.

The heterogeneity of approaches to understanding discourse is evident in a statement by two researchers within the discipline of social psychology, Potter and Wetherell (1994b), known internationally for demonstrating the relevance of discourse theory and analysis to social inquiry. They comment:

> In the last decade we have been attempting to forge a coherent theoretical and analytic programme of discourse oriented research by focusing critically on linguistic philosophy, rhetoric, ethnomethodology and conversation analysis, post-structuralism and developments in the sociology of scientific knowledge. (Potter & Wetherell, 1994b, p. 1)

They position their comprehensive research endeavours firmly within the context of the disciplines of social psychology and sociology. Their primary goals are to make a contribution to understanding such issues as identity, constructions of self, other and the world, and the conceptualisation of social action and inaction. They argue that giving a better account of language and language use is an admirable pursuit.

Discourse theory, as distinct from discourses as such, is described as:

> An interest in properties of texts, the production, distribution and consumption of texts, sociocognitive processes of producing and interpreting texts, social practices in various institutions, the relationship of social practice to power relations, and hegemonic projects at the societal level. (Fairclough, 1992, p. 226)

Texts here include spoken as well as written language. Fairclough's (1992) interest in 'social practice' arises from his assertion that language is a form of social practice, rather than a form of individual activity (Fairclough, 1992). The above quotation also suggests Fairclough's position on discourse and ideology.

Fairclough (1992) asserts that certain ideological interests in society can gain authority over other interests. He proposes, firstly, that:

> Discourse is a mode of action, one form in which people may act upon the world and especially upon each other, as well as a mode of representation. Secondly, it implies that there is a dialectical relationship between discourse and social structure, there being more generally such a relationship between social practice and social structure, between social structures or institutions. (Fairclough, 1992, p. 65 - 67)

Here, Fairclough is arguing that discourses engage in a dialectical relationship with social structures. Therefore, discourses are concerned with power relations. In other words, he believes that discourse theory espouses a critical approach to how texts (these include both written and verbal) constitute particular forms of reality and hence authority. Of particular relevance to this thesis are his arguments that language use is a form of social practice and that social practices within institutions are of interest. It could be argued, on this basis, that verbal and written NFR texts in a health care institution are social practices and that there is a relationship between social practices and social structures.

Another thread extends discourse beyond language to non-verbal sign systems. Purvis and Hunt (1993) suggest that:

> Its key characteristic is that of putting in place a system of linked signs. Whilst the more important examples are speech systems or written language (texts), discourse can be non-verbal; for example, practices in which males open doors for females, rise when females enter rooms, etc. are elements of a discourse whose organising framework is a strict sexual division of labour, in which females are secondary but valorised as in need of male care and protection. (Purvis & Hunt, 1993, p. 485)

Implicit in this description is the notion that both language and non-language communication are forms of social action, revealing Purvis and Hunt's adherence to the overall goals of sociology. They give discourse primacy over experience, and meaning, in keeping with post-structural thinking.

Conversely, van Dijk (1997a) places discourse exclusively within a language framework that extends from private and informal interactions to interactions at Government level. He points to the contribution that discourse theory can make to the humanities and psychology and addresses discourse as a practical, social and cultural phenomenon which largely emerges from the social sciences, asserting that:

> Language users engaging in discourse accomplish social acts and participate in social interaction, typically so in conversation and other forms of dialogue. Such interaction is in turn embedded in social and cultural contexts, such as informal gatherings with friends or professional, institutional encounters like parliamentary debates. (van Dijk, 1997a, p. 2)

Here, van Dijk, like Fairclough, espouses the notion that discourse is a social practice and that it exists at every level of social action in a society, from individual communications to national decision-making.

Hence, it is understood in this study that language constructs and represents meaning in the way that NFR knowledge is shared or contested, primarily in the disciplinary discourses of medicine and nursing. It is assumed that the talk of individual practitioners within those disciplines may be one of the ways that NFR social practices are constituted. The position that practitioners take on NFR is negotiated through their use of pre-existing language. This, in turn, allows for the creation and understanding of the 'subject', who they are in specific situations and how they relate to one another. Subjects live in a social reality that is constructed and controlled by social conditions (Potter & Wetherell, 1987). My approach to understanding discourse adheres closely to the approaches of Potter and Wetherell (1987; 1994a; 1994b) and Fairclough (1992; 1995), and Fairclough and Wodak (1997), by focusing on the language utilised by different professional positions within the context of NFR, that is, technical or disciplinary discourses.

Technical or disciplinary discourses

According to Purvis and Hunt's (1993) description, the context in which discourses are most likely to be coherent and cohesive is in specialised or technical discourses:

> A discourse is a system or structure with variably open boundaries between itself and other discourses. This suggests that discourses "channel" rather than "control" the discursive possibilities, facilitating some things being said and others being impeded. (Purvis & Hunt, 1993, p. 486)

Here it is asserted that a discourse is a system or structure in relationship with other discourse systems or structures. There is a suggestion that this relationship is a competitive one whereby each discourse is vying with the other to be influential or, alternatively, conceding to the more influential discourse by becoming silent. These possibilities then, constitute discursive possibilities; ways in which language is channeled.

It could be argued that medical discourses, for example, have achieved pre-eminence in human sciences over other disciplines like psychology or nursing because of their overall unity and cohesion. This dominance is explained through the example of the discourse of the medical specialty of pathology:

> A discourse, moreover, is not merely a narrow set of linguistic practices, which reports on the world, but is composed of a whole assemblage of activities, events, objects, settings and epistemological precepts. The discourse of pathology, for example, is constructed not merely out of statements about diseases, cells and tissues, but out of the whole network of activities and events in which pathologists become involved, together with the laboratory and other settings within which they work and in which they analyse the objects of their attention. (Prior, 1989, p. 3)

Levin and Soloman (1990), cited in Parker and Burman (1992), suggest a less prescriptive reality: that medical discourses are becoming more tolerant of a range of approaches to solving health problems. Another possibility is that medicine is being threatened by the rise of other discourses and is fighting for its previously pre-eminent position (Turner, 1992).

The above discussion identifies a number of characteristics of discourse theory that have the potential to contribute to a study on NFR. The next two sections examine the origins of these concepts. Foucault's legacy, in particular, is very significant, with regard to discourse in general and disciplinary discourses in particular, especially medical discourses.

The contribution of Foucault

Discourse, language and medicine

The French scholar, Michel Foucault, sets up discourse in opposition to ideology in, *The Birth of the Clinic* (1973). In this publication, Foucault tracks the rise of the discipline of medicine. Foucault explains that, within a few years in the eighteenth century, there was a significant change in the way that medical practitioners viewed the human body. The knowledge of the individual patient was structured in a new way; disease was systematically reorganised so that the limits of the visible and invisible followed a new pattern. This does not mean that existing theories and beliefs were discarded outright. Rather, Foucault argues that there was a shift in emphasis; he refers to the primacy of language as method and the primacy of the corpse as the subject of medical gaze. Foucault describes this:

> In the clinician's catalogue, the purity of the gaze is bound up with a certain silence that enables him to listen... The clinical gaze has the paradoxical ability to *hear a language* as soon as it *perceives a spectacle* ... To this extent, observation and experiment are opposed but not mutually exclusive: it is natural that observation should lead to experiment, provided that experiment should question only in the vocabulary and within the language proposed to it by the things observed; its questions can be well founded only if they have answers to an answer itself without question, an absolute answer that implies no prior language, because, strictly speaking, it is the first word. (Foucault, 1973, p.108)

'The 'gaze', a kind of active vision was described as a 'speaking eye', one which incorporated a pure gaze to create a pure language (Fillingham, 1993). Foucault identified this new way of seeing as the anatomo-clinical method, a structure in which space, language and death were articulated. He argues that the way in which doctors began to see death and more significantly, the dead body, gave rise to a new knowledge of the individual, new developments in medical language and new boundaries to the discipline of medicine. This last, Foucault considers, is the most significant reason for the change in medical knowledge and practice, as well as the increased status it has given medicine.

To follow that line of argument, doctors in the twenty-first century might incorporate a structure to articulate, via language, a space for death: with a NFR order, just as they may create a new space among the living for the body when they and others resuscitate people who have collapsed. To paraphrase

Foucault's words above, the clinical gaze means that health professionals in a hospital ward, coming upon a person who has suffered a cardiac arrest, have the paradoxical ability to *hear a language* or discourse about the resuscitation, NFR and death of a body as soon as they see the collapsed person, the spectacle. In Foucauldian terms, this research should then be not about the spectacle, the embodiment of death as such. The interest should be in the clinical gaze and the language that is heard and used to articulate the spectacle. Particularly in his earlier works, Foucault (1973) saw language as the articulation of a way of seeing. He said, in concluding the Preface to *The Birth of the Clinic:*

> What counts in the things said by men is not so much what they may have thought or the extent to which these things represent their thoughts, as that which systematises them from the outset, thus making them thereafter endlessly accessible to new discourses and open to the task of transforming them. (Foucault, 1973, p. xix)

Here, Foucault is acknowledging the systematic or structural nature of discourse, at the same time arguing that this system is open to movement, change and transformation.

Power and its compatriot, resistance

Foucault believed that part of the power of the human sciences is based on the capacity of people to adapt their behaviour and govern themselves according to the dominant truth claims of these 'sciences'. According to Frank (1991), Foucault believed that the way in which humans construct an understanding of the self as an effect of discourse is through truth games or discourses, for example, through the disciplines of economics or biology (Frank, 1991), or, it could be argued, through nursing or medicine. This belief is evident in Foucault's work, *Discipline and Punish: The Birth of the Prison* in which Foucault

(1977) departs from the Enlightenment notion of the individual as a separate rational unity, isolated from the world but in it. Foucault (1977) argued that power was everywhere and inseparable from bodies. The symbiotic relationship between power and resistance is explained thus:

> Resistances are all the more real and effective because they are formed right at the point where relations of power are exercised; resistance to power does not have to come from elsewhere to be real, nor is it inexorably frustrated through being the compatriot of power. (Foucault, 1977, p. 142)

This explanation allows for Foucault's position on the relational nature of power and his refuting of the idea of historical progress. It also eschews the notion of ideology, both positive and negative, and of hegemony. In his studies on the relations of power, Foucault was concerned with the various historical relations between forms of knowledge and forms of the exercise of power. Essentially one cannot be considered without the other. So the distinction between truth and falsehood is a political question.

Another way of explaining Foucault's understanding of power is to extend its effects beyond the institutional or structural forms of power and locate it in processes of power, that is, manoeuvres, tactics, techniques, functioning, policies. Foucault argues that it cannot be assumed that the operation of power is always the expression of opposition between the rulers and the ruled. As he puts it:

> There is no binary and all-encompassing opposition between ruler and ruled at the root of power relations, and serving as a general matrix - no such duality extending from the top down and reacting on more and more limited groups to the very depths of the social body. (Foucault, 1977, p. 94)

Here, Foucault is describing the notion of resistance. To Foucault, the opposite of power is not powerlessness or oppression but 'resistance' not in a structural sense but in a series of techniques, strategies and multiple points on which power relies for its existence. So power is not restricted to one economic or cultural class, neither is it a fixed and rigid phenomenon. Foucault argues that power has to mask a substantial part of itself to be successful. It must have a productive function, that is, it must achieve the goals of those who, in a particular context, control the relations of power (Foucault, 1977).

Relations of power

In *Discipline and punish: The birth of the prison* Foucault (1977) argued that if prison authorities did not make use of violent or bloody punishments, and prescribed lenient methods involving confinement and correction, it was always the body which was at issue - the body and its forces, their utility and docility, their distribution and submission (Rabinow, 1984). In other words, even if the body was not actually touched and physically hurt as a punishment, regulation of prisoners was possible because of the understood potential to harm them if they did not follow the requirements for surveillance and control. At the local level this meant the prison authorities, at a national level, the state that had authorised the prison's purpose. Foucault identified the institutions of the asylum, the hospital, the prison, and the psychiatrist's couch, not only as contexts in which the relations of power have been formed and exercised, but also as 'laboratories' for observation and documentation. Foucault claimed that from these contexts, bodies of knowledge have emerged about the mad, the sick, the criminal and 'sexual' subject. The interest in this thesis is in the sick subject being observed and documented in a hospital context; the seriously ill patient who appears to have little chance of recovery. These are the subjects for whom NFR may be an issue.

Foucault (1984) suggests five methodological 'precautions' to reveal the relations of power. The first of these is that analysis is directed at techniques embedded in local, regional, material institutions; not at legitimate and centralised forms of power. The second is that analysis is directed at the practice of power, its application and effects, its processes; not at classes, groups and individuals and their motivations. The third precaution is that analysis is directed at power as a dynamic, circulating process functioning in the form of a chain, exercised through a net-like organisation. It has the effect of causing certain bodies, gestures, and discourses and desires to be identified as individuals. It was the third point that Flax (1990) disputed. The fourth precaution argues that analysis does not arise from the macro level (the power of the state); it has as its foundation the micro-level of analysis. That the level of analysis must begin at the local, micro level is illustrated in Foucault's (1984) comment that:

> The manner in which the phenomena, the techniques and procedures of power enter into play at the most basic level must be analysed, that the way in which these procedures are displaced, extended and altered must certainly be demonstrated; but above all what must be shown is the manner in which they are invested and annexed by more global phenomena and the subtle fashion in which more general powers or economic interests are able to engage with these technologies that are at once both relatively autonomous of power and act as its infinitesimal elements. (Foucault, 1984, p. 87)

In other words, an investigation of power relations should have 'an ascending level of analysis' (Smart, 1985). It is when the particular processes of power are analysed at micro-level that more general patterns can then be analysed in terms of their political and economic usefulness. This is the fifth precaution and arises from Foucault's argument:

> Mechanisms of power have been accompanied by instruments for the formation of knowledge: methods of registration, procedures for investigation and research, apparatuses of control. The exercise of power creates sites where knowledge is formed. (Foucault, 1984, p. 93)

Foucault claims that the emergence of these apparatuses of control was fundamental to the constitution of industrial capitalism and to the development of knowledge and the formation of the social sciences. What differentiates modern Western society from earlier societies, Foucault believes, is the development of Government technologies to control the processes of life in order to maximise their political and economic usefulness. This leads to their redefinition as technical problems that are portrayed as resolvable through more scientific knowledge and better techniques of intervention. In reality, this promise is not fulfilled, in that developments in scientific knowledge and better techniques of intervention have failed to resolve fundamental issues about decision-making regarding the process of dying.

Foucault, nursing and NFR

Foucault's work has begun to be used to explore nursing problems. For example, the merging of the public and private aspects of terminally ill patients' characters in nursing 'knowledges' has been identified by May (1992) who states that:

> These knowledges have the effect of defining the patient's social and organic character... by establishing the patient's status as the public object of attention and administrative procedures... and by the way in which nurses are now required to 'extend' their gaze beyond the concrete condition of the body, and to intrude into the patient's private, *subjective* sphere. (May, 1992, p. 591)

Other technological means might include sustenance and chemotherapy through intra-venous infusion, surveillance of the heartbeat through cardiac monitoring and maintenance of lung function through respiratory support systems. None of these, Foucault would argue, allow the 'subject' to face up to the truth of his or her own mortality and death or to acknowledge the suffering that may be part of the process of dying.

Foucault sees the power over life and death as a modern phenomenon, but argues that when death occurs, power ends. He sees death as the most secret act of existence, the most private (Foucault, cited by Rabinow, 1984). It could be argued that Foucault resists the medicalisation of death if medicalisation means the identification of death as a technical problem, surmountable by technological intervention rather than an act or event involving the dignity of privacy. Decisions regarding NFR status may well have intrigued Foucault, especially if they are decisions made by doctors and nurses without consultation with the patient. The clinical gaze on some patients as they approach death, and its articulation through the language of resuscitation or Not-For-Resuscitation, Foucault might argue, are techniques of power because the way that the disciplinary discourses speak of CPR and DNR may determine what happens to the patient. This possibility is in keeping with Foucault's approach to revealing the elements of power relations at the capillary level. According to Cheek (2000), Foucault offers us a way of understanding power and its effects, rather than a grand vision of how power might be overcome. This means that analysis should occur at the very edges of power networks, in the hospital ward, for example.

Critical social science: language, ideology, discourse

One main thread in discourse theory arises from the work of Michel Foucault. The other main thread arises from the work of the critical social scientists that developed and extended the social theory legacy left by Karl Marx through Western Marxism. Three major points of difference between Foucault and Western Marxism are the place of general theory, and the questions of the centrality of ideology and of language:

> Foucault's strategy of engagement with Marxism was to avoid operating on its terrain by eschewing the project of general theory itself. If western Marxism has been an engagement with the impasse of classical Marxism, then Foucault's work can be conceived as a response to the difficulties encountered by western Marxism... The specific field of Foucault's encounter with western Marxism... is his self-conscious attempt to avoid not just the concept of ideology, but the field designated by that concept. (Purvis & Hunt, 1993, p. 488)

The question of the centrality of language was also in contention. Twentieth century social theorists consider that Marx neglected language and relegated it to a peripheral role. One explanation for the apparent oversight states:

> Much of the inadequacy of Marx's approach to language stems from the philosophical context in which Marx worked; his conception of all-embracing confrontation between idealism and materialism and his own commitment to the latter resulted in a preponderant emphasis upon the material integument of social life and a parallel suspicion of the mental and ideational dimensions. (Purvis & Hunt, 1993, p. 480)

There is a brief reference in Marx's 1844 publication *The German Ideology*, to the importance of language as practical consciousness, a necessary element in the social relationship (Purvis & Hunt, 1993).

Marxism, language and ideology

The classic Marxist position on the study of language, therefore, is that language would not be studied as an end in itself but ‘as a means of developing the science of the laws of thought, and to developing the general theory of human life and human aims, free from idealist illusions and perceptions' (Cornforth, 1965, p. 378). The Soviet linguist Volosinov (1973) who faced opposition from his contemporaries when he argued, in the 1920's, that human language was the most fundamental characteristic of 'man as a species', confirms this view. In illuminating the Marxist idea of 'social psychology' through analyses of the speech act, the link could then be made between the mental creativity of man and the material basis. In so doing, Volosinov assigned language a central role in dialectical materialism (Matejka & Titunik in Volosinov, (1973)). Unfortunately, Volosinov's work was not given the credit it deserved until much later in the century when both Soviet and Western social theorists turned again to language as a possible means of investigating social questions.

Western Marxism

In concluding their introduction to a series of essays on Marxism and the interpretation of culture, Grossberg and Nelson (1988) opine:

> Marxism is a territory that is, it would seem, paradoxically at once undergoing a renaissance of activity and a crisis of definition. There is a greater sense of distance between our theoretical categories (even those of common sense in our daily lives) and the historical reality within which those categories must function. There is an intellectual drive to deal with the disjunction between our need and our ability to intervene in our own historical reality. (Grossberg & Nelson, 1988, p. 12)

They situate Marxism squarely in the field of culture and ideology and by so doing align their work with that of the Western Marxist school of thought:

> In broad terms, Western Marxism has given considerably more emphasis than other forms of Marxism to cultural dimensions of societies, emphasising that capitalist social relations are established,

> maintained (reproduced) in large part in culture (and hence in ideology), not just (or mainly) in the economic 'base'. (Fairclough & Wodak, 1997, p. 260)

Ideology takes its place within Western Marxism's attempt to understand how relations of domination or subordination are reproduced with only minimal use of direct coercion. It implies that there is a link between people's interests and forms of consciousness (Purvis & Hunt, 1993). There has been considerable debate within Western Marxist thought regarding ideology. Larrain (1983), in his study on Marxism and ideology, (cited in Purvis and Hunt (1993)), proposed that there were two distinct conceptions of ideology: positive and negative. The significant one is the negative conception because it explains a distorted representation of reality where some people remain advantaged and others remain disadvantaged through the acceptance of existing social relations. Particular interests become disassociated from their specific location and come to appear universal and neutral (Purvis & Hunt, 1993). It is these 'universal and neutral' ideologies that should be subjected to critical discourse analysis, according to Fairclough and Wodak (1997) in the interests of emancipation of the disadvantaged. In the health sector this comment might be taken to mean that the traditionally dominant discourses, those of the health professions for example, need to be exposed to critical discourse analysis in order to reveal the way their power is maintained by consumers continuing to believe that NFR decisions should be left in the hands of doctors.

Foucault and Marx: The legacy

> Discourse is constitutive of social relations in that all knowledge, all talk, all argument takes place within a discursive context through which experience comes to have, not only meaning for its participants, but shared and communicative meaning within social relations... A discursive formation is never entirely 'closed' in the

> sense of providing a unitary or bounded system that permits only some statements and excludes others. (Purvis & Hunt, 1993, p. 492)

A central aspect of Purvis and Hunt's argument about the way in which ideology and discourse should be seen in relation to each other is that there may be 'ideology' effects in discourse. This allows for the contention that the interpellation of subject positions operates systematically to reinforce and reproduce dominant social relations, that is, the directionality of ideology. It is also an expression of a resolution between the traditions of Marxism and twentieth century social theorists who opposed Marxist ideas. It departs totally from the classical Marxist argument that all consciousness arises from the economic structures of society. It departs partially from the Marxist notion that society is divided into classes and the ruling class imposes its rules and beliefs on the other classes. It recognises the integration of thought and action.

Challenges to Foucault

There continues to be considerable comment on and criticism of Foucault's notions of power and knowledge and language as a medium for struggle. Commentators on Foucault's ideas are especially critical of his conceptualisation of power/knowledge, his construction of the 'subject' and his ideas on the body (see, e.g., Fox, 1993; Habermas, 1991; Lupton, 1997; Porter, 1996; Turner, 1995). He has been charged with inconsistency in his analysis and conclusions, and with self-parody. Furthermore, Fraser (1989) in Wicks (1999) criticises Foucault for failing to develop a new, normative framework for understanding modern power, which, she argues, is necessary so that we can understand what is wrong with the current power/knowledge regime, and develop ways to oppose it. Wicks' (1999) view of Foucault's analysis is that by giving an inadequate account of subjectivity, agency and resistance his analysis of power and resistance is inadequate. Not all feminists hold to these feminist criticisms, however, and a number of feminist writers acknowledge Foucault's contributions to an analysis of power, including Flax (1991) and Lather (1991).

All of the above relate to a fundamental question: is social action possible? One of the criticisms of Foucault is that, if his account of social reality as multiple realities is 'correct' there is no point in organising for social change because the actors will always be defeated by yet another power configuration whichever way they turn (McNay, 1993). If this argument is related to a discourse analysis of NFR policies and practices, it could be argued that there is no point in involving participants in NFR research about their practice because it may not point to any possible ways of changing current practice regardless of how damaging it might be to patients. Another way of looking at the problem is to consider that discourse can have both emancipatory and oppressive effects and that the study of discourse can itself be a form of social action (Parker & Shotter, 1990). There is also the question of whether discourse theory can be named as such when the work of Foucault and others can be described as an attack on theory, that is, 'a systematically developed conceptual structure anchored in the real' (Best & Kelleher, 1991, p. x). Poststructuralists might argue that these structures are useful but also limit the boundaries of thought. However, even taking an anti-theoretical stance imposes a structure of its own (Dzurec, 1989).

Theory, discourses and action

Fairclough (1992) suggests that there are four reasons why social scientists should see discourse analysis as a useful process. First, a theoretical reason is that discourses, in particular textual communication, constitute one form of social action, that is, social processes, movement and social change. In textual analysis, social scientists cannot take language for granted. Fairclough argues that language is an integral part of social and political life and that the work of language in producing, reproducing or transforming social structures is worthy of the social science researcher's interest. The second reason, a methodological reason, why social scientists should see discourse analysis as a useful process, Fairclough argues, is that texts constitute a major source for the authority of social structures, relations and processes. The evidence for these constructs comes largely from texts, hence their methodological significance. Fairclough is especially interested in the way that texts serve the interests of dominant groups in the maintenance of power. The third reason, particularly significant in Fairclough's mind, is that texts, compared over time, can be a crucial indicator of social change. The fourth and final reason is a political one. It is increasingly through texts that social and political control is exercised (Fairclough, 1992). His views are summed up succinctly in the following more recent quotation:

> In broad terms, language has become more salient and more important in a range of social processes. The increased economic importance of language is striking.... In many service contexts, a key factor in the quality of the 'goods' produced and therefore in profitability is the nature of language that is used in 'delivering' services. Hence the preoccupation with the 'design' of spoken and written language used by service personnel (air hostesses, shop assistants, etc). The increasing marketisation of public services - the way they are required to operate on a market basis - has entailed a large-scale extension of these design concerns. (Fairclough & Wodak, 1997, p. 259)

Reference has been made in Chapter One to the influence of market forces in the New Zealand health service from the onset of the reforms in 1984. If Fairclough and Wodak's analysis is applied to the services in hospitals in New Zealand there may be some evidence of attempts to 'design' NFR social processes. For example, NFR policies may be written in a way that reflects particular socio-political interests.

Discussion

As indicated at the beginning of the chapter, this study is a critical discourse analysis of NFR discourses. Three levels of analysis are conducted on data collected from conversations between the researcher and twelve individuals holding different ranks and positions in relation to NFR in a Crown health Enterprise (CHE). Chapter Two discusses the theoretical foundations of this approach to research. Two key tenets of the study are that language and discourse create reality.

Language

While acknowledging that discourse may consist of non-verbal activities and strategies as well as verbal and written strategies, I selected language as the phenomenon to be studied. In doing so, I embrace Foucault's argument regarding language as a way of seeing. As a result, I argue that the participants in the research are assumed to gain their status as selves by taking a position, within a pre-existing form of language regarding NFR. In keeping with post-structuralist thinking, language is rejected as a neutral phenomenon. It is understood in this study that language constitutes reality as well as representing it. It is fitting to undertake social inquiry with language as the central tool of investigation because, as more and more researchers are finding, it is an effective way of raising and answering social questions.

Discourse

The focus in this thesis is on technical or disciplinary discourses. While Foucault's main interest was in the discipline of medicine, how it emerged as a dominant discipline in the human sciences and how it maintains its power, my interest is in a particular social practice within the context of medicine, that of NFR. I am taking up the question of whether medicine remains dominant in the area of NFR. A reasonable question to consider is whether medicine has opened up its discourses to other discourses, for example, nursing, bioethics, management, policy and lay discourses. I am also interested in whether there is such a thing as productive power, which will exert itself as resistance to dominant discourses in specific local circumstances, for example, the NFR talk in a ward in a hospital. Put simply, medical power/knowledge regarding the NFR status of a patient is resisted by nursing writers such as Yarling and McElmurry (1983) who argue that nurses are just as capable as doctors of making NFR decisions. In other words, their resistance is the assertion of another power/knowledge nexus. In addition, I am also interested in whether there is a relationship between social NFR practices at the bedside and at the institutional and societal levels, and whether they can be identified as power relations, that is, as part of a sociopolitical ideological project.

Foucault's methodological precautions

In keeping with Foucault's direction and argument, I take on board the necessity to analyse the construction of NFR power and knowledge at a local, material level. I interpret this as a general medical ward within a New Zealand hospital where NFR is an accepted part of ordinary practice. It is also in keeping with Foucault's fourth precaution that the micro level should be the beginning point of any analysis. In keeping with his second precaution, I accept that the practice of power is examined, rather than the motivations, classes and individuals who exhibit power. While the data are to be collected from twelve individuals, they are selected for the research because of the positions they hold in the institution. Their conversations with the researcher are examined for how they represent their positions from the existing NFR discourses. Also incorporated into the research is the notion of an ascending level of analysis because while the micro level NFR social practices are of interest, so too are the more macro level of NFR policies at institutional level. Also assumed in my approach to the research is Foucault's fifth precaution that control emerges from the exercise of power which creates sites where knowledge is formed. This gives rise to the questions: What social practices give rise to constructions of NFR knowledge in a medical ward? What relationship might there be between NFR social practices in a medical ward and Government technologies to control the processes of life to maximize their political and economic usefulness?

Commitment to social change

An important assumption for this research, arising primarily from the contributions of Foucault and Fairclough, is that power is a dynamic, circular process and that discourse analysis is an effective way of revealing social processes, movement and change. A justification for the linguistic turn in social science research is the increasing use of language as a major source for the authority of social structures and social relations. Like both Foucault and Fairclough, I am interested in whether the interests of dominant groups and disciplines are served by discourses and to what extent social and political control is maintained by discourse.

The framework used for the investigation

This position leads me to the modification of a framework for analysis of data proposed by Fairclough (1992). The first level of the framework is derived from the discipline of social linguistics and leads me to focus on individual words and phrases of speakers. This is in order to identify any individual characteristics in the way that speakers represent themselves regarding NFR. The second level involves paying attention to the presence or absence of disciplinary discourses, for example, nursing, medical or bioethics NFR discourses. Attention is paid here to the presence or absence of existing discourses identified from the published disciplinary discourses. It is also an opportunity to identify any old discourses that may resurface and new, previously unknown NFR discourses that may emerge in the talk, as indicated by both Foucault and Fairclough. The third and final level of analysis requires the researcher to focus on the ideological content in the talk of the speaker. Here, the framework departs most clearly from the notion that the speaker's words are systematised at the outset by pre-existing NFR language. The third level of analysis assumes that there is some agency held by the speaker and that those ideas may be expressed as ideological interests, or indeed reflect the dominant or hegemonic ideas in society.

Summary

My purpose in this chapter has been to present the key ideas underpinning the methodological approach to the research project. The specific aim of the chapter was to position language, disciplinary discourses and ideology in the thesis. The position is this: that language is a social practice, rather than a form of individual activity. This means that in any particular historical period or setting we can write, speak or think about a given social object or practice (madness, for example) only in certain specific ways and not others. "A discourse would then be *whatever* constrains - but also enables - writing, speaking and thinking in that setting" (McHoul & Grace, 1993, p. 31). This thesis is about disciplinary or technical discourses in a specific context: NFR. At the beginning of the twenty-first century, in a health care context, in New Zealand, what specific ways is NFR being written, spoken and thought about? How are they produced? What is their relationship to power relations? And is there a link between them and any hegemonic projects at the societal level? This thesis is about how NFR discourses in a health-care setting enable people to act upon the world and upon each other, especially on patients nearing the end of life. It implies that there is a relationship between the discourses that occur in a hospital ward and those that occur in the hospital and in the wider socio-political context of New Zealand and countries with similar health services.

Chapter Two also acknowledges the main threads in the development of discourse theory including the contestation of ideas on language, discourse, texts, ideology, power and knowledge, and something of the relative authority of each of these concepts. I have drawn out the relevance of these ideas to problems in the health sector and more specifically to how they have provided the foundations for the methodology of the study. Chapter Three looks in greater depth at the contestation in existing NFR knowledge and research in order to demonstrate more specifically the reason for undertaking an interdisciplinary critical discourse analysis of NFR policies and practices.

CHAPTER THREE
THE COMPETING NATURE OF NFR DISCOURSES: A LITERATURE REVIEW

Introduction

Chapter Three puts forward a construction of existing NFR knowledge. The published commentary regarding NFR discourses is critiqued and examined in order to surface influential NFR discourses as well as to consider the possibility of a different and more effective approach to NFR talking and writing. The aim of the review, then, is to provide a background and justification for this interdisciplinary study into talk generated by a population that was involved in NFR as an everyday social practice.

In Chapter Three there is a discussion of the language of NFR. The way that different disciplines position themselves in relation to NFR and death is outlined. Foucault's questions of, 'How is power exercised?' and 'What are the effects of power?' inform the thesis as theory and as method (Foucault, 1977). These questions are addressed in both the theoretical foundations of the thesis and the method, including the conduct of a critical review of published sources. Attention is paid to the way that individual disciplines and popular commentary construct NFR knowledge. These include the positions of sociology, medicine, public policy, law, bioethics, economics and nursing disciplines on NFR.

Conceptualising resuscitation and NFR

Cardio-pulmonary resuscitation

Prior to the establishment of NFR in Western hospitals in the 1970's there was a long history regarding resuscitation. Tossach first reported successful mouth-to-mouth resuscitation in the medical context, in 1744. However, it was not until 1878 that Boehm first described closed chest massage though the practice did not survive in the short term (Liss, 1986; Nolan, 1998). It was not until the 1950's that interest turned again to closed chest massage and mechanical means of reviving patients. Emergency resuscitation of a hospital patient from 'ventricular standstill' through the application of a cardiac pacer is first attributed to Dr Zoll, a cardiologist at Beth Israel Hospital in Boston, USA in 1952 (Jeffrey, 1995).

Reports of closed chest cardiac massage in a hospital setting did not emerge until 1960 (Kouwenhoven, Jude & Knickerbocker, 1960). The work of Kouwenhoven et al. has been credited with establishing the practice of closed chest massage as the preferred form of cardio-pulmonary resuscitation (Karetzky, Zubair & Parikh, 1995). In most Western medical institutions there are systems of training, policy, expertise and equipment to anticipate and respond to those situations where closed chest massage may be indicated as an intervention (Taylor, Ramsay, Parker & Peart, 1996). CPR outside hospitals is now commonplace (Cobbe, Dalziel, Ford & Marsden, 1996) and a worthy area of research, though it is not the topic of discussion here.

A cardiac or pulmonary arrest occurring in a hospital may represent considerably more than meets the eye. What observers bring to the encounter is a multi-layered gaze arising from their knowledge, experience, status, gender, personal and professional philosophy, authority and expertise. The action they take will depend on the particular mix of these characteristics (Wenger, Pearson, Desmond, Brook & Kahn, 1995). Observers' actions may support, or be contrary to, existing professional and legal norms, whether they are involved in a patient's resuscitation or not. There have been legal challenges to health professionals about whether they should have resuscitated the patient. Such challenges have tended to revolve around informed consent and advocacy issues. For example, in a North American legal case, a patient sued a hospital because a nurse had defibrillated and revived a patient against his wishes. The Court's argument in favour of the patient was that even *emergency* (italics added) medical treatment without consent was considered to be battery (Rodriguez, 1999). In contrast, also in the United States, a nurse was dismissed for not resuscitating a patient even though the patient had indicated clearly that he did not wish to be resuscitated. Her telephone consultation with the attending physician had resulted in his agreeing with her assessment that the patient was dead. The argument for her dismissal was that she had acted illegally in certifying the patient dead. The State Nurses' Regulatory Board exonerated the nurse because the State Statute indicated that the physician did not have to determine death at first hand (Sloan, 1996). Such ambiguous findings do not provide any comfort or guidance to health professionals, even those outside American legal jurisdictions.

The length of time the person has come under the medical gaze may also be significant because of the opportunity this gives staff to inform themselves about the patient, for example, how the position of that person in the community is perceived. In a North American study of resuscitation outside the hospital, it was found that African American people, older people, and those with less education were less likely to be revived than younger, white, well-educated people (Heller, Steele, Fisher, Alexander & Dobson, 1995). It is possible that the racist and ageist attitudes that this study reveals, may also apply within hospitals. The make up of the attending health care team in the hospital may be of significance. The particular configuration of nurses and medical staff includes variables like qualification, experience, knowledge of local and international social practices, knowledge and understanding of the patient and their families, knowledge of medical practitioners in charge of the case and their practices, including an understanding of support services. An arrest may occur at night when there are fewer staff available. A doctor may be called from another area in the hospital and take precious minutes to arrive at the scene of the arrest (Eastwick-Field, 1996). The significance of the makeup of the medical team - consultants, registrars and house surgeons, may revolve around all of the things that contribute to effective medical practices, for example, the degree to which they believe they hold decision-making responsibility, their availability to the ward, their reliance on information from nurses and their other responsibilities outside the ward and to other patients in the ward (Aarons & Beeching, 1991; Koch, Mayers & Sandroni, 1992; Taylor, Ramsay, Parker & Peart, 1996).

The effectiveness of the procedure of cardio-pulmonary resuscitation (CPR) tends to be discussed in terms of short and long-term quality of life during the hospital stay and after discharge (Mead & Turnbull, 1995; Miller, Gorbien, Simbartl & Jahnigen, 1993; Stewart, 1995). Other measures of success take into account the social, physical and psychological characteristics of patients and their support networks (Rodriguez, 2000). A feature of major acute care facilities is that different departments within them may have quite distinct policies and practices regarding the availability of CPR intervention systems. Medical wards, surgical wards, mental health facilities, outpatients' clinics, areas for the care of adults over seventy years of age (Doyal & Wilsher, 1994; Watson, Wilkinson, Sainsbury & Kidd, 1997), intensive care units (Baggs, 1993; Slomka, 1992), children's wards (Kirschbaum, 1996; Street, Ashcroft, Henderson, & Campbell, 2000) and operating theatre suites (Cohen & Cohen, 1992; Dautzenberg, Toon, Hooyer, Schonwetter & Duursma, 1993; McGraw, 1998) may all have distinctive policies. Patients in these areas and their families may not be aware of the distinctions; nor may some of the health professionals who work there (Eichorn, Meyers, Mitchell & Guzzetta, 1996). Non-hospital institutions, for example, hospices and long term care institutions may have more cohesive policies (Hosford, Brown & Duncan, 1997; Murphy, 1988; Weatherall & Mathewson, 1995). It was not always like this. When CPR was first used, candidates for CPR were very carefully selected (Ardagh, 1997). Now, common practice is that CPR will be commenced, in the absence of an NFR order.

Exclusion from cardio-pulmonary resuscitation

Outcome studies of the effectiveness of CPR suggest a range of survival rates upon discharge from hospital. Karetzky, Zubair and Parikh's 1995 retrospective study of in-hospital CPR events revealed that only 14% of attempts outside the intensive care unit were successful. When research indicated that fewer than 16% of resuscitated patients survived until discharge from hospital, there began to be changes in practice (Bedell, Delbanco, Cook & Epstein, 1983; Lo, 1991). Decisions about the 'resuscitation status' of the patients were generally understood by senior physicians to be their responsibility and were undertaken without recourse to the patient or the family. Medical discourses of justification for a NFR policy generally evoke such concepts as therapeutic privilege, beneficence, medical futility, justice and paternalism (Hulme & Faull, 1997; Kerridge, Mitchell & McPhee, 1997; Savulescu, 1995; Youngner, 1988).

The decision to resuscitate or not, may rest on people's understanding of the procedure itself as well as what the result might be. It makes sense for patients, families, nurses and doctors to know what the chances of success are. There is a tendency for doctors and nurses to be over-optimistic about patient survival of a cardiac arrest. Health professionals may then misrepresent the likely outcome of CPR (Wagg, Kinirons & Stewart, 1995). These features are likely to be of significance for patients and families trying to come to an agreement about what should happen (Gleeson & Wise, 1990; Hackler & Hiller, 1990). The concern, in this particular research project, is with the practices of health professionals and the possibility that they can and do determine whether patients will be resuscitated.

Not-For-Resuscitation

NFR has become increasingly significant in the last thirty years because of the proliferation of technology that can extend life. Doctors and other hospital staff can choose whether to apply technology to a particular patient or not. This places the responsibility for the extension of life on members of the medical profession. Armstrong (1987) argues that bioethicists should make these decisions. The other side of this decision-making power is enacted by a deliberate decision not to intervene with CPR in the case of cardiac or pulmonary arrest. Is there a connection, if any, between bioethical and medical power over NFR? Do other disciplines have anything to say about NFR? What follows is a survey of social, popular, medicine, public policy, law, bioethics, economics and nursing disciplines on NFR. This ordering suggests there is no overlap or cohesion between disciplines. That is not necessarily the case, but in the interests of a cohesive account, the discussion has been organised in this way. Finally, the nursing position regarding NFR is examined to ascertain its positioning regarding the construction of NFR knowledge.

Death and NFR

Social and popular commentary

The prominence of particular ideas regarding death, NFR and medical technology in the United State of America is evidenced but also lampooned in an American political journal, with irony. *The Nation* refers to the need to create a new enemy once Communism had been defeated:

> Quite clearly then, from an economic point of view, we need a new enemy, ideally one that would foster new technologies and industries, and

> sponsor increased armies and bureaucracies, like its predecessor. One that could be embraced by right and left alike, one rooted in a fear quite as powerful as xenophobia and patriotism and loss of markets... the fear of death dovetails beautifully with our exquisite national belief that humans should not have to die. (Sale, 1994, p. 689)

This overtly political point is given a legal and economic flavour by an influential American legal opinion, which suggests that "a society's general attitude towards death (as well as other factors) will shape the type and amount of information that individual patients receive... and strongly affects its approach to health sector finance" (Annas & Miller, 1994, p. 393). According to this statement, in a society where death is feared, patients are likely to receive information that would lead them to believe they will survive. This presupposes that doctors and nurses do not want to be bearers of bad news to someone who is dying and who is afraid of death. Therefore, the argument goes, they are more likely to speak to patients about ways of staying alive than ways of dying well. In order to protect patients from death, society is prepared to direct health care finances to prolong life. English society is different from US society, so Annas and Miller (1994) opine, to the extent that it is even suggested that the English hospice movement first flowered primarily because of economic limitations. Writers use these assertions to argue for more refined informed consent mechanisms especially in end-of-life situations (Annas & Miller, 1994). This assertion assumes that greater refinement of informed consent mechanisms may allow for the emergence of a patient discourse that accepts death rather than demanding more expensive treatment in order to avoid it.

The medicalisation of dying

The insertion of an economic element into the desire for immortality/fear of death debate, suggests a revolutionary turn on death at the turn of the new millennium, at least in the American setting. A French social historian (Aries, 1981) proposes that death practices have changed through history. The twentieth century apparently has seen a change from extremely private death practices at home to the full medicalisation of death, so that the local hospital gained a virtual monopoly on the location of death. In the late twentieth century, according to Aries (1981) there remains a heavy silence over the subject of death in Western cultures; a silence controlled by medicine. Reference is often made to the flood of mostly sociological, medical, psychological and religious works published in the 1960s and 1970s (Aries, 1981). Aries himself did much to publicise the study of death and, among historians, Aries is acknowledged as a pioneer of death (McManners, 1981). The flood has, if anything, gained momentum since the publication of Aries' work (see, e.g., Armstrong, 1987; Bradbury, 1999; Giddens, 1991; Kellehear, 2000; Macklin, 1993; Nuland, 1993; Rothman, 1991; Scott, 1988; Seale, 1995; 1998). Walter (1994) calls this flood 'the revival of death' in his publication of the same name, and refers to the proponents of a contemporary meaning for death, as revivalists. This revival includes a breaking of silence and allowing the dying person to talk about the experience (Walter, 1994).

Death 'revivalists' include Jordens (1988) who argues that death is a function of social practices towards bodies:

> The medically authorised pronouncement of death is a 'death sentence', which also reaches well beyond the bounds of hospital wards and medical discourses. It resonates across other important social practices and institutions as well. (Jordens, 1988, p. 99)

Jordens (1988) argues that, through the application of end-of-life technologies, death has become less certain, and out of this uncertainty arise undecidable cases:

> The mobility which redefinitions of death afford to the moment of death are instrumental in opening up a space where the pronouncement of death can serve certain social interests rather than remaining slave to inscrutable (and silent) biological processes. (Jordens, 1988, p. 101)

Jordens' (1988) view turns upside down the notion of death as the final mystery. His claim that the moment of death has been made 'mobile' to suit the social interests of the medical profession is a radical and disturbing one and arises from Foucault's work. It extends Aries' (1981) argument and at the same time signals the appropriation of death and removal of mystery. Similarly, the Indian sociologist Madan (1992) identifies that modern approaches to death are represented by silence and traditional approaches represented by speech. Madan (1992) says that Western medicine, by bringing death under the purview of high technology in the twentieth century, has medicalised death and replaced everyday speech about death with medical jargon. The result is the trivialisation of death; a loss of dignity for the dying. Illich (1974), cited in Madan (1994), contends that death is the ultimate form of consumer resistance. According to the above argument, doctors silence those very people who, in order to give death meaning, should be articulating their own experience of dying.

Medicine, law and death

Sawicki (1991) echoes earlier arguments when she asserts that the dominance of the medical model is expressed through the power of the medical profession. This power has developed into a vast medico-industrial complex penetrating a wide range of commercial and professional endeavours, for example, drug companies, multi-national manufacturers of medical technology, policy committees (including ethics committees), lobbying organisations, insurance companies and private hospital boards of governors. A New Zealand sociologist, in a scathing critique of medical influence, argues that the medical profession retains power in the self-defined right to define health and sickness, the meaning of symptoms and their treatment and indeed what constitutes life, quality of life and death (Fougere, 1990). In this, he supports the kind of argument made by Jordens (1988) above.

Another significant characteristic of medicalisation is its ability to draw into the ambit of medical care that which has previously been a private or social affair. Childbirth is a case in point. What midwives and 'consumers' are currently trying to resist is the medicalisation of childbirth. In their publication on the medicalisation of childbirth Papps and Olssen (1997) assert:

> The fusion of *power and knowledge*, in this instance, is that knowledge and skill in one area at one time is used to create the conception of a coherent linear process of technical development where every innovation is presented as a qualitative improvement as if in some continuous process. (Papps & Olssen, 1997, p. 22)

Medicalisation is seen to reduce social and political and personal issues to medical problems, thereby giving scientific experts the power to resolve them within the constraints of medical practice. This means that remaining social problems end up being sidelined into the private and personal domain (Sawicki, 1991). Aries (1981), in contrast, places this kind of power in the hands of sociologists and other social scientists:

> The time of death has been both lengthened and subdivided. Sociologists have the satisfaction of being able to apply their classificatory and typological methods; thus there is brain death, biological death and cellular death (Aries, 1981, p. 585).

Yet another view, this time that of a nurse ethicist, Johnstone (1999) places the responsibility for determining death in the hands of both the medical and legal professions:

> Whereas laypersons typically regard the cessation of heart and lung function as determining death, the law and the medical professions regard the permanent cessation of brain function (viz. 'brain death') as determining death. Just which of these two conceptions of death is 'correct' is a question that sparked enormous philosophical debate. (Johnstone, 1999, p. 308)

What all of the disciplines referred to above have in common is that they are either asserting their own authority in decision-making about death or arguing that another discipline has undue influence and that the situation should be rectified. The above discussion makes apparent some of the elements of competition between particular disciplinary discourses regarding the power to decide who will have access to life extending technology and who will not. It also begins to make clear the centrality of language as a means of conveying meaning about death and technological means of delaying it. One of the most significant themes to emerge from the review so far is the mobility of death; a movement from biological death, to death as a social practice; a movement that brings death out from sequestration into the public arena; a movement from certainty to uncertainty. One of the problematic elements of this mobility is the potential that language has to either silence or 'talk up' NFR knowledge, just as it also has the potential to silence or 'talk up' people's knowledge of their own deaths. The position of the consumer discourse is peripheral to the current discussion; it hovers, sometimes having a voice, sometimes not. There is certainly rhetoric present in terms of patient advocacy and the best interests of the patient. This is apparent in a number of different disciplinary positions on NFR knowledge, which will now be examined.

Disciplinary positions

The medical position

The medical profession appears to have the most extensive discussions on professional concerns regarding the control of resuscitation in their professional commentary and research (see, e.g., Asch, Faber-Langendoen, Shea, & Christakis, 1997; Bedell, Pelle, Maher, & Cleary, 1986; Cobbe, Dalziel, Ford, & Marsden, 1996; Hosford, Brown & Duncan, 1995; Kamer, Dieck, McClung, White & Sivak, 1990; Komesaroff, 1997; Stewart, 1995; Street, Ashcroft, Henderson & Campbell, 2000; Watson, Wilkinson, Sainsbury & Kidd, 1997; Zoch, Desbiens, DeStefano, Stueland & Layde, 2000). Critics of the medicalisation of life in general and the dying process in particular would not express surprise at this. They would argue that this would be one of the means of maintaining control, not least of all, through the use of language. Such terms as therapeutic privilege, medical futility, life support, clinical death, quality of life, feeding tube, no code, extraordinary treatment, advance directives and euthanasia can all be described as new terms and coercive concepts (Meyer, 1992).

The argument thus far indicates that the resuscitation status of patients is of great concern and interest to individual medical practitioners. Medical practitioners are required by law to support the autonomy of patients in their right to refuse treatment. The doctor's obligation to 'do good' to patients has been a tradition in medicine since the Hippocratic oath was first invoked. In 1992, the American Medical Association Council on Ethical and Judicial Affairs published guidelines on resuscitation in which the point is made that cardio-pulmonary resuscitation and emergency cardiac care have the same goals as all other medical interventions; to preserve life, restore health, relieve suffering, and limit disability. An additional goal, unique to cardio-pulmonary resuscitation, is the reversal of 'clinical death'. It is acknowledged that these goals are often not achieved, for example, the provision of resuscitation may conflict with a patient's own desires and requests or may not be in the patient's best interests (American Medical Association, 1992).

One feature in such a situation may be that resuscitation would be 'futile'. This is not a well-defined or precise term and has undertones of subtlety and complexity. It may refer to the inability to postpone death, to prolong life or maintain an acceptable quality of life. If the decision not to resuscitate was about the level of quality of life or made on the basis of a low success rate for the procedure, the family or representative should be involved (Hackler & Hiller, 1990). Other comments call for greater patient participation in the above decisions (Alpers & Lo, 1992; Ardagh, 1999; Sayers, Schofield & Aziz, 1997). This view argues that the law on informed consent has encouraged a more interactive relationship between physicians and patients. This could be termed power sharing but the point is made that a grant of power to patient or family does not necessarily diminish the power of the physician to practise good medicine.

Numerous methods have been used in medical research into NFR events. Studies vary in scale from a nation-wide survey of NFR policies in Swedish hospitals (Asplund & Britton, 1990) to an audit of No-CPR orders in a general medicine unit in a teaching hospital (Aarons & Beeching, 1991; Lowe & Kerridge, 1997). These, and other studies, have consistently highlighted major shortcomings in the formulation, documentation and communication of NFR orders. Lowe and Kerridge (1997) sought to investigate this situation by auditing practitioners' compliance with the guidelines on No-CPR of a hospital ethics committee. Their conclusions were that 61% of patients who died in the study period had a No-CPR order. There was very little evidence of patient or nursing involvement in the decision-making (Lowe & Kerridge, 1997). This raises the question of how doctors might attempt to monopolise the construction of NFR knowledge. Critical sociologists like Sawicki (1991) propose that medicine constructs NFR knowledge in the public policy sphere as well. The next section examines this possibility and considers other issues regarding NFR in the wider sociopolitical context.

The public policy position

Medical scholars, Alpers and Low (1992), called for a national health policy on the definition of futility. They believe that doctors must be involved so that policies reflect sound medical judgement. According to this view, it is also important to include non-medical input; any working party set up to develop working definitions and guidelines for medical practitioners would benefit from the input of legal, political and lay representatives. The process of policy development is also identified as integral to a policy's success (Alpers & Lo, 1992). This could be interpreted as an attempt by doctors to influence public policy unduly though the invitation to others to join in the policy development does suggest a willingness to include other influences.

In 1981, a US President's Commission for the study of ethical problems in medicine and bio-medical and behavioural research including end-of-life decisions put the case for public policy involvement thus:

> A major issue in establishing wise public policies on life-sustaining treatment is the degree to which the community and its agents should be involved in medical decision-making. (President's Commission for the study of ethical problems in medicine and bio-medical and behavioural research, 1981)

This assertion is a useful starting point for the consideration of NFR and end-of-life issues at institutional and societal level. There are on record many attempts to codify medical and nursing obligations to patients in the difficult areas of resuscitation, prolonging life and medical futility. The Hastings Centre in New York published very detailed guidelines on the termination of life-sustaining treatment and the care of the dying in 1987 (Hastings Centre, 1987). The frequent citing of these guidelines in medical and nursing publications is testimony to their influence in medical discourse. In 1991 the Council on Ethical and Judicial Affairs of the American Medical Association published guidelines for the appropriate use of do-not-resuscitate orders (Council on Ethical and Judicial Affairs (1991. The United States Joint Commission on the accreditation of health care organisations now requires all hospitals to have written DNAR (Do not attempt resuscitation) policies. These policies are reviewed regularly to ensure that they reflect legislative changes and changes within care (American Heart Association, 2000). The Canadian Nurses Association, the Canadian Medical Association and Canadian Hospital Association published a joint statement on terminal illness in 1984 (Godkin & Toth, 1994). In 1999, in the United Kingdom, the Royal College of Nursing, the British Medical Association and the Resuscitation Council issued joint guidelines on DNR. The New Zealand Medical Association and the New Zealand Nurses Organisation have published guidelines on dealing with patients who are in a persistent vegetative state (New Zealand Medical Association, 1993; New Zealand Nurses Organisation, 1996). They state that families, health care professionals and institutions should make decisions together (Henneveld, 1994). Neither the Code of the New Zealand Medical Association (1988) nor the New Zealand Nurses Organisation's Code of Ethics (1995) contains specific clauses regarding the care of terminally ill people.

In New Zealand, there are no clinical guidelines on the construction of NFR policies emanating from a national public agency, for example, the Ministry of Health, the National Health Council (previously the National Health

Committee), (Feek, personal communication, 2000). The 1996 national standards for ethics committees acknowledge the responsibilities of ethics committees regarding service delivery issues. A caveat states:

> It is not mandatory for professionals, providers or individuals to seek Ethics Committee approval in matters relating to the delivery of health and disability services and any opinion given by an ethics committee on these matters is only advisory. (National Advisory Committee on Health and Disability Services Ethics, 1996, p. 12)

This caveat confirms only an advisory role for ethics committees in the development of guidelines or advice on NFR and contrasts with the more active role of ethics committees reported in Lowe and Kerridge's (1997) Australian research.

The New Zealand Resuscitation Council has developed national guidelines for CPR and is beginning to look at the development of national DNAR or NFR guidelines (Jennings, personal communication, 2000). In the public sector, the Senior Medical Officers of New Zealand District Health Boards have discussed the possibility of setting up national guidelines on NFR (Feek, personal communication, 2000). Reference has already been made to the artificiality of distinguishing one disciplinary position from another. In public policy, as in other arenas, professional disciplines interface with other disciplines for example, bioethics, economics and law. What follows is an exploration of the legal position on NFR orders.

The legal position

Statutory law governs medical and health care practices in Western countries according to individual jurisdictions. American and New Zealand law, for example, are quite distinct from one another but information about American law cases in the health sector can influence practices in New Zealand. Nurses in New Zealand are fearful of legal action in resuscitation situations. New Zealand nurses may be afraid because of what they understand about the American legal climate (Anonymous, personal communication, 1994; 1998, 2000). I know of only one case of a New Zealand (enrolled) nurse being disciplined regarding NFR practice by the nursing regulatory body, the Nursing Council of New Zealand (O'Connor, 1999). Legal support of patients regarding NFR has been approached in a variety of ways.

The Patient Self-Determination Act 1991 (United States)

In Ontario, Canada, there is a Substitute Decisions Act 1992, which details the right to delegate the power of attorney. There is a 1990 federal Canadian law of consent to treatment (Grant, 1993). In 1991, the American Congress adopted the Patient Self-Determination Act. This made it a requirement for all Medicaid and Medicare facilities to ensure that all residents and prospective patients write a complete written advance directive (Mezey, Evans, Golub, Murphy and White, 1994). However, some difficulties have been identified in evaluations of the effects of the Act. In the first five years of its enactment, less than 10% of patients had completed advance directives (Stone, 1996).

Staff of United States health facilities are supposed to conduct community education programmes to inform the public of their rights but such programmes are not reimbursed so interest in running them is low (Mezey, Evans, Golub, Murphy & White, 1994). Another study endorses the above findings regarding the low level of public awareness, particularly with regard to living wills (Hague & Moody, 1993). It is interesting to note that physicians have been given no specific role regarding the implementation of the Patient Self-Determination Act (Menikoff, 1992). In a more recent study, it was shown that education was the most important factor differentiating patients who did and did not execute an advance directive. The less education they had the less likely they were to complete a directive (Mezey, Leitman, Mitty, Botrell & Ramsey, 2000).

NFR legislation

In 1988, New York became the first state in the USA to enact legislation aimed at protecting patient autonomy by severely limiting exceptions to the discussion of NFR with patients. Its effect was not to increase the number of resuscitations, as predicted by some. Rather, it tended to result in more formal orders being written in patient notes, something that the researchers claimed had been achieved already in some hospitals with the development of formal policies (McLung & Kamer, 1990). Another effect has been that patients who want to remain in denial about their own impending death are denied that right (Pollack, 1996).

New Zealand law

In New Zealand it is the Bill of Rights Act 1990, Section 8 that ensures the right not to be deprived of treatment and Section 11 that provides for the right of consumers to refuse treatment:

> Section 8
> Right not to be deprived of life - No one shall be deprived of life except on such grounds as are established by law and are consistent with the principles of fundamental justice.
>
> Section 11
> Right to refuse to undergo medical treatment - Everyone has the right to refuse to undergo any medical treatment.
> (New Zealand Bill of Rights Act 1990)

The principle of informed consent inherent in the legislation can be observed only if the patient or consumer is fully informed about the treatment before the decision is made to refuse to have it (Collins, 1992). Right 7 of the Health and

Disability Commissioner Code of Health and Disability Services Consumers Rights, the Right to Make an Informed Choice and Give Informed Consent, states that every consumer may use an advance directive in accordance with common law (The Health and Disability Commissioner Code of Health and Disability Services Consumers Rights Regulations1996).

In the Code Regulations, an advance directive is defined as a written or oral directive:

> (a) By which a consumer makes a choice about a possible future health care procedure; and
> (b) That is intended to be effective only when he or she is not competent:
> "Choice" means a decision -
> > (a) To receive services:
> > (b) To refuse services:
> > (c) To withdraw consent to services:
> > (Code of Consumer Rights and Responsibilities Regulations 1996)

Doctors and other health professionals in New Zealand are also subject to sanction under Section 151 of the Crimes Act 1961 if any treatment is carried out without informed consent. The Protection of Personal and Property Rights Act 1988, Sections 18 and 98, are also relevant as is case law in determining decisions. In New Zealand there appear to be no plans for drafting a Bill, parallel to the American Patient Self-Determination Act 1991 (Feek, personal communication, 2000). Like medicine and law, bioethics and law are closely linked and even sometimes mistaken for one another.

The bioethics position

The position of the bioethics discourse in the field of health policy, particularly on death and NFR issues, is distinctive for the kinds of questions it asks (Hunt, 1994). A prominent bioethicist comments:

> Death, as never before, is looked upon as evil, and we are mobilizing technology in an all out war against it. If not death itself, at least certain types of death are beginning to be seen as conquerable. We are being forced to ask the question: "Is death moral in a technological age?" Veatch, 1976, p. 3)

Veatch argues for philosophy having a legitimate place in health policy development and analysis. The task of philosophers, according to Wikler (1991) is to seek the morally preferable policy choices, decided on the basis of care in argument, conceptual clarity and dependent upon being theoretically informed. Some of the limitation on a bioethical contribution in the past has arisen from ethicists' limited knowledge of the health system. Another key difficulty has been, according to philosophers, the alleged difference between facts and values. They argue that economic effects, that is, the saving of resources, and reducing a hospital's services, are material facts that can be substantiated by empirical data. The morality of reducing those services is not a fact but an evaluation about which there is unlikely to be agreement. In spite of these difficulties, it is argued that the task of moral evaluation is an inescapable one (Wikler, 1991).

Criticism of the involvement of bioethics in public policy development comes from, as previously indicated, a competing discourse in public policy, that of law. Weisbard, cited by Momeyer (1990), speaking in the context of legal discourses, claimed that no social programme could survive scrutiny as rigorous as that which philosophers urge. The rationale for such a view is that the standards of justification in philosophy are impossibly ideal, even unreal, for the world of social policy (Momeyer, 1990). Another observation comes from two nurse philosophers, Liaschenko and Davis (1990), who argue that nurses' ethical lives are constrained by medical culture and the ethical language that doctors use. They argue, "this is a matter of cultural discourse on the meaning of our lives" (p. 269). They observe that a common thread running through both nursing and medical bioethical literature is the cultural tension between two bioethical perspectives: the absolutist, and the contextualist. Nurses' moral decisions, they say, are very much influenced by the context in which they work. Those who claim to make moral decisions from a more theoretical perspective tend not to value the standpoint of those who make moral decisions taking context into account, hence the tension to which Liaschenko and Davis (1990) refer.

The conclusions of Liaschenko and Davis (1990) are borne out by a study conducted by Slomka (1992) into end-of-life decision-making in an intensive care unit. Slomka (1992) suggests, in the context of the institution of NFR orders, that there is an illusion of choice in medical decision-making, as offered by the physician. She uses case studies to make the point that decision-making is less likely to be based on ethical principles than on a 'cascade' of decisions which occur in the context of differential power among professionals, patients and families. In Slomka's view, the focus on NFR is somewhat misplaced: it is only a small part of the total negotiation process. It is when the physician offers the illusion of choice that the process of negotiation begins, a negotiation of meanings that allows a sharing of moral responsibility for medical failure and its eventual acceptance by patient, family and physician alike. This process, Slomka suggests, signals resistance to the medicalisation of death and a move towards patient autonomy (Slomka, 1992). Notably, the word, 'nurse', is totally absent from the report of the research yet it would be reasonable to assume that nurses too provided professional care to patients at the research site and might have contributed to NFR decision-making processes.

Slomka's (1995) article on moral issues in artificial nutrition highlights the inadequacy and obscurity of terms like 'feeding tube', 'artificial nutrition' and 'basic care' (Slomka, 1995). Once again, she fails to acknowledge the different positions in power relations of those involved in clinical practice, that is, doctors and nurses and other health workers. They all appear to be subsumed under the term, 'health professionals'. Nurses and doctors are not identified separately from each other within the paper (Slomka, 1995). One of the ways to understand the deeper meanings of decision-making in the area of end-of-life care and treatment might be to identify the different voices that give meaning to the debate.

The economics position

There are two threads to the economics position regarding NFR; one at the theoretical level and one at the operational level. The first concerns the meaning of the concept 'consumer sovereignty', a term espoused by the neo-classical school of economics and pertinent to the belief that individuals work rationally to maximise their own interests. The choices that people make are referred to as an expression of consumer sovereignty. In a way it is a form of self-determination but neo-classsical economic theory argues that consumer sovereignty depends on such features in the market as homogeneity of products, ease of entry and exit to the market (by providers) and all consumers having access to the same amount of information about the product (Boston, 1991, Boston et al., 1996; Easton, 1992; 1997). This explanation can help in understanding the relationship between health care providers (for example, doctors and nurses) and consumers, and the place of consumer sovereignty. If the neo-classical economic theory ideal of consumer sovereignty was enacted, the consumer, weighing up choices about NFR, should be fully informed of all the options.

The second thread of economics that is pertinent to NFR is the efficient use of resources. It is significant that health economists argue in support of the efficient use of resources on a bioethical basis, that is, that any wasteful use of resources denies other people access to those resources to achieve health (Williams, 1992). The resource implications of NFR policies and their implementation are mentioned in published professional writing but usually only as a peripheral concern (see, e.g., Aarons & Beeching, 1991). In the health care commentary at large, rationing has become an increasingly prominent topic of debate (Boyd et al., 1996; Burstin, Lipsitz & Brennan, 1992; Grant, 1992; Emanuel & Emanuel, 1994; Zimbelman, 1994). Of particular concern in the area of public policy is the judicious use of public money (Blank, 1992).

The question that is relevant to this research is the question of the possibility of NFR choices being an illusion for some patients: their choices distorted by the resource implications. One writer in an American newsletter claims that the United States Patient Self-Determination Act 1991 was designed to contain costs by people opting for the NFR position (Anonymous, Hospital Ethics, American Hospital Association Newsletter, 1994). The same writer refers to a proposition that advance directives be a requirement for registering in the American Medicare and Medicaid, with reduced premiums for people to join a Health Maintenance Organisation if they sign an advance directive. Such a proposition presumes that among those who sign an advance directive would be a number who would opt for minimal treatment or none at all. However, there appears to be no significant difference in costs of care between those who have living wills and those who have not (Anonymous, Hospital Ethics, American Hospital Association, 1994). Schneiderman, Kronick, Kaplan, Anderson and Langer (1992) report that most surveys suggest that patients are calling for less, not more, of the expensive high-technology treatments often used in terminal illness.

On the one hand, it seems that self-determination is being secured in the public domain as a regulatory mechanism to ensure individual autonomy. On the other hand, the need to limit the provision of health care could be seen to place autonomy in jeopardy through arbitrary restriction of access to health care. This notion is pursued through the idea that such acts as assisted suicide and euthanasia are aspects of a managed death. The question is raised about whether the temporal convergence of these two movements has any bearing on sound public policy making (Sulmasy, 1995). The above issue represents one other significant convergence, already signalled, between the private world of individual suffering and death, and the world of policy development and implementation. This concern extends to the event of death in a hospital and the question of whether it is possible for a patient's death in hospital to be a private act. One party to that possibility is the occupation, which, through the nature of its professional work, regularly invades the privacy of patients in hospital: nurses. It is to the nursing position on death that I now turn.

The nursing position

The precariousness of nursing discourses vis a vis other discourses has already been alluded to. What follows is an examination of the nursing position on death and NFR. In 1983, Roland Yarling and Beverley McElmurry, the former a PhD candidate at the University of ChiPACo and the latter a Professor of Nursing at the University of Illinois, raised the possibility of nurses taking responsibility for instituting what were then known as Do-Not-Resuscitate (DNR) orders (1983). This discussion of nurses' freedom to be moral in DNR decision-making is less well known than the later, very well known assertion that nurses were not free to be moral in their professional practice because of institutional constraints (Yarling & McElmurry, 1986).

Since the 1970's there has been lively debate in scholarly and clinical nursing publications regarding DNR orders (see, e.g., Cameron, 1997; Ivy, 1996; Johnstone, 1999; McGraw, 1998; Schultz, 1997; Wilson, 1996). Hailing nurses as responsible professionals who were morally capable of being the decision-makers in DNR makes the 1983 Yarling and McElmurry paper controversial and challenging. In it, the authors point out:

> Many hospitals, regardless of size, still have no DNR policy, and even in those that have a policy, problems continue largely because physicians frequently disregard it even when it has been approved by the Medical Board. Furthermore, the issue has symbolic importance. The conflict between nursing and medicine around this issue is paradigmatic of the general nature of the relationship of nursing and medicine historically. Medical authoritarianism and unjustifiable institutional constraints have long served to impede the practice of nursing as defined by the profession and to render nurses less able to act responsibly vis-a-vis the needs and rights of their patients. The conflict around DNR orders is a microcosm of the larger picture. (Yarling & McElmurry, 1983, p. 2)

Here, Yarling and McElmurry are referring to the practice that they claimed existed in many American hospitals where physicians gave only verbal orders or where they refused to honour patients' requests not to be resuscitated or did not consult with them at all. Such a position is controversial and challenging on two counts. First, it challenges the practice of the time, which firmly centred decision-making regarding DNR orders in medical hands. The other challenging element is that there are many nurses almost twenty years later who would argue that the situation described above still exists. Yarling and McElmurry (1983) argued that these problems were the basis on which nurses urged the adoption of a responsible institutional policy "to regularize decisions and procedures pertaining to DNR orders" (p. 2).

Such calls were still being made fifteen years later in the same region of the United States, this time by a nurse ethicist at the University of Minnesota. Cameron (1997) conducted a survey of her international email discussion group as a result of claims made by local gerontological nurses that patients were being subjected to CPR against their wishes even when a written DNR order had been lodged. Feedback indicated that communication breakdown was the primary cause of the situation; only a standardised system would honour clients' preferences. There is no evidence in Cameron's paper of support for nurses having the authority to write DNR directives. Mention is made of a 1991 study by Sachs, Miles and Levin, which showed considerable variability in states' provisions for standardised policies on DNR (Cameron, 1997). The nurses consulted by Cameron, believed that who made the NFR decision was less important than the full documentation of the order. This conclusion might also mean that North American nurses in 1997 were less likely than their 1983 predecessors to consider themselves to be in a position to write a DNR order. Where Cameron, Yarling and McElmurry are in agreement is in the positioning of DNR decisions as a moral discourse but also as one element in a more general discourse of domination where medical discourse dominates nursing discourse.

Yarling and McElmurry (1983) capture the incongruity in the argument that DNR decisions should be made only by physicians, by pointing out that nurses bear the life and death moral responsibility for starting CPR. This incongruity is apparent in the decisions that have been made when cases are brought to court, as referred to previously in this chapter (see, e.g., Rodriguez, 1999; Sloan, 1996). There could be no greater responsibility than this, yet, nurses are not seen as responsible enough to write a DNR order once the patient has made a decision (Yarling & McElmurry, 1983). Five years later, a nursing study of DNR decision makers in a long term care facility revealed that residents, in addition to themselves, wanted doctors, nurses and family members to be involved in a DNR decision relating to individual residents (Godkin & Toth, 1994). A survey of staff and residents was carried out, a chart audit was conducted, and the family members of eleven residents who had died were interviewed. Sixty five percent of nursing staff thought they should not be involved in the decision. It is not clear whether they meant they did not want to be, or believed they did not have the moral or clinical authority. Fifty percent of respondents were nursing assistants. This may explain their reluctance to accept responsibility (Godkin & Toth, 1994), but even taking that into account it is apparent that nurses tend not to want to be involved in the decision-making process.

A 1990 study by Stolman, Gregory, Dunn and Levine surveyed registered nurses' perceptions of their role in NFR decision-making in a multi-centre attitudinal survey of 831 nurses, 146 physicians and 106 lay people. The section of the survey focusing on decision-making revealed that 40% of the nurses believed that nurses should only answer questions about NFR orders, 41% of nurses believed it was acceptable for nurses to initiate discussions with patients about NFR orders, whilst 14% of nurses thought all questions should be referred to the doctor. Interestingly, in this study 61% of patients believed nurses should discuss the issue with them; 39% did not (Stolman, Gregory, Dunn & Levine, 1990). These research findings demonstrate a degree of ambiguity about the place of nurses in discussing NFR with patients.

A subsequent grounded theory study, in a critical care facility, deliberately placed nurses in the foreground of moral and clinical responsibility regarding

NFR. The aim of the study was to ascertain twenty-one nurses' NFR interactions with patients and family members (Jezewski, Scherer, Miller & Battista, 1993). The justification for the study was the paucity of evidence of nurses' experiences with patients and families signing consent for NFR. The researchers' conclusions were that nurses played a complex part in a complex process. They played roles as decision-makers, educators, information brokers and advocates. Timing was crucial to the success of the consent process, which was divided into five stages: initiating NFR discussion, determining the appropriateness, obtaining the order with the family as witness, concluding the process and care after the signing. Different kinds of conflict were identified, particularly among staff and family members. In addition, no collective agreement on the meaning of NFR could be ascertained.

CPR practices

The nurse's key place in decision-making was also noted in Eastwick–Field's 1996 study investigating the CPR event. While bedside nurses have been responsible for starting CPR, the members of the expert medical and nursing team called to the bedside to provide advanced life support, have generally taken final responsibility. A case study, conducted in a Reading, UK, hospital indicated that nurses were just as effective as medical staff in providing advanced life support. Their technical proficiency was noted; there was no discussion of any concurrent moral responsibilities. Likewise, a report of an education programme to enhance staff nurse effectiveness in CPR at Pontiac Osteopathic Hospital in Michigan indicated a total focus on technical tasks with no concurrent discussion of ethical issues of CPR (Arnott & Warner, 1995). This may lead to the kind of scenario alluded to by Cameron (1997) in which patients were being resuscitated against their wishes. If the nurse knows that the patient wishes to be excluded from CPR it can put the nurse in a morally distressing position if someone in a position of authority, for example, a physician, insists that they resuscitate the patient.

A nursing ethics study by Davis and Slater (1989), asked 30 American nurses and 32 Australian nurses to respond to eight theoretical vignettes about passive euthanasia. The findings revealed considerable differences in the two cohorts. The authors of the study conclude that the social position of nursing as a profession, the relationship among health professionals, patients and families which serves as the context for definition of ethical duties and patient rights, and the role of the law in health care decisions, account for the distinctions between the two groups of nurses. In the body of the report, the term passive euthanasia is used to describe the parameters of the study, whereas the title of the paper reporting the study refers to U. S. and Australian nurses' beliefs about 'the good death'. There are no quotation marks around 'a good death' in the publication reporting the study. This suggests that the authors and publishers are asserting that 'a good death' and 'passive euthanasia' are interchangeable terms. This would be a radical and powerful assertion because it assumes that the only good death is one where passive euthanasia is enacted. This assumption appears too, in a 1995 study by Davis, Phillips, Drought, Sellin, Ronsman and Herschberger, of 40 American cancer nurses and 40 American dementia care nurses through interviews to ascertain their attitudes on active euthanasia. While the details of the research are not relevant to this study, the concluding comments of the researcher highlight nurses' moral responsibility to become informed about ethical principles as they relate to end-of-life issues (Davis, Drought, Sellin, Ronsman & Herschberger, 1995). Davis et al., (1995), like Yarling and McElmurry (1983), believe that nurses need to understand how their practice could be affected by political and legal decisions.

In 1997, Puopolo, Kennard, Mallatrat, Follen, Desbiens, Conners, Califf, Walzer, Soukup, Davis and Phillips, conducted a study involving 1763 seriously ill hospital patients and 1427 nurses. They compared patient preferences for CPR with nurses' perceptions of those preferences. The results showed that nurses understood preferences accurately for 74% of the patients but they discussed CPR with only 13% of them. In a 1998 study, an Australian nurse researcher, Manias, surveyed 360 registered nurses in six acute care public hospitals in the Melbourne region. She was interested in their attitudes and experiences of NFR practice through their responses to scenarios on NFR. The majority of experiences described were ones of frustration. Such experiences were a consequence of medical practitioners making the decisions rather than the patient, family or nurse. Nurses' experiences were also the result of the decisions that had been made (Manias, 1998).

Hierarchies within nursing discourses

In a review of the research knowledge base for end-of-life decision-making in adult intensive care units, two nurse researchers, Baggs and Schmitt (2000) surveyed medical, bioethics and nursing studies from 1979 to 1998. They concluded that very few studies of nurse involvement in decision-making had been carried out. They noted that most studies had been retrospective and they recommend real time studies so that behaviour and communication can be observed. Their review did not identify Slomka's (1992) case studies of behaviour and communication regarding end-of-life decision-making in an American intensive care unit. This omission somewhat limits the value of their assessment but may be explained through nurses not being named or included in Slomka's (1992) study.

Baggs and Schmidt's (2000) review also failed to identify a study by Isaak and Paterson (1996), published in the *Western Journal of Nursing Research.* This was a phenomenological study of nine intensive and cardiac care nurses' lived experience of unsuccessful resuscitation. The findings revolved around several practices to manage the aftermath and deal with the guilt of not being able to resuscitate the patient successfully, including focusing on tasks and attempting to detach themselves as a self-protective measure. They were not always able to do this and the study showed that there was a need for nurses to explore and express feelings associated with unsuccessful patient resuscitation (Isaak & Paterson, 1996). The omission of the studies by Slomka (1992) and Isaak and Paterson (1996) from Baggs and Schmidt's (2000) review, which claims to be a comprehensive review of research studies, indicates the precariousness of nursing studies within the NFR research commentary. As indicated previously, in the case of Slomka's (1992) study, there may be some justifcation for exclusion; after all, nurses are silent as participants in the research and as expert practitioners in the intensive care unit where the end-of-life decision-making practices were under scrutiny. There is no such justification for excluding Isaak and Paterson's (1996) study. The search mechanism that Baggs and Schmidt used failed to identify a relevant study even though it is named as a nursing study. There may be other omissions. What these two examples show is the uncertainty of exposure and recognition, both of nurses as appropriate research participants and as appropriate researchers.

Research: From nationwide quantitative to small scale qualitative

The only known systematic nation-wide study of NFR practices was conducted in 1990 in Sweden, involving all 92 acute care hospitals (Asplund & Britton, 1990). A survey revealed that 191 different symbols, for example, a sunset and heart shaped figures, were used to indicate NFR status. Thirty-one different code words were also used, for example, 'tender and charitable care' and 'no acute alarm'. Orders were sometimes written in pencil in the notes so they could be erased if things changed. Such a practice would not be considered acceptable in New Zealand. Wilson (1996) surveyed Alberta, Canada's acute care and long term care facilities' NFR policies. It was shown that the majority had DNR policies, which named the patient as the primary decision-maker. Large facilities were more likely to have a policy than smaller facilities were. A sobering finding of the study was that 21% to 30% of patient charts showed that staff did not comply with the facility's DNR policy. The researcher concludes that end-of-life care decisions may reflect socially sanctioned professional practices, including highly individualized or contextualised decision-making (Wilson, 1996).

New Zealand research

The most cited relevant research in the New Zealand context is Taylor, Parker, Ramsay, and Peart's (1996) study at Dunedin Hospital. In this investigation they developed and audited a hospital-wide NFR policy. In keeping with similar overseas studies, this research revealed that although there was an NFR order for 88% of deaths, in only 26% of cases was practice consistent with the formal policy. This points to communication and attitudinal problems among staff. Staff responses indicated that they found it difficult to raise the issue with the patient and family. Only 61% of the staff had read the formal policy (Taylor, Parker, Ramsay, & Peart, 1996). In 1995, a survey was carried out of 32 long-term care institutions in New Zealand to determine residents' preferences regarding CPR. Sixty eight percent of residential care homes said they had a written CPR policy and 82% said they discussed CPR with their residents. Two homes had applied CPR to residents in the last six months (Weatherall & Mathewson, 1995). More recently, a study by Watson, Wilkinson, Sainsbury and Kidd (1997) was conducted in Christchurch, to ascertain whether 95 elderly patients' views on CPR preferences changed during their hospital stay. Between admission and discharge, the percentage of patients stating that they wished to have CPR, if necessary, dropped from 80% to 69%. Conversely, the percentage stating that the patient should make the decision regarding CPR rose from 74% at admission to 84% at discharge. Notably, the report does not use the term NFR, DNR, DNAR or No-CPR. Yet, 31% of respondents seem to be indicating that they do not want to be resuscitated should an arrest occur. This reluctance to name and use NFR language and terms in the context of a research report on CPR and NFR is puzzling. It fits with nurses' views that doctors are generally more reluctant than nurses to face up to talking about the end of life. Indeed, Shepherd (2000) reports that the British Medical Association Conference heard how nurses pressurise junior doctors into making DNR orders in breach of the national guidelines.

Patient involvement in NFR decision-making was also investigated in an undergraduate study conducted by a Dunedin medical student (McLachlan, 1994). This was a mixed method study including interviews with seven patients who had a NFR order recorded in their medical notes. The study showed that patient autonomy was not always respected, not least because there was insufficient time in a busy hospital setting to attend to it. An unpublished study by five Dunedin nurses on the ethical dilemmas of resuscitation, concluded that medical and nursing perspectives and responsibilities, together with the rights of patients and their families, were necessary for quality discourse in decision-making. Taken together, these made for effective communication, which in turn led to high quality NFR discourse (Arthur, Dorne, McHugh, Theewis & Welsh, 1994). A nurse lawyer (Brett, 1996) completed a thesis for her Honours dissertation at the University of Auckland, in which she examined the law pertaining to NFR. Other NFR commentaries have featured in New Zealand nursing publications (Niles, 1996; Paterson, 2000; Schroyen, 1997; Wesney, 1985). Others have commented in unpublished work, for example, Rose (1997; 1998). The local concerns echo those expressed in the international commentaries: muddled decision-making with major and interdisciplinary anxiety about the patient voice, insufficient time and resources to do the right thing, non-compliance with existing policies, and a mixture of practices and patient outcomes as a result.

Commentary on methods and methodologies

The main feature of the preceding literature review is that research has been conducted in this area for at least twenty years and the findings are remarkably consistent in showing up NFR problems; very little has changed. The research, regardless of scale and method, indicates that NFR continues to be a problem for health professionals, patients and policy makers. Strong emotions are a feature of nursing research findings, particularly qualitative studies. No matter how grand and/or reductionist the approach is, studies tend to point to problems of communication and responsibility at an individual level.

Themes of secrecy, privacy, surveillance and control permeate the reports. These features, and the particular way language is used with regard to NFR, even the ambiguity in the term itself, point to a study that focuses on language; not language as a taken-for-granted reality, but how NFR language is constituted and whether that is used to influence and dominate the way NFR knowledge is constructed. If one disciplinary discourse is dominant over all others, then that discourse will determine, more surely than any other, what the patient or consumer's experience of death in a hospital setting will be. There is also another possibility: that a study which focused on how health professionals talk about and therefore construct NFR language might reveal previously unknown NFR discourses. If this is the case, these new discourses have the potential to change an individual's experience of death, including a change in location from hospital to home.

There is now a firmly established library of analyses of health care practices, which acknowledge or are informed by Foucault's ideas. For a small sample of those studies see Armstrong (1987; 1993; 1995); Bradbury (1999); Carr, (1996); Grace, (1991); Lupton, (1992; 1994; 1997); Lupton and Barclay (1997); May (1993, 1995), May and Fleming, (1997), Cheek (2000); Cheek and Rudge, (1994); Nessa and Malterud (1998); Opie (1997); Peterson and Bunton (1997); Wicks (1999). These studies cover a range of fields of interest from consumer reflexivity to surveillance medicine. In medicine, Komesaroff has addressed a postmodern interpretation of bioethics in his publication *Troubled Bodies: Perspectives on Post-modernism, Medical Ethics and the Body*, (1995). McGrath (1998), McInerney (2000), McNamara, Waddell and Colvin (1994), have completed poststructural studies specifically in the area of end-of-life practices. For example, McGrath (1998) examined the place of autonomy in the discourses of a palliative care facility in Australia.

Nursing publications indicate that a number of nursing scholars are using discourse analysis as a methodology, or more generally, a focus on embodiment, subjectivity and reflexivity in their research (see, e.g., Boutain, 1999; Gastaldo & Holmes, 1999; Hall, 1999; Powers, 1996; Robinson, Avis, Latimer and Traynor, 1999; Rolfe, 2000; Tilley, Pollock & Tait, 1999. Australian examples of this approach include the research of Crowe, 1998, Henderson, 1994; Lawler 1991, 1997; Manias & Street, 2000; and Peerson, 1995. In New Zealand, Papps and Olssen (1997) used a discourse analysis to discuss the medicalisation of birth. King (1999), McLunie-Trust (2000) and Wilson (2000) have completed MA theses as postgraduate nursing students using discourse analysis as a method in the areas of pain discourses, body boundaries and surveillance practices respectively. While none of the above claim that such approaches are totally unproblematic, it is reasonable to suggest that discourse analysis is at the very least fashionable, and, as Crowe (1998) says, "It provides nursing with the possibility of challenging the power structures which determine the individual's experiences of health and illness" (p. 339).

Reflection on the current construction of NFR knowledge

One conclusion from the review of the published research commentary is that the issues and problems regarding NFR have remained consistent for at least twenty years. Little progress seems to have been made since the late 1970's on establishing effective NFR practices based on widely accepted guidelines and policies. Health professionals are represented in discourses across the disciplines as experiencing tension and contradictions in their work with patients who may possibly be excluded from CPR. Much of the tension appears to centre on responsibility for decision-making and communicating NFR knowledge at two levels. The first and probably most obvious one is at the bedside in the clinical setting. The second level is at the policy level both within the institution and more broadly in the health service at regional and national level. Underlying both levels are particular uses of language. Structural and ideological change permeates both clinical and policy discourses. What also permeates all the discourses is the rhetoric of the interests of the patient being primary, and the concept of informed consent or informed choice.

It is taken for granted that absolute truth and meaning are unrealistic goals in this investigation. It is accepted that distinctions between the meaning of terms like autonomy and consumer sovereignty in relation to NFR may depend on the positioning of those who speak the discourses. The discourses referred to are disciplinary discourses, rather than popular discourses. It is not taken for granted that power relations are central to the construction of NFR knowledge, but this chapter does reveal the competing nature of the discourses relevant to the review. The challenge is in the consideration of both the disparities between and within the disciplines, as well as the commonalities. The original question in this thesis was centred on what really goes on in NFR events. This means that the primary focus is on the professional discourses enacted by the staff involved in NFR practices. Will the talk of nurses and doctors reflect the discourses that dominate NFR knowledge construction through published professional literature? Alternatively, might an investigation of their talk reveal other discourses, either those of other disciplines or a new discourse that supersedes all preceding NFR texts? The other disciplines that represent themselves as co-constructors of NFR knowledge include sociology, law, public policy, ethics and economics. An investigation of staff involved in NFR action needs to take these disciplinary discourses into account. Institutional influences on NFR practices may also generate NFR knowledge, as may wider policy and political influences.

Conducting an investigation into NFR practices necessitates the involvement of a range of speakers in order to collect data from a range of discourse positions: nursing, medical, policy, management and bioethical. In contrast to previous researchers in this area, I wish to take into account the particular ways that language is used to represent NFR realities and construct new social entities regarding NFR. This concern is based on the belief that language imbues the NFR world with meaning. It establishes the link between how individual staff share the same knowledge, and how ideas and values can be contested (King, 1999). In so doing, I am taking up a way of doing research that is gathering momentum in the health sector.

Summary

The aim of Chapter Three was to provide a construction of existing NFR knowledge. The way that aim has been fulfilled is through a brief history of resuscitation including cardio-pulmonary resuscitation and exclusion from cardio-pulmonary resuscitation. Then the review broadened to consider more generally the contemporary discourses of death and NFR by selecting distinctive features of medical, bioethics, sociology, legal, economic and nursing texts. The way these discourses represent themselves and the contribution of other discourses to NFR issues in particular and end-of-life decision making in general are discussed. An assessment has been made, where possible, of respective discourses' positioning in the context of clinical practice, the wider policy context and in research. The chapter concludes with a discussion of the contribution that discourse analysis approaches have already made to health research and the potential for a discourse analysis to identify emerging issues in NFR and the possibility of challenging the power structures that determine the individual's experiences of death. Chapter Four moves to a discussion of the selected methodology of critical discourse analysis including a justification of its applicability to the investigation of NFR policies and practices.

CHAPTER FOUR

CRITICAL DISCOURSE ANALYSIS AS METHODOLOGY AND METHOD IN THIS STUDY

Introduction

Chapter Four is divided into two main parts. The first part discusses methodological issues in the utilisation of critical discourse analysis as the preferred method for the study. The second part of the chapter describes in detail how the data collection process was developed according to the critical discourse analysis method in order to achieve the aim of data collection; the generating of new NFR texts. Ethical considerations and the relevant approval processes are detailed. The chapter finishes with a summary of the content, highlighting the function of Chapter Four in providing the rationale for the selection of the method for this study and in laying the foundations for the way in which the next four analysis chapters are organised and presented.

Clearing a path to completing the study

This section indicates how the study was done and why it was done that way.

NFR research: Language, discourse, talk and social practice

In Chapter Two the significance of discourse and language was established. The traditional idea of language as neutral and organised through rules and ideas is refuted. Rather, meanings are to be found in the concrete forms of differing social and institutional practices and are, therefore, part of a political process. As indicated in Chapter Two, Foucault was among the first writers to make a distinction between discourse and language and to identify language and discourse as central to the study of social phenomena. The decision to examine the NFR talk of a number of health professionals was based on the assumption that new insights might be revealed through the application of this method.

'Talk' about NFR, in this study, is considered to be a social practice in which words are the medium through which relations of power and knowledge are played out. The purpose of the data collection process is to study talk employed in NFR work in a health care institution, based on the premise that an analysis of NFR talk might help to explain why particular things happen. The analysis might help to explain why there appears to be contestation between professions regarding NFR and ambiguity in institutional policies on NFR as discussed in the critical review of published NFR texts in Chapter Three. It might help explain what happens to hospital patients and their families around NFR practices.

NFR: Problems and difficulties and dissenting discourses

This study is an attempt to think through the problems of NFR policies and practices. The decision was made to focus on crises and contestability of NFR discourses. The eye turns away from the study of what harmonises and orders towards what is variable and dissonant. In so doing, through conversations with research participants, I am enacting Potter and Wetherell's assertion that this approach is more likely to reveal techniques of power and resistance than are harmonious discourses (Potter & Wetherell, 1987). This approach must therefore include any distinction in power relations between the participants and me, the researcher.

In this study, I do not take for granted that I elicit knowledge about NFR social practices through a democratic and free discussion with research participants (Crowe, 1998). I also recognise that writing about the research is an enactment of the social relations that produce the research itself. Care needs to be taken not to become rule-bound in conversations with participants. On the other hand, it is also necessary to avoid collecting data that are so contextually constructed that there can be no meaning beyond the conversation itself. The significance of these parameters for this study is that I need to create a balance between the extent to which I shape and influence the NFR texts that emerge in conversation with the participants and the extent to which their individual representations shape the research. The decision made was that the power relations between the participants and myself were one aspect of the investigation commensurate with the assumption that there may be social and political processes going on between the participants and myself that might influence what is talked about and what is not talked about.

Investigating one NFR discipline is not enough

Fairclough (1995) argues that an interdisciplinary approach to the study of discourses is desirable because this can lead to a higher level of debate between proponents of different approaches, methods and theories than either a single disciplinary or multidisciplinary approach. The result should be the establishment of at least some consensus over what the main methodological and theoretical issues are regarding discourse analysis (Fairclough, 1995). It is with this assertion in mind that I made the decision to investigate NFR discourses arising from a number of disciplines. Published discourses from a range of disciplines were critiqued in Chapter Three as a foundation from which to establish and refine the research questions. The decision to talk to participants in nursing, medical, managerial and policy discourses was based on the assumption that a range of competing disciplinary discourses was likely to emerge. By talking with more than one participant from nursing, medicine, policy and management, I allowed for the possibility of the emergence of competing and dissenting discourses within disicplines. Of central significance was the potential for talk generated in this research to surface rich, diffuse text that either mirrored or departed from published texts.

How the method of critical discourse analysis in this study can surface NFR discourses

In Fairclough's (1992) view, it is essential that critical discourse analysis includes the linguistic characteristics and form of the text, an interpretation of 'why' the text is and an explanation of what the relationship is between the text and sociopolitical structures and processes. In other words, the analyst must seek to address the 'how' question in order to answer the 'why' question, by asking 'how do texts work to support particular discourses, which in turn sustain particular institutions, social arrangements and practices?' In taking this position, Fairclough (1992) reflects Foucault's belief that discourse is the tool that sustains certain social and political arrangements. In other words, discourse has a role in the promulgation and distribution of power. It is also a site of struggle for power, hence, the potential significance of the analysis of discourse in social science and health research.

According to Fairclough (1992), it is up to the analyst to read the text in such a way as to reveal the nuances and contextualisations hidden within it. This reading takes place at different levels. First, the text is read as a piece of discourse embedded in an immediate situation. This analysis provides information about the linguistic and rhetorical techniques and devices employed by the speaker, which are instrumental in positioning the speaker in a certain way in a particular discourse (Fairclough, 1992). These may involve key words, the repetition of certain terms or phrases and metaphors or other imagery, which are all employed for the purposes of persuasion (Billig, 1990). This is the point at which critical discourse analysis is closest to linguistic analysis. Next, it is examined for what it can reveal about the wider institutional context in which it is situated. Fairclough (1992) suggests that this level of analysis involves an examination of the discourse process to reveal dominant, contradictory and silent discourses. These levels of analysis include an examination of the functions that these discourses serve in the texts. This process also reveals the way in which the speaker positions him-or herself in the discourses. This last feature is one way, which distinguishes critical discourse analysis from other approaches (Fairclough, 1992). Finally, the text must be scrutinised as an integral part of the social and political environment in order to expose the larger forces at work in the constitution of power relations. In an NFR study, this might expose, for example, an economic interest in promulgating certain policies.

For Potter and Wetherell (1994a), discourse is centred on notions of constructed knowledge, institutions and practices, and the impact they have on actions and behaviours of individuals. For them, discourse analysis is concerned with talk and texts as social practices. In their view, people use language creatively, to achieve certain effects and actions. During the course of an interaction for instance, people create a particular version or argument or implicitly read into a text. Therefore, the "focus on language function is also one of the major components of discourse analysis" (Potter & Wetherell, 1987, p.32). What people do not say can be just as significant as what they do say. In this, Potter and Wetherell echo Fairclough's (1992) view that silence is a key aspect of discourse.

Potter and Wetherell pay attention to grammatical forms and linguistic content of texts but for them "the discourse analyst is after the answers to social or sociological questions rather than linguistic ones" (1994a, p. 48). Fairclough's (1995) work and Fairclough and Wodak's (1997) work reflect a similar interest. Fairclough's idea of discourse as social practice is also reflected in Potter and

Wetherell's view that people perform actions of different kinds through their talk and writing (Potter & Wetherell, 1994a).

I decided that there would be conversations with the research participants organised around talk of NFR, beginning with a history of the development of their understanding of NFR events, and their representations of specific NFR events including crisis events. The plan was that transcripts would be examined for the immediate situation of an NFR event, focusing on individual words and phrases. Because, like Potter and Wetherell, I am more interested in the answers to social or sociological questions rather than linguistic ones, the major focus in this study was on the next phase of inquiry; the examination of the text for what it might reveal about disciplinary and institutional practices; an examination of the discourse process to reveal dominant, contradictory and silent discourses. It was only after the texts had been read and re-read that it became possible to examine them for what was missing; what constituted the silent discourses regarding NFR social practices. Finally, in accordance with Fairclough's framework, my plan was to examine the text for what it might reveal about wider sociopolitical realities, for example, possible societal attitudes towards death.

Rigour and validity

Several scholars have claimed that the formal rigour demanded of research strategies is not appropriate for discourse analysis (see, e.g., Burr 1995). Nevertheless, it is important that there are satisfactory ways of maintaining the rigorous standards, which are a feature of other, more traditional research methods, in order for this approach to research to maintain credibility in the social science research community. Critical discourse analysis can be seen to be a valid research method, if; for example, extensive extracts from participant transcripts are inserted into the research account. In this way, readers can determine for themselves whether the researcher's analysis is a reasonable one or not (Lupton, 1992; 1997). Also, it allows the voices of the participants to stand in their own right (Parker & Gardner, 1992). The inclusion of extensive excerpts from the participants' transcripts into the research account, allows the reader to take an alternative view.

In this study, extensive excerpts from participants' conversations are included, on the basis that my understandings can only be partial, embedded and incomplete. As Loveridge (1992) says, "I experience this as a tendency towards being less ambitious and more rigorous in what we can claim for our partial representations, and continually questioning what is effected by our claims" (Loveridge, 1992). The design of this project is based on guidelines suggested by Fairclough (1992) who proposes that people approach discourse analysis in different ways according to their own views on discourse and the specific nature of the project. It is therefore important also, that the researcher, provide detailed information about the process of analysis, particularly why I may have privileged one explanation over another. Another standard by which the validity of the methods used in this project needs to be judged is whether the analytic scheme can make sense of new kinds of discourse and new explanations (Lupton, 1992; 1997; Lupton & Barclay, 1997).

Walking the path to a study of NFR talk

To summarise the chapter so far, the following decisions determined how the research was planned and carried out. The decision to examine the NFR talk of a number of health professionals was based on the assumption that new insights might be revealed, thus justifying the research. 'Talk' about NFR, in this study, is considered to be a social practice in which words are the medium through which relations of power/ knowledge are played out, focusing on the crises and contestability of NFR discourses. A decision was made to follow the line of thinking in critical discourse analysis regarding the role of the researcher. I therefore considered myself to be a producer of discourse. I assumed that there was an asymmetric power relationship between the participants and myself. The decision to talk to holders of nursing, medical, managerial and policy positions was justified on the basis that valuable new insights might emerge from this approach. It was decided that there would be conversations with the research participants organised around talk of NFR, beginning with a history of the development of their understanding of NFR events, and through their talk of specific NFR events including crisis events. The intention was that transcripts would be examined for the immediate situation of an NFR event, focusing on individual words and phrases. However, as I am more interested in the answers to social or sociological questions than linguistic ones, the major focus in this study was on the next phase of inquiry, the examination of the text for what it might reveal about disciplinary and institutional practices. Finally, my objective was to examine the text for what it might reveal about wider sociopolitical realities, for example, possible societal attitudes towards death. With the above decisions having been made and justified and with the above considerations regarding rigour and validity requirements in mind, attention now focuses on the research site and the research practicalities.

The research site

The texts generated in the data collection phase of the project were predominantly from those who worked at the clinical interface with patients. My interest extended to those staff holding positions with responsibility for policy-making because of the large number of international disciplinary published discourses which point to the need for institution-wide policies aimed at standardising NFR practices, (see, e.g., Birtwhistle & Nielsen, 1998; Godkin & Toth 1994; Jevon, 1999). The Regional Ethics Committee, which had ethics jurisdiction over the health care organisation where the research was conducted, had also produced NFR policy guidelines (see Appendix A). These were designed to assist the staff of the institution and were updated by the Ethics Committee during the course of this study (see Appendix E). I was interested in how the institutional staff positioned themselves with regard to the Ethics Committee's NFR policy and the Ethics Committee's position with respect to the institution's responsibilities regarding NFR policy and practice. This was significant because the hospital where the research was conducted also had an NFR policy (see Appendix B). Wider discourses, both national and international, influence the way that the Regional Ethics Committee and the research institution position themselves generally, and with regard to the primary focus of the research, NFR social practices. Background information about these influences is necessary to locate the discourses that emerged in the research.

At the outset of the research, the Regional Ethics Committee, which had ethical jurisdiction over the health care organisation in this research project, was the only one in New Zealand known to have produced a policy and guidelines on NFR. No other CHEs had NFR policies. A number of individual hospitals have institution-wide NFR policies. Here, the interest is in policy at three distinct levels. The first level of policy interest is in the Regional Ethics Committee. The second level of policy interest is at the health care organisation level; a Crown Health Enterprise (CHE) comprising two general hospitals and related services, where a Professional Advisory Committee, responsible to the Chief Executive, developed and implemented clinical policies. The members of the Advisory Group represented different clinical services and disciplines within the organisation. Also at this level of policy development and implementation are the Manager of Medical and Surgical Services and the Resuscitation Education Co-ordinator. The third level of policy interest is at the operational level; specifically one medical ward where nursing, medical and managerial staff were interviewed.

Deciding on the positions and participants

It was necessary to gain access to and collect data from the Chairperson of the Regional Health Authority Ethics Committee. This constituted the first level of interest, arising from the knowledge that the Committee had written NFR guidelines. The second level of interest consisted of four participants in all: two members of the CHE Professional Advisory Committee, the Service Manager of the relevant medical service, and the Resuscitation Education Co-ordinator of the Crown Health Enterprise (CHE). The hospital NFR policy had its origin in the Professional Advisory Committee, the Service Manager headed a service in which the hospital policy was implemented and the Co-ordinator's work responsibilities included the training of staff to carry out CPR effectively. It was possible that the training might include discussion on who should not receive CPR. For these reasons, I believed that these people would have professional positions on NFR policy and practice. The third level of interest was a medical ward: a Medical Consultant, a Medical Registrar and a House Surgeon from one medical team, the Charge Nurse, an Enrolled Nurse and two Staff Nurses. These staff members were selected because of their different positions in the power relations of the institution, particularly in the area of NFR policy implementation. The Ethics Committee's NFR guidelines and the CHE's NFR policy were given to me by the Ethics Committee chairperson and the senior nurse consultant respectively.

The research proceeded after ethical approval from the Massey University Human Ethics Committee and the relevant Regional Health Authority Ethics Committee. Full ethical approval was dependent on CHE management approval. One medical ward in a public hospital was selected as a setting where NFR policies were implemented. This was on the recommendation of the Director of General Medicine, who identified three medical wards I might approach. As a result, a Charge Nurse discussed the research with me. She agreed to participate, and also agreed to set up a meeting with nursing staff in the ward to tell them about the research and engage their interest.

How the selection of positions and participants was made

In keeping with the concept that it was to be an examination of discourses rather than individuals (Fairclough, 1992), the positions of the participants in the discourses of NFR became the primary reason for inviting their involvement in the research. There were key points in the production, dissemination and interpretation of NFR discourses that propelled me to certain voices. It was important, therefore, to involve a Medical Consultant and representatives of the different medical hierarchies that were professionally accountable to the consultant, that is, a Medical Registrar and a House Surgeon. Once the consultant had provided consent it became necessary to approach a Medical Registrar and a House Surgeon who fitted that criterion. The Charge Nurse contributed to negotiating access to the ward as well as being a participant.

It became apparent in the course of the conversations within the CHE that other people involved with policy development and implementation of NFR orders should be invited to participate because of the perception that their NFR talk might be valuable and distinctive. They were the senior Nurse Consultant and the Chairperson of the Professional Advisory Committee. It was expected that they could comment on the institutional aspects of NFR policies as well as the clinical aspects. One other participant was recruited for the same reason: the Resuscitation Education Co-ordinator of the training programme for all non-medical staff in the CHE. She was an experienced registered nurse. In total there were twelve participants in this study: Isabel (Charge Nurse), Sarah (Ethics Committee Chairperson), Hugh (Medical Registrar), Albert (House Surgeon), Alice (Enrolled Nurse), Debbie (Staff Nurse, two years' experience, Resuscitation Education Co- ordinator for the ward), Judith (Staff Nurse, thirty years' experience), Jim (Medical Consultant in the ward), Helen (Policy Adviser, Member of Professional Advisory Committee, Nurse Consultant), Kate (Chairperson, Professional Advisory Committee, Medical Consultant), Anne (Education Co-ordinator for training throughout the Crown Health Enterprise), and Lucy (Service Manager).

Participants and their positions

Charge Nurse, Isabel

A nurse who had over twenty years of experience, most of it within the same institution, she was currently undertaking an undergraduate nursing degree part time and had been in charge of this ward for eight years. She considered herself to have abrogated the role of clinical leader to the most senior staff nurses in the ward and considered herself to be a manager. There was a notable shift in her philosophy of practice between the first and second conversations. Initially, she represented herself to be a supporter of the company and positive about many of the changes that had been made since the institution of the health reforms. In the period between the first and second conversation, Isabel indicated a shift in emphasis towards nursing values and some cynicism regarding the announcements for company restructuring made prior to the second conversation. She acknowledged that university study in nursing had contributed to the change in her attitude. She remained intensely loyal and committed to 'her ward'. Isabel was proud of the ward's reputation for retaining staff long term and for the standard of service provided to patients. With regard to policies and practices in the ward she saw herself as an innovator, advisor and supporter.

Chairperson of the Regional Ethics Committee, Sarah

Sarah was an experienced lawyer who had been Chairperson of the Committee for two years. She was there as a lay representative. Sarah was very clear about the role of the Committee in protecting the public interest and was proud of the fact that the Committee had developed guidelines in NFR policies for the CHE. There was some variation in the way in which Regional Ethics Committees developed around the country. This Ethics Committee had been able to operate with an office and with the ability for the Chairperson to act as an advisor for, and undertake consultation with, health professionals. An NFR policy had been developed three years previously. A year after the completion of data collection, the Regional Ethics Committee reviewed its original NFR policy but did not involve me in this process. The revised NFR policy is included as Appendix E.

Medical Registrar, Hugh

Hugh was a Medical Registrar, working in the team headed by the Medical Consultant who took part in the research. He was in his late twenties and carried major medical responsibilities in the ward along with other areas in the hospital at various times, for example, the Emergency Department. He had had experience in his own family of decision-making regarding NFR. At the time of our first conversation he was nearing the end of a six-month association with the ward. To conduct the second conversation with him, I travelled to another CHE where he was pursuing his training.

House Surgeon, Albert

The first conversation I had with Albert occurred just three weeks into his three month 'run' on this ward. He was primarily responsible to the Medical Consultant but was also responsible to other consultants in the ward. Like the

Medical Registrar he had responsibilities in other parts of the hospital, especially at nights and the weekends. He was in his twenties and like Hugh, moved to another CHE during the data collection period. The second conversation with him was held in another CHE.

Enrolled Nurse, Alice

Alice had partly completed general nurse training as a young woman and had eventually completed enrolled nurse training seven years prior to the commencement of research project. She had worked in the ward for several years and was clear about the degree of responsibility she held as a second level nurse. She appreciated the way the Charge Nurse acknowledged her skill and experience in the ward.

Staff Nurse and ward Resuscitation Educator, Debbie

Debbie was in her second year as a staff nurse, having completed a pre-registration nursing degree straight out of school. She was keen to pursue post-graduate study and enjoyed her role as a Resuscitation Clinical Educator in the ward.

Staff nurse, Judith

Judith had many years of experience as a nurse, mostly in the same institution. She had worked in this ward for several years out of choice and considered herself to be one of the most experienced and skilled nurses in the ward. She was able to recall when cardio-pulmonary resuscitation was first introduced in the hospital and when the issue of NFR first arose.

Medical Consultant, Jim

Jim's responsibilities included clinical consultancy in general medicine, research, and teaching in the medical school and in the clinical area. He had worked as a researcher overseas and had been a Medical Consultant for over ten years. His clinical responsibilities rotated over several weeks with other medical consultants.

Policy Adviser, Nurse Consultant, Helen

Helen held a full time professional advisory role for the CHE. Among her responsibilities was membership of the Professional Advisory Committee that had developed the hospital policy on NFR. She had many years of experience as a nurse and midwife. She too could recall when attempts at cardio-pulmonary resuscitation by closed chest massage were first made in a New Zealand hospital.

Chairperson, Professional Advisory Committee, Policy Advisor, Medical Consultant, Kate

Kate was a medical consultant who was clinical head of one of the seven services in the CHE. In her position as Chairperson of the above group she advised the Chief Executive Officer of the CHE and chaired meetings of the Group. In her practice area, a NFR policy originating from the British Geriatric Society was in place (see Appendix F).

Resuscitation Education Co –ordinator, Anne

Anne was responsible for co-ordinating training programmes for all non-medical staff in the CHE to ensure their preparedness to carry out CPR. She liaised with trainers from all areas within the CHE (including the ward Resuscitation Co-ordinator) and ran the training-the-trainers programmes for them. Her inclusion in the research indicates the assumed relationship between cardio-pulmonary resuscitation (CPR) and the policies and practices associated with NFR.

Service Manager, Lucy

This manager had recently transferred from another CHE where a considerable amount of research has been carried out on NFR policies and practices. The findings had been used to establish and review hospital-wide policies (Taylor, et al., 1996). Lucy had a health professional background and was Manager of the service in which the medical ward was placed. She had had experience in her own family of decision-making regarding NFR. She took an active interest, and assisted in, the drawing up of an NFR protocol in the other hospital in the CHE during the period that data were collected. Between the first and second conversation, major plans to restructure the CHE were announced and her position was dis-established. Lucy was planning to take early retirement and believed that the plans for restructuring were not feasible.

Data collection

A conversational encounter

As stated earlier, the aim of the data collection method was to elicit data through purposeful conversations between the researcher and individual participants, rather than through interviews. The traditional interview is not considered to be effective because focus for analysis is only on answers given by the participant to questions asked by an interviewer. A more humanistic and democratic manifestation of the interview as a research tool was noted by Jupp and Norris (1993), citing Plummer (1983), who argued that there are four criteria for the use of a humanistic interview as research tool. First, the researcher must pay tribute to human subjectivity and creativity. She must also heed concrete human experiences such as talk and feelings. Third, she must show a closeness with the researched person and, finally, be committed to the reduction of exploitation. In the fulfillment of those criteria some reciprocity in sharing personal views may emerge in the interview. This last has been a feature of, for example, feminist research interviewing (Oakley, 1981). The research conversation in a critical discourse analysis modifies the characteristics of the traditional and humanistic interview tools further so that both participant and researcher may actively ask and answer questions as they seek to make sense of their conversation (Mishler, 1986). The questions of both the researcher and the participant are, therefore, just as much part of the analysis process as the answers. Conversation as a data collection tool is pertinent to this study because I want to reveal techniques of power and resistance including any power differential between the participants and me. This requires an examination of my questions and answers and comments as well as those of the research participants, in keeping with the approach preferred by Potter and Wetherell (1987).

Active participation of both parties was expected. Nevertheless, I aimed to start the conversation by framing some questions, primarily to get participants talking about their NFR practices, but also because the researcher's questions becomes as important a topic as the participant's responses. The questions were as follows:

1. What written NFR policies currently exist in the institution in which you work?

2. What unwritten rules exist?

3. What part do you play in the construction of NFR policies?

4. How are NFR or DNR policies implemented?

5. What part do you play?

6. Can you tell me about 'moments of crisis' that have occurred in the implementation of policies?

7. What do you think the meaning of written and unwritten policies might be?

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5. What part do you play?

6. Can you tell me about 'moments of crisis' that have occurred in the implementation of policies?

7. What do you think the meaning of written and unwritten policies might be?

8. Can you suggest further areas of investigation that may be relevant to this research?

This resulted in stilted conversations, built around researcher questions and participant answers in the early conversations, so a decision was made to trust the discourse analysis method more and depart totally from the traditional question and answer format and 'go with the flow'. The overall result was a greater participation by the researcher in the conversation and the gathering of data of greater quality, more specifically focused on power and resistance techniques. The conversations ranged over a wide area and I found it easier to get people talking by asking them to tell me first about their background and education. This often included stories about the first NFR and CPR event they remembered. The conversations included talk about the NFR policies in the CHE, but not everyone was aware that they existed. Participants generally talked freely about NFR conflict. A detailed presentation and analysis of the above processes occurs in the next chapter.

Ethical considerations

Gaining informed consent

Informed consent is a key tenet of ethical social science research involving people as participants. In this respect, any power differential between the researcher and the participants was important. Kidder (1981) states that the ethical responsibility for the welfare of the participants lies with the individual investigator, hence the emphasis on informed consent.

Another feature of critical discourse analysis is that it does not take on trust what people say. In other words, there is an assumption on the researcher's part that language will be used to persuade the researcher (Parker, 1992). A question arises, therefore, about the ability of prospective research participants to have a real grasp of the way in which the words in the conversations will be analysed by the researcher. How can this be expressed in an information sheet or consent form or in a discussion between a researcher and a prospective participant? This could be seen to be a contradiction in the ethical requirements of research. On the one hand, informed consent processes suggest that trust is a fundamental requirement between the researcher and the participant. On the other hand, the only way trust can be assured in a critical discourse analysis project is for the participant to be fully informed about the way that critical discourse analysis is carried out. These issues are addressed in Chapter Five where the position of the researcher is discussed and analysed in detail.

Informed consent to participate was gained first through a telephone call, then the forwarding of the information sheet and consent form. Time was allowed for questions and for consideration of the possibility of involvement. The consent form was signed at the beginning of the first conversation. (See also Appendix C, the information sheet and Appendix D, the consent form). A pseudonym for each participant was mutually agreed upon. Even though the focus of the conversation was to be on the discourses emanating from the position which each of the participants held in the institution rather than the individual, it was convenient to individualise each conversation and transcript with a name.

Written informed consent for involvement in this study included the right to refuse to answer any particular question, and to withdraw from the study at any time. Participants could ask any further questions about the study and also ask for the taping to be stopped in the course of a conversation. Participants understood that they provided information on the basis that it was confidential to the researcher, her supervisors and examiners. They received a signed form indicating the transcriber's agreement to respect confidentiality. The participants also understood that they would be given access to a summary of the findings from the study when it is concluded. Each participant's place in the research arose in the course of the conversations between the researcher and the participant. The issues that came up are included in the analysis in Chapter Five.

Confidentiality

In social research, confidentiality is maintained if the identity of the participant is protected at every stage of the research and beyond the completion of the research to subsequent publications. No such guarantee could be given in this research project because of the nature of the topic, the size of the hospital and the position of the researcher in the New Zealand nursing community. Nevertheless, it was indicated in the information sheet that information gathered in the course of the study would be used only by the researcher for the purpose of developing and writing the thesis to meet the requirements of the degree of Doctor of Philosophy at Massey University and for associated publications. The identities of individual participants or people or places to which references are made during conversations would be disguised; the goal being to protect participants' identity. Privacy of participants' identity cannot be guaranteed.

The transcriber of the audiotapes used to record the conversations between the researcher and the participants was required to sign a confidentiality agreement whereby no identifying names would be revealed. She was required to keep all details of the transcripts confidential. Field notes, and transcripts were kept secure with access restricted to the researcher, transcriber, supervisors and examiners. The researcher retained only one document with the identities and contact addresses of participants. The information sheet for participants included a statement that the researcher would retain all tapes, transcripts and field notes for five years. The tapes would then be offered to participants to keep or be destroyed by the researcher.

As indicated previously, participants' confidentiality was promoted by the use of pseudonyms or agreed code names. Field notes and transcripts were screened by the researcher for any reference identifying either individuals or third parties or institutions. The final research report was screened for its ability to retain the privacy of participants and the information they provided. In my view, this process did not detract from the quality of available data.

Conflict of interest

The primary role of the researcher is that of researcher engaged in human participant research, with ethical responsibilities related to that role. The researcher is a registered nurse and midwife and therefore bound by the professional ethics of the Nursing Council of New Zealand. This means that I had an ethical duty to act responsibly if, in the conduct of the research, I became aware of any situation where patient safety appeared to have been compromised. If this situation had arisen, I would, in the first instance, have discussed with the participant, possible courses of action that he or she could take. If the situation were to remain unresolved the researcher would have sought the participant's consent to pursue the matter with appropriate senior staff in the institution. If the participant had not given consent, the researcher would have informed the participant that she would seek advice from her supervisors. This eventuality did not arise.

The Treaty of Waitangi

This research was conducted without any special consideration of any obligations to the Treaty of Waitangi in spite of the Treaty's relevance to Maori health. When approval was granted by the two relevant ethics committees there was no requirement to stipulate how the research might affect Maori. It is acknowledged in Chapter One that the unregulated, unfulfilled, and unrequited nature of the relationship between the partners to the Treaty, the Crown and Maori has resulted in significant and detrimental effects for Maori health (Reid, 1999). This means that there is a special significance for health-related research and its impact on Maori. In the preparation of the research proposal it was not seen that research on NFR might have particular significance for Maori and therefore require consultation with Maori advisers. It was possible that one or more of the participants could have identified as Maori and might have had particular concerns about the way Maori patients were treated regarding NFR. This was not the case. It is also possible that NFR practices could discriminate against Maori patients and families by decisions being based on racist values. This issue is well worth investigating but is not addressed in this project. Any such future investigation would involve a consultation process in order to develop research partnerships with Maori and identify research design methods most useful to Maori (Health Research Council of New Zealand, 1998).

Location and privacy

It was intended that all of the conversations would take place within the institution. The aim in so doing was to cause as little inconvenience as possible to the participants. Some of the participants chose to talk with me in a space where their colleagues would not see us. It was possible to set up the tape recorder in a private and soundproof room in the case of almost all of the interviews. Most of the interviews lasted between 60 and 90 minutes.

Reporting mechanisms

Interim reports were made to the Regional Ethics Committee two years (written) and four years (verbal to the Chairperson) from the date that ethical approval was first granted. A full research report was submitted to the Regional Ethics Committee at the completion of the project.

Coming up

The second part of the thesis includes the data analysis, organised into four separate chapters. Chapter Five examines the relationship between the researcher and the participants and the part that the researcher played in the generation of the research texts. Chapters Six and Seven focus on texts generated by professionals whose work involved contact with patients for whom NFR was an issue. The first part of the analysis, presented in Chapter Six, considers social practices that were classified as everyday or ordinary. Chapter Seven examined moments of crisis based on Foucault's idea that this was when new discourses are likely to emerge. The final part of the analysis, in Chapter Eight, focuses on those who held institution-wide responsibilities regarding NFR social practices. In keeping with the general principles of discourse analysis, in which importance is attached to variation and inconsistency, an examination was made for distinctions between discourses generated at the bedside and those generated at organisational level. Chapter Nine follows with a discussion of the language and ideological implications of the analysis. The final chapter in the thesis, Chapter Ten, reports the research conclusions, associated limitations, and recommendations arising out of the investigation.

Summary

This chapter presented an overview of the methodology and method of critical discourse analysis, and the rationale for the selection of this method for this study. Discourses are constituted and reproduced through language, but take on a life independent of language, a life of political and sociopolitical significance. It is therefore appropriate to apply critical discourse analysis to

NFR talk in order to gain an understanding of why NFR social practices occur in particular ways. In this chapter, justification for the selection of the research method of critical discourse analysis has been provided along with an outline of the framework for analysis of the data, NFR talk. The practical and ethical aspects of data collection have been outlined. A discussion of the relevant ethical issues as they were addressed in the data collection process, is included. This chapter concludes the first part of the thesis. To prepare the reader for the analysis section of the thesis, a key to reading the research participant interview excerpts is attached below.

Key to reading quotations from the research interviews

Quotations

All speech indented and in single spacing

- Participants' speech recorded in italics
- Researcher's speech recorded in normal Palatino type

Identification of individual participants

Each participant has a pseudonym and represents a particular position in relation to NFR policies and practices

Isabel CN (Charge Nurse)
Judith SN (Staff Nurse with thirty years in clinical practice)
Alice EN (Enrolled Nurse)
Debbie SNE (Staff Nurse/Educator with two years' experience as a staff nurse, with responsibility for education in the research ward re CPR)

Anne REC (Resuscitation Education Co-ordinator for CPR training throughout the Crown Health Enterprise)

Helen PANC (Policy Adviser, Nurse Consultant, Medical and Surgical Services responsibilities, member of CHE Professional Advisory Committee)

Kate PAMC (Policy adviser, Medical consultant, Chairperson of CHE Professional Advisory Committee and clinical head of one of the seven CHE services)

Lucy SM (Service Manager of the CHE's Medical and Surgical Services in which the research ward was situated)

Sarah EC (Chairperson of the Regional Ethics Committee)

Albert HS (House Surgeon in the research ward)

Hugh MR (Medical Registrar in the research ward)

Jim MC (Medical Consultant in the research ward).

The two conversations

The first conversation with each participant is designated A, the second, B.

Identification of each extract

Following each extract the participant's pseudonym, position, interview A or B and page of transcript is recorded. For example:

Isabel, CN, B, p. 3

indicates the speech of Isabel, the Charge Nurse's (CN) second conversation (B), page 3 (p. 3).

Use of upper casing

Where research participants' positions are referred to in the subsequent chapters of the thesis, upper casing is used, in order to differentiate research participants from other staff. If any other staff positions are referred to in the text, lower casing is used. For example:

> In Chapter Six, Isabel the Charge Nurse reports an incident where she advises a staff nurse (i.e., a staff nurse who is not a research participant).

CHAPTER FIVE
POWER RELATIONS WITHIN THE RESEARCH

Introduction

Chapter Five is the starting point of the exposition of the results of the research. It examines the part that the researcher played in the generation of the spoken texts on NFR. Chapters Six, Seven and Eight focus on the texts generated from the research participants and examine everyday NFR social practices, moments of crisis and institutional NFR social practices. The primary purpose of this chapter is to make explicit the social relations that existed between the participants and the researcher, based on the assumption that the nature of those relations influenced how and what research texts would be generated. This purpose is fulfilled by examining the social practice of the researcher in the process of conducting the interviews with the participants.

There is a taken-for-granted assumption in critical, feminist and particularly post-structuralist, approaches to research that a power differential exists between the researcher and the researcher. There is a supposition that the researcher is the one who holds the power and the reduction of the supposed power differential must be the aim of the researcher, in order to produce multiple voices and discourses. There is also a possibility that the relationship between the researcher and participants is somewhat precarious, especially with a relatively inexperienced researcher. It is these problematic aspects of the researcher/participant relationship that point to their discrete treatment in the research account. These need to be understood because of the effect that they may have on the content and quality of the data collected.

The presence of a section on the relationship between researcher and participants in the thesis may suggest a somewhat arbitrary and artificial division between discourses generated by the researcher and those generated by the research participants. It could be argued that organising a chapter in the thesis around the researcher's talk is a distortion of the central assumptions of critical discourse analysis, especially the assumption that competing discourses exist only in relation to one another (Foucault, 1984; Cheek, 2000). Nevertheless, the decision to write the researcher discourse into the research account is justified because of the distinctive and discrete social practices and ideological issues that emerged. This demonstrates a commitment to the notions that the researcher is a producer of discourse, a creator of meaning, and that a thesis is a construction or fabrication. What follows is an attempt to draw analytically on my experience as a researcher. Like Aldridge (1993), I understand the writing of a research account to be a partial, personal, and limited construction and reconstruction of the research event.

Constructing myself as a researcher

There were a number of features and events that helped shape my approach to the data collection process. My background as a nurse suggested that I might have a different relationship with nurse participants than with others, particularly doctors. I may have assumed that the nurse participants I would meet would be more likely to speak the same language and that they might regard me as a peer. They may have felt that they had little to contribute to the research on NFR if they were modest about their expertise and experience. My research relationship with the medical participants could have been influenced by the views I held regarding the relative level of expertise and knowledge held by the two professions. It was reasonable for me to assume that I would have less in common with these participants and that this distinction would affect the interview style. I was also a relatively inexperienced researcher using what was considered to be a difficult method of data collection and analysis in an interdisciplinary research project about a sensitive and contentious issue, NFR.

The research proposal had been scrutinised by medical clinicians, managers and policy advisors within the organisation where the data were collected, as part of the process of gaining ethical and management approval.

Some participants had indicated their fear of being identified. All of these elements influenced the way in which I approached the first interview: with a mixture of anxiety and excitement. The original intention was to conduct all of the first interviews over a three-month time span. In the event, this extended to six months and the second interviews were completed within the following year, totaling eighteen months for the data collection process. Time, memory, professional and research positions, all contributed to the construction of the researcher as both a subject and object of knowledge. To paraphrase Dreyfus and Rabinow (1982), I became an organiser of the spectacle in which I appeared.

The second conversation usually began with a reflection on the first conversation including a review of the conversation. Participants provided me with clarification of any ambiguous points from their point of view and then the second conversation proceeded to fill in any gaps in the first conversation. I also used the second conversation to provide participants with an update on the progress of the research project as a whole and provide them with a chance to voice any concerns about the method used or about any ethical issues arising from their involvement. This was in keeping with the initial research questions and the underlying framework of social change.

Researcher as barometer

I began the analysis by listening to the transcripts and responding to them by noting obvious points. This was intended to be a superficial analysis only; a way of familiarising myself with the content and form, an initial and 'naive' reading of the texts. This served as an exercise in testing my position on the texts, in watching for my perceived bias towards nursing discourses and in testing my position regarding the framework I had chosen for the purposes of the analysis. I was also acutely aware of the special responsibilities of the analyst using this method of analysis. According to Fairclough (1995), the effectiveness of the analysis depends on the analyst's interpetive and strategic biases as well as his or her experience of, and sensitivity to, relevant orders of discourse.

Taking into account the theoretical, methodological, social and political dimensions of the project, my initial focus in the analysis is on the relationship between the participants and me the researcher. This is also a way of establishing the position of the voices while also acknowledging the danger of staking out distinct positions. It could serve to create rigidities and hierarchies that are not justified; a way of ordering discourses that prevents further work on movement, change, diversity and resistance. Still, it is necessary to begin somewhere, even in circumstances where the ground shifts and uncertainties arise. Chapter Three identifies the disciplines considered most pertinent to the research project: medical, public policy, bioethics, legal, economics and nursing discourses on NFR. Chapter Four has identified the individual voices and positions represented in conversations with me, the researcher.

The nervous researcher

The first conversation was with Isabel, the Charge Nurse. She played a pivotal part in providing access to participants in the clinical area. She was also pivotal in another sense: this speaker represented a juxtaposition of nursing and management discourses. Furthermore, she regularly engaged with medical, as well as nursing discourses. The conversation began with a barrage of questions which were designed to put the interviewee at ease but reflected more my tentativeness and nervousness as a researcher:

> To begin with, could you possibly tell me a little bit about yourself, especially about when and where you trained as a nurse, what your nursing experience has been like, how long it's been and so on, what extra qualifications you might have and how come you ended up being a charge nurse in a medical ward (Isabel, CN, A, p. 1).

'To begin with... ' 'a little bit', 'and so on', 'how come you ended up' is informal and non-specific language, demonstrating my uncertain approach to the conversation. 'Could you possibly tell me a little bit about yourself?' along with the vague language quoted above suggests a tentativeness on my behalf. 'Where you trained as a nurse, what your nursing experience has been like, what extra qualifications you might have' are the sort of questions I, as a nurse, might ask an unknown nursing colleague. 'Where did you train?' is a very common opener for nurses who talk to each other. It is pertinent to those nurses who trained in a hospital training programme. This appears to be a somewhat contradictory beginning in that I was attempting to control the exchange in order to elicit information from the participant about NFR social practices. At the same time I was using indirect and tentative language presumably to help the participant feel in control. By utilising the sort of language I would use in any conversation with another nurse I was probably trying to give the appearance of equality in the relationship; that we were both members of the same discipline and profession, nursing.

My response to detail about the participant's background and experience also indicates how much I wanted to establish our relationship as one of equals:

> You sound just like me. It's just incredible.

Here I am, first, aligning myself with the Charge Nurse, and then, in the expression of amazement, which follows, I indicate that I distanced myself from her in advance of the conversation. I was surprised that our backgrounds seemed so similar. The language also suggests that I was relieved to find the similarity, possibly because it would then be easier to establish a relationship and talk more meaningfully. A little further on, Isabel adds:

> *Within 6 months I found myself being the Charge Nurse's Deputy, which I loved - the power.*
>
> What do you mean?
>
> *What do I mean by power?*
>
> Yes, and that you loved it?
>
> *Well you know - there's Chiefs and there's Indians and I like being a Chief (Isabel, CN, A, p. 4)*

The above language text, to some extent, reflects the contradictory positions we were taking. I was confirming my own power by the use of particular language, 'What do you mean?' At times the participant was confirming her power or lack of it by the language she utilised. In studying the Charge Nurse's text, it is possible to discern some contradictions and asymmetries in her positioning. In this instance, she represents herself as a powerful player in the social practices of the institution.

The conversation with Judith, a Staff Nurse who completed her training in 1962 and has been working in the hospital since 1974, revealed some similarities and some differences from the way in which I had related to Isabel. As one of the most senior clinical nursing staff in the ward, Judith frequently worked as the most senior nurse on duty for the shift and occasionally ran the ward. The language I use to introduce the conversation, similar to that used with the

Charge Nurse, is indirect and informal; a device to elicit information from the other speaker:

> Judith can you tell me a little bit about yourself as a nurse, how long have you been working as a nurse, where did you train, that sort of thing? (Judith, A, p. 1)

There are three questions from me regarding Judith's background. Tentativeness and indirect forms of language are much less apparent here, apart from 'a little bit' and 'that sort of thing' . I followed with :

> Now Judith when I was making enquiries about doing this research in the ward and explaining that I was interested in people's views and experiences of the NFR policies and practices, other people mentioned your name and said, 'Oh, Judith would love to talk to you'. Now I'd be interested to know why you have this reputation. (Judith, SN, A, p. 3)

'Now' used twice, suggests a persuasive device to steer the conversation towards the main focus, NFR. 'I am interested to know why you have this reputation' suggests I am creating a rigid framework from within which she is forced to answer. Even before she speaks, her talk is identified as being distinct from other nursing talk within the ward. The way in which the nurse responds confirms this distinction. The language that the Staff Nurse uses to answer the question suggests a nurse in charge of her practice:

> *Well there would be several reasons, one would be that I started my nursing at a time when this wasn't in practice and the only people who would be resuscitated would be people who died suddenly, such as people who have a cardiac arrest but were younger people or people that were electrocuted or drowning, that type of thing, but you didn't resuscitate sick people. So this has come in gradually over the years, also I am a great believer in nature and nature is the deciding factor in people's deaths, particularly old people. I'm not meaning young people or someone of my age... but I feel very strongly that old people shouldn't have this indignity, particularly if they haven't been asked. It annoys me that we presume that everybody wants to be resuscitated, and this is one of the faults of the system, is that if we haven't asked them, or we haven't heard what they think, that we would automatically do this and to me it is as wrong to do it as to not do it. (Judith, SN, A, p. 3)*

Here Judith is positioning herself directly with a distinctive characteristic of her nursing practice. The last section of her comment refers to the practice of resuscitating all patients unless an NFR order has been decided upon and documented according to the policy in the hospital (See Appendix B). In this last sentence the language used seems to suggest that she is not in a dominant position in power relations in the clinical setting and could be seen to be asserting herself against a more dominant discourse. The directness of the language makes clear Judith's position regarding NFR, the research project and me.

The patronising researcher

In my first conversation with Alice, the Enrolled Nurse I once again provide a barrage of questions about the participant's background:

> You're an enrolled nurse, can you just tell me please where and when you did your training, what it was like, how long ago that was, and how come you ended up working in a medical ward and how old you are?
>
> *I'd never admit to that, I have found that people treat you by your age, rather than your knowledge, so I have never owned up to a specific age.*
>
> OK that's fine. (Alice, EN, A, p. 1)

Here I employ a politeness strategy by using the word 'please' but do not use the kind of tentative language I employed in my initial conversation with Isabel, the Charge Nurse. This suggests a different relationship with the Enrolled Nurse, who held the most junior professional position of all those I interviewed. The participant answers the last question first, refusing my request to give her age, and giving a reason for so doing. In terms of power relations, my being less tentative was an indication that I saw myself as more powerful than the Enrolled Nurse. I attempted to reduce that power imbalance by the use of the word, 'please' but with the general agenda of eliciting information from her. The fact that she refused to answer my question about her age suggests that she gained some power herself. It also acts to assert her position as a holder of knowledge. This is very powerful discourse that resists the dominant nursing discourse that believes that Enrolled Nurses do not have nursing knowledge. My limp response, 'OK, that's fine', shows that I backed right off, so much so that I didn't take up the question of what kind of knowledge that might be. The wider ideological question of age and ageism is apparent in the Enrolled Nurse's stated need to conceal her age.

Knowledge and its relationship to authority and responsibility do continue to be an interest for me as evidenced further into the conversation when I asked:

> Yes, and maybe it's just worth your elaborating for me how you see the differences in degree of responsibility between enrolled nurses and registered nurses.
>
> *I look upon myself as a very valuable second tier nurse, rather than the ultimate responsibility in the acute phase. I don't like that responsibility and I would never be a staff nurse for that reason. I'm a good Indian, I'm not a good Chief, but I'm a brilliant Indian. (Alice, EN, A, p. 5)*

'Maybe it's just worth your elaborating for me', indicates some uncertainty about the value of asking the question. In contrast, the answer is very clear and confirms the enrolled nurse's position in the knowledge hierarchy. It also indicates some pride in her abilities. While I asked the above question of Alice, I did not ask the registered nurses to whom I talked, how they saw the degree of difference in responsibility between registered nurses and enrolled nurses. That enrolled nurses were very clear about their level of responsibility, was a pre-conception I took into the research. It could be argued that the above question was primarily designed to confirm my position on this issue, rather than elicit information in a free and democratic way.

The following excerpt is in relation to my interest in whether Alice was aware of a hospital-wide NFR policy or not. Her reply reveals a contradictory discourse, which is a mixture of a politeness strategy and a challenge.

> So correct me if I'm wrong, but does that mean that you see it as the individual doctor's decision? The person in charge of a particular case as it were, they decide, maybe not necessarily on their own, but as you say the doctor has ultimate responsibility, so the doctor decides?
>
> *I would say it's a consultant decision. Not by himself, but definitely a consultant decision once they've decided that they can do no further treatment for them. (Alice, EN, A, p. 4)*

'So correct me if I am wrong' invites Alice to disagree with me. The question is then shaped up into a set of phrases designed to lead the participant to answer in a particular way. In this way, I am organising the spectacle in which I appear. In other words, I am almost telling the Enrolled Nurse what to say. By so doing, I am limiting the value of the conversation and inhibiting the possibility of the Enrolled Nurse's voice contributing to the emergence of new NFR discourses. The exchange identifies a preoccupation with responsibility and authority regarding NFR, indicating the acknowledgement of medical authority over nursing authority in the research institution.

The other Staff Nurse who participated in the research was Debbie who had two years of experience as a Staff Nurse and some pre-registration experience as a caregiver in a rest home. She was twenty-two years of age and already held a position of responsibility in the ward as the CPR Educator. In the medical ward where the research was conducted Debbie worked full-time as a registered nurse. I had hoped to talk to a young nurse because I suspected that their views about resuscitation and NFR might be different from those of nurses who had many years of experience (for example, the Charge Nurse, the Nurse Consultant and the considerably older Staff Nurse). What I had not considered is what difference that might make to the way I talked to the participant. What is soberingly obvious through viewing the transcripts of the conversation with Debbie, is the extent to which I dominated the conversation in both interviews. Almost half of the transcripts consist of my voice. I begin the conversation with my usual attempt to engage with the participant in order to elicit. talk, 'Can you first of all tell me a little bit about yourself', 'How come you've ended up here in this ward?' A number of my questions are aimed at clarification: 'Why was the role of CPR coordinator interesting to you and what do you do?' 'Have you been involved in any discussions about whether a person should be for resuscitation or not, as a registered nurse?' 'Can you tell me a little bit about the ward NFR policy?' The alleged purpose of the conversation, to discuss with the Staff Nurse the social practices of NFR from her perspective, was usurped by my need to give her a lot of information. By so doing, I accentuated the power differential between researcher and participant by talking almost as much as she did. The only other conversation in the data collection process that showed this tendency was the discussion I had with the House Surgeon. He too, was in his twenties and the age difference between him and me could have been a reason for my tendency to talk more, as evidenced by the fact that a third of the transcripts recording my conversation with him are of my speech.

What follows is a more detailed examination of the beginning of the first conversation with Debbie, an inquiry into Debbie's background and memories of NFR policies and practices:

> Before you registered, did you do any practical work apart from being a student, did you work part-time in a health setting?
>
> *Yes I did, I worked part-time throughout my student years at a rest home. I worked there part-time and I also worked there pretty much full-time during the holidays but it all depended on how many shifts were available and that was just at a home for the elderly.*

> Can you recall in your experience as a student, or as an aide or caregiver in a rest home. . . . any instances about resuscitation or NFR?
>
> *No, not when I was a student because.. . . oh, I suppose because it was a home for the elderly, it would have been 'Not-For-Resuscitation'.*
>
> Why do you say that?
>
> *Because they were in the home, they were... like the patients I was looking after were expected to die, they knew that and their quality of life wasn't resuscitatable, I suppose you could say. So that's why and also being a student, I wasn't really au fait with resuscitation or NFR I didn't know all the policies and all that sort of thing went on,*
>
> Right, that's understandable, but the impression you get is that they had a kind of unwritten policy if you like for Not-For-Resuscitation?
>
> *Yes. (Debbie, SNE, A, p. 1)*

The conversation moves very quickly to the issue being researched. 'Oh, I suppose because it was a home for the elderly, it would have been Not For Resuscitation, elicits a very direct response from me, 'Why do you say that?' Here, I believe I was acting as an advocate for the older person, an instance where my personal and social position impinges on the research. I have a relative who lives in a rest home and my fear that residents in rest homes may be declared NFR without their consent manifests itself here. I may also have been testing this young person's attitude towards elderly people. Debbie placed herself in a position of little power in the rest home by acknowledging that she had not been familiar with any NFR policies in that setting. I, as the researcher, supported that position by commenting that her lack of knowledge was understandable.

The egalitarian researcher

Anne, the Resuscitation Education Co-ordinator, also played a role in controlling the development and implementation of policies of the health care organisation. Our conversation generally reflected the harmony of discourse arising from the fact that we were both nurses and both had a background in cardio-thoracic nursing:

> You might like to explain to me a little bit about your own background, what your professional qualifications are and how you came to be in the position that you are and then we'll go on and talk a little bit about what the position involves.
>
> *First up, I'll just change the title a bit, I was originally employed as CPR Education Co-ordinator but last year I decided that I wanted to expand the title to actually Resuscitation Education Co-ordinator or Resuscitation Educator. My emphasis being that CPR tended to sort of narrow my focus, you know the CPR Queen, the CPR Person as if that's all I was interested in and really it's not, CPR's a small part of resuscitation and that's why I feel that my title explains more what my role is about.*
> *(Anne, REC, A, p. 1)*

At the beginning of the conversation, as usual, I use indirect language like 'you might like to,' 'a little bit' (twice), and 'how you came to be'. This suggests that I am trying to include the other speaker and present myself in a non-intimidating way. In other words, as I did with other nurse participants, I appear to have been attempting to harmonise two discourses, research discourse and nursing discourse. Anne's comments suggest that she is positioning herself in terms of the research 'that's why I feel that my title explains more what my role is about' and revealing something of how her position is regarded within the institutional discourse: 'the CPR Queen'.

In my first conversation with the Policy Adviser Nurse Consultant, Helen, I checked out a question regarding which sub-group of staff may be more likely to resuscitate patients:

> I'm aware that young new people are more likely to resuscitate and older more experienced nurses will have the courage of their convictions as you say, and let the person die with dignity. Is that a reasonable assumption to make about common practice do you think. Is that a generalisation that we can make?

> *I think that is a generalisation you can make. I think occasionally there will be a newish nurse who is firm enough in her own convictions to act on that rather than have the interference of "Should I or shouldn't I? What do they do around here?" They should just do it. But I think that it is someone who has had considerable life experience, rather than your average new graduate. But while they're exposed to working with somebody who has got a very clear view, and is very explicit about what they think and their thinking is borne out in action, well then that nurse also sees that over and above the legal technicalities I suppose, that she can influence... you don't need to stand by and think how awful this is. That there are ways she can control it. In some areas they will comfortably talk with the doctors about it and I think there's quite a lot of negotiation but it's like self-perpetuating. You talk with the ones who are comfortable with the idea of talking and listen. There's a different relationship, but some people won't talk about it. Some doctors just apparently aren't comfortable with it.*
>
> Comfortable with talking to nurses about such things, or comfortable with the idea of NFR?"
>
> *Comfortable I suspect with the processes that would bring them to the point of being able to formally write an NFR order. So they defer it or they decide not to embark on it at all, which then puts the nurse in the position that there is no order so how does she stand legally and professionally if she doesn't respond in the way that's expected?*
>
> You mean when the nurse chooses not to intervene if somebody is discovered in a comatose state?
>
> *Again, I suppose if you're not fully in command of everything and even if you are, the risk that you will be accused of causing a person's death because you didn't intervene etc - that is always the risk . Then you have to be very clear about the assessment you made and the reasons and everything else and would that stand up in court? They don't know.*
>
> So you're not talking about a degree of risk?
>
> *This will be one of the instances when nurses are aware that they might be called to account for their independent actions and that awareness may be enough. (Helen, PANC, A, pp. 10 - 11)*

This conversation is between two nurses who are contemporaries and reflects the harmony of discourse arising from this fact. My use of the pronoun 'we' suggests that I am attempting to align myself with Helen to show that we are speakers of the same discourse. Here, use of 'you' in her response indicates that she is separating herself from my position. Here, Helen is positioning nursing influence regarding NFR decision-making alongside medical influence. My questions are ones of clarification, leading to further elaboration on her part and an opportunity to make clear what she wants to say.

Supporting existing NFR knowledge hierarchies

Confirming my own position in the hierarchy of knowledge, I faced the prospect of the first conversation with the Medical Consultant, Jim, with a considerable degree of anxiety. I felt grateful that he had agreed to be part of the research. I understood that he was very busy and had multiple responsibilities, as a clinician, as a researcher and as a teacher. I thought I had believed that nurses led equally extraordinarily busy and responsible lives. Yet my attitude of gratitude towards the consultant suggests that I was complying with the notion of medicine as the dominant discourse; that a medical consultant research participant is therefore more important than a nurse participant. The first conversation with him began with some questions and answers on his choice of career, where he had trained and what experience he had before taking up his current position. The conversation went on to discuss NFR more particularly:

> Can you describe for me how your views on NFR decision-making, the responsibility and the moral aspects of it, developed?
>
> *Well I think like everything, your views change with time and they change with changing perceptions of the time, not just as you change, but as the community changes and also your views are a combination I think of not only your personal views on life, but also your personal experiences. I think that my current views on resuscitation, they actually affect my personal... my philosophical views on what medical practice works best for the patient and why a certain action is best clinical practice. I think it also would be shaped by my experience as a junior doctor when one had to carry out the views of a consultant whether one agreed with them or not. . . I think that my views on resuscitation and the experience I've had in the past, the negative experiences, have shaped my views probably more than the positive experiences.*
>
> Now what do you mean by negative experiences?
>
> *I think in particular my six month period as a registrar, at a stage when I had some experience as a registrar, where I was forced to observe medical conduct that I considered to be unacceptable on personal terms. It was an*

> *unfortunate way of treating the situation and I felt quite strongly that the wrong decisions were made. It was a very autocratic system where the consultant made the decision without, in my view, an appreciation of the views of the family or the patient, and the medical and nursing staff.*
>
> And your own views obviously?
>
> *And my own views, and I think that has shaped my views far more than any positive experience in this respect... I think the negatives shaped my views far more than the positives. (Jim, MC, A, p. 2)*

The language that the Medical Consultant uses, is not dissimilar to that used by the nurse participants. His use of 'you' and 'your' suggests an informality aimed possibly at creating an inclusive environment. The Medical Consultant constructs his current position as a clinician with responsibility regarding decisions about NFR from personal views and personal experiences, particularly 'negative' ones. Like the Charge Nurse and the senior Staff Nurse, the Medical Consultant used strong language to represent himself: 'I was forced', 'unacceptable', 'unfortunate', 'I felt quite strongly'. This suggests that, like the Charge Nurse and senior Staff Nurse, the Medical Consultant's talk involves the representation of strong feelings.

My first question to him, in contrast to the ones I addressed to the nurse participants, was in bioethical language; decision-making, responsibility, and the moral aspects. It also reveals the extent to which I might have been subject to the power and cohesion of medical discourse on NFR. On the other hand, the use of the word, 'Now' to begin a question, suggests a business-like assertion on my part. The term, 'obviously indicates a desire to be seen as a peer and is, I suggest, even slightly patronising.

The conversation with Albert, the House Surgeon was less overtly couched in terms of decision-making, responsibility and the moral aspects of NFR.

> So how would you say your views on NFR have been formed then?
>
> *From different consultants really, and different people. Some geriatricians I've spoken to have an attitude towards death, which is more natural and humanistic, than some other physicians who are more mechanistic and try and stop people dying as much as possible. I probably tend more to the first camp, regarding death as natural as long as people's quality of life can be maintained, I think life should be maintained, whereas I don't think people should be left in a sort of medical limbo. People wanting to die, just kept alive on machines, people should have the right.... I think for me personally at the moment, most of my input would be from the consultant I'm working under, if they want... a person 'not for resus' then really I have to follow that, of course, and most consultants I think probably would be respectful of patients' wishes and I know that from this ward, if patients decide that they'll refuse all treatment and the patient is known to be actually wanting it as a conscious decision. (Albert, HS, A, pp. 1 - 2)*

The reason Kate, a Medical Consultant in gerontology, was included in the research was her position as Chairperson of the Professional Advisory Committee. My primary interest was in talking about the work of the Group and what role it played in the construction of the CHE-wide policy on NFR. The first conversation began with the usual enquiry about background and views.

> Kate, if we could start at the beginning, can you tell me please a little bit about your own background, I suppose both professional and personal, where you were educated and some of the things that might have shaped your beliefs and values about NFR?

My usual techniques of tentativeness and politeness are evident here, 'if we could start at the beginning', 'can you tell me please', 'a little bit', 'I suppose', 'some of the things'. This style contrasts with the nature of the discourse I employed when beginning the talk with Jim, the Medical Consultant in the ward. What the two above excerpts of conversations with medical consultants have in common is the use of bioethical terms, 'moral aspects', 'beliefs and values'. In her reply, Kate described her family background, medical education and considerable experience as a specialist gerontologist.

She referred to a service that existed in a facility separate from the main hospital from 1974 to 1989. Then it was re-located and refocused. She was one of two consultants working in the area and has been in charge of the service since 1989. The excerpt from her transcript below places her clearly within the medical discipline. It provides a construction of her position on 'not-for-resuscitation'. Note that the practice of resuscitation or NFR is supported by the reference to international guidelines (not the hospital or ethics committee guidelines). Another distinctive aspect of Kate's conversation is the way in which resuscitation is referred to as a 'very stressful and physical assault'.

> *It became also clear to us with the sorts of people we were working with, that those in the acute assessment area were not going to be resuscitatable, that they were beyond the clinical criteria for successful resuscitation. So it was just clearly acknowledged but not written that this would not happen. For the occasional person who was sort of in their sixties who came to us, we did have some dilemmas but they were things like motor neurone disease and significant multiple sclerosis sort of more terminal..., so they really didn't fit any criteria for CPR and so it was not done. On the other hand, the people who went into the rehabilitation ward were expected to actually move out of there to their own homes and that's always been the case, it's even more so now with the new political climate. So the dilemma has arisen a little bit for some of those people about who is resuscitated and who is not. Again we've gone along with the international guidelines, that those people who have multiple reasons for being within our service and who have really basically unresuscitatable situations, i.e. they're very old, they've got cancers, they've got dementias, they've got progressive diseases of various sorts, they've got dreadful strokes, they've got dreadful hearts and so on and who would simply not survive the very stressful and physical assault on them. These people are regarded as 'not for resuscitation' and this is identified clearly in the notes with a stamp and signatures, consulted and discussed with the patient and/or the relatives, or both or the whole whanau or whatever's appropriate for those people.*
> *Kate, PAMC, A, p. 2)*

What is noticeable about this speaker throughout the conversations I had with her, is the amount of detail and lengths to which she went to provide me with a picture of her practice and the views on which it was based. This suggests that she was prepared to focus on the research and put as much time into it as was necessary for the collection of sufficient evidence. The result was that considerably more talk was undertaken in this conversation than with the one involving the other Medical Consultant. The focus of the conversations with him was primarily on his clinical practice. Kate's position in constructing and disseminating policies at health care organisational level placed her in a more crucial position with regard to the sociopolitical practices of the hospital.

A major shift in disciplinary discourses is evident with Lucy, the Service Manager who identified her position in relation to the hospital and the health care organisation. She had previously been a health professional until two years previously when:

> *I moved into this position, which is one of the medical and surgical services managers and it is I guess strategic management, third level manager, putting the policies into place, making sure, monitoring outputs, monitoring budget spending, negotiating for contracts and that type of thing.*
>
> And that would mean that you're accountable to the General Manager?
>
> *Yes, I'm accountable to the General Manager of Medical and Surgical Services and I've got eight wards in general medicine, cardiac care, cardiac thoracic wards. The Charge Nurse is virtually a team leader who would report to me. (Lucy, SM, A, p. 1)*

Lucy's position on NFR social practices will be examined in more detail in Chapter Eight. Nevertheless, the above excerpt from the beginning of my first conversation with Lucy clearly discloses her line authority and power in relation to institutional policies and practices generally. My line of questioning indicates my interest in establishing how Lucy situates herself within the social practices of the institution and leads her directly to that kind of response.

The one participant who was situated outside the CHE was positioned as the Chairperson of the Regional Ethics Committee. My questioning at the beginning of the first conversation focuses on the relative positioning of lay and professional members on the Ethics Committee:

> Can you tell me please a little bit about your own background, how you came to be on the Ethics Committee and how long you've been on the Ethics Committee?
>
> *Sure. I've been on the Ethics Committee since 1992 . . . . I'm a lawyer on the Committee and because the Ethics Committee is an inter-disciplinary body, it's necessary to have a range of backgrounds and perspectives on the Committee ... I was appointed in 1992... as a lawyer on the Committee, I was there not to give legal advice to the Committee, but to provide another professional discipline, I suppose you'd say in terms of a way of thinking to the body of the Ethics Committee, because at that time, there were 10 members of the Committee and I was appointed as one of the lay members. You know about the Constitution of Ethics Committees don't you? Do you want me to expand on that?*
>
> That would be good, thank you.
>
> *Since the Cartwright enquiry, one of the key recommendations that came out of that enquiry, apart from the appointment and setting up of the Health and Disability Commission, was essentially the revamping of Ethics Committees to make sure that they were independent from the institutions that they were reviewing the health research from; and to that end, the Area Health Boards took on the task of setting up these committees, including the requirement that each committee had at least a half or 50% lay membership and the Chair of the Committee be a lay member so in 1992, I was appointed as one of the lay members to the committee,*
>
> And the idea behind having lay membership was so that the Committee's work wasn't captured by a group of health professionals?
>
> *That's right. It's to ensure that community values have some input into the ethical review of research . (Sarah, EC, A, p. 2)*

My usual characteristics are present here, politeness; 'please' and 'thank you', tentativeness; 'a little bit', and a propensity for asking very leading questions. Here Sarah is making statements about the importance of the consumer voice being heard in the ethical review of health research projects. My politeness strategies, and the leading question, could have been motivated by a desire for Sarah to see me, not so much as a researcher, but as a health professional who was very dedicated to ensuring the consumer voice was heard. Sarah, in turn, also uses politeness strategies, for example, her use of 'Sure' and 'That's right'. Checking out that she is providing me with appropriate information also occurs, 'Do you want me to expand on that?' This, and her willingness to be interviewed, could have been a strategy for her to show that lay members of Ethics Committees were very ready to communicate with health professionals about consumer concerns.

Discussion

The aim of the research, as discussed in Chapter Four, was to gain the active participation of both the participant and the researcher and to discuss key questions about NFR policies and practices. This was in keeping with Potter and Wetherell's (1987) understanding of interviews; the provision of an opportunity for the research participants to have their say about NFR, in relation to their position in the institution. The three opening excerpts from conversations with the Charge Nurse, the experienced Staff Nurse and the Enrolled Nurse indicate my attempts to converse rather than interview. As far as my effectiveness with regard to inclusion was concerned, the above excerpts speak for themselves. The conversations were initially stilted and awkward.

Even though I had supposed that I would be comfortable talking to nurses and to be seen as an equal by them, the above excerpts from the transcripts indicate that this was certainly not always the case. Even within the discipline of nursing there were obvious distinctions in the way that I judged the participants and their potential contribution to the research data. The purpose of talking with professional people holding different positions within the institution was to ascertain whether their talk about NFR was congruent or divergent. I wanted to find out whether the expected dominance of medical authority was borne out by the way people talked or whether there were other NFR discourses emerging. An analysis of excerpts from my conversations with nurses, as outlined above, shows that my approach confirmed, rather than questioned, the existing lines of authority. The effect this had on the data was that I shaped the data according to my pre-conception of the individual nursing participant's place in the organisation. In this sense, the purpose of the data collection was distorted. If new NFR discourses emerge from this research it may then be in spite of the researcher's position in the research rather than because of it.

In the above brief excerpts from conversations with those other than nurses in the research, there appears to be less use of devices to establish and maintain my own authority. This suggests that I give people who I consider to have greater authority on NFR in the existing power relations of the institution, more chance to have their say. The effects of this could be that their discourses have more opportunity to maintain their dominance and there may be less chance for new or different discourses to emerge through the data. Very few examples from each of the research conversations have been used here. However, the test of the supposition, from the small number of excerpts provided in this chapter, lies in the following chapters where attention is focused on the social practices of NFR, rather than the way in which the researcher set up the conversations.

Summary

Critical discourse analysis assumes that the researcher, along with the other participants in the process of generating real texts, co-constructs a discourse. The discourse is likely to reflect the relative positions of power of each speaker. The effect of this is to shape what can be spoken and what cannot. Chapter Five’s main purpose was to disclose something of the researcher’s language, social practice and ideological positioning that became evident during data collection. In so doing, the reader has also been introduced to some of the power relations evident in NFR discourses. Chapter Six will examine the everyday NFR practices of those who have direct contact with patients; the immediate context of NFR.

CHAPTER SIX

EVERYDAY NFR TALK

Introduction

The next three chapters highlight the result of the social relations between the researcher and the participants and are organised around the three main features of these NFR discourses. In this chapter, everyday social practices of NFR are examined. As indicated previously, social practice, for the purposes of this study refers to the NFR talk of the research participants. The approach to Chapter Five is repeated in this chapter in that the texts are first examined for individual words or phrases that are distinctive and that indicate how the speakers organise texts to achieve a particular effect. Secondly, texts are read for evidence of the dominance of any individual disciplinary discourse and finally, they are read for evidence of ideological positioning in the wider social context. This is in keeping with the earlier established methodological and analytical framework for the study.

Setting the scene

There are a number of considerations that need to be taken into account in order to fully appreciate the contents and approach of Chapter Six. First, a distinction needs to be made between talk that represents everyday NFR social practice and talk that represents NFR social practice as crisis. Crisis talk has been identified in the research by terms like, 'disaster' and grief', 'agitation', 'tragic' 'frustration', 'conflict' and arises in the event of cardiac arrest where there is uncertainty and ambiguity about whether a patient should be resuscitated or not, whether resuscitation should be continued or whether it should be stopped. This language is examined in detail in Chapter Seven. The social practices of NFR examined in Chapter Six refer to social practices other than those arising in a cardiac arrest situation. Both this chapter and Chapter

Seven examine NFR practices in the clinical area. The focus in Chapter Six is on everyday NFR events. The focus on Chapter Seven is on NFR/cardiac arrest crises. Chapter Eight, in contrast, focuses on institutional and policy practices.

Chapter Six is organised to focus, first, on the texts about NFR that were generated from the institutionally powerful, in order to assess whether texts generated at this level could demonstrate any movement in power relations and a sharing of power/authority with respect to NFR. For that reason the first cluster of texts examined, arise from the Charge Nurse, the Nurse Consultant, the Medical Consultant with Professional Advisory Committee responsibilities, the Resuscitation Education Co-ordinator, the Medical Consultant with clinical responsibilities within the research ward and the Medical Registrar. The remaining positions that are then examined are those of the very experienced Staff Nurse, the less experienced Staff Nurse, the House Surgeon and the Enrolled Nurse. In Chapter Six, the aim is to investigate whether, taking into account the researcher's effect on the data collection process, the texts generated by the research participants provide evidence of the construction of everyday NFR knowledge in ways that resist and reshape traditional notions of NFR power and authority.

Opening up a space

The analysis begins with the Charge Nurse's position. The Charge Nurse played a pivotal part in the research project because she played a key role in providing access to other participants. Importantly, the Charge Nurse's words indicate intersecting nursing, medical and managerial discourses more comprehensively than any other position. The early part of the first conversation with the Charge Nurse has been examined in Chapter Five. Later in the same conversation there is a change to that of story telling. It refers to a situation in which a person was being resuscitated not through CPR but through nasogastric feeding. The language of NFR is silent in the conversation. The Charge Nurse comments:

> *We had a female patient who'd had a really severe stroke ... whose prospects seemed pretty jolly terrible and who had been a terribly active person with a very precise, proper lifestyle and this person found themselves terribly disabled by the stroke and absolutely hated being disabled, hated being dependent, hated anything and everything about it and couldn't swallow properly, had to be nasogastrically fed...*
>
> Was she able to communicate?
>
> *She was able to communicate and we had... and I had a recent graduate who was the nurse working with that patient and I remember her coming to me and saying that she was sure that the patient knew very well what they were doing in pulling out the nasogastric tube, that the patient, whilst depressed, was depressed about their situation, but was still able to make decisions, that they knew full well what they were doing and the nurse feeling terribly angry that the medical instruction was to replace the nasogastric tube and to restrain the patient ... and I remember sitting and talking with her - this is awfully fuzzy, doesn't sound very specific, I remember sitting and talking with her and her being reduced to tears at feelings of powerlessness and the physician was a younger physician but a person whose attitude then, and even now, and God we're talking 10, 15 years later, is known for being a person who never gives up. Even if the patient wants to call it quits, the physician will never say die.*
>
> *I remember talking with her and... like what could we do? and encouraging her to sort of get her thoughts together and get her ideas together and be very clear about why she felt that this was what the patient was wanting. To say to the physician one day I'd really like to talk with you about... because she wanted to have it out with him in the team meeting in front of everybody and I sort of said well you'll never get anywhere because he'll just take umbrage, feel like you're trying to put him on the spot in front of the whole team and his reaction will be just like a brick wall and you'll get nowhere - whereas if you sit down with him in a private place and say, this is what I find from my work with the patient, this is what I believe that the patient wants. The result of that was surprising, it really was very surprising that he listened to what she had to say, they talked about it, then he went to the patient with his new insight into where the patient was coming from, talked with the patient, found that this is what he too believed that the patient was saying - we got in psychiatrists to make sure that the person was able to make that kind of decision and as a result of that we stopped being active. That patient was allowed to die.*
>
> Did you get any feedback from the nurse?
>
> *Oh yes, she felt great. Because she felt... should you feel great about helping a patient die? But she did because that was what the patient wanted and that the patient was being freed from their misery and from all the things that they found unbearable because they had been to a hairdresser every week, bridge player, car driver, well preserved, all those sort of hackneyed*

> *terms - the sort of archetypal person who says they hope they drop dead in the vegetable patch while pulling up a lettuce for Sunday night's tea. She actually found herself imprisoned in a body that didn't do what it used to do and it had really let her down she felt. (Isabel , CN , A, pp. 9 - 10)*

There are a number of contradictory elements in this excerpt from the Charge Nurse's conversation. On the one hand, the participant refers to the suspected poor quality of the content of the conversation and whether it could be of any value or not. This is highlighted by, ' this is awfully fuzzy, doesn't sound very specific,'. On the other hand, the language used to describe the episode is definite, strong and action-oriented. It includes emotional terms like 'absolutely hated being disabled', 'terribly angry', 'taking umbrage' and 'things that they found unbearable'. The above passage confirms the participant's representation of herself and of her staff member as effective advocates of the patient. Here, Isabel is constructing a place for herself in the order of discourses within the ward and hospital. She is also portrayed as a very effective operator in opening up the discourse between medicine and nursing regarding what was perceived as a patient's wish not to be treated. My contribution as the researcher was in asking questions of clarification and in affirming the value of the talk.

The language utilised gives meaning both in terms of the immediate clinical practice setting, staff interacting with patients, and in terms of the social practices of professionals: nurses, doctors and managers. The above excerpt implies a particular position regarding NFR. Isabel tells the story of a patient whose primary nurse feels 'powerless' to achieve something that she, the nurse, believes is in the patient's best interests. She believes that the medical order for the nasogastric tube to be reinserted against the patient's wishes and for the patient to be restrained so that she is unable to pull the tube out again, should be rescinded. There is no evidence in the story of recognition of the doctor's reasons for continuing the treatment. The Charge Nurse's description of the advice she gave to a young staff nurse on how to negotiate with a physician to achieve a goal, 'what the patient wants' suggests that the Charge Nurse has a clear view about what her preferred outcome for the patient would be.

The story indicates particular beliefs about death, for example, as 'freedom from misery' and the part a nurse can play in decisions made about death: 'she was allowed to die'. The passage makes very clear what the position of the physician was considered to be and how much it contrasted with her views and the views of the staff nurse. There is an implication here, though never directly stated, that the physician is known never to give up even when both the Charge Nurse and the staff nurse considered it not in the interests of the patient to continue to give treatment. The above story refers to therapeutic privilege, freedom, power and powerlessness, action and inaction. It suggests that there is an emotional element in nursing work as well as a place for negotiating and listening skills. The progress of the story implies that the patient had the nasogastric tube removed with her (the patient's) consent and eventually died.

There are four discourse positions presented in this story: those of patient, practising nurse, Charge Nurse/nurse and physician. Here, a medical discourse is signaled as a dominant discourse, which the nurse was complying with by following the medical instruction to keep the nasogastric tube inserted. Her angry response and approach to the Charge Nurse suggests a resistance to medical discourses and the assertion of a new discourse regarding the treatment of the patient through the intervention of the more senior Charge Nurse. The physician's subsequent response also suggests a further new discourse; one of greater tolerance and the creation of a new space where decision regarding the patient can be negotiated with, first, nursing staff and later with the patient. The Charge Nurse's comment that ten to fifteen years later the physician still maintained his 'never give up' stance, suggests that the excerpt under discussion did not permanently transform the physician's social practice. There is a suggestion, however, that the story of an episode that took place ten to fifteen years previously, confirms that a patient advocacy discourse in nursing is not a recent development. The above passage also shows that the Charge Nurse speaks a powerful discourse that can help to determine what happens to patients at the end of life in the ward.

Closing down the possibilities

Conversations with staff with institution-wide responsibilities were aimed primarily at investigating NFR policy development, rather than the implementation of NFR policies. In the event, they also included reference to social practices of NFR policy implementation in the clinical setting. One such instance was illustrated in the conversation with Helen, the Policy Advisor/Nurse Consultant. The following passage describes a recent episode where a senior nurse in a ward contacted her for assistance.

> *This particular person was a little distressed about a situation in the wards where there was a person dying - her relatives were coming from overseas I think and the doctors were clearly showing the inclination to actively resuscitate - it seemed appropriate and the staff were a bit flurried, so I thought I'll go along. I knew the charge nurse was off, that's right that's why I went along. .... I went in to see the woman and she was clogged up to about here, she was... you could see that she was on her way out. So I went in and asked the nurse what the understanding was, what was going to happen to this woman when she died. She said that the doctors had said that they were actively going to resuscitate her. I said well, that really seems rather unnecessary to me - what are they hoping to achieve? She said she didn't know.*
>
> Was this patient an older person?
>
> *Yes. This is the other extraordinary thing. Yes, she had come from I think a rest home where she had been quite nimble and everything else and she had fractured a femur and she'd come in and she'd gradually gone off. So I spoke with the Registrar and I said that the nurses were concerned that things were going to happen and I was concerned and what was she going to do, what did she think about it. This was what really struck me as funny 'Well, she was all right when she came in'. If she hadn't have been all right when she came in, maybe they wouldn't have been going to do it and they*

> *really needed the son's permission to not do anything and so until he arrived they would have to do something if she died in the interim. I said 'Well why are you bothering, you can see that clinically, whatever you do, it's not going to change this woman's situation - she's just drowning essentially'. She said 'I know, I know, but we'll only do a little try' I said 'Why try at all? If you're going to try, you'll have to do a full-scale try, or you don't try. Why is it so difficult not to try?' She said 'Oh no, no I can't - I'll talk about it with my consultant.' So that was as far as we got and there was really nothing I could do because I had no power at all in the clinical area in that sense.*
>
> Any decision you make has no authority, is that what you're saying?
>
> *No. No validity at all. Fortunately the son arrived before she expired and didn't want anything done. But I just found that really stupid; apart from... I mean whether or not the son says resuscitate or not has got no legal validity anyway and somebody has got to make a clinical decision based on the patient's best interests. She was clearly incapable of making any response at all and you could only expect that any humane person would have taken the courage of their convictions and said 'no'. Instead of this weak-kneed response well, we can't do anything really, because the son hasn't arrived.*
>
> Was the son coming from overseas?
>
> *Yes. But that is my only personal involvement, but I know from a friend who worked there for a long time, the distress it caused her because there's no clear instruction. Newish staff would call the doctors and things would be done. But more knowledgeable staff would just let the patient die, then call the doctor when it's too late. (Helen , PANC, A , pp. 8 - 9)*

Like the previous one, this text contains strong language: 'really stupid', 'no legal validity', clearly incapable', 'weak kneed response', 'no clear instruction', and 'call the doctor when it is too late'. In contrast, in the same segment of conversation, there are instances of rather vague language, for example, 'a bit flurried', 'concerned that things were going to happen', and 'things would be done'. Another feature of the discourse type is the informality of a number of terms that I recognised, given that I too am a nurse, but that may not be so apparent to another audience. For example, 'she was clogged up to about here, she was... you could see that she was on her way out'. The participant had gestured to her neck in her conversation with me to indicate that the patient's lungs had been filling up with fluid, and 'you could see she was dying'.

The discourse genre of the narrative is used here to tell a complex tale of NFR discourses, or rather resuscitation discourses. There are NFR meanings attached to the patient's age, gender, place of residence, role as mother, her medical condition (fractured femur and respiratory problems) and her inability to communicate. Nursing discourses and medical discourses are represented as divergent in that the medical impetus is towards treatment and the nursing impetus is towards the cessation of treatment. Questions are raised regarding legal, medical, family and nursing responsibilities and accountabilities. The tale also acknowledges the resistant practices of the nurses in letting the patient die before a doctor is informed, to spare the patient the onslaught of CPR: 'But more knowledgeable staff would just let the patient die, then call the doctor when it is too late.' This comment represents a concealment of nursing NFR discourse. Moreover, it diverges widely from medical NFR discourses.

Even though this nurse held the most senior nursing position in the Medical and Surgical Service, she believed that she had no power at all to change the situation she described, beyond talking to the medical registrar involved in the case. She considered any instruction she might have given to have no validity at all in the eyes of the health professionals working in the clinical setting. Yet, from the language she uses, her views about the correct action, were very clear. There is some inconsistency here, in that the nurse consultant also utilised rather euphemistic terms, for example, 'things would be done' meaning, presumably, CPR would be initiated. In a sense, medical discourses are given total dominance here. Yet, there is evidence of a distinct nursing discourse from the nurse consultant herself, expressed indirectly in the phrase, 'fortunately the son arrived before she expired and he didn't want anything done', as well as a judgement on resistant practices among nurses regarding NFR practices. In the above extract, the nursing NFR discourses are widely divergent from medical discourses in that they promote patient and family advocacy over medical control. Yet, nursing discourses here were ineffective in that they were unable to influence what happened to the patient. The above extract indicates that one way in which nursing discourses seek to be effective in patient advocacy regarding NFR is by being covert and by closing down any possibility of engaging in negotiation with speakers of medical discourse. Here is evidence of considerable divergence within nursing NFR discourses.

Opening up the space between policy and practice

According to the Chairperson of the Professional Advisory Committee and Medical Consultant Kate, the involvement of the patient and family in the NFR decision appears to be a taken-for-granted aspect of NFR policy implementation in the clinical area over which she has control:

> *We've gone along with the international guidelines, that those people who have multiple reasons for being within our service and who have really basically unresuscitatable situations, i.e., they're very old, they've got cancers, they've got dementias, they've got progressive diseases of various sorts, they've got dreadful strokes, they've got dreadful hearts and so on and who would simply not survive the very stressful and physical assault on them and these people are regarded as 'not for resuscitation' and this is identified clearly in the notes with a stamp and signatures, consulted and discussed with the patient and/or the relatives, or both or the whole whanau or whatever's appropriate for those people.*
>
> What does the stamp say?
>
> *The stamp says not for resuscitation, the reason and the period of time that is stated for. So these are the guidelines that come from the British Geriatric Society and after discussion here have been validated by the Professional Advisory Committee, have been discussed with the medical and legal people, including the legal advisor. They can only be signed by the consultant or registrar, not the house surgeon or anybody else and they are at the front of the notes and in the notes, so that anybody not knowing the case, knows that the person has in fact been assessed and sorted out before they get called in the middle of the night to start this. And the nurses know, everybody knows, what the expectation of these people is. Now, I mean you can sign them off in 48 hours, three weeks or indefinitely, depending, but we need to have a justification, which is what we do.*
>
> Right and if they are signed off in 48 hours, does that mean... that the patient is still living...?

> *Yes exactly. It has to be revisited and we learnt our lesson fairly quickly, we had a 88 year old woman who collapsed on the ward in front of the house surgeon who didn't know what to do, so he started CPR and it was a total, dreadful disaster and of course... I mean the woman died naturally, but it caused a huge amount of grief to the staff that were involved. The ones who believed it should never have been started, the house surgeon who didn't know what to do and go into this sort of impasse situation and who needed some long... not really counselling, but discussion and prioritising and help afterwards and the whole distress was absolutely appalling so we're rather more careful about making these decisions at the appropriate times, as near as possible to admission and not some way down the track. Because the woman was clearly... she was bed-bound, dreadful heart, unable to move, it was simply the wrong clinical indicator. Because it is a clinical treatment, we're clear about that. We've had one or two people who are for resuscitation if they collapse and they haven't done so and if they were to do so, they would be given the full programme. However, it would be my personal opinion, that almost all the people on the rehab ward would not survive because the reason they get to the geriatric rehabilitation focus, is because they have a multiplicity of problems - we don't have people who have just one problem. (Kate, PAMC, A, p. 2)*

'We' is scattered throughout this excerpt from the talk of the medical consultant who was also the Chairperson of the Professional Advisory Committee. As the head of the service to which the consultant alludes, it would be expected that the 'we'; to which she refers is a term that suggests that her statements would be supported by members of her staff. As in the two preceding extracts, the talk here also calls on extreme and emotional terms like 'dreadful strokes', 'very stressful and physical assaults', 'total dreadful disaster' 'huge amount of grief' and 'absolutely appalling'. Here, these terms are applied to the medical conditions that patients have, the actual event of CPR and the effects on staff if CPR is carried out inappropriately. The reference to CPR as an assault suggests that the activity is carried out without the patient's consent and may have serious physical side effects. The discourses identified above suggest that NFR is a rather dramatic area of clinical practice.

What this excerpt also reveals is the position that NFR social practices in this service are consistent with international guidelines on NFR, specifically, those of the British Geriatric Society. The proposition is that everyone in the service area adheres, without exception, to the guidelines, 'everybody knows, what the expectation of these people is.' The consultant is representing her area of practice as exemplary in congruence between policy and practice. As if to emphasise the position, she tells a story about an exception to the rule when a house surgeon did not know what to do. This too is dramatised. What this excerpt also illustrates, is the tenuous distinction between everyday practice and crisis practice. To all intents and purposes, the story of the house surgeon's experience represents a CPR episode that was a crisis. Yet it was told within the context of everyday effective NFR practice. An argument is made that CPR 'was simply the wrong clinical indicator. Because it is a clinical treatment, we're clear about that'. Here, the consultant claims medical control over CPR as a treatment. At the same time, the use of the term 'assault' suggests that the consultant is opposed to CPR in that context.

Uncertainty in practice

Uncertainty in medical and nursing discourses is evident in the talk of the Resuscitation Education Coordinator, Anne. As indicated in Chapter Four, Anne played a role in controlling the development and implementation of policies of the health care organisation. Because of her Crown Health Enterprise - wide responsibilities, she had constant and ongoing contact with a high proportion of all nurses. Here, she refers to the question of the documentation of an NFR order.

> *Often nurses will say there is a real reluctance on behalf of medical staff .... to actually document it so then you've got a problem with verbal orders - it doesn't happen very often now thank God, if at all, but there is also the odd one who has actually expressed the fact "well, just walk".*
>
> What does that mean, 'just walk'?
>
> *What about if this person arrests? Don't rush, just walk. You know - exactly, ..That is what nurses will say 'what does that mean? Well you know, don't rush or anything, just take your time - what do you mean?*

> *And that is where this conflict comes up because you say 'what does it mean? Does it mean we don't start CPR or by the time we sort of pull the curtain and go and make a cup of tea, which is another thing nurses have been told before today, we come back and the person will have died - in which case you're saying the person is not for resuscitation? It doesn't happen very often, but nurses have been in that sort of situation. Don't rush. (Anne, EC, A, p. 15)*

Here, Anne is referring, first of all, to reports that doctors are very reluctant to write an order for NFR in the patient's notes. This suggests that they would prefer that the order be passed on verbally. When a nurse asks a doctor for direction on whether to carry out CPR or not, if a patient arrests, the reply might be, 'Don't rush, just walk.' This is another way, a coded way, of saying the patient is not for resuscitation. This represents an acute and crucial instance of a particular discourse, albeit in code, dictating a social practice. Anne's talk presents 'just walk' as kinds of medical code for NFR that nurses are expected to understand and conform to. The use of a code suggests that patients and relatives are excluded from this discourse, and possibly, so too are those nurses and doctors who might be opposed to the non-action indicated by the code use.

Coherent and cohesive control

The ward medical consultant's position on NFR is quite distinct from the two previously discussed positions. This excerpt highlights the relationship between NFR and withdrawal of treatment.

> *For most patients, I think, the issue of CPR or 'not-for-resuscitation' is almost irrelevant in that it's not actually an important decision.*
>
> For them?
>
> *For them.*
>
> What do you mean, why isn't it important?
>
> *Well you may have a patient who has had a major stroke and is unconscious, no possibility of recovery, who has complications like an infection, and has active treatment . Eventually a decision may be to withdraw treatment and make the patient comfortable. And talk to the*

family and to make a decision about what is to be the outcome of that person's life. In which case, in my view, it is quite inappropriate to start talking about a not-for-resuscitation order. You have already made a decision as to what one's approach is to the outcome of that person's life. You could have another case where you have a very elderly patient, say a 95-year-old person who is in a nursing home and has a major problem, has dementia. You may make the decision to treat aggressively with antibiotics and intravenous therapy or give oxygen. If the patient has a cardiac arrest or illness, prior discussion about doing CPR may be inappropriate for two reasons. One is that a discussion may raise expectations that a CPR may be successful. The other thing is that it would send a mixed message to the patient. On the one hand you are saying I am going to treat you aggressively, on the other hand I'm not going to resuscitate you. And the whole understanding of what is resuscitation and what's irretrievable gets confused. To say to the patient 'You have a future and we're going to treat you but we're not going to resuscitate you,' may leave this patient thinking, 'What is this person talking about, what is he trying to tell me?' A suspicion might come, 'Is he tricking me or is he not?'

In other words, has he really got my best interest at heart?

Yes. An instance was a patient who was in their 90s who had a good quality of life and who was admitted during the night with severe heart failure. The registrar rang me up to ask me whether he should put a 'not for resuscitation' order in the notes and he got the history of the person, that they'd had a good quality of life and were in their 90s, had a poor prognosis in terms of they had heart disease, of which the heart failure was a complication of the heart disease, but in whom aggressive treatment had been initiated and in my opinion, it was inappropriate to be writing 'resuscitation' orders in the notes. My understanding is that if the treatment was unsuccessful in... a 90 year old with severe heart failure having a cardiac arrest, that resuscitation would be unsuccessful and that at a time when he was telling the patient "we're going to treat you maximally to see if we can cure you" to then have to go through the informed consent issue of 'not for resuscitation' was inappropriate and it was with some awkwardness the next morning or later on the ward round that I had to really resolve that issue with them.

With the staff?

With the patient and the family because they were very agitated about what resuscitation was all about. Now in fact the patient made a good recovery and went home but that's... it was a worry for them what we were telling them because on one hand we were telling them that we were going to treat the patient aggressively and on the other hand we weren't going to resuscitate their mother.

So a mixed message from their point of view?

Yes.

So what sorts of things were they saying to you?

> *I honestly can't recall, but they didn't quite understand what we were trying to tell them.*
>
> And you felt comfortable that you did resolve that?
>
> *Yes, we did. We did resolve it, and in fact, the patient to my recollection basically reassured me at the end of my discussion that it was all a lot of nonsense to have to go through this procedure and that she knew what was going to happen, you know, which I thought was quite interesting, that she had a better understanding of what it was all about than the family. (Jim, MC, A, pp. 3 - 5)*

The above is an instance of medical discourse that excludes dialogue and cooperation with other discourses. The Medical Consultant, in his recollection of the events surrounding the admission of a 90 year old for active treatment, which did not include CPR, believed that the consultant and the registrar should retain the burden of truth of the inappropriateness of CPR. In this instance, the admitting registrar had asked the consultant whether a NFR order should be placed in the patient's notes. The consultant believed that it was inappropriate for the family to be asked to consent to a NFR order. He preferred the staff to remain silent about NFR, not because the most appropriate treatment for the patient was CPR in the case of arrest but because it should be a taken-for-granted that a 90 year old with severe heart failure who arrested should not be resuscitated. In this instance, he wished the burden of truth to remain with the medical staff, not with the family. In a real sense the consultant did share the burden of truth with the family however, because he raised the issue with them and acknowledged the contradiction facing them. The patient too, later acknowledged that she knew what was going to happen.

Divergence within medical discourses

Like nursing discourses, medical discourses are not necessarily coherent and cohesive. The consultant's preference had been to remain silent about NFR. The registrar's preference had been to talk to the family but he also enacted his responsibility to discuss the situation with the consultant. The medical registrar, Hugh, confirms the hierarchical system of authority and responsibility in the medical team:

> What differences are there in the degree of responsibility between the house surgeon's role and the registrar's role in NFR, if any?
>
> *Right the first thing is that often on site the registrar's the senior person on the medical team - the consultants are not always on site, after hours, therefore in that acute setting it must come on the registrar to make the decision to resuscitate or to persist with a resuscitation which may have already been begun. So there is more responsibility on the registrar and this is where you sort of move up from a house surgeon situation - you still want the information but then you've got to do something about it. The house surgeon may well be thinking about these things, and may well have an opinion and to express that opinion, but the registrar does have the responsibility to act on that information. So that's different. It really is a discussion thing, it's something you discuss between all members of the team, but ultimately, the senior person on the spot has to have some sort of reaction, otherwise you just go around in circles. And you do need to make that decision pretty quickly in those situations.*
>
> *The other thing about registrars, they're often people who see people acutely down in A&E and may be the person who's come in is gravely unwell and in those circumstances, you may need to raise the subject, or you will need to raise the subject of resuscitation early on and there might be an opportunity... sometimes family members come in with patients and want to go home and collect pajamas or whatever, but you've got to use that time to raise these options. Not always do you come to a decision then, and one of the things that I find difficult is to impress upon people the importance of the need to make decisions now which you can review later kind of thing..... Yes, but even having said that, if you raise these issues early on, it's something people can think about and most people will have some sort of opinion, even if it's a bit hazy and they might want to go away and think about it and so on. I think the sooner you raise these kinds of issues with the person who is there, well the better. So I think that's a responsibility the registrar has, breaking perhaps bad news. I think there's no point in hanging around until the bad news has happened or something, or the worst outcome has happened - well you can't avoid it then, but you should have at least discussed these issues that may come up or will come up. So I think they're two things - okay you may have to make a decision acutely in a stressful resuscitation situation, you've got to make it then and secondly, you've got to bring up these issues and hopefully after the discussion you will have come to some conclusion, some plan as to what the best way to proceed would be and obviously also you'll be discussing with the patients - Sometimes you're lucky or the patient's lucky and they've thought about these things before and that's great, that's an issue, it's out of the way, it's sorted, you can concentrate on other things.*
>
> *I often wish that people had written something down a bit earlier on when they could think about things in a more real atmosphere. Sometimes you just have to bring them up in a situation where a person is stressed to the extent that you wonder how much their answer is clouded by their stress.*

> *Sometimes you have to do that. Ideally, you discuss it when they're a bit more settled and so on. (Hugh, MR, A, pp. 3 - 5)*

The registrar identifies two approaches to accepting responsibility. The first instance is in an acute emergency situation, 'to make a decision to resuscitate or to persist with a resuscitation when it had already been begun'. The second situation gives an account of the way in which decisions are made when there is more time for consideration: 'Again, it really is a discussion thing, it is something you discuss between all members of the team, but ultimately, the senior person on the spot has to have some sort of reaction, otherwise you just go around in circles.' The distinction between the house surgeon and registrar is articulated quite unambiguously. According to this excerpt, discussion contributes to, but does not overrule, the final decision of the most senior person.

Further divergence within medical discourses

The House Surgeon starts out with a representation of his values and beliefs and moves immediately to an explication of two approaches to NFR.

> So how would you say your views on NFR have been formed then?
>
> *From different consultants really, and different people. Some geriatricians I've spoken to have an attitude towards death, which is more natural and humanistic, than some other physicians who are more mechanistic and try and stop people dying as much as possible. I probably tend more to the first camp, regarding death as natural as long as people's quality of life can be maintained; I think life should be maintained, whereas I don't think people should be left in a sort of medical limbo. People wanting to die, just kept alive on medicines, people should have the right...*
>
> And where does that idea... you've said mostly consultants, but does it come from anywhere else as well, like your religious views, or experiences in your own family or...?
>
> *They're my own personal philosophies developed over the years really. My attitude towards life etc. You could say it's a religious view, but I don't belong to any particular religion, it's a philosophy of my own in respect to life. (Albert, HS, A, pp. 1 - 2)*

The House Surgeon makes it clear, although in a slightly tentative way ('probably') that he aligns himself with the 'natural and humanistic way'. His discourse contrasts with that of the consultant and nurse participants, in that there is less evidence of strength of feeling; less language use to convey emotion. There appears to be an absence of extreme or absolute language of the sort conveyed in other participants' discourses, for example, in the Charge Nurse's speech: 'terribly angry' and 'freedom from misery'.

The House Surgeon's conversation is intriguing for the terms that he selects to summarise different discourses and practices regarding patients/people near the end of their lives. They can be divided into two different discourses: the first of which he supports: 'natural and humanistic', 'death as natural', 'quality of life', 'life should be maintained'. The second is couched in less approving terms: 'mechanistic', 'medical limbo', 'people wanting to die left alive on machines'. He introduces a 'rights-based' ethical discourse with:

> *People wanting to die, just kept alive on machines, people should have the right...*

and later,

> *But if you know that in the end it's not going to work and the patient really has had enough, well from what I've seen here, then most people respect their wishes. (Albert, HS, A, p. 2)*

Covert power

Here, Judith, a Staff Nurse of thirty years' experience who works with the Charge Nurse, Isabel, answers a question from the researcher about why she has a reputation as a nurse who is in favour of NFR:

> *I have a fear of people being resuscitated and then being left in a vegetative state. And I know that the rate of people who are successfully resuscitated is quite low ... I guess my main criticism is that we rush into it without thinking about it and I know that I have a reputation because I would not consider resuscitating somebody who was say 85 or 90 but I notice my younger colleagues do and they have an understanding that everybody has to be resuscitated unless it's been specified not to. I would not do that and I do not have any problem with that and I'm not frightened of getting*

> *pulled up for it because to me that is the right thing to do. That is how I perceive it. So they all know that that is how I feel.*
>
> Is that because... your position a) is somewhat unusual and b) it is well known, that it is distinctive about your practice?
>
> *Yes. (Judith, SN, A, p. 2).*

The use of codes within NFR social practice has already been alluded to in the CPR Nurse Educator's extract above. As the experienced Staff Nurse, Judith, articulates:

> *I'm not worried about how I feel about resuscitation - I feel that if I make a decision, I'm not scared of that or what may happen... so that it's quite easy for someone to die and you just know they've gone and you just leave them. You don't tell anybody for five minutes and I could do that without any sense of guilt. There's a common expression that you may have heard, that somebody made up years ago, take a teabreak when somebody dies, and it just means that you don't go and announce it immediately. You just have a little gap, then there's no problem about what people will do. And I feel quite comfortable with that (Judith, SN,A, p. 17).*

Here, the experienced staff nursing discourse is spoken around the nurse's feelings of comfort, conscience and guilt. Keeping silent for the duration of the teabreak removes 'the problem' of others' actions. Here Judith is positioning herself directly with: 'I feel that if I make a decision, I'm not scared of that or what may happen'. Essentially, the excerpt above indicates a statement of beliefs or philosophy regarding NFR practices. Judith, as a practising nurse, is asserting a more independent nursing discourse than was expressed by the Charge Nurse. It is a concealed or covert discourse because it reports a practice of withholding information that would normally be passed on to her colleagues.

The statement 'Then there's no problem about what people will do' suggests that the senior Staff Nurse is not in a dominant position in the clinical setting and could be seen to be asserting herself against a more dominant discourse, possibly, medicine or management. The main contrast between the two positions of Charge Nurse and the senior Staff Nurse, is that the Charge Nurse promotes herself as a speaker of the discourse of inclusion and change regarding NFR practices. Conversely, Judith's talk suggests concealment and silence. Nevertheless, she is a speaker of a powerful discourse that can determine what happens to patients at the end of life. This is apparent in the following extract also from the discussion with the experienced staff nurse:

> Other nurses I talked to seemed to think it would be unusual for a patient and nurse to discuss 'not for resuscitation'. But this suggests to me that this is part of your practice, and while it's certainly not an everyday occurrence, it is something you would see as part of your normal interaction, is that right?
>
> *Yes, in some situations, it is deemed to be quite appropriate, and you get the feeling and I might have said this before, often when you're in a situation like when you're showering somebody or giving someone a bath and you quite often talk about them as a whole person, it is often at a time like that you talk about their life and their family and what they've done and it can sort of come up quite naturally and you might just start saying "Oh, how do you feel about your illness, do you think you're going to get better, how much do you want to get better?" particularly people who actually say to you "Oh, I'm fed up, I'm tired, I wish they wouldn't keep pushing me along". So it is... it's not a common occurrence but it... and probably I do just perhaps take it that little bit further because I have an interest in it. I have an interest in how people feel and what they think and what they feel and if I get any suggestion at all that I think people are being pushed along a path they don't want to go, I'll sort of latch on to it because I have a real empathy for that attitude in people; and people are so frightened and I think I've said this before. They'll talk to nurses about not wanting things done but they won't talk to doctors because they're afraid to talk to doctors about it.*
>
> Why do you think that they're afraid?
>
> *Well, certainly with older people, it's because doctors have always been held in a God- like position. That you don't challenge them and you accept what they say and they're always right. This comes through very strongly (Judith, ESN, B, p. 6).*

The above excerpt from Judith's talk is consistent with the discourse from the earlier conversation. She mentions the value of talking between patients and nurses and refers to the patient's fears of resuscitation. This extract also speaks a powerful discourse that can determine events at the end of a patient's life.

Opening up the space between nursing, medical and patient discourses

The representation of a patient-initiated conversation about NFR as referred to by Judith earlier, 'they'll talk to nurses about not wanting things done' was followed up in conversation with the other much less experienced staff nurse, Debbie:

> And have you been involved in any discussions about whether a person should be for resuscitation or not, as a registered nurse?
>
> *Yes, I have.*
>
> Can you tell me about that?
>
> *Well, one that I was involved in was that the patient actually requested to be NFR so I just relayed that on to the doctors. When a patient says that they don't want to, you know, that's fine. I was involved in another one where a patient was dying but they weren't totally sure why, so the medical staff found it quite difficult to talk to the patient about being not for resus because they weren't totally sure what was going on. Unfortunately that patient ended up going through quite a painful death and died in ways that we really didn't like. I would have preferred it to be at home with the family etc.*
>
> Can we go back to that first patient, this was an instance where the patient initiated the conversation?
>
> *Yes, that's right.....*
>
> Right, and what did she actually say to you? Can you remember?
>
> *She's got quite a direct personality anyway, she didn't have any difficulty saying that. She was very sick and was in quite a bit of pain and she just said to me that she wanted it documented that she's not for resuscitation. That was her words. "Can you please get it documented, that I'm not for resuscitation'.*
>
> Did that surprise you?
>
> *No, it didn't. Because I knew the patient. A little bit, it surprised me. But in other ways, no.*

The conversation continued. I reflect back to Debbie a summary of what she had said earlier:

> So you saw it as your role to hear what she said and pass that on to the person who you thought was responsible for implementing it?
>
> *Yes.*

> And what happened then?
>
> *I contacted her doctors and just got them to document it. They of course have to go and talk to her themselves and just discuss with the patient that this is definitely what she wanted. She knew what she wanted and what she was saying.*
>
> And what actually happened with that, she died?
>
> *No, she didn't die.*
>
> So did she go home?
>
> *Yes, she went home.*
>
> Because most of the literature says that if 'not for resuscitation' orders are put in place for the patient, most times they die very shortly afterwards, like 24 or 48 hours in most cases.
>
> *Unless it's because this patient isn't your typical patient. She's someone that knew the ward, she knows the hospital very well, she's in here quite regularly so she instigated it herself, but as you said it's not the usual thing for somebody to say... unless they've got family who are from the medical nursing fields. (Debbie, SNE, A, pp. 4 - 6)*

This is a report of a patient representing herself and her own interests. Debbie's representation of a discourse that works to empower the patient is elaborated in the following excerpt from her first interview:

> Who do you think has got the most power in the decision about NFR?
>
> *The documentation decision part, or the actual...?*
>
> Right, when an NFR order is placed on someone, a patient, which means that they won't be resuscitated if they arrest, who is the most powerful person in that decision?
>
> *The very most powerful person would be the patient, if the patient is able to say "I'm not for resus" and they have an informed decision where they actually know what it involves. It really does come down to the patient, they're the ones that can say yes or no. Then the next person would be the senior medical staff. They're the ones that document it. So it would get more tricky I suppose you would say when there's a patient who's unconscious and there's no family and that comes into the ward, then it would be more on the medical side of it. They're the people who would make the decision, whereas someone who's got family and things like that, it would be patient first and then discussion with the family.*

> So where would you put the nurse in that power spectrum?
>
> *I think they're in the middle, they're the advocate usually.*
>
> So you could argue that that's actually being extremely influential because if that part of the equation doesn't happen, then the patient doesn't have any power at all.
>
> *Yes.*
>
> So that means that communication and negotiation skills are quite an important part of the job.
>
> *Definitely. Often I think also the medical staff, even though they try and put it into layman's terms and terms that the patient understands, I think nursing staff, because they know the patient better and have a better rapport with the patient and family, they can actually express the ideas of what the medical staff are thinking and sort of discuss more in detail what the patient's wanting and what 'not for resuscitation' is more so than the medical staff and the medical staff like... They'll go and sit down with the patient for 10 minutes and discuss it and then leave, whereas the instances that I've been in, when they've left, I was the one that sat there and listened to the patient cry and talked to them about, 'Is this really what you want?" and they will actually tell me what they really want whereas they may actually say something different to the medical staff, or slightly different, or not convey everything. (Debbie, SNE, A, pp. 13 - 14).*

Here, again, nursing discourses are represented as discourses that keep open the communication between patients and doctors. Debbie grants the ultimate power over NFR to patients. When the same question was asked of the Medical Registrar his response was:

> *I think if the patient expresses a feeling one way or another that is the most powerful... that's the single most powerful statement or expression of a wish they've got - that's the guiding wish, so that's certainly the best... in the setting with a person coming into hospital gravely unwell, the fact that they're in a physically powerless (often) situation, and to a certain extent other people have got to take on some of that responsibility for those kinds of decisions. This is where there's some uncertainty in my mind. I think ultimately the consultant's responsible because the patient's under their care. The wish of the family's important, but not always the most important thing if it's felt that the patient's best... what's the word?*
>
> Interest?
>
> *Interests are not those of their next of kin's wishes, then there can be an argument for doing things a different way. (Hugh, MR, A, p. 6)*

An emerging nursing discourse

The Enrolled Nurse, Alice, referred to a patient that she believed should have been designated NFR and allowed to die at home which was what the patient wanted. Here the discussion revolves around 'active treatment' rather than NFR. The Enrolled Nurse speaks:

> *Well, thinking back on a patient over the last few months, it was very gung-ho and very active treatment for the lady. She would have preferred to have gone home and died at home. By the time we were able to say "this is not what she and her family want", it was too late, she actually died here in hospital. Had it been a few weeks earlier, she could have gone home with all the support services and been where she wanted to be. So sometimes, the... medical staff actually want to... all right, they try everything they can - it's not always what's in the best interests of the patients or families.*
>
> You're saying she was treated actively until she died?
>
> *Up until probably a week before - yes.*
>
> What made the difference, was it the medical staff that finally decided...
>
> *The nurses finally said "enough is enough" and the medical staff had already done everything they could do and there was nothing else they could.*
>
> So why didn't she go home?
>
> *I don't know whether she and her husband were given enough...information to actually base a decision on, or whether she just kept hoping that the next test they did, or the next procedure they did, might make her better. So whatever they suggested be done, she went ahead and did it.*
>
> She agreed to have it done to her?
>
> *She agreed with them to go ahead with the procedure, whereas I think, if they'd been totally honest with her... maybe they didn't know themselves.*
>
> How do you know that she actually did want to die at home?
>
> *It was made known to me after the event. The nurses were talking about it and they were all saying that it was a pity that she couldn't have gone home because that's what she wanted. But the family still think that the ward's marvellous and... I think sometimes medical staff are loath to say that they can't do anything else and that's where a lot of it starts I think. Whereas if they would say "look, there's nothing else we can do, this is what the outlook is" then the family can sit back and think about it and relatives can think about it and we can get involved. We can tell them what's available, like they can go home, or there are support services, or just sit there and keep the patient comfortable and the relatives have got someone to talk to. But until*

> *you say "we can't do any more" you can't start those processes. (Alice, EN, B, p. 8)*

Here, the Enrolled Nurse appears to be expressing regret at the inability of the staff to ensure that a patient's wish to go home before dying was granted. The nurse represents herself as a patient advocate, more in tune with the patients' interests than the medical staff; yet compromised by her distance from the decisions made about the woman's care. Yet, in a study of the working practices of NFR in an English hospital, medical and nursing staff believed their views on who should be resuscitated would be different (Miles & Burke, 1996), but the study showed that their views were the same. The Enrolled Nurse's comment that 'until we say we can't do any more, we can't start these processes' sums up the pivotal emerging discourse. Her use of the pronoun 'we' suggests that she includes herself in the decision-making arc.

Discussion

On the face of it, the conversations between researcher and participants used in this chapter are widely divergent in their content and style. There are stories about individual patients, either as stand-alone exemplars or as illustrations for more general statements about NFR policy and practice. Reference is made to individual practices. This diversity is in keeping with the accepted approach to critical discourse analysis. What is of interest here is how individual participants see themselves and represent themselves in relation to the power relations possibilities of NFR social practices. The evidence in this chapter points to a number of distinct positions.

Language in words and phrases

There were three prominent themes in the use of language in words and phrases. First, a distinctive characteristic of the language used, was the employment of terms to convey extremes of emotion, particularly anger on behalf of the patient. This is noteworthy given that the focus of this chapter is specifically on non crisis situations when it would be reasonable to assume that there would be less need to call on extremes of language. This was more apparent in passages that related stories of individual patients, for example, that of the Charge Nurse, the Nurse Consultant and female Medical Consultant. They used quite extreme language in their descriptions of patients' medical conditions. This helped to convey their practice as a drama, suggesting a 'larger than life' quality about their work. In contrast, the conversations with the male medical practitioners did not reveal any similar dramatisation effects.

A second prominent feature of language and phrase use was the utilisation of codes in NFR talk, for example, 'Taking a teabreak' and 'Just walk'. These terms were designed to have the effect of conveying particular meanings to particular personnel. In Judith's case, this use was restricted even further to include only nurses. Codes are used to mask, or make secret, the power to influence what happens to patients. The codes are a way of granting more power to the professionals who use and understand their meaning. Conversely, those who are not privy to their meaning and their effects, are denied the choice of accepting or rejecting the power that the codes imply.

A third prominent feature of language and phrase use was in the utilisation of 'the good of the patient' and 'patient advocacy' discourses. These discourses, unlike the use of emotional language, had different meanings and effects in NFR social practice. It is clear that not all participants represent themselves as having the power to determine what happens to patients at the end of life. Nevertheless, the question remains about whether they do or not. The next section goes on to examine whether these representations reflect the dominance of any individual disciplinary discourse or not.

Evidence of the dominance of any individual disciplinary discourse

Medical power and authority were evident in the texts, in both those generated by medical practitioners and those generated by nurses. Between the two Medical Consultants, the Medical Registrar and House Surgeon there was a measure of cohesion regarding medical responsibility for decision-making about NFR and cessation of treatments. Another measure of this cohesion was evident in the expressed willingness, with the exception of the ward Medical Consultant, to include patients, families and other professionals in the decision-making process. What is also apparent is that these processes are spoken up and enacted openly in the institution.

The Charge Nurse enacts a pivotal role at the intersection of nursing, medicine and management to overtly and powerfully determine what can happen to patients regarding NFR. Other positions held considerable power to determine what happens to patients, but only through covert measures, for example, in the case of the experienced Staff Nurse, Judith. The young Staff Nurse and the Enrolled Nurse expressed considerable power in passing on patient-initiated requests for NFR. The Nurse Consultant represented her position as having no power, either overt or covert, although she condoned the practice of knowledgeable nurses in concealing impending death from doctors.

Here we have evidence of the dominant discipline, medicine, continuing to assert a public and pivotal role in the construction of NFR knowledge. Yet, medical discourses, in enacting the rhetoric of the good of the patient, demonstrates willingness to open up to dialogue with patients themselves and their families, and to other professionals. The Resuscitation Education Co-ordinator, also a nurse, represents another rather more ambiguous point of intersection between nursing, medicine and management. In particular, her position highlights the potential for confusion regarding NFR decision-making that will be explored in greater detail in Chapter Seven.

Just as powerful as medical decision-making regarding NFR is Judith's covert, disciplinary power when she initiates conversations with patients about NFR and when she 'takes a teabreak'. As acknowledged in Anne's transcript, 'taking a teabreak' is not restricted to nursing as a code to conceal NFR social practices. Nevertheless, 'taking a teabreak' does have particular meaning for the nursing discipline regarding the power relations of NFR and the construction of NFR knowledge. It suggests that nursing discourses seek to exert power over, and exclude medical discourses from, decision-making at the end of life. What the discourses have in common is the rhetoric of 'good of the patient' and 'patient advocacy' but here, there is wide divergence between nursing and medicine about the techniques of power used to effect that rhetoric.

Ideological positioning in the wider social context

Two particular ideological positions apparent in the everyday practice identified in this chapter are the professional position on death and the professional position on patient and family voice. Jordens (1988) asserts, as discussed in Chapter Three, that the moment of death has been made mobile in the interests of the medical profession. In other words, he argues that death in hospitals has moved from being a physical event to an event that is judged and decided upon by professionals. His argument assumes that it is in the interests of increasing professional power over death that they do so. Madan (1992) claims that medical language, in effect, silences the dying person. As indicated previously, Armstrong (1987), alternatively, contends that:

> The new discipline of medical ethics took over the medical analysis of death and required the confession of the physician while the new

> discourse on dying encouraged the dying *qua* subject to speak. (Armstrong, 1987, p. 656)

The evidence presented in Chapter Six suggests that neither of these assertions is totally justified. They do not explain completely, the range of positions on patient death and patient voice apparent in the NFR talk generated in this research. What Armstrong et al. have not taken into account is the possibility that, in one hospital setting, a range of social practices around death can occur. In the Charge Nurse's story, the young Staff Nurse became the voice of the silenced patient. The Nurse Consultant's story showed that she, in that instance, was unable to supersede the medical judgement made regarding the patient's death. Kate's account of the patient who was not offered CPR, suggests a professional analysis of death based on institutional policy that discounted all possibilities of survival or revival. Unwritten, but prescriptive professional judgement, also determined patient death in the episode about just walking to a cardiac arrest, in the account of the 90-year-old-patient's treatment, and in the use of the code, "taking a teabreak." Also, according to the Enrolled Nurse's account, medical silence meant that the patient needlessly endured painful and futile treatments.

Patient involvement in talk about whether they should receive resuscitation was apparent in some of the instances of everyday practice reported in this chapter. Direct patient NFR talk was also reported in the young Staff Nurse's talk: 'Can you please get it documented, that I'm not for resuscitation'. This appears to fit with the argument by Armstrong (1987) and others (Walter, 1994) that patients, in recent times, do speak about their impending death and seek to be involved in decision-making about the end of their lives. The Enrolled Nurse asserts that the processes to support the patient and family to face death cannot occur until there is a medical confession of defeat; that there is nothing more they can do. This is an argument for an open and inclusive professional discourse that is needed to overcome current practices of collusion and silence. It is a discourse that assumes co-operation with patient and family discourses. This raises the ideological question of patient choice and autonomy. McGrath (1998) argues that an institutional setting tends to disempower and alienate both carers and patients. Taking a postmodern position on bioethics, she argues that it is possible for patient choices and pathways about end-of-life decisions to be socially constructed through discourses, even though these new discourses will be constrained by existing ones. The talk of the research participants in this chapter provides evidence that supports this claim.

Summary

The aim of this chapter was to provide evidence that everyday NFR knowledge is constructed in ways that, to some extent, resisted and reshaped traditional notions of disciplinary power and authority. This has been achieved through an examination of the texts generated by those research participants whose positions provided them with access to clinical practice settings in the research ward. Individual words and phrases were studied for insight into how the speakers spoke their 'piece' to achieve particular effects. More emphasis was given to the second aspect of the reading, that is, for evidence of the dominance of a particular discipline. This was in keeping with a major intent of the research, that is, to study the possibility of new discourses of NFR emerging. Thirdly, the texts were read in order to discern any evidence of wider ideological interests. What the texts revealed was a variety of ways of using language, from dramatising NFR practices possibly in order to give them a 'larger than life' quality to codifying NFR practices in order to render them silent and invisible. While the medical discipline was prominent in the discourses it was not dominant. In the power to determine what happened to patients regarding NFR, the medical discipline did not hold the monopoly. That power was shared through particular, overt and inclusive systems of practice, and also through highly covert and exclusive practices. What were the effects of these techniques of power on patients? Every discourse was represented as aiming at the achievement of the good of the patient. In effect, the results for individual patients could be very diverse, from continued aggressive medical treatment to death without any intervention whatsoever.

Attention now turns to the area of NFR social practice designated as not everyday, not ordinary even though it is acknowledged that this is a somewhat artificial distinction. NFR crises can also be cardiac arrest crises and have as their defining characteristic for the purposes of this research account, on the one hand, immediacy, and on the other, events where there is a very clear conflict between two opposing points. Chapter Seven proceeds to an analysis of the words and phrases, disciplinary power relations and ideological interests that determine what happens in these situations. Once again, the emphasis is on the clinical setting. It is not until Chapter Eight that the research focus turns to NFR social practices at an institutional level.

CHAPTER SEVEN
NFR CRISIS TALK

Introduction

The previous chapter demonstrated how participants' talk about their work constructed knowledge of NFR through the emergence of divergent discourses. Chapter Seven takes the analysis to a deeper level by focusing on the reporting of episodes identified by such descriptions as; 'horrible', 'disaster', 'grief', 'stupid', 'everything turning to shit *(sic)*', or where, even though the language is less extreme, there is obviously a clear disagreement or conflict. In most, but not all cases, the event of cardiac arrest is examined. The aim of Chapter Seven is to examine situations of urgency and immediacy regarding cardiac arrest situations and situations of conflict to ascertain whether these more extensively rearrange NFR discourses and therefore expose new ways of constructing NFR knowledge. As in Chapter Six, the texts are first examined for individual words or phrases that are distinctive and that indicate how the speakers organise texts to achieve a particular effect. Second, texts are read for evidence of the dominance of any individual disciplinary discourse and finally, they are read for evidence of ideological positioning in the wider social context.

Setting the scene

An important element to think through in analysing moments of crisis is the language used by participants to represent 'NFR' crises and whether or not the language departs from more traditional forms and vocabulary of NFR practice. Do the discourses demonstrate new and different ways of representing NFR events?

> This process of looking again, of hearing with less certainty, of thinking and analysing with atunement for silent and routine violence in the way our institutions and discourses are made is difficult since

> the language by which we perceive and evaluate is, by this process, in question. The irritation we feel when our normal structures and processes of being constructive, ordered and decent are put in doubt is itself an important element to think through. (Scott, 1987, p.336)

This comment allows for the possibility of ambiguity, uncertainty in the exercise of a critical discourse analysis of talk in a clinical setting. The moments of crisis selected in this chapter may not be named as 'moments of violence' necessarily. Nevertheless, the identified instances of disruption and conflict demonstrate ways in which the language of NFR social practices is predicated on new forms of discourse.

It was difficult to distinguish clearly between everyday practices and crisis practices. Therefore, to some extent, the division between Chapter Six and Chapter Seven is somewhat arbitrary. There are identified instances of disruption and conflict in Chapter Six. For example, the Nurse Consultant recounts how her visit to the ward did very little to reduce the uncertainty regarding the very ill patient. Nor did it do anything to establish the knowledge and authority of the nurse consultant. Many studies point to NFR decisions being fraught with uncertainty (see, e.g., Schultz, 1997; Youngner, 1987) and a central question for this study remains: Do crisis situations bring about new NFR discourses?

Speaking to agreement

The Charge Nurse, Isabel, raised the ambiguities and uncertainties that can be apparent in the social practice of care of people who have been designated NFR. She points to the case of a patient who had been received in the ward from the intensive care unit and comments on the part that the staff in the ward should play in the decisions made. In particular, she argues that patients and their families can get mixed messages:

> *The point that I'm making is that all those conversations were had in the intensive care unit. The family appeared to have taken the information in. It was all written up. The plan was to transfer to the ward to die. But they left in the central line and the nasal gastric tube and the extra peripheral line for emergencies, you know, so all the clobber said 'Here's a person for whom we can do something'. And that is where it all turned to shit. So our actions, our treatments and our words, the manner we convey - they all have to add up to the same thing. When you think of all the people involved and in contact with that person and the family, that's a real challenge I'd imagine. And I don't think, like I think an important professional value to convey to the team when you are setting the team, or setting the culture, is that no one has the right to opt out of that without discussing it with the team. If the team has come to a decision and it has all been discussed and documented and so on, people should stick to it. Or if they find that it haunts their absolute conscience, that then becomes a point of negotiation and they have the possibility of withdrawing from care of the case on the understanding that it is going against their conscience, but not arbitrarily. It is not an abandonment, that's what we're trying to get across to some people. And people's reaction to this, I think, is really important - it's got to be discussed with the patient if they're of sound mind and if they're not of sound mind with the nearest and dearest. (Isabel, CN, A, p. 17)*

Although this scenario does not portray a cardiac arrest situation as such, it captures the contradiction and conflict inherent in a situation, which suggests that the family might expect cardiopulmonary resuscitation and the ward staff expect otherwise. The language here is notable for its inclusion of everyday terminology and an absence of professional jargon. Some anger is evidenced by the phrase, 'And that is where it all turned to shit'. This works to add power to the assertion the Charge Nurse. 'It is not an abandonment' is a clear assertion of support for the decision not to resuscitate. Isabel is raising the issues here within a management and professional discourse. It is a discourse in support of consensus and agreement and also one of conformity with the values, knowledge base, and practices within the ward. She is suggesting that things 'turn to shit' when individual staff make decisions and act on them (for example, commence resuscitation on a patient designated NFR) without regard for the team decision and the negotiated agreement between the team and the patient and family. In other words, for the Charge Nurse, conflict and disarray are to be avoided through negotiated order. This finding is in agreement with a

1996 Swedish study (Swensson, 1996), which argued that the analysis of the structural basis of negotiations and its knowledge context is necessary to understand the medical, and nursing staff's opportunities for exerting power.

Medical or nursing dominance?

Even though the following excerpt from the Nurse Consultant is not totally coherent it reveals an incident where a patient was designated and documented as NFR. Nevertheless, it appears that the patient received CPR when he suffered a cardiac arrest. The incident had been lodged through the reporting system in the CHE and the nurse consultant was investigating this as part of her responsibilities for quality in the clinical areas:

> *I was reading a patient's chart, they fell out of bed and they fractured something like a femur I suspect and died, so in my job of following up all major instances .... We have an incident hazard reporting system, which a group of us developed. So every incident report goes in, and the data entry person puts it in and each of us has got responsibility. I've got the treatment areas.... and it was in the course of that I followed up what contributed to the gentleman's fall and the fact that he died of course raises anxieties from the company's point of view, so I investigated what could we have done that might have avoided this and in this particular instance, there was nothing we could do. I read the chart through from the incident. Now he was clearly deteriorating when he fell and that didn't help and he continued to deteriorate and at some point like the next day, there was an entry I think 'NFR' it was initials on the chart - they had done a clear description of what was going on and I think they had discussed it with the family and he was already, I think even prior to the incident, on some analgesic, so he was put on sub-cut, continued sub-cut morphine or whatever to keep him comfortable. It was quite clear that that was to keep him comfortable and eventually he died, I think on about the second day. He gradually... the chest filled up*
>
> And there was no active treatment on the fracture of the femur?
>
> *No. The family agreed that they just wanted it left and have him kept as comfortable as possible that was the recorded agreement. So there he was happily dying and he died... It's interesting, the nursing record doesn't show any of this, but the doctor's record does. I think it says cardiac arrest at such and such a time, and the person who was called and this is in spite of the 'NFR' order and about 30 minutes later they finally accepted that the poor old fellow had died. Now I thought where are we at? The whole procedure is gone through, it's up front and everyone is happy. I mean this is what some twit does, where was the nurse? The only thing the nurse would know is that he died peacefully.*

> Do you think it's possible to get it as right as it can be?
>
> *Oh, yes - yes I do believe so. If you lead from the top and everyone knows and everyone is comfortable with the decisions that are reached and it's, if necessary said repetitively 'That's all we're going to do.' (Helen, PANC, A, pp. 20 - 21)*

This discourse shows a tendency to rate an incident in terms of happiness; 'he was happily dying', 'everyone is happy'. Both the above excerpts and the excerpt from the Nurse Consultant's text in Chapter Six, use everyday, popular, even slang terms 'This is what some twit does' 'Where are we at?' to convey meaning. In this instance the use of a slang term 'twit' suggests an angry and disapproving response. There is an assumption made that someone other than a nurse resuscitated the patient and that if a nurse had been present he or she would have known about the NFR order and prevented the crash team being called. The last statement, 'the only thing the nurse would know is that he died peacefully,' possibly refers to the absence of a record in the nursing notes. The consequence would be that any nurse coming on to a later shift would not have read a record of the incident described above and therefore would remain unaware of the event. The Nurse Consultant places responsibility for the inappropriate CPR firmly on the shoulders of the nurses in the ward at the time of the arrest. Yet, in the previous excerpt from her practice, in Chapter Six, she portrayed herself as having no power to change things in a similar situation and yet she is suggesting that a ward nurse should be able to do so. Later, the language she uses indicates that she concurs with the view of the Charge Nurse regarding the necessity of everyone having a common understanding regarding NFR situations. However, she presents a much more hierarchical view in that 'you need to lead from the top down'. Here, she accepts some responsibility as a senior nurse but also expects the nurses at ward level to claim some power to determine what happens and report publicly and truthfully in the patient's nursing notes what actually occurred.

There are four discourse positions presented in the above excerpt. One of these is a risk management position indicating the company's interest in investigating a patient fall while in hospital. Liability is the question being investigated by the representation of quality control through the nurse consultant. That the patient died subsequent to the fall is of particular legal and financial interest to the company. In the course of her investigation, the Nurse Consultant discovered that an attempt had been made to resuscitate the patient, presumably against the wishes of the family acting on behalf of the comatose patient. Therefore an attempt at resuscitation could be considered to be an assault, another possible reason for the company to be concerned, although this possibility is not addressed specifically in the above extract. Presumably, it is a situation that Kate, the Medical Consultant with Professional Advisory Committee responsibilities, would describe as assault. The pronoun 'we' as in 'there was nothing we could do' suggests that the Nurse Consultant was presenting herself as a company representative and therefore was a speaker of institutional discourse.

Another discourse here is a medical discourse but it is implicitly, rather than explicitly referred to; in the pronoun 'they' as in 'they had done a clear description of what was going on and I think they had discussed it with the family'. Also, 'they finally accepted that the poor old fellow had died' was evidence of acknowledgment of a medical discourse. It is reasonable to assume that the speaker means doctors when she uses the term 'they' because she later indicates that nurses were totally absent from the decision-making. On the other hand, the passive voice is used also: 'The whole procedure is gone through.'

A third discourse position is the patient advocacy representation. The man is referred to as 'patient' then as 'gentleman', and finally as 'poor old fellow'. The patient is also referred to as 'he' and 'they'. The narrative is provided with the aim of positioning the Nurse Consultant as a patient advocate as well as, somewhat contrarily, an advocate for the company. 'The whole procedure is gone through, it's up front and everyone is happy' suggests support for clarity, certainty, openness and consensus in NFR situations inclusive of the patient's family. The fourth discourse position is the speaking up of nursing leadership as performed by the Nurse Consultant in a situation where nursing discourses, in determining what happened to the patient, are silent, at least in the patient's documentation.

Family power versus medical power

Similarly, the incident recorded below is not a cardiac arrest situation but it clearly constitutes a conflict between medical power and family power. There is a portrayal of quite different positions and actions about a woman admitted to the hospital:

> There is some discussion in the literature of ways, especially with older people, of encouraging them to sign an advance directive of NFR.
>
> *I listen to people's advance directives and then I make a clinical decision and I tell them that and we've had a case in point where a woman came in, she ended up in the neurology department because she had some sort of bizarre behaviour. Her husband decided that she was demented and they had signed what they said was a legal living will that if one of them got demented, they would have no procedures done on them, they would simply be allowed to die. In fact, actively helped to die. Well, as you know, that's illegal anyway. However, he persisted in this, and finally the neurologist saw sense and called our department and we took the lady over, made the diagnosis that she was depressed and that what she needed was some treatment. She wasn't demented at all. He was extremely difficult to deal with, extremely difficult. He kept producing this paper and saying "this is wrong, all she needs is morphine to put her out of her misery". We said "no she doesn't need morphine, what she needs is treatment for her depression". It took a very long time and we were at the point of getting some medical legal advice on the matter because we thought that under the... we never took it that far, but we did think that under the Protection of Personal and Property Rights Act 1988 we could have actually got some urgent advice*

> *on what to do next because the diagnosis was not dementia and... well two thing: one the diagnosis that the husband had made was incorrect and she did have a treatable disorder and the second thing was that in this country, living wills, although they might be drawn up by lawyers or anybody else are only worth the paper they're written on, they're not legally binding on these people. But being who we are, we would not have done things that were inappropriate, but we certainly weren't going to inject her with morphine and put her out of her misery. Anyway finally we got to treating her, she's now at home and recovered and everybody's happy again. But I've never heard of not doing CPR as an advance directive. Quite often when we're talking to families they say "well, mother would never have wanted this". And I say "well, mother wouldn't recover from this". It's a clinical issue. And if mother who's compos mentis says "I do want something done" then we talk with mother, not with the rest of the family's perceptions on the matter. (Kate, PAMC, A, p. 25)*

Once again happiness is evident in 'everybody's happy again'. In the preceding three excerpts families are mentioned as a part of the decision-making process. Here, the husband of the patient is openly and persistently opposed to the medical treatment being offered to his wife. In the incident described by the Nurse Consultant, the family was happy with the decision made not to resuscitate the patient. That an attempt was made to resuscitate the patient must have puzzled them and created uncertainty, if they were told. In the Charge Nurse's account of a different instance, 'the family appeared to have taken the information in. It was all written up. The plan was to transfer to the ward to die'. Yet, in the latter instance, the presence of technological means of treatment apparently led the family to a different impression regarding the NFR status of their 'nearest and dearest', leading to uncertainty and potential conflict.

The advance directive and the way its attempted application was portrayed by the Medical Consultant in the excerpt above, suggests that a consumer-driven initiative stipulating in advance what might be expected to happen, had the potential to prevent the patient getting the best possible result. The medical opposition to the implementation of the advance directive was represented by Kate as being in the patient's best interest. Here, the Medical Consultant is asserting medical control because of the apparently ill-informed nature of the husband's position. Nevertheless, this report is an example of the engagement of a consumer discourse with a medical discourse. Now attention turns again to a cardiac arrest incident where the question of the possibility of new discourses arising is discussed.

Frustration and conflict

In the conversation with another health professional with both clinical and policy responsibilities, the Resuscitation Education Co-ordinator for the health care organisation, I raised the question of conflict in a resuscitation situation, understanding that a Medical Registrar was usually the team leader at a CPR event.

> *I think there's a general lack of direction and the feeling of frustration when there's conflict, not just between doctors and nurses perhaps but between doctors and doctors. Someone not necessarily taking direction and there can be a real feeling of frustration amongst nurses about "where are we going here, are we going to carry on or are we going to stop, what is happening, someone give us some form of direction".*

> Can you tell me of any instances of... conflict about whether this person should be resuscitated at all - is it always clear whether they are to be resuscitated or not to be resuscitated?

> *Definitely not, and I think it's one of the biggest conflicts really. The situation...that happened last night, a senior nurse arrived at the arrest to find out half way through that the patient was 88 years old with a diagnosis of cancer and supposedly... I don't know who he had actually verbalised this to, that he didn't want to be resuscitated. But I don't know whether that was hearsay, whether it was the actual nurse who was there or some other nurse who sort of said at some earlier stage - it was all verbal and then the one particular medical staff was wanting to go on, the senior nurse...*

> When you say go on, you mean...

> *With the resuscitation.*

> You mean revival didn't occur within the first few minutes, so then there came a decision point like 'do we proceed?'

> *Yes, and the resuscitation lasted for about 40 minutes with this particular registrar wanting to carry on - very little input from the other senior medical staff, and again this is this lack of direction, lack of team leadership, and the senior nurse being ignored in what she was trying to input as concern. The other senior registrar twigged on that she actually knew what she was talking about as far as rhythm recognition is concerned and was actually starting to listen to her. And this is what happens. What is the D N R status? And of course, there wasn't any resuscitation status on this person. Often it is not clear. I don't know how many are actually written or how many are out there, but I'd say very few are clearly stated "this person is not for resuscitation". (Anne, REC, A, p. 10)*

Here the speaker is reporting an incident told to her by a colleague about a cardiac arrest that had taken place in the hospital the previous evening. Anne is in a sense speaking on behalf of her nursing colleague but represents the event in a way that suggests that she, Anne, is speaking the same discourse as the nurse who participated in the event. Anne identifies feelings of frustration rather than anger but the feelings are elicited by inappropriate action, lack of direction, lack of team leadership, and professional knowledge being ignored (in this instance, regarding the senior nurse's recognition of the particular type of cardiac rhythm present in the patient; a significant aspect of CPR). In reporting a nursing discourse such as this, Anne is presenting nursing knowledge in competition with medical knowledge. Yet the above excerpt does not necessarily represent a challenge to medical power in decision-making. It appears to be a discourse in support of the opening up of medical discourse at CPR and NFR events to include, even incorporate, the particular nursing expertise reported to have been involved in the event. The implication is that cooperative discourses may lead to a better outcome for the patient. In this, Anne's representations echo those of the Charge Nurse and the Nurse Consultant.

In this incident, as reported, the conflict can be traced to a moment when action must be decided upon. It could be argued that in the heat of the moment, CPR decision-making may be compromised. There is no time for what Youngner

(1987) describes as reflection and discussion. The above discourse also suggests that where uncertainty and waiting for direction exists, it is likely that resuscitation will be performed, regardless of the patient's potential for benefiting from it. Other New Zealand nurses also report this (see, e.g., Niles, 1996; Paterson, 2000; Rose, 1997;1998). The nurse's representation of feelings of frustration in the above incident appears to arise from confusion about a range of situations: when someone other than themselves is supposed to make a decision and does not; when someone makes a decision but it is the wrong one; when it is known that a decision has been made but nobody knows what it is; when a decision is made too soon or too late. The above incident might appear to fit with Stenburg's (1988) notion of responsible powerlessness, because the nurses' voices were not heard initially.

A closer examination reveals that the senior nurse was eventually able to exercise power by asserting her knowledge regarding the patient's physiological state. What might appear to be an example of powerlessness is, through applying the principles of critical discourse analysis, an example of a nursing discourse resisting a medical discourse. It is also an example of a medical discourse opening up to allow the alternative discourse to operate. Yet, as indicated previously, an argument has been made that, if nurses can manage CPR (Eastwick-Field, 1996) they should also be able to manage NFR.

Medical power versus institutional power

The research ward Medical Consultant represented his role in decision-making regarding NFR quite unequivocally:

> Obviously the actual decision-making process involves the nursing staff, do you see that you have a responsibility to coach or teach nurses or new staff on the ward for example?
>
> *No, I don't see I have a role in that at all. But I would like to think new staff on the ward would approach me and that I... in essence I think that there's a strong consensus on the ward amongst the nurses but I think it's important*

not to attempt to be dogmatic. Normally I find that there's not actually. Surprising when you think about our different background, ages and experience, personal and religious beliefs that in fact there's very seldom difficulty between different people.

Yes, can you recall any instances where there has been a position of conflict where the views are varied, clearly differentiated and I think you've also already indicated that in those cases, your way of dealing with it would be that considerable weight would be given to diverging opinion if you like?

Absolutely, yes. I can't recall a major conflict. I think the only conflict would be where the charge nurse has a more dogmatic approach with the documentation and the notes and I think she... the charge nurse would feel more comfortable with the guidelines, and that the guidelines should be administered more closely and to the letter...

Than they are?

Than they are. But I think that approach is not shared by the staff nurses.

Why would that be do you think?

Just a different approach.

I'm just thinking, might it be because it's the staff nurses and the enrolled nurses who are actually the practitioners of the policy, whereas the charge nurse has a responsibility in terms of management and documentation?

Yes, I think so. Yes. But that doesn't influence us much. In fact I feel quite comfortable - she provides more balance to my role, which is far more relaxed and...

What do you mean by relaxed?

Well in fact I don't seek documentation of patients on a 'not for resuscitation' order because I think that's inappropriate, but sometimes I know the charge nurse has confronted the junior medical staff and said "well you've got nothing in the notes, we don't know what your views are, have you discussed it with the patient" and gone through the obligations under the policy. In fact, normally when she does so, I think she's probably right, there probably is a case where it may have been helpful to have cleared up the grey areas where it may not be very obvious on what should be happening. I think she has an important role, and I support her in her role, I think she provides a balance that she probably ensures more than I do that the staff know of their obligations and I don't have any difficulty with that approach myself and I think it's probably important for us to have that.

So you're both fulfilling your respective responsibilities?

Yes. (Jim, MC, A, pp. 11 - 12)

It is apparent that, even when emotional and oppositional language is avoided by the consultant, he identifies a distinctly different approach between the Charge Nurse and himself: 'I think it's important not to attempt to be dogmatic' and 'I think the only conflict would be where the Charge Nurse has a more dogmatic approach.' Yet, he goes on to express support for her. While here diminishing the possibility of conflict and speaking up the importance of consensus decision-making, the consultant reveals a practice, to which other texts generated within his practice area are opposed, and about which there is potential for considerable conflict: 'I don't seek documentation of patients on a NFR order because I think that's inappropriate.' This admission, which is consistent with his practice as discussed in Chapter Six, has major implications for the institution and will be revisited in the discussion section of the chapter.

Medical uncertainty

The following excerpt from Hugh, the Medical Registrar's conversation, demonstrates a departure from the clarity voiced by the Jim, the Medical Consultant and reinforces the ambiguity and silence regarding decision-making referred to by the Nurse Consultant and Resuscitation Education Co-ordinator:

> Have you ever been involved in a case where someone has been resuscitated where in your judgement that was not the appropriate thing to do?
>
> *I've been involved in a case where somebody... resuscitation was attempted when it was certainly not appropriate - the person was about 90 years old and came in with pneumonia and I was on my way to discuss with the patient who was gravely unwell, but more particularly with the husband their feelings regarding resuscitation and she arrested literally as I walked into the room and it hadn't been discussed, she had arrested, the policy of the hospital was a cardiac arrest call which was completely and utterly inappropriate in my mind and that person however a junior staff member viewed it as my decision and it wasn't my decision...*
>
> Your opinion about that patient was based on your previous assessment and clinical judgement, you knew the person?

> *Yes. So in the event that this was one of the situations where resuscitation is begun with that futile sort of feeling, you try but it's a completely worthless idea and although you can say there's no place for half hearted resuscitation, even so in those sort of circumstances it is difficult to be as... well what's the word... as vigorous as you might otherwise be. I don't know, it is... you know clearly in your own mind that resuscitation is not indicated but equally you know that this is a decision that you're not really in a position to make. In the event, the crash team arrived, we discussed it and decided pretty quickly that this was an inappropriate way to proceed. But I suppose that sort of shaped my opinion that these kinds of questions should be raised fairly early on - this person had been in overnight and had been seen by the team that day and that was a decision we were planning to make, but wanted to discuss in a little more depth - yeah, I think perhaps something could have been discussed perhaps a little bit earlier on. (Hugh, MR, A pp. 6 - 7)*

This excerpt is also further evidence that, where there is delay and uncertainty, resuscitation is likely to be commenced in situations where the prevailing opinion is that it is wrong to do it. When in doubt, do it. The medical registrar uses the pronoun 'you' to refer to himself in the text and 'we' for a general way of including others in the text. 'You know clearly in your own mind that resuscitation is not indicated but equally you know that this is a decision that you're not really in a position to make'. This comment captures the ambiguity, indeed dilemma, where the clinical indicators, referred to by both the medical consultants here and in the previous chapter, for NFR, are superseded by a policy directive. Here, the Medical Registrar attaches NFR meanings to the patient's age, medical diagnosis and the severity of the illness.

Another manifestation of uncertainty and disorder, acted out through the hierarchy of discourses within medicine, is apparent in the event voiced by Albert the house surgeon regarding his first experience of raising the question of NFR with a patient:

> Yes. And so do you use registrars generally as sounding boards or do you report to them or... they're more senior to you?
>
> *Yes.*

And you did mention last time that you thought medicine was quite hierarchical as a discipline.

Yes.

Yes. Did that mean that you thought your roles were quite clearly delineated?

Not necessarily. I'd been asked by a registrar to go and work out what a person's not for resus status is. I was a little bit unhappy about that because I was only an on call house surgeon then.

What happened then?

Well I had to go and do it. It was awful.

In what way was it awful?

I found it awful because I'd never actually had to go and sort it out myself, I knew one day I would have to, but when you go and talk to the family, and you've got to try and stick to the point as much as you can and you think if it was my father in bed there and you've got to really keep your mind on it so you don't become too emotionally involved. I mean you have empathy around the questions, but you can't lose your objectiveness at the same time, or your professional responsibility which is to work out what is best for this patient and gather the information from the family about what they believe is best and in that case they chose a decision which I'm sure all of the medical staff would... not have agreed with, but we still carried out what they wanted.

So did you feel unsupported?

Not really. The registrar said 'If you're having trouble, just give me a call and I'll come and deal with it,' but he also said 'I've got four patients down in A & E to see.' I knew it was a job I had to do, basically. But if I'd really really got stuck and didn't want to do it, I'm sure he would have done it.

That is one of the things that seems to come up time and time again yet this is the sort of thing you need time to reflect and think about what you're going to say.

Yes, I was a little bit upset because I was just the on call house surgeon in the evenings and the team during the day knew about this problem, they knew the patient, they should have asked them then. But I had to quickly go and look in the notes to try and understand what level this person was at, quickly assess them as a review for medications and then bring up the

> *subject with the family. I was quite annoyed actually (Albert, HS, A, page 5).*

Albert added to this in our second conversation:

> *I found that first 'not for resus' experience where I had to talk to the family, I found that quite an affecting sort of situation, I didn't find it very easy. There wasn't a lot of feedback from other people about whether you did it right, or... you're just talking about it, it didn't happen, so... it is quite tough, I found it quite hard talking to this family about... the grown son and elderly wife, both started to cry in front of me, just when I said, ' Look we need to talk about a few things, they may not be easy to discuss, etc etc and they knew from the word go what I was talking about. It was very hard (Albert, HS, B, p. 13)*

The rather restrained expression concluding the former extract 'I was quite annoyed', becomes 'It was very hard' in the latter. Given that several months separated the two conversations, this episode had obviously weighed on Albert's mind. This excerpt gives rise to three questions: the question of having a sufficient medical knowledge base on which to base a discussion about NFR, the question of the house surgeon having sufficient decision-making power and finally the question of involving the patient and family in a decision-making process. Albert's speech reflects some competing discourses. It is desirable to 'have some empathy' but against that is the stated need 'not to get too emotionally involved'. It is necessary to be 'objective'. On the other hand he regards 'what if it was my father' as a legitimate way of weighing up the options. At the same time he is aware of his 'professional responsibility' including the need to gather information on which a decision could be based. The fact that the family made a decision that he disagreed with, is indicative that, in this instance, a medical discourse did not dominate. The episode also reflects a disruption in the form of the absence of instruction or support for the learner practitioner. Unfortunately, Shorr, Niven, Katz, Parker and Eliasson's (2000) study indicated that even when resources to educate medical professionals about discussing end of life issues with patients, were increased, no significant change in behaviour was observed.

Institutional dominance

The following conversation highlights the situation where a NFR event is reported where the prevailing policy in an area of the hospital was not to resuscitate. A patient due for discharge home the following day arrested and was not revived, in circumstances where successful revival was a possibility, in the view of the registrar. Nurses and doctors do have over optimistic expectations of CPR (Lo, 1991; Wagg, Kinirons & Stewart, 1995).

> Have you ever been involved in situations where there's been a real conflict of interest or things have gone dreadfully wrong?
>
> *Sometimes there are difficulties as to the prevailing sort of feeling on a ward or in an area, for example when I was doing nights, a patient arrested on one of the geriatric wards, although this patient was due to go home the next day and was completely well, but because of perhaps inexperience and because of a feeling that most of the patients on the ward were not for resuscitation, this person also was not; a rather inadequate sort of well... call was made and no resuscitation was begun until I'd arrived on the scene by which time the patient was dead. I felt in that setting that a resuscitation attempt should have been made and might have been successful - it is more in the sense of that community arrest kind of situation rather than an arrest in a geriatric ward and a person living out the last of their days kind of thing. It is a different sort of setting. So that's a situation that did occur where I think the optimum treatment wasn't given, although in reality if it had happened twenty four hours later, the treatment would have been the same. So I didn't feel too bad about what had happened in the end but I did feel that we could have done more and perhaps should have done more.*
>
> So was that an example of where a kind of unwritten rule if you like, or a policy within the ward?
>
> *It wasn't written down, it was a feeling in the ward that most of their patients would not benefit from resuscitation and consequently the ward simply wasn't geared up for that way of thinking - you know, it's a different thing, you've got to run and grab the trolley and get down there and that kind of thing, and I can understand that there's some reluctance to do that but I think that in that setting, that that was what was needed, that sort of acute, sharp and definite response, rather than... I actually happened to be on the ward and they just came along and said 'oh, this person isn't breathing' and I said 'well, what are you doing about it?' (Hugh, MR, B, p.14)*

The Medical Registrar here is raising the competing discourses of ward management policy and clinical decision-making. The disruption is not so much centred on the survivability of the patient, rather, around the event of decision-making being distanced from the patient and practitioner. Judith, the Staff Nurse of thirty years' experience, couched things going horribly wrong in terms of episodes where people had been resuscitated successfully and then gone on to have no quality of life:

> *Can I talk about a case that was actually not in the hospital, where the resuscitation took place on the street, but then we got the patient? Well that was a really tragic case of a person who was reasonably young, I think only around 60 or maybe even in their 50s, who had been to a clinic in a hospital, had walked out and was waiting for the bus at the hospital bus stop and had a cardiac arrest; was resuscitated by... I can't remember now who resuscitated the person or whether they waited for the ambulance to come, which of course was quite close, but obviously there was a time lapse which was too long and he became brain damaged.*
>
> *And we then got him as a patient from that resuscitation episode and he was very 'knocked off' as they say. He was quite brain damaged, but he was physically still able to walk but mentally there was not much happening and he became a terrible burden to us and to his family because physically he was able to walk about and wasn't safe. He used to do terrible things like leaving the hospital in his pyjamas and jumping on a bus and going places and I just feel that that is a classic example of somebody that was resuscitated and would have been better not to have been. But then it is very hard to make that decision at the time.*
> *(Judith, SN, A, pp. 10 - 11).*

That Judith describes the patient as 'a terrible burden to us' indicates her willingness to speak on behalf of all nurses involved in the care of someone who has very little quality of life. Here, she is highlighting the practical and moral consequences of a successful resuscitation for those whose responsibility it is to look after the resuscitation survivor. The excerpt is consistent with her overall view on NFR, reported in Chapter Six.

The young Staff Nurse Debbie represents the CPR event as a discourse of disorder, uncertainty, danger and ambiguity. She had been involved in very few CPR situations:

> What are your feelings about that procedure, you've mentioned how relations are worried about their loved one being jumped on, what does it feel like to be the jumper if you like?
>
> *It's awful. It's horrible. It's a horrible thing to do and it's very messy, it's not a planned thing and it's awful for other patients if it happens... I was just thinking of an incident where it happened in a four bedded cubicle, it's awful, even though you draw the curtains, everyone can hear what's going on and people are saying "pass me that, pass me that" and jumping on cords and things are really messy. I always feel horrible for the patient if they're half conscious and they can... especially when they're being intubated and they can... there's a horrible tube being shoved down their throat and just looking into their eyes, they look really scared and they don't know what's going on - yeah it is horrible. A horrible thing to do. (Debbie, SNE, A, p. 13)*

'Awful', 'horrible', and 'messy' are terms used repeatedly to describe an incident of CPR. 'Looking into their eyes they look really scared'. CPR is not a planned event. This excerpt suggests that it is the inability to anticipate a CPR event that creates the confusion and distress. Another element is the immediacy of the event and the need to impose order rapidly, in order to conduct the relevant treatment.

Yet, in the middle of the chaos and uncertainty there can be moments of lucidity and clarity at a CPR event, as in this case, Debbie is speaking about the most senior medical professional present:

> You described an episode where somebody comes in and says 'do you want to continue' I suppose that question might be addressed to nursing staff and medical staff who might be involved in the resuscitation.
>
> *Yes, ... I think it was the consultant who actually said under the circumstances that he thought that resuscitation shouldn't be continued. So I think we'd started it for a few minutes and he said, under his judgement, it shouldn't be continued, and "is there anyone here that objects to that or is there anyone who would like to..." but he said it... he didn't say it in a demanding sort of way, it was really a sort of... well I thought that if I'd wanted to resuscitate this person, I could quite easily say "yes I want to"*

> *and it would have gone ahead without a problem. When he said that, I actually admired the way he said it.*
>
> *Yes and especially because the patient had only been a day or two at the very most, that he thought that maybe one of the nurses or someone would know the patient better and may have a better understanding as to what the patient would have wanted (Debbie, SNE, B, p. 8).*

The Staff Nurse represents the consensus-seeking process at a CPR event aimed at providing an opportunity for someone to express the patient's wishes. This excerpt also demonstrates the imposition of order on a chaotic situation. Here is another clear and unambiguous position regarding CPR events.

I ask the Enrolled Nurse, elaborating on the excerpt used in Chapter Five, what happens when she hears the three bells signal that an arrest has occurred:

> And what do you do when that happens?
>
> *Try not to be first person there.*
>
> Why?
>
> *I think it's... I don't know the word I want... my lack of security, confidence... lack of confidence, in that maybe I might not do the right thing. I'd far rather be the gopher, the runner. Somebody saying to me "do this, do that, do something else", I'm far more confident in that position - yeah, I'd be happy doing that, I don't want to be the one telling someone to go somewhere and do this. But I think probably as an enrolled nurse it wouldn't happen anyway, even if I was first on the scene, I'd be very quick to hand over to a staff nurse.*
>
> Yes, and maybe it's just worth your elaborating for me how you see the differences in degree of responsibility between enrolled nurses and registered nurses.
>
> *I look upon myself as a very valuable second tier nurse, rather than the ultimate responsibility and the acute phase. I don't like that responsibility and I would never be a staff nurse for that reason. I'm a good Indian, I'm not a good chief, but I'm a brilliant Indian.*
>
> Do you see yourself as a responsible person?

> *Yes, I can be relied on to do what I'm asked to do and to accept whatever responsibilities I'm supposed to accept. But I don't go out of my way to accept anything more than I have to. I still think that a lot of that is education and more experience than I've got, well more knowledge than I've got, I've got the experience, but I don't have the knowledge. (Alice, EN, A, p. 5)*

Here, the Enrolled Nurse speaks in a direct, unambiguous fashion about how she sees her role in a cardiac arrest situation. The boundaries of responsibility are articulated clearly. In a situation where actions need to be very rapid and based on complex levels of knowledge: 'I don't want to be the one telling someone to go somewhere and do this.' This acceptance of the authority of registered nursing and medical staff and a willingness to be directed and expression of lack of confidence contrasts with her position in Chapter Six where she has strong, confident views on whether particular patients should continue to be treated. She places a CPR situation outside her field of authority. For others, CPR situations, as discussed above, can be fraught with uncertainty and ambiguity and evoke emotional response. This is not the case for the Enrolled Nurse.

Discussion

In this chapter, discourses are identified which arise from NFR situations where uncertainty, conflict and strong feelings exist. The most obvious evidence occurs in the stories of cardiac arrest situations where there is ambivalence about what should happen. Other situations are discussed where tension and opposition are more apparent than in the talk analysed in Chapter Six. The result is a collage of disorder and confusion with representation of widely varied results for individual patients and their families. Regarding CPR situations, a dying man had CPR imposed against the wishes of his family even though a written NFR order existed. In two other instances, the NFR status was uncertain but the patients endured prolonged resuscitation attempts. In these instances, staff were following the hospital policy of applying CPR where no NFR order exists. In yet another contrasting instance, the patient did not receive CPR and died because the policy specific to that area of the hospital was for NFR. A man collapsed outside the hospital, was revived, going on to have a very low quality of life. The young staff nurse describes the awfulness of the CPR experience for the patient, 'they look really scared'. In the midst of all this, a Medical Consultant proposes that documentation of NFR status is unnecessary while conceding that the others may believe differently. These apparently contradictory discourses are contrasted with instances of clear NFR social practices, such as the story of a consensus decision in a cardiac arrest situation. The Enrolled Nurse, the staff member with the least responsibility of all the research participants, holds the most unambiguous position on CPR.

Language in words and phrases

As in Chapter Six, words were used to indicate anger, 'Where it all turned to shit'. In contrast, a satisfactory situation produced talk of happiness. There was also, as in the previous chapter, the utilisation of quite dramatic language, particularly in talking up patient advocacy, 'It was not abandonment'. Once again strong language is used to express frustration and grief. 'It was awful' was language used to describe a CPR situation and an NFR decision-making situation. The word 'horrible' features again and again. There was a varied use of personal pronouns. 'We' might refer to the speaker, or to every member of staff. 'They' features when the patient was being referred to and when medical staff were being referred to. Most notably the Nurse Consultant and the Cardiac Education Co-ordinator use the passive voice. Other participants use the personal pronoun 'I' throughout. This suggests a greater ownership of their talk.

What is consistent throughout both everyday social practice and crisis practice is the use by nursing speakers, of semi-coded slang terminology like 'knocked off', and, more euphemistically, 'mentally there was not much happening'. 'All the clobber', the chest filled up', 'everyone is happy', 'what some twit does'. An interesting question is whether these terms are used to make the language and meaning more accessible to the listener or not. NFR codes like, 'taking a teabreak' and 'just walk', suggest secrecy and revealing meaning to a select few. On the other hand, using the kind of popular slang quoted above, it seems as if nurses are seeking to make a link between their professional talk and the everyday language of the general public. By doing this, they may be seeking to democratise nursing discourse. The result is a contradictory situation, at least in the field of NFR; some aspects of nursing social practice aim at inclusion of others, some others aim at exclusion.

Language specifically promoting patient advocacy and the good of the patient is absent in these extracts. It could be that patient advocacy is a present but silent discourse, in that it is only ever expressed indirectly if at all. What is consistent throughout everyday practice and crisis practice are differing representations of participants' power to determine what happens to their patients. What is distinct about crisis practice is the frustration of not being able to secure the good of the patient. The next section examines this from different disciplinary positions.

Evidence of dominance of any individual disciplinary discourse

Everyday practice was characterised by relatively stable, cohesive but open medical discourses. But the reverse could also be argued; that where medical discourses were cohesive, stable but open, everyday practices occur. Do NFR crises occur, because there are no unifying and stabilising NFR discourses? Or do lack of clarity and disunity in disciplinary discourses result in NFR crises?

This chapter has shown that in the power to determine what happened to patients in an NFR situation, only the positions at medical consultant level remain assured and one of those was seriously challenged by a family member rather than a representative of another discipline. The Medical Consultant Kate reserves the right to assert: "'But being who we are, we would not have done things that were inappropriate". Likewise, the other Medical Consultant, Jim, asserts confidently his right not to document an NFR order. Yet, there is evidence here of the dire consequences of NFR orders not being documented. He, himself, refers to the Charge Nurse's different position on this. The Charge Nurse contradicts this position: 'our actions, our treatments and our words, the manner we convey - they all have to add up to the same thing.' The power to determine what happens to patients regarding NFR apparently continues to be claimed by senior medical staff. At all other levels, those of the Medical Registrar, Nurse Consultant, Charge Nurse, House Surgeon, Staff Nurses and CPR Education Co-ordinator and Enrolled Nurse, power is dispersed. This is evidenced by participants' expressions of anger, uncertainty regarding authority, outright distress, regret, accusation and frustration. So, in times of crisis, there is a polarisation effect between senior medical power, junior medical positions and other disciplines. Nevertheless, it needs to be restated that, throughout all kinds of NFR practice, what all positions have in common is a commitment, both stated and implicit, both spoken and silent, to the good of the patient expressed as patient advocacy.

What the evidence in this chapter also shows, is that a discourse that is identified in the context of everyday practice, also asserts itself in times of crisis, that is, the voice of patients and even more assertively, the voices of families. In so doing, this discourse inserts itself in the gap between senior medical power and that of less traditionally powerful positions. The result, therefore, in spite of all of this chaos and grief is a chance for new NFR discourses to emerge, that are constructed by the talk of patients and their families. This is an opportunity for the construction of a new NFR knowledge that may have the effect of resolving some of the dilemmas spoken of here.

Ideological positioning in the wider ideological context.

As in Chapter Six, two particular ideological positions are apparent in NFR crisis situations: a professional position on death and a professional position on patient and family voice. The analysis in this chapter suggests considerable ambiguity regarding the determination of events at the end of patients' lives. This leads to the question of whether the way that health professionals talk about their NFR practice, is a reflection of their fear of death. If this is so, to what extent does this fear reflect the wider ideological impetus that death can be delayed by intervention. How might that influence their NFR practice?

On the one hand, professionals talk about their responsibility to save lives. On the other hand, they also address the futility of an attempt to resuscitate patients when the procedure will not be successful. The question that arises here is whether the uncertainty in CPR events is commensurate with a reduction and dispersal of professional power. Regarding the opening up of CPR discourse to include patient and family discourse, might the consequence be that patients can and should negotiate consent to be resuscitated?

Summary

The aim of Chapter Seven has been to examine situations of urgency and immediacy regarding cardiac arrest situations and situations of NFR conflict to ascertain whether these more extensively rearrange NFR discourses and therefore expose new ways of constructing NFR knowledge. It is asserted that talk about these situations is likely to reveal new NFR discourses and therefore new ways of constructing NFR knowledge. It is acknowledged that the separation of everyday and crisis NFR talk was a somewhat arbitrary one in the study. The analysis of everyday practice in Chapter Six showed that new discourses could emerge in everyday practice. Chapter Seven shows that NFR discourses in times of crisis can reflect traditional hierarchies of NFR knowledge.

The staff discourses are a collage of disorder, confusion, distress and uncertainty regarding NFR. Their practice can range from a clear and knowing breach of the relevant NFR policy to unthinking compliance. It is clear that, whether the situation is an everyday one or a crisis, staff will take different positions of power and knowledge on NFR and resuscitation. The most secure power position at times of crisis is the senior medical NFR discourse whether it is situated in the ward Medical Consultant distancing himself from NFR policies or in the Medical Consultant with Professional Advisory Committee responsibilities, committing herself and her staff to total compliance with NFR policies. All other staff, in times of crisis, report a dispersal of their professional power. The language that constructs this dispersal is emotive and extreme, resulting in an NFR discourse of staff anger and distress and patient suffering.

Chapter Seven revealed that there is a professional position on death and on patient and family voice. There is a possibility that the uncertainty of NFR events in the institution may allow for the emergence of new more co-operative and inclusive NFR discourses that incorporates patients and families in a more certain and less ambiguous way. Chapter Eight shifts the focus to the talk of those people who are not at the patient's bedside. They work at policy and management level in the institution. Institutional social practices regarding NFR are highlighted and the ideological effects of identified discourses are explored.

CHAPTER EIGHT
THE INSTITUTION TALKS NFR

Introduction

The previous two chapters identified NFR policy and practice talk as they were represented primarily from participants' experiences in their practice environment. Chapters Six and Seven reveal that NFR policy and practice talk, structures NFR events ranging from orderly to chaotic. The NFR talk examined in this study so far shows that the medical discipline is prominent and, at times of conflict and disorder, it is the most coherent discipline. In considered and deliberative times, both medicine and nursing exhibit overtly powerful discourses that determine what happens to patients regarding NFR. Nursing discourses also exert covert power. There is evidence too of potentially powerful discourse positions for patient, or consumer and family. This is in keeping with wider societal ideas about death including fear of death, notions of individualism and the voice of consumers and their families in health care decision-making. Although the social reality for patients apparent in everyday and crisis NFR talk is very sobering, this is not the primary focus of the study. It appears, to paraphrase Scott (1987), that silent and routine violence is one way our institutions and NFR discourses are made, in spite of the patient advocacy rhetoric. Against this though, run two discourses that suggest possibilities of an alternative to the violence of NFR and CPR practices cited in the previous two chapters. The first of these possibilities is the flexibility observed in the NFR discourses of the nurses and doctors who were prepared to lay their practices open and negotiate with others towards a consensus. The second possibility is that patient and their family discourses contribute to that consensus.

The aim of Chapter Eight is to surface discourses addressing NFR policy in the institution as a whole for their exposition of everyday practice and for any disruptions or points of disagreement. In particular, NFR practices and disruptions that intersect with, and possibly interrupt, clinical NFR practices are of interest. What follows is an illumination of this talk as it is relevant to NFR policies and practices and as spoken by representatives of the three different areas of NFR institutional policy. First the Regional Health Authority level, as practised by the Regional Ethics Committee, is analysed. Then the Professional Advisory Committee area of policy development is considered. Finally, the focus turns to the areas where the policies are implemented. As previously, each of these areas will be analysed for three different levels of discourse. The texts are then examined for individual words or phrases that are distinctive and that indicate how the speakers organise texts to achieve a particular effect. The texts are then read for evidence of the dominance of any individual disciplinary discourse and finally, they are read for evidence of ideological positioning in the wider social context. Each of the organisational structures referred to below can be identified in the section in Chapter Four detailing the research site.

Bioethics

First, the discourses of institutional policy development are examined through the talk of the Regional Ethics Committee, represented by the Chairperson. The relative power of the committee regarding NFR is illustrated in the Chairperson's description of the function of the Ethics Committee:

> Can you explain to me the functions and responsibilities of the Chairperson of the Committee?
>
> *I think it's important that you acknowledge that there are different models of the administration of the Ethics Committee throughout the country because our committee has been fortunate that we've been able to run a part-time office and that the Chairperson is available for consultation with health professionals and this is mostly the following up of health research proposals*

> *that have been before the committee, but as Chair of the committee, I've also been invited to clinical meetings to discuss ethical aspects of a particular case presentation. I've been consulted on at least two occasions, maybe three, by doctors regarding implementation of 'do not resuscitate' orders - do you prefer 'no CPR' - I know that's the way we are heading?*
>
> *What we've found... is that there's also a number of nurses within the hospital who have often from time to time obtained copies of our guidelines that we drew up in the area, although I have to say, I've had less discussion with the nurses than I have with the doctors. I am aware that from time to time, people have come to us, knowing that we hold guidelines and also literature and articles and things like this on these topics, so it gives something for people to sort of get their teeth into and have a think about... (Sarah, EC, A, pp. 2 - 3).*

Here, there is reference to a change in the terminology of the key research focus, NFR. The Chairperson's question regarding a possible preference of no - CPR indicates a shift in the terminology evident in the published research available at the time of the data collection process (see, e.g., Wenger, Pearson, Desmond, Brook & Kahn, 1995; Taylor, Ramsay, Parker & Peart, 1996). This is in keeping with the terminology employed by the policy published by the Ethics Committee in their policy published two years prior to the data collection and the revised version (No-CPR) published after the data collection was completed. Subsequently, the Ethics Committee Chairperson also uses the term 'do not resuscitate' order or DNR.

The powerful position of the medical profession in clinical decision - making is acknowledged through the language of involvement in case presentations by invitation only. Presence at clinical presentations is not considered to be an automatic right. The Chairperson reports that on two or three occasions doctors have consulted the Ethics Committee about NFR issues. This does not necessarily mean that the doctors were aware of the existence of an Ethics Committee NFR policy. Nurses have also approached the Ethics Committee, specifically to obtain the guidelines. The question arises, were those nurses aware that the hospital had a separate set of guidelines? Later in the same conversation, this question is addressed:

> Have you got any idea of why they were making that inquiry [with respect to the NFR policy and guidelines], what they were going to use it for?
>
> *As a result of either clinical meetings on the ward and people being unsure about what the general policy was or individual clinical situations.*
>
> So they were seeking some answers to some questions, which may have arisen from a situation with different points of view?
>
> *And of course the policy doesn't provide the answers but it sets the framework, that's the general idea of ethical discussion. (Sarah, EC, A, p. 6)*

The Chairperson portrays the role and position of the committee as a resource for clinical staff, so that they can think more deeply about NFR and other issues within an ethical framework. She goes on to elaborate:

> *I think the true value of the ethics committee having a role here is that our prime focus is the ethics, the actual moral dilemmas, in the moral moment as it were in looking at these situations. The background to that, the layer underneath that of course are the legal issues for example. Who takes responsibility? Is it the consultant that ultimately calls the shots if someone doesn't have the capacity in a certain situation in terms of 'do not resuscitate' or the decision-making in terms of whether a 'do not resuscitate' order might be implemented. And of course what the research is also showing is that nine times out of ten, that's not an accurate figure, but of course you've got to go to the heart of the matter as to whether or not the issue has been raised with the patients in the first place. I think what the research is going to show is that a lot of the times, they haven't discussed it with their consultants or the nursing staff on the ward. So my point here is that it attempts to put in some ethical discussion whereas, my observation of the policies being implemented by the CHEs, those being the only ones that I've seen so far have much more risk management, legal focus i.e. what are the legal requirements for staff, what are they required to put in their notes, what are they required to have signed if they need a 'do not resuscitate' order and basically if there's any questions about a given situation, what should staff have done in terms of meeting or ensuring that... basically protecting the liability of the individual health professionals and the institutions they work for. It's an understandable approach. (Sarah, EC, A, p.7)*

In the above excerpt, Sarah's discourse represents a distinction between the Ethics Committee's discourses and the discourses of institutional policies with regard to NFR and 'other important moral issues'. She places the institutional policies within the field of risk management, incorporating legal discourses. This suggests that, in the view of the Ethics Committee Chairperson, NFR policies within the hospital are designed more to protect the organisation and its staff than to present the consumer with the possibility of decisions based on informed consent.

The Ethics Committee Chairperson argues that a consultative and co-operative discourse, involving a partnership with clinical and managerial personnel, is the most desirable one:

> *I think no CPR is an area where there's such a range of situations and scenarios that I think ethical discussion's more important than setting out too many black and white rules about it.*
>
> So does that mean that you're saying that NFR decision-making sits more comfortably in ethics discourse than in a legal framework?
>
> *Yes, I think so, because it seems to me, of my observations and the feedback that I've got from clinicians and by clinicians I mean, not only the responsible consultant who ultimately has some legal control over the situation, but nurse clinicians as well have is that there's a lot of judgement calls that are made about the appropriateness of a) discussing the patient in the first place, and b) how that discussion's going to take place and who's involved in that discussion in terms of family members and all the dynamics that go with family and next of kin. (Sarah, EC, B, p. 11)*

In the context of power relations, the researcher asked the Ethics Committee Chairperson who she considered to be the most powerful person in NFR decision-making. She responded:

> *Could you define what you mean by power?*
>
> I suppose a short, brief way of describing it is the ability to influence what happens.
>
> *It is essentially the doctor who is the one that is left to make the decision that would be assumed that the doctor has more power than a nurse. But I think that would very much depend on the dynamics of the particular health care team. I'm sure there are experienced nurses out there who are either relied upon by the doctors that they work with or... and I don't mean this in*

> *a derogatory way but manipulate the situation, that they assume certain areas of control or responsibility for. So I imagine to some extent there would be a spectrum of situations, but it's all right to think that health care teams operate as such, as a team. It might be interesting to follow the age dynamics of... you know if you're dealing with doctors who are in their 50s and 60s as opposed to a registrar that's just completed their training in their 30s, whether that has a bearing on it. And I suppose the other aspect of this is the gender issue, with there now being more women doctors that are coming through. I don't want to make any generalisations, I've got no idea, but whether or not they're either more comfortable with the nursing staff that they're working with or feel that they can share the decision-making out I don't know*
>
> *We're seeing that vast numbers of patients never even get to know that this is an issue. I mean I just don't think that in reality the patient is... ultimately the decision is raised with them, you know, if they're competent and obviously have the capacity to make a decision, I would hope that they would have some power in the decision-making. But even that is so strongly influenced by the medical and clinical practice around them ... I understood your question was in relation to professional power, to make decisions. (Sarah, EC, B, p. 13)*

The Ethics Committee Chairperson's language is rather tentative and conciliatory. For example, 'I think sometimes there's a bit of confusion', 'I don't want to make any generalisations, I've got no idea, but whether or not they're either more comfortable with the nursing staff that they're working with or feel that they can share the decision-making out I don't know.'

Here, the complexity of NFR decision-making is acknowledged and some recognition is given to the possibility that decision-making may be conducted in a covert rather than overt way. The primacy of patient discourses in NFR decision making is proposed as the most in keeping with bioethics discourses and therefore most desirable. In this excerpt, bioethics discourses are considered by the Ethics Committee Chairperson to be in competition with medical and nursing discourses. A power differential between nursing and medical NFR discourses is also acknowledged.

The background of the existing Ethics Committee NFR Guidelines/Policy is offered:

> *I'd only just joined the Committee when this guideline was implemented, but I was involved with the final stages and the former Chairperson of the Ethics Committee, took on the task first of all. There were a number of incidents that led to some discussion among clinicians around the hospital, about the benefit of having some guidelines for some staff, particularly junior staff looking at 'do not resuscitate' policy and having some form of guidance and as a result of that, the Chairperson drew up these guidelines. These were discussed with the Ethics Committee along the way. The guidelines were circulated quite widely within the hospital at the time and there was quite a bit of discussion about them, but ultimately, so I understand it, these were put in place and they were guidelines and never intended to be anything else, and because at that time, it was the Area Health Board, it was interesting actually, the Chief Executive endorsed the guidelines . ... The clinical staff were sent the draft. The draft guidelines were sent out for discussion. But what was interesting was that the Area Health Board signed it off as a guideline that had been promulgated by the Ethics Committee... I remember walking along the corridors of the hospital and seeing it up on notice boards. We have had a number of inquiries for a copy of the policy. (Sarah, EC, A, p. 4)*

The Ethics Committee Chairperson was aware that the research hospital had a NFR policy developed separately and independently from the one promulgated by the Committee:

> *I am aware for example that there is a 'do not resuscitate' policy in the staff manual, but we've been consulted quite separately by another CHE within the region because presumably they just don't have the resources to go around spending lots of time writing guidelines. So I think this is quite confusing for the health professional out there at the coalface because when seeking guidance on these matters, and it's important that they do seek guidance, and feel comfortable about doing that, I think sometimes there's a bit of confusion as to policies and guidelines that they're being asked to follow.*
>
> Yes, and I guess...it is efficient, I use that word in terms of best use of time and resources, to have guidelines that are common throughout the region. You'd think it would make sense to co-operate to develop them.
>
> *It goes more than that I mean surely this should be... I would like to see the National Ethics Committee actually doing this and I have discussed that with members of the National Ethics Committee. (Sarah, EC, A, p. 7)*

Here, the Chairperson is referring to the discourse of managed competition that dominated health service funding and delivery. The above representations of bioethics discourses in the context of the Health Funding Authority-funded

Ethics Committee suggests a rhetoric of co-operation and collaboration regarding NFR decision-making through the device of NFR guidelines for staff in the institutions with which the Committee has a working relationship. On the other hand, the talk of the Ethics Committee Chairperson indicates some ambiguity in that against the argument supporting a partnership approach there are references to competing NFR discourses. The Chairperson's position is that many competent patients do not get the opportunity to participate in NFR decision-making, the inference being that nursing and medical staff claim professional power by making those decisions instead. What the Ethics Committee Chairperson's talk reveals is that patient rights to participation in NFR decision-making is considered to be synonymous with the pre-eminent positioning of the bioethics discourse. It is reasonable then, to suggest that in the excerpts above, medical and nursing discourses are represented as primarily aiming at professional power rather than patient participation in decision-making. In other words, the talk of the Ethics Committee Chairperson positions bioethics as a morally superior discourse to that of medicine or nursing because the bioethical position more clearly supports the inclusion of the patient voice in NFR decision-making.

Following on from the reference to the National Ethics Committee, the Chairperson for the Ethics Committee proposes that:

> *Legislation can be helpful I believe, in providing a framework for ethics committees to operate under because it's quite a quagmire of interrelationships between committees that form the basis, the structure of ethical review of any research in New Zealand. So I would like to see some legislation which recognises the framework and our interrelationships with other bodies. There is only one piece of legislation currently that sets up the National Advisory Committee on Health and Disability Service Ethics, otherwise known as NACHDE, the acronym, which is an advisory committee to the Minister and that's under the Health and Disability Services Act, 1993. So it came in with the health reforms although the Committee wasn't set up until two years later and I think it's not actually set out to be a National Ethics Committee for a local committee like us. My criticism of its set up is it was really set up as an advisory committee to the Minister of Health. (Sarah, EC, B, p.1)*

The plea for a legislative framework was answered in the most recent changes in health legislation in the Public Health and Disability Services Act 2000. The National Guidelines for Ethics Committees (1996) remain largely unchanged (Cole, personal communication, 2000):

> *The national standard now recognises that under matters for ethical review we have a clear brief or jurisdiction to cover health and disability research, but also the national standard now recognises that ethics committees have a role in giving advice on a wide range of ethical issues. So for example, in service.... or what they call service delivery matters, it can be in a sense clinical ethics, or it can be policy. (Sarah, EC, B, p. 4)*

In summary, the Ethics Committee discourse supports the values of co-operation and inclusion. It argues for the presence of these values across the board; from the clinical area in one hospital, to hospitals and health facilities throughout the region, to the Ethics Committee itself and to national legal and policy structures to support the function and purpose of the ethics committee. Some acknowledgment is made of the presence of conflict and disagreement, and the silence of patient discourses in NFR talk is raised. The right and responsibility of the Ethics Committee to write guidelines for clinical situations is a taken-for-granted. The Ethics Committee Chairperson is aware of the existence of the hospital NFR policy but asserts that there is a place for the Ethics Committees and even the national Ethics Committee to develop guidelines and policies separately. Some satisfaction is expressed that the national standard for ethics committees endorses that function. Some frustration is revealed in the perceived difficulty of operating in a competitive climate. It is worth noting that this sense of competition refers to health delivery systems rather than other ethics committees.

Resisting the Ethics Committee

In the following sections, the focus is on the other elements of institutional NFR policy discourses. Some of these indicate particular positions with regard to the Ethics Committee and its work regarding NFR policies and these will be highlighted where appropriate. My attention now turns to the second area of policy to be examined that produced by the Professional Advisory Committee in the CHE. The Chairperson of the Professional Advisory Committee was asked how the CHE hospital NFR policy originated:

> *The Professional Advisory Committee took the high ground and said "We believe we need a CPR policy for this institution", and got hold of a legal advisor and a whole lot of literature and talked to miles of people, drew the thing up and passed it all around and published one. We put it into the manual and got around to the whole hospital and we were quite sure that it was within the informed consent and every other policy that we were supposed to have. Then about, I don't know, 12 months ago, the Chairperson of the Ethics Committee sent me a note saying that by this time she'd established who I was and she sent me a note saying that the Ethics Committee wished to draw up a CPR policy for the CHE. So I wrote to her and said 'Excuse me but we already have one in place, we've taken legal advice, we've got all this going on, we've now got it to a point where it's in the Policy and Procedures Manual, we've invited individual units to query it if they absolutely have to, or to change the implementation details if they absolutely have to, like our own. I sent her a copy of ours and said, 'I don't see that it's very useful for you to re-invent the wheel', which of course was not... she was very unhappy about that.... I find it difficult that she would not accept that we have done what has been a very carefully worked out document, well recognised by a legal law. (Kate, AG, A, p. 16)*

The first conversation with Kate occurred after the workshop called by the Ethics Committee to consult regarding the revised Ethics Committee NFR policy. This above position is reiterated:

> *I suppose I get irritable actually that I see a group of people dabbling in what I think is inappropriate. I think that they have a role to make sure we have a policy and a role to make sure that the policy that we have in place is sustainable, both in legal and clinical terms. Beyond that I don't see that they have a role because then it becomes an operational matter and I don't believe that the Ethics Committee has a role in operational matters. I feel quite strongly about that and I keep saying that to them. I don't think they hear what I'm saying. (Kate, AG, A, p. 27)*

Here speaks a discourse that is oppositional to the Ethics Committee discourse on NFR policy, in a health care delivery system where two distinct policies have been developed independently of each other. The above speaker couches the resistance to the Ethics Committee position in extravagant and dramatic terms, 'took the high ground', 'talked to miles of people', 'I don't see that it's very useful for you to re-invent the wheel', 'I get irritable', 'I don't think they hear what I am saying'. This is in considerable contrast to the Ethics Committee Chairperson's tentative and conciliatory language, as referred to previously.

The Nurse Consultant, Helen, described her position with regard to policy making as follows:

> *I believe my skill... lies in a breadth of view, a totally professional view, a very strong grounding in nursing which is immovable but... well it has a bottom line but is not intransigent if you know what I mean, so I can look at things from a variety of ways as long as in the end the best nursing care possible is provided and the patient has a good experience. I'm not committed to any one way of doing that and I have certain skills in terms of being able to get patient focused.*
>
> *I have that primary concern and involvement in clinical practice development - a lot to do with risk management and quality development. I'm a resource for anybody's particular needs in nursing. Lots of people use me for a variety of things and I'm quite useful for writing policies as well .(Helen, NC, A, pp. 2 - 3)*

'A totally professional view, a very strong grounding in nursing which is immovable', is a strong claim for a position as a professional leader. 'Lots of people use me for a variety of things and I'm quite useful for writing policies as well', is, on the other hand in keeping with the previously reported understated representation of the nurse consultant's expertise.

The Nurse Consultant is a member of the Professional Advisory Committee:

> *We essentially advise the General Manager about things clinical.... He never seeks our advice. We have concerns about that because there are quite a few things that go on that he could use this resource for. You see he set it up because he didn't have chief nursing and chief medical advisers, this was to replace that and provide a multi-disciplinary view of the whole picture..... He needed an identifiable medical person who would take on the responsibility of being that medical person in the legislation that you have to have. So the Chairperson of the Professional Advisory Committee also fulfils that function in the organisation but no one else does.... The major*

> *amount of work I have to say has been generated by the Nursing/Midwifery Practice Committee (of which the nurse consultant is a member) because for us, it's been terribly useful. We develop our policies and we get them ratified by the Professional Advisory Committee, not always without question, there's usually some rigorous questioning and remodelling and that then goes into the Policies and Procedures Manual. (Helen, NC, A, p. 16)*

What is notable about this representation is first, the stated distinction between how the Chief Executive Officer uses the Professional Advisory Committee and how members and other staff use it. Second, the nurse consultant enthusiastically regards the Professional Advisory Committee as a useful resource for the health care organisation at large, by providing the organisational authority to bring about documented policy improvements which are inserted into a policy and procedures manual, a red book, which is held in each of the clinical areas. The above talk illuminates the nurse consultant's position on the value of a forum to discuss, debate and create policy. Her talk indicates she sees the Professional Advisory Committee as an effective policy-making and approving mechanism. Helen's talk also suggests she is less certain about the universal implementation of the policies:

> *It's a really good thing for us. It gives legitimacy, which because of our absence of structural authority, would otherwise be absent. We could send out anything and say "here you are, here's our policy" but what might happen to it, we wouldn't have a clue. So at least we know that it's in that red book and some people do refer to them. We certainly do expect that it's part of everyone's orientation, but that depends - some people are more assiduous than others. (Helen, NC, A, p. 16)*

How the CHE NFR policy and guidelines originated

The nurse consultant had also been on a separate organisation-wide committee to set up the CHE policy and guidelines for writing NFR orders. This is the same policy to which Kate refers above. The impetus for writing these policy and guidelines had its origins in the draft Consumer Code of Rights circulated by the Health and Disability Commissioner in 1994. The right of patients to make treatment decisions in advance was one of the rights under discussion.

The Quality Improvement Facilitator of the CHE had become aware of problems in the documentation and the absence of documentation regarding NFR. An *ad hoc* group was set up to formulate NFR guidelines consisting of medical and nursing representatives, the Chairperson of the Professional Advisory Committee, a representative from the Maori Advisory Unit and the Quality Improvement Facilitator:

> *The ad hoc committee developed and those of us on the committee, we'd report back with our progress and then when it was complete, it came to the Professional Advisory Committee an....It got ratified.*
>
> And how does the Professional Advisory Committee know that it works?
>
> *That's the flaw... I was on, even before it got ratified, as to how we were actually going to inform people who were going to be affected by the implications it had for them and it was clear that... the only way we would be able to achieve any shift with the medical group, which was precisely what was needed, because the contentious thing is the gaining of the consent in such a way that true information has been shared, it has been heard and understood .... There was active opposition from one or two quite vociferous people who put pen to paper and that was really amazing because clearly the legal advisor had never had his opinion challenged in this way, it was quite illuminating.*
>
> *We knew that the only way that we would get anywhere, would be for the legal advisor to present this policy to the medical folk as many times as necessary, to ensure that all would have got it, and that never happened, it never happened at all. And while I keep on saying - we've got this policy but nobody knows about it unless... for example some of the Charge Nurses have seen it as a real support and they can go along and say "now come with me so and so" and they point out what it says and "you haven't done that have you now" and some of the doctors are really happy and say "oh, I've never seen this before" and so it goes on. So yes it has slipped ; there is not the person power to ensure that these things go on. Neither is there, generally speaking among the medical world, a commitment to it. Those people who are really committed in one way or another, they know they have to and so they either comply with the letter of the law or they think it's really a good thing and they talk with their patients and staff. They aren't the culprits - it's the ones who totally ignore it and still see themselves as the ultimate authority and who will choose to inform people of what they think they should know or not. (Helen, NC, A, p. 18)*

> Is there a system in place to review the policy?
>
> *No there isn't but I'm sure at some point, and I can't remember which committee, whether it's that committee, that we would all review policies annually. (Helen, NC, A, p. 26)*

What I have identified so far is that there are three distinct NFR policy texts in the CHE, with a potential to influence professional practice. The Ethics Committee Guidelines, the Professional Advisory Committee NFR policy and the British Geriatric Society Guidelines. As well, there are individual medical NFR practices occurring, independent of institution guidelines. Those that have worked on the provision of guidelines and policy do not know whether their policy is being utilised or not. Therefore they cannot know whether practice is influenced by NFR guidelines and policies or not. Chapters Six and Seven identified individual practices involving the use of codes, and other NFR practices indicating both co-operative and contesting discourses. This evidence may help explain the degree of uncertainty and disorder that the analysis established.

Resisting any, and all, NFR policies

Taking a position that precluded the necessity of a policy as a basis for practice could resist NFR policies. I asked the Medical Consultant working in the research ward about the NFR policies:

> *I couldn't tell you exactly what our policy was. My understanding of the practice is staff both nursing and medical staff are aware of the guidelines which is that one must have gained informed consent from the patient to have a CPR order and my understanding is that we are all aware of the guidelines, but that our practice is somewhat different. In that respect you could say we don't have a policy or you could say we don't have a formal policy or you could say we have a practical policy of a more different approach than the guidelines that have been produced.*
>
> And in fact if you interpret the term 'guideline' literally, that's okay isn't it. A guideline is but a guideline...
>
> *Well except when a guideline comes from the Ethical Committee, my view is that it has slightly more strength to it.*

> So you're talking about the Regional Ethics Committee guidelines?
>
> *Yes.*
>
> What about the hospital's?
>
> *My understanding is that is the hospital's guidelines and that is where I may be wrong.*
>
> There are two sets of documents.
>
> *I'm not sure which ones I'm actually referring to. My understanding was that they were the same and that one must get full consent if one wishes to do CPR and one must document that in the notes. (Jim, MC, A, p. 5)*

In Chapter Six it was made evident that the Medical Consultant's everyday NFR practice did not necessarily include discussion with a patient or the family if he considered it to be superfluous. This was in direct contrast to the everyday clinical practice of Kate, the other Medical Consultant and Advisory Group Chairperson. Kate claimed that it was clear to all of the staff in her area of responsibility what every patient's NFR status was. In Chapter Seven, Jim's preference for not documenting an NFR order is noted. Here, his lack of certainty regarding the existence and co-existence of the Ethics Committee guidelines and CHE-wide NFR policy is evident. Nevertheless, he is quite certain of his understanding that 'one must have gained informed consent from the patient to have a NFR order.' His statement 'and my understanding is that we are all aware of the guidelines, but that our practice is somewhat different' raises the possibility that he sees the policies as designed for somebody other than himself.

I was also interested to know what part an individual medical clinician might play in the development of institutional policies. I asked Jim:

> What part do you play in the construction of 'not for resuscitation' policies. We have discussed that in some respects, but is there anything you wanted to add? Do you have a role in any committees or consultative processes at institution level?

> *No I don't, not relating to this policy.*
>
> Right, so if the hospital's reviewing its NFR policy, how would that be implemented, are you aware of that, would you expect to be consulted?
>
> *I would like to be consulted but I would not expect to be consulted. Consultation isn't the major focus of this management.*
>
> Would you like to be consulted?
>
> *Absolutely. Yes I would.*
>
> On the other hand, it seems to me that you've indicated that there is a degree of clinical freedom in that there are no constraints as far as you are aware on your practice in the ward as a physician?
>
> *Yes, and that I appreciate, but I can appreciate that the senior management may wish to be more prescriptive if they consider they have a responsibility to ensure that certain practices don't happen in the hospital. I can envisage that they may well have a right to take a role that if a decision is to happen that they prescribe that these things cannot happen.*
>
> So there's a standardised practice for implementation of policies throughout the hospital?
>
> *Yes, but I would be concerned if they attempted to do so.*
>
> Why?
>
> *Because we have a prejudice that often clinical decisions that are made by management are not necessarily logical or reflect good clinical practice. (Jim, MC, A, p. 10)*

In spite of the use of the term 'prejudice', this comment signals a struggle for supremacy between the institutional discourses represented by such devices as policy documents, and clinical (medical) practice. The following excerpt from the conversation with the medical consultant represents a defence of his clinical practice

> *Obviously I'm concerned that our practices are somewhat different from our guidelines, as I've said to you because if the Ethical Committee has stated this is what is ethical and you do something else, I assume that that's unethical and that obviously is a concern to me and you know we obviously attempted to better our documentation. I think that we perform very well on the informed consent and management decisions and approaches and discussion of prognosis and I think we perform very very well in that regard but I think we are doing what we should in terms of documentation and notes, relating specifically to CPR, I think we don't read the guidelines: we*

> *reflect the spirit of the guidelines in our overall management. (Jim, MC, A, pp. 15 - 16).*

I asked the Resuscitation Education Coordinator:

> The (NFR) policy and guidelines that you mention, how did they arise?
>
> *I discussed it with a Nurse Consultant. She said that they had gone through the Professional Advisory Committee and that it was a big bone of contention - there was a lot of conflict about it and that's why they were like they were.*
>
> You mean very brief?
>
> *Yes, very brief. (Anne, REC, A, p. 15)*

The Resuscitation Education Co-ordinator told how she found out about the NFR policy:

> *It's in our Policy and Procedures manual, and in it is "Guidelines for the writing of 'do not resuscitate' or 'No CPR' orders'. So they are simply guidelines to the writing of them. And I'd say a very small proportion of nursing or medical staff actually know that they're there and that was highlighted in a small survey I did where the nursing staff did not know that they were there and even though they had been involved in perhaps 'do not resuscitate' orders before, very few actually use them as a guideline. It's simply guidelines to the writing of them and they're suitably shortened and vague and generic. Basically people will come to the decision themselves and it will be written in some sort of...*
>
> Medical staff?
>
> *Medical staff will hopefully in discussion with nurses, not always, in discussion with the person and it will be documented - but a lot of the time, it ill not be in any sort of standard format, because of lack of knowledge about the policy.*
>
> So are you saying that it's custom and practice within the institution, the way it's done will vary according to the area and the staff?
>
> *Yes. And how much input, how much experience different people have had. Generally once the orders are written, they're very clear and hopefully succinct because that leads to other conflict.*
>
> You mean if there's ambiguity?
>
> *Yes or if it's not written... there's often reluctance to actually document it so then you've got a problem with verbal orders. (Anne, REC, A, p. 15)*

Here, while the Resuscitation Education Co-ordinator represents herself as being concerned about problems that may occur if there is no documentation, Jim, the Medical Consultant, indicates that his own practice is not necessarily in keeping with the institutional policy requirements. His conversation indicates that he separates out his own authority and practice from those of more junior medical staff regarding NFR policy and protocol.

The ways that staff talked about the CHE and Ethics Committee Policy and Guidelines demonstrated both their attitudes towards the parties that produced the documents and the authority of the documents themselves. I asked the Resuscitation Education Co-ordinator:

> Are you familiar with the NFR policy and guidelines that were developed by this Regional Health Authority Ethics Committee? Have you seen those?
>
> *No... I'm probably vaguely aware that they're there but I certainly haven't seen them. (Anne, REC, A, p, 17)*

The Resuscitation Education Co-ordinator summed up the Professional Advisory Committee thus:

> What is the function of the Professional Advisory Committee and the level of authority it has in the institution?
>
> *I'm not even that sure myself. It's a representation of medical nursing and other clinical staff from throughout the health care organisation, who basically look at any clinical policies that come through and discuss them... so any clinical policies really tend to go through the Professional Advisory Committee...*
>
> So they have quite a clear role in the construction and implementation of policies?
>
> *Yes, the construction.. I don't know about the implementation, once they're there. Some people may view that book as another thing to blow dust off.*
>
> You mean the Policy and Procedures manual?
>
> *Yes.*
>
> What do you think the barriers are to being aware of the policies?

> *I think it's just a general lack of awareness of the relevance of the Policy and Procedures manual, that it's up there and everything - there's just this general lack of awareness about what is in it that may be relevant to us. Policies come in batches and I don't know whether they're necessarily disseminated. A lot falls on the Charge Nurse doesn't it, that a batch of new policies may arrive on his or her desk and whether they make their staff aware that we've got these new policies... I think we all have to take personal responsibility like everything else to glance through the Policy and Procedures manual and I make sure that because both the guidelines for management of chest pain, the CPR policy and the do not resuscitate policy are all in those manuals. (Anne, REC, A, p. 18)*

The effects of NFR policy silence

One of the effects of some staff not knowing of any NFR policies at all, is that, if discussion and conflict about resuscitation arises, efforts will be made to create something new. This was the case with another participant in the research. The service manager of cardiopulmonary and general medicine services. She was accountable to the General Manager of Medical and Surgical Services. She came from a health professional background and her previous place of employment had an institutional NFR policy (see Taylor et al, 1996). In the following excerpt, she remarks on the contrast in NFR practice between her previous workplace and the current situation:

> The previous CHE where you worked, I understand has a well-established 'not for resuscitation' policy set up or there certainly has been substantial research done there, can you recall... were you involved with that at all?
>
> *I wouldn't have been involved with setting it up, but as a health professional working on the wards, it was always very obvious when you had access to patient notes. There was a way of discreetly displaying it on the bed head, that this patient was not for resuscitation. I seem to remember that it was just a thing that hung there and it was just a coloured disc and that would signify, ... especially in long-term medical wards. You were sensitive when you talked to those people. In this hospital, there doesn't seem to be anything like it.*
>
> No?
>
> *And I have been involved...at another hospital within my area of responsibility where I've got two medical wards. One of the things that we've been discussing at monthly meetings is the establishment of a... I*

> *think they call it the 'not for resuscitation' policy, but there's been quite a lot of unhappiness about it from some of the clinicians I guess, some of the doctors are not happy to identify clearly those patients, but they have pushed it through and they have got a policy now.*
>
> And does that include some system of clearly indicating?
>
> *Yes, it's really only clearly indicated within the patient notes - there's a signed consent form on behalf of the patient that they are happy that with their condition that they're not for resuscitation. Some times I guess it's signed by someone who's a close relation.... There's no evidence I don't think on anyone's bed or anything like that so it would be purely for people who really knew the patient and it's in the patient's notes. (Lucy, SM, A, p. 2)*

The Service Manager's level of awareness with regard to the ethics committee guidelines and the Professional Advisory Committee policy and guidelines is apparent in the following conversation. A level of moral responsibility is reported through the involvement in an initiative at the secondary hospital:

> I wonder if you could just describe briefly for me the process of the policy development at the other hospital- who was involved in it?
>
> *Well I think it arose from an incident really where I think it had been something that obviously people had talked about for quite a while and that is the consultants and senior nursing staff and it was brought to a meeting that they would like to develop it and there had been an incident I think where a patient had obviously expressed a wish to the consultant, but when the event occurred, it was either at night or something and attempts were made to resuscitate this patient and as a result, the patient and the relatives... or the relatives were not particularly pleased because they felt... and so there was a lot of discussion that if we were going to keep faith with people, then we would need a better system than just the consultant knowing, because they're certainly not there 24 hours per day and so someone did volunteer to... it was a page really, I haven't got it here, I should have probably got it, but it was a page, like a consent form saying that the person had had a discussion and really did not want to be resuscitated and I think there was the patient's name, the consultant's name and I think there was a witness's name and there was lots of discussion as to where this would be kept and how everybody was going to know and I think it was decided it was kept right in front of the notes and I guess they were looking at being extremely sensitive because although notes are extremely... they're confidential documents and there's a lot of people in hospital who have access to those notes, so it has to be done in a sensitive manner. I mean you don't want a great big NFR sticker on the front of the patient's notes or anything like that because I think that someone, somewhere is going to make a comment on that, whether it's a medical student, but somebody's going to make an inappropriate comment and it has to be handled very sensitively. So there was lots of discussion around*

> *how it was going to be and it is just this one piece of paper and it's kept at the front of the notes and then it is really passed on by the nurses each shift.*
>
> *Yes. I'm not aware whether there's a policy at this hospital. I've never heard it discussed at a meeting.*
>
> You mean here?
>
> *Yes, whether there is actually a piece of paper that is used at this hospital or not. (Lucy, SM, A, pp. 5 - 7)*

I subsequently asked the Nurse Consultant whether she had been involved in the development of the policy referred to above:

> Have you been involved in the development of policy at another hospital within the CHE?
>
> *Which policy?*
>
> There's been an NFR policy developed at another hospital within the CHE in recent months.
>
> *Yeah. We don't know about that.*
>
> The Service Manager does.
>
> *The Service Manager?*
>
> Yes.
>
> *Why would they develop something, when there's one in the book (Policy and Procedures Manual)?*
> *(Helen, NC, A, p; 23)*

The Service Manager did not know about the existence of either the hospital or Ethics Committee policy. The initiative at the secondary hospital indicated that nobody there knew either. They started from scratch on the development of a new policy. Such duplication appears to work against the effectiveness of any policies presumed by policy groups or ethics committees to be relevant or effective.

My attention now turns to the speaker whose responsibility it is to enact the institutional policies in the medical ward, the Charge Nurse:

> How would a ward staff member know that there was a policy on CPR and not-for-resuscitation in the ward?
>
> *All my staff know that there is a policy on that because there's a company (CHE) policy on it now which is one of the good things about the new system that we're in that there's a Professional Advisory Committee which has a multi-disciplinary membership and which anybody really can put anything up to them and say 'Well we think this should be company policy' and like my staff... it's mainly the junior medical staff that I have to make sure that they understand.*
>
> House surgeons?
>
> *Yes, and registrars. They see themselves as being lone rangers, unconstrained by any institutional policies really. They can do what they like when they like.*
>
> What gives you that impression?
>
> *Well I suppose experience.*
>
> Can you give me some examples of that?
>
> *Oh yes. You can open the files and see 'not-for-resuscitation' written down and there'll be no indication as to what that means because to me 'not-for-resuscitation' can mean a myriad of things other than just cardio-pulmonary resuscitation at the agonal moment. (Isabel, WM, A, p. 21)*

'Lone rangers, unconstrained by any institutional policies' positions this speaker as closely aligned with 'the company' and the company's goals. Hence, anyone who does not conform with company guidelines is regarded as operating totally independently and without communicating with others. The Charge Nurse classifies medical registrars as 'junior' medical staff and it is her job to 'make sure that they understand' their responsibility to conform to the policies. As noted previously, the Charge Nurse speaks from the intersection between medical, nursing and managerial discourses here.

The theme of policy surveillance was followed up in the second conversation when I asked the Charge Nurse to comment on earlier claims:

Language in words and phrases

Language was used to align the speakers with particular disciplines and also revealed the relative authority that speakers granted themselves. Generally, in contrast with Chapters Six and Seven, words to denote extremes of emotion were absent. An exception was the talk of the Chairperson of the Professional Advisory Committee who expressed anger towards the Chairperson of the Ethics Committee. Speakers tended to be more certain and confident in their language use, the more aware they were of the existence of policies. For example, the medical consultant and the CPR Education Co-ordinator, became vague in their language when they were asked about the NFR policy, especially the Ethics Committee policy. Tentativeness was most apparent in the language of the Ethics Committee Chairperson and the Nurse Consultant. The certainty of the language or lack of it worked to increase or diminish the authority of the speaker. This tentativeness was not necessarily in keeping with the position of authority the speaker held in the institution.

Evidence of dominance of any individual disciplinary discourse

There was no evidence here of the dominance of one discipline regarding NFR policy texts. Rather, what became apparent was an unstable and distorted array of positions on NFR policy. Policy enthusiasm emerged from the lay/legal Ethics Committee position, from the nursing and medical positions in the Professional Advisory Committee (PAC) and from the Charge Nurse and management positions. The PAC Chairperson's enthusiasm was restricted to the Hospital NFR policy only and the Service Manager's enthusiasm was evident only in the development of a 'maverick' policy in one of the two other hospitals in the CHE. Wholesale resistance to the project of NFR policy development was attributed to the medical registrars, ‘the lone rangers’. The ward Medical Consultant was happy for there to be a policy but did not regard it as relevant to his own practice. The NFR hospital policy was represented as being unknown to nursing and medical staff. The Advisory Group Chairperson applied the British Geriatric Society Guidelines in her own area of policy and practice. Even though the Professional Advisory Committee seeks to promulgate NFR policy and guidelines that applied to all staff, their work is represented as a futile exercise because they don't know whether they are implemented. They are aware that some staff deliberately ignore the existence of policy and guidelines.

In summary, both the Ethics Committee NFR policy and guidelines and the policy generated by the Professional Advisory Committee, are represented by speakers as having a variety of effects in the institution. The effects range from full implementation to total ignorance about their existence. The authority of both committees appears to be questionable; their place in NFR social practice marginal and uncertain. These findings are in keeping with the findings presented in Chapter Seven. The consequences for patients are quite possibly also ambiguous and uncertain. The question arises of the possibility that the disorder apparent in everyday and crisis situations in clinical practice regarding NFR, either influences, or is influenced by, the degree of disorder identified in the policy processes which are the focus of this chapter. Opposition to particular NFR policy discourses resulted in the active silencing of NFR policy discourses in some cases through the assertion of staff members' individual practices, for example, Jim, the Medical Consultant or, in the case of the Professional Advisory Committee position, the silencing of one NFR discourse and the promotion of another. Another discourse that had the effect of silencing the policy discourses arose from the staff ignorance of the existence of any institutional NFR policies or guidelines.

Ideological positioning in the wider policy context

Participants representing themselves as patient interests and patient advocacy is less evident here than in the two previous chapters. The focus of this chapter points to the professional position on institutional policies in general and NFR institutional policies in particular. The institution was operating in a climate of severe cost constraint set up by the frameworks and infrastructures of the health reforms of the early nineties. Furthermore, the contractual arrangements at the time were contestable on the basis of cost and quality. Financial accountability mechanisms direct processes that develop, implement and evaluate policies for their efficiency and effectiveness. This chapter shows that NFR policies were set up but were not evaluated for their effectiveness in imposing order by the standardization of NFR social practices in the research institution. A significant question is; what effect does this have on patients and what effect does this have on the institution and its survival? Whose ideological interests are served by this situation? There is another prospect to be considered; the prospect that the absence of standardised practice of the institutional aspects of NFR policy does not necessarily lead to adverse consequences for patients or for the institution. These questions are explored further in Chapter Nine.

Summary

The aim of Chapter Eight is to surface discourses addressing NFR policy in the institution as a whole for their exposition of everyday practice and for any disruptions or points of disagreement. The second level of critical discourse analysis revealed fractured disciplinary discourses on NFR policies. Competing NFR policy discourses and the talk of those individuals who resisted policy discourses had the effect of silencing NFR policy. Certainly, they prevented the emergence of any coherent or cohesive NFR policy discourse. Those who aligned themselves most closely with the institutional project of NFR policy development and implementation were those whose responsibility it was to develop or implement NFR policies: the Ethics Committee, the Professional Advisory Committee and the person responsible for managing the ward, the Charge Nurse.

The NFR policy rhetoric of standardisation of practice throughout the institution has a very hollow ring when the above evidence is considered. The competing policy discourses revealed by this analysis help explain the wide variety of patient NFR experiences. The analysis conducted in this study has revealed that the disciplines of nursing and medicine and individual voices within them, appear to arrange themselves in a variety of ways, in NFR policy and practice talk. The ideological effect of the failure of NFR policies to impose order on NFR social practices in the research institution, remains uncertain. The task of Chapter Nine is to discuss the significance of these findings.

CHAPTER NINE

NFR TALK: MOVING POWER BY SILENCE AND VOICE

Introduction

Chapters Five to Eight presented a range of NFR discourses according to a reading and analysis of the talk generated by the twelve research participants and the researcher. Each chapter addressed one major contextual element of NFR: the positioning of the researcher; everyday practice of NFR events; moments of NFR/CPR crisis; and institutional NFR practices. Professional participants consistently represented themselves as advocates for patient concerns. The discourses of patients and their families were not directly investigated in this study, but professionals focused on them in their talk. There was evidence that patient and family discourses were part of the institution's social practices of NFR. Previously published research awards the greatest authority claims regarding NFR to medicine, because medical practitioners are seen to be the primary NFR decision-makers.

The aim of Chapter Nine is to present an argument based on the analysis of the previous four chapters. The argument is this: that NFR talk, as represented by the twelve positions at the research site, is a collage of speech and silence, which works to assert professional power and knowledge. There are four layers in the collage. The first layer is a layer of silence; nursing silence, collusion in the silence of others and medical silence. The next layer consists of a mixture of multidisciplinary silence and speech techniques. The third layer of the collage consists of consumer and family voices. The fourth and final layer is the CPR/NFR event, a rupture of speech and silence.

The first section of the chapter elaborates each layer of the collage. The implications for those who work in the area of NFR, for patients and their families are discussed.

The second section of the chapter discusses the construction of nursing knowledge. It is argued that nursing has a distinctively influential position in NFR talk, a position that is often hidden by nurses, by other professions or by patients. Recognition of the complex, sometimes contradictory nature of nursing talk regarding NFR is a prerequisite for a more comprehensive understanding of NFR events, including the influence that the discipline of nursing may have over them. The third section of the chapter identifies speech and silence techniques occurring at institutional level. This includes the impact that speech and silence have on the relationship between institutional policies and the clinical practices of individuals. The fourth and final section considers how the NFR social practices of speech and silence reflect the wider socioeconomic discourses on death at the beginning of the twenty-first century.

A collage of speech and silence

Nursing silence

Silence in professional discourses of death was discussed in Chapter Three. There, attention was drawn to the argument that historically, professional discourse excluded consumers or patients from knowledge and authority regarding their own deaths (Aries, 1981). In stark contrast, late modern professional discourses have changed, to the extent that consumers or patients could even be coerced into speaking about their own deaths (Walter, 1994). In this study of professional discourses of NFR practices, there emerged a discourse of silence that had as much power to influence events as a discourse of talk. The suppression of information regarding the death of a patient was an ideological technique employed by nurses in evidence of their authority. An illustration of this was provided by the very experienced nurse who talked of 'taking a teabreak' in order to delay passing on information about a patient's death until it was too late to intervene with CPR (Judith, Chapter Six). The same social practice of silence is implied in the Nurse Consultant's comment in Chapter Six that ‘the more knowledgeable staff’ would just let the patient die, and then call the doctor.

Yarling and McElmurry (1983) argue that both inexperienced and experienced nurses grant themselves the authority and responsibility to attempt to revive patients through CPR. This study suggests that experienced nurses are more likely than inexperienced nurses, to grant themselves the authority to make independent decisions about letting patients die without CPR intervention. Moreover, they do so in direct contradiction of institutional practice. They enact that decision through silence. This duplicitous social practice has been previously identified as ‘responsible subversion’ in which experienced nurses deliberately make decisions they consider to be moral, by flouting institutional policies (Hutchinson, 1990). Such practice is also a deliberate contestation of medical discourse regarding CPR and NFR.

Nursing discourses of silence around CPR/NFR are extremely powerful ideological techniques. Through silence, experienced nurses become expert witnesses to death; constructing their own form of NFR knowledge and authority. Nursing 'silence', enacted as 'a teabreak', constitutes a powerful disciplinary discourse because it is the primary professional influence in the death of some patients. It may also be regarded as a form of resistance against the dominance of medical and institutional discourses, which dictate, through medical orders and institutional policies, CPR intervention. In other words, nurses confront medical power with concealment. The confrontation is not a direct, spoken form of resistance. It is enacted by indirect, covert means.

Colluding in the silence of others

As would be expected, given the unstable and ever-changing aspects of NFR talk, nurses in the study were also involved in apparently collusive practices; they were complicit in a medical silence, which precluded the possibility of patients being aware of their own prognosis. The discourse expressed through collusion is identified and analysed in Chapter Six, when the Enrolled Nurse talks about a patient's real situation being withheld by nurses until the relevant doctor makes the decision to reveal all to the patient. Nurses suppress their own professional judgements regarding futility of treatment and concede to medical judgement regarding informing the patient. They go along with doctors' reluctance to admit that death is inevitable and participate in the administration of treatments even when they think the treatments will be futile. They keep this secret from the patient until the doctor brings it out into the open.

It is possible that some nurses do not initiate any negotiated discourse with doctors about whether and when the patient should be told that further treatment would be futile. Once the doctor admits to both the patient and the nurses that treatment is futile, the nurses proceed to speak about ways of dealing with the inevitable. The nurses wait until the doctor speaks. I suggest in the study that the Enrolled Nurse represented a delay in speaking out as much as keeping silent; a delay, which would possibly have had the effect of creating false impressions for the patient and family. The Enrolled Nurse's talk implicitly supports the value of coming out into the open and talking about what is really happening. This interpretation echoes the findings of Zerwekh's (1994) research in a Californian hospice setting, which suggests that nurses have a crucial role as truth tellers by encouraging patients to 'confront' their impending death. This finding is supported by a qualitative study of American critical care nurses who identified decision-making, education, information brokering and advocacy as requirements for nursing practice regarding NFR (Jezewski, Scherer, Miller & Battista, 1993).

Medical silence

The social practice of silence is confirmed in the study's findings regarding the NFR practices of the ward Medical Consultant, identified and analysed as everyday practice in Chapter Six. The Medical Consultant represents an argument for silence, rather than speaking up where he considers that speaking up would be likely to result in confusion in the patient and relatives. From his disciplinary position, applying CPR to a patient with heart failure and who was very elderly (90) did not make sense because CPR would not be effective in resuscitating the patient to any standard of quality of life. Therefore, speaking up about NFR, which the attending registrar proposed doing, was considered by the Medical Consultant to be inappropriate. The Medical Consultant's position is echoed in a study comparing British and American medical and nursing attitudes to resuscitation and autonomy, in which a British senior physician is reported as saying:

> I think there are some people who one is under no obligation to offer what is in essence a useless treatment. When you ask people (family), and if they say "no" they feel they have deprived their mom of something that could have been useful, then I think you put them under an unfair burden. (cited in Mello & Jenkinson, 1998, p. 419)

According to Mello and Jenkinson, both British and American physicians support autonomy but amongst British physicians this is less likely to extend to futile treatments. Their study shows that it is not common practice in either country to speak to patients about their resuscitation preferences (Mello & Jenkinson, 1998).

In this investigation, the Medical Consultant was arguing for a distinct kind of medical silence, a silence that allowed for the possibility of a patient not receiving resuscitation. This kind of silence prevents the possibility of specific informed consent by the patient for NFR. A number of studies indicate that the practice of maintaining medical silence by not communicating the decision to exclude the patient from resuscitation, to other staff through a written order, is an international problem (Aarons & Beeching, 1991; Arthur, Dorne, McHugh, Theewis & Welsh, 1994; Asplund & Britton, 1990; Cameron, 1997; Taylor, Ramsay, Parker, & Peart, 1996). On the other hand, there are surveys of patients that indicate that not all patients want to discuss NFR with their doctors (see, e.g., Bedell, Pelle, Maher & Cleary, 1986; Bruce-Jones, Roberts, Bowker & Cooney, 1996; Stolman, Gregory, Dunne & Levine, 1990). In the case of this study, the Medical Consultant's preference was to remain silent about NFR and CPR. The registrar's preference was to speak to the patient's family about it. The Medical Consultant intervened and spoke to the family himself to represent his views. The Medical Consultant's intervention could have been an attempt to reduce the contradiction between medical talk and silence, to overrule the registrar's talk and enact his more senior medical power.

The hierarchy of discourses within medicine has already been referred to in Chapter Seven, regarding an episode where CPR was initiated and then stopped. Certainly, the Medical Registrar remained silent about his knowledge of the likely futility of resuscitation because he did not see himself as an authoritative speaker of CPR/NFR discourse. He delayed speaking about his knowledge until someone with more authority, the crash team, could share the power that the knowledge provided. Nevertheless, he represented himself as being in a silent/powerless position precisely because NFR had not been spoken about earlier.

Invoking speech

In this study, persuading others to talk about NFR was a feature of a variety of professional discourses, including that of the researcher. In Chapter Six, the experienced Staff Nurse Judith, represented herself as a patient advocate who encouraged (or coerced) patients to speak about their fatigue and their wish for treatment to stop. A space was allowed for the patients to speak to the nurse, with the inference being that the patients were too afraid to speak directly to the relevant doctor. A result of such a conversation would be the approach to the medical staff by the Staff Nurse to echo the patient's words and advocate for the cessation of treatment and possibly an NFR order. It was implied here that patients, particularly older patients, were less likely to talk to a doctor than to a nurse. Yet major surveys of patients regarding end-of-life decision-making tend not to take that possibility into account (see e.g., Mead & Turnbull, 1995; Stolman, Gregory, Dunn & Levine, 1990; Slomka, 1992). These investigations focus on discussions between patients, families and physicians.

Nursing discourses spoken by Judith are represented by her as 'natural' discourses, ones that represent advocacy for patients, in patient language for example, 'being pushed along a path they don't want to go'. In contrast, she represents medical discourses as scientific, granted divine authority by the patient; discourses that pursue active treatment regardless of the patient's feelings. In this instance, nursing discourses speak into the silence by representing nurses as the health professionals most closely aligned with the patient and therefore supportive of patient autonomy. The test of the power and influence of nursing discourses are in the ability of the Staff Nurse to represent the patient's concerns and by so doing influence medical discourses to the extent that active treatment is stopped and an NFR order issued. This suggests too, that a new discourse comes into play, a patient discourse. Nursing discourses may allow the patient discourses to be heard. The openness of medical discourses then allows the entry of a patient discourse into medical discourses via nursing discourses. The entry of a new discourse into the contest to be heard suggests a form of resistance to existing ideological arrangements.

Coercion: Forced into speaking up

The House Surgeon's recollection of talking with a patient's family about NFR is discussed in Chapter Seven. He represents himself as an inexperienced practitioner with a responsibility ‘to work out what was best for the patient.’ He was coerced into speaking about NFR even though he had not previously met the patient or family. The House Surgeon also invoked the family's talk about it: ‘they knew from the word “go” what I was talking about’. Here, invoking speech regarding NFR, involves the coercive persuasion of a medical member of staff to raise the talk of NFR with patient and family. Albert, the House Surgeon, in a discussion of an event where he was asked to talk to a patient’s family, confessed, ‘It was awful’. His speech expresses concern for the patient and the family. The House Surgeon’s experience in this study illustrates the propensity for the task of breaking bad news to be delegated to a junior staff member (see Franks, 1997).

When a junior medical practitioner is coerced into speaking about NFR to a patient and their family, how is power being exercised? The Medical Registrar who issued the instructions, in this example, used his own silence as an ideological technique. In being forced to speak to the patient and family, the House Surgeon colluded with the registrar and submitted to his authority. By so doing, he acknowledged the power of the medical hierarchy but confessed to his own ignorance. Yet, the patient and family, in listening to the House Surgeon, submitted to his medical authority and by so doing assumed he had authority/knowledge about NFR.

Speaking up

In this study, 'speaking up' is a technique of power utilised by nurses, doctors, managers, policy makers and the Ethics Committee Chairperson. Here, the language of 'speaking up' to patients and to other staff in the clinical setting is discussed in relation to its potential to constitute a form of authority. An example is the experienced Staff Nurse's recollection of the way in which she first 'speaks up' to a patient, raising the issue of unwanted treatment. She implies that, having spoken with the patient, she then speaks up to the doctor about the cessation of treatment and the ordering of NFR. The CPR coordinator also strongly advocates the desirability of speaking up when she retells the narrative of the CPR event where the senior nurse speaks up but is not listened to (Chapter Seven). The Nurse Consultant portrays herself as having the task of speaking up to a Medical Registrar considering the appropriateness of resuscitation in the ward setting, even though she believes she has no power to intervene. The Charge Nurse represented herself as a significant speaker in the episode detailed in Chapter Six on everyday practices. The Medical Consultant, who also served in the role of Chairperson of the Professional Advisory Committee, when talking about clinical episodes of NFR, argues that speaking up is likely to lead to the reduction of ambiguity in clinical decision-making.

The discourses identified in this study fit with the arguments of Walter (1994) regarding shifts in authority in modern and neo-modern death. In modern death, authority comes from expertise; the expertise of the doctor and the nurse. In neo-modern death, however, the only authority is the person him-or herself, epitomised by the saying, 'I did it my way' even though the dying person may discover the way to die through others such as nurses or counsellors (Walter, 1994). The application of this typology to the instance referred to previously where the experienced Staff Nurse invokes patient speech about fatigue and wanting treatment to stop, leads to the conclusion that the patient was discovering, through the nurse, a way to die. It also suggests that, where this results in the nurse 'speaking up' to doctors, treatment being stopped and an NFR order being issued, the authority of experts is transferred from the nursing and medical staff to the patient: a 'patient NFR discourse'. The above discussion argues, then, that ideological techniques ranging from silence and concealment to speaking up are used in order to claim authority and that this authority may be medical, nursing, interdisciplinary or patient constituted.

Family NFR voice

As indicated previously, what was consistent throughout the NFR talk in this study was the rhetoric of working for the good of the patient, in the patient's interests and from a foundation of patient and family advocacy. In Chapter Seven the Medical Consultant (Chairperson of the Professional Advisory Committee), referred to a situation where there was a clear distinction between the discourses of a patient and the patient's husband. There was also conflict between the husband's position and the medical position. In this situation, the Medical Consultant represented herself very clearly as a patient advocate. This was the only instance in the research, where families were represented as adversaries. In contrast, in a 1999 study involving 42 interviews with legal counsel and clinical staff about end-of-life care problems, lack of consensus or agreement involving family members was reported to be the leading source of problems (Zuckerman (1999) cited in Levine & Zuckerman, (2000)). The latter study was conducted in New York state where there is specific legislation governing hospital responsibilities regarding NFR. This legal requirement may have been a factor in the way that legal counsel, in particular, regarded the families of patients.

On the other hand, there are now calls for the patient's family to be involved in the CPR event, for example, Brown (1989), who argues that, "relatives need to be told that it is OK to touch and speak with patients during resuscitation" (p. 6). Where family and patient interests compete or diverge, Levine and Zuckerman (2000) suggest an ethic of negotiation and accommodation. They refer to a distinction between patient interests and patient preferences:

> Where these basic interests are at stake, the physician's obligation is to respect patient choices. On the other hand, patient preferences include value-laden choices about the way in which these aspects of life are maintained or provided. In this context, family members' well being and vital interests also come into play. (Levine & Zuckerman, 2000, p. 15)

In the situation in this study, where the husband was insisting that his wife should be provided with an easy death, the husband's interests did not override the view of the Medical Consultant (Chairperson, Professional Advisory Committee). This suggests that the Medical Consultant was acting as a patient advocate in that Kate assumed that the patient would give her consent in retrospect, once she had recovered.

A rupture of speech and silence: The CPR event

The NFR social practices researched in this project cannot always be read in terms of whether they reflect discourses of either silence or speech. Particularly in representations of CPR events, there is a complicated mixture of speech supporting the speaker's own actions, speech on behalf of other professional discourses and patient discourses, silence aimed at protecting others, and invoking speech in others, either to protect oneself or others. There are representations of incidents of practice where a person collapses and there is silence about whether the person should receive resuscitation or not. There are some speech elements containing information that may contribute to a NFR decision, for example, age, gender, social support, medical condition, outlook or prognosis, but there is an absence of clearly spoken and written direction on NFR status.

In Chapter Seven, the Medical Registrar represented an indecisive CPR event as a regrettable situation brought about by the lack of clear leadership and direction. In this instance, CPR talk and action superseded NFR talk. There remained a silence regarding NFR because the 'worthlessness of the idea' of CPR had not been raised. It could be argued from this report of CPR situations that there is a contest between NFR talk and CPR talk in hospitals. This is reiterated in the Resuscitation Education Co-ordinator's talk, also in Chapter Seven, when she reports the silencing of the expert nurse and the effect that had on the procedure. The senior nurse's input into the talk around the CPR attempt was portrayed as being initially ineffective but eventually influential. This suggests that an incident where a person arrests in the hospital is quite likely to involve a mixture of CPR and NFR speech and silence from speakers of medicine and nursing discourses.

Several speakers in this research have identified CPR/NFR events as moments of crisis. The argument that crises can lead to the emergence of new discourses, if applied to the CPR event, suggests that this is where new, possibly more tolerant and accommodating CPR and NFR discourses arise. In this study, it appears that the rupture in language that occurs in disorderly CPR events has the opposite effect. It is more likely to be a time when techniques of speech and silence serve to reinforce the status quo. Nursing and medical discourses confront each other and there is a standoff. The disorderly nature of the event does not result in the establishment of new NFR or CPR discourses. In an orderly CPR event it is much more likely that there will be accommodation and tolerance between different disciplinary discourses. What emerges is a multidisciplinary CPR discourse.

In summary, out of the discourses of speech and silence there emerges a hierarchy of NFR power that does not fit with the published authority claims of individual disciplines. The texts generated by this research indicate that in the institution where the research was carried out, NFR authority arises from a number of different sources or discourses.

The construction of nursing knowledge regarding NFR

This section addresses the discursive practices of NFR in nursing, which indicate a sequestered, but nevertheless very influential, place in NFR social practices in the institution. The part that nursing discourses play at ward level and at institutional level, by silence, by speech, by the invocation of speech and by shifts between silence and speech in moments of crisis, possibly imbues more meaning into the institution's NFR social practices than any other disciplinary discourse. It is possible that nursing NFR discourses have most meaning to patients and their families because the nurse may be the first person that the patient and family talks to about NFR, but that question lies outside the scope of this study.

Discourse theorists argue that the most cohesive and coherent discourses are the most powerful (Fairclough, 1992; Foucault, 1977). Nursing discoursess regarding NFR events that have been surfaced in this study cannot be classified as cohesive and coherent. Rather, what is notable is the great variation in nursing discourses and the extent to which they overlap and intermingle with other discourses. There are three main effects of this. First, nursing social practices regarding NFR are wide-ranging. As a consequence, what happens to patients can depend on what nursing discourses they are exposed to. Secondly, others, individual nurses wield power both by remaining silent and through speaking out. In some cases, there may be delays in speaking out which may have undesirable effects on patients, but eventually talk will emerge. This variation in practice is not restricted to nurses. It also occurs among medical practitioners who may claim, as the Medical Registrar in this study did, that he could not speak out because it was not his responsibility to make the decision. Nor are such practices restricted to individual practitioners.

The influence of nursing discourses on other disciplinary discourses

The potential for nursing power and authority to influence other disciplines regarding NFR was most obvious in the claims of the Charge Nurse who represented herself as an effective operator in opening up the NFR discourses between nursing and medicine (see Chapter Six). It is significant that the young staff nurse sought her advice and the Charge Nurse advised her. The result was an engagement by the staff nurse in dialogue with the physician, resulting in the negotiation with him of a change in NFR practice. The role of the Charge Nurse in setting this situation up was presumably not made clear to the physician. The same participant also referred to her role in the general education and orientation of house surgeons and registrars new to her ward; a role in medical education that was possibly not always acknowledged.

The senior Staff Nurse's practice of 'taking a teabreak', in contrast, involved no negotiation with medical staff at all. The consequences for the patient, in that situation, were just as significant as they were for the patient in the incident reported by the Charge Nurse. It is possible that 'taking a teabreak' incidents may occur as a result of a breakdown in negotiations between nurses and medical staff. In both instances, nursing discourses assume priority over medical NFR discourses.

Institutional NFR policies: Spoken and silent

In this study, the positioning of participants within the organisation did not necessarily determine the position of their NFR knowledge and authority, even though the researcher's approach to conversations with the participants increased the likelihood of that happening. The NFR social practices of working secretly, keeping silent, concealing practices, speaking on behalf of others or invoking speech in others could not be linked in an orderly way to the position of individual speakers in the research. The NFR collage of speech and silence is evident both in the talk that participants reported they engaged in directly with patients and indirectly, through discourses occurring at institutional level. The collage is not an orderly temporal or spatial creation. Each social practice, for example, keeping a secret or coercing someone to talk, can be occurring concurrently with others.

A written NFR policy represents a generally orderly NFR social practice of speech and silence. This project showed that the written policy statements were not the dominant discourse in spite of their expressed purpose of standardising practice. Individual practitioners and policy advisors reported little knowledge of what their colleagues were doing and thinking. Their practices were based on a mixture of individual, disciplinary and institutional discourses of expertise and authority regarding NFR. Some practices conformed with ward and hospital policies, others digressed from them, either because of ignorance or deliberate usurpation by other discourses. Policy discourses within the institution did not acknowledge some of the discourses that were occurring in professional NFR practices. Professional and institutional efforts to standardise and supervise the practice of NFR were thwarted not only by the individual practices of speech and silence that resisted institutional policies but also by the multiplicity of institutional policies. This

Mello and Jenkinson's (1998) comparative study of British and American physicians and nurses showed that:

> Overall, the American nurses were far more familiar with their hospital's policy than the American physicians. Three of the ten physicians did not know that the hospital's policy existed. All seven nurses knew that patients were asked about advance directives when they were admitted, but five out of the ten physicians were quite surprised to learn this. (p. 421).

In this study, awareness of policies was higher in those who were involved in the development of NFR policy documents. In contrast to Mello and Jenkinson's (1998) findings, nurses in the study did not show a greater awareness of policies than doctors.

Society, death, autonomy and professional power

Informed consent has been promoted as an essential aspect of decision-making regarding NFR for those people capable of deciding about resuscitation (Miller, 1989). This pre-supposes that the principle of autonomy is paramount. This research does not confirm or deny that this is the case in the institution studied. It might be argued that staff resistance to institutional policies are occasions when professional autonomy is exercised. The techniques of silence through to speaking out against opposition could be seen to be ways in which staff effect professional autonomy. In this sense they are reflecting society's value on individualism and self-reliance. On the other hand, this research has shown indirectly, through the talk of the participants, that individual patients in the hospital may have varied NFR experiences, with varying degrees of personal autonomy. Does this mean that society's values of individualism and individual autonomy somehow do not apply to patients? If not, why not? This question requires further investigation. Now, I turn to the question that Walter individual autonomy somehow do not apply to patients? If not, why not? This question requires further investigation. Now, I turn to the question that Walter (1994) asks of people at the end of their lives, "Is it possible to accept death in a detraditionalised, secular, post-modern society?" (Walter, 1994, p.188).

The link between professional power and society

The relationship between social practices in hospital and social practices occurring in society at large, as indicated previously, are of relevance to this study, and "In respect of structural change, changes which appear to move across boundaries between institutional orders of discourse are of particular interest in their possible links to wider hegemonic projects" (Fairclough, 1995, p. 79). The focus in this research was on the social practices of NFR within a New Zealand health care institution. Of secondary interest was the possibility of the discourses within the institution having a connection with the ideological direction in the community at large. Of relevance are the values and beliefs about death and decision-making about death. The NFR professional discourses can be understood by their position on a grand trajectory from total professional control over knowledge of death to total consumer control over knowledge of death. There are two main conclusions supporting the idea of such a trajectory. The first is that speech and silence about facing death and regulating death are not necessarily in opposition. The second is that the decisions made about death that are reported in this study, do not necessarily reflect an increasing acceptance by professionals of consumer autonomy.

Summary

The argument in Chapter Nine asserts that new NFR discourses emerge from this study. They have the potential to transform NFR social practices. The NFR discourses are a collage of speech and silence techniques, which work to assert professional power. First, the chapter addresses the techniques that are used by control over NFR, or keeping secrets from patients and other staff. Silence can also be a form of concession. The invocation of speech was another form of the exercise of power as was enforced speaking. Some power remains with the existing prominent discourses; some power shifts to new locations, for example, to family members or patients themselves. The most disruptive NFR event identified in the study was the disorderly CPR/NFR event, which contained a mixture of speech and silence. Contrary to expectations, the disruptive nature of the disorderly CPR event did not result in the emergence of new NFR discourses. Rather, the orderly CPR event and everyday NFR practices in the ward were more likely than crisis NFR events, to surface new, accommodating and inclusive discourses.

NFR policies were also found to be disorderly. This disorder undoubtedly contributed to the disorderliness of NFR practices at the bedside. Among the policy disorder, however, there emerged individual social practices that constituted new NFR discourses. Some practices complied with institutional NFR policies, some ignored them, and some indicated total ignorance of their existence.

Chapter Nine also addresses specifically, the construction of nursing knowledge regarding NFR. There is a wide variation in nursing NFR social practices with a number of different effects on patients. The implications of the findings that nursing discourses have a previously concealed degree of influence on the NFR social practices of non-nurses were addressed. This was followed by a section discussing the significance of institutional NFR discourses, especially the written texts and their relationship with the discourses of the clinicians. The study points to nurses as powerful speakers of NFR truths and knowledge. Some nurses in the study enacted that power openly through talk involving such techniques as negotiation. Other nurses enacted that power by wielding it indirectly through secrets and feigned passivity, that is, by claiming they had no power over NFR events. This research suggests that the NFR knowledge constructed by nurses may result in a range of types of death experiences for patients. This point is merely a suggestion. A separate study is required to investigate if this is the case. Certainly, this study cannot claim that it is possible to predict with certainty whether a patient will be able to die according to his or her wishes. Whether patients die the way they want to, in any setting, may depend on the extent to which individual staff members can assert their professional power in an open and accommodating way.

The arguments referred to previously are but one reading of the research data. Other perspectives on the research questions and data may well give rise to distinctly different positions. With this conditional outlook in mind I proceed to the tenth and final chapter, which reports the research conclusions, reviews the research process and discusses future research possibilities.

CHAPTER TEN
REVIEW AND NEW DIRECTIONS

Introduction

Initial interest in this research arose from my curiosity about what really went on in NFR policy and practice. This chapter summarises the value of undertaking the study and what it has to offer those to whom NFR is pertinent. Chapter Ten begins with what the investigation revealed, detailing the foreground to the study and revisiting the aims of, and the justification for, the research. The research conclusions are stated and discussed. Then the research limitations are identified and the implications of the study discussed. What this study offers patients and families is included, as well as possible directions for health and policy researchers, nurses in practice, medical practitioners, policy advisors and managers of health care institutions, and ethics committees.

What the study revealed

Foreground

This inquiry was inspired primarily by a desire to understand and explain everyday language and events about not-for-resuscitation in a hospital. The origins of this curiosity were my observations of the considerable anger and distress regarding not-for-resuscitation among my nursing colleagues. My impression was that their anger and distress were based on the assumption that nurses understand patients' needs better than other health professionals but that they are frustrated by the power of others to make decisions regarding patient care. Specifically, nurse colleagues seem to believe that they are coerced into attempts at cardio-pulmonary resuscitation on patients who would certainly not benefit from such interventions. To a limited extent these observations are confirmed in scholarly nursing writing (Johnstone, 1999; Lessey, 1996; Yarling & McElmurry, 1983). A preliminary search of medical, sociological, bioethics and legal research findings failed to identify or acknowledge nursing distress. In some cases, nursing involvement was overlooked altogether (Slomka, 1992). Given that much of my colleagues' anger seemed to be directed towards medical staff it seemed that it would be useful to include doctors in an investigation into NFR events in a hospital, as well as other staff working in managerial and policy positions.

I believe that research based in social reality provides the possibility of greater understanding of, and improvements in, everyday practices within health care institutions. Critical discourse analysis was selected as the methodological approach because it appears to fit with current developments and directions in health care research methodologies. In investigating why there may be conflict between nursing practice and medical practice regarding NFR, it seemed reasonable to consider whether medical authority is greater then nursing authority. In *The Journal of Advanced Nursing*, Crowe (1998) asserts that:

> The language of authority is reproduced by a process in which individuals in society participate by adopting the same language to exhibit an alignment with the values of authority. In the process of competing for authority, discourses compete with each other to produce the most persuasive meaning to ensure continuance of particular power interests. (p. 339)

If this assertion is applied to nursing, medicine, and NFR discourses it could be assumed that they compete with one another for authority. As it happened, the data revealed a range of discourses regarding NFR policies and practice. These discourses represented knowledge claims, in particular, claims of authority that would determine what happened in NFR events. In this research the authority claims to NFR knowledge were not restricted to a dominant disciplinary discourse. They were scattered throughout nursing, medical, policy (including bioethics policy) and managerial discourses within the health care organisation in which data were collected.

With regard to NFR events, techniques of speech and silence were used to manage uncertainty and ambiguity but not always or necessarily to serve professional interests. What a post-structural approach has done for this research is to allow for the possibility that those who work in the health service do so to serve their own socio-political interests through occupational power, rather than to serve who they claim to serve: the patient. In the event, I developed a great respect for all of the participants in the research. I believe their readiness to be involved in the research was a reflection of their overall commitment to involve themselves in anything that might contribute to a better standard of patient care. They trusted me to deal with their contributions faithfully.

The aims of and justification for the research revisited

The aim of the research was to investigate the social practices of the construction and implementation of NFR policies in a general hospital through a critical analysis of the language used by those working in one medical ward, and those working at an institutional level in the same health care provider organisation. The Regional Ethics Committee which gave ethical advice to the health care organisation and which was funded by the Regional Health Authority was included through interviews with the Chairperson. Concurrent theoretical and methodological developments within the social sciences opened up the possibility and relevance of an investigation of everyday practices with a focus on language, not in the traditional linguistic sense, but in the sense of the use of language to determine and limit reality and action. My primary interest was in what NFR disciplinary discourses might be uncovered by a critical analysis of the talk of those involved in the social practices in the ward. I was also interested in what NFR disciplinary discourses might be uncovered by a critical analysis of the talk and texts of those involved in the social practices across the health care institution. Also of interest was the identification of a relationship between practice and institutional understandings and the wider socio-political context. The approach I took supported the idea that the language used in practice has a purpose in constructing a particular reality, which determines what happens and what does not happen regarding NFR policies and practices in the hospital.

At the outset of the research I was concerned about claims made by social scientists that the experience of the dying person in the late twentieth century was likely to be that of infantilisation; metaphorical and literal speechlessness (Madan, 1992). The inference was that health professionals were instrumental in silencing the patient. Theological comment suggested that the medicalisation of dying had resulted in death being considered a burdensome experience endured in emotional isolation (McCabe, 1994). The public sector reforms that occurred throughout the OECD countries in the 1980's and 1990's were significant with regard to the promotion of values like individual autonomy and self-reliance. I assumed that these ideas could also permeate views on health and illness, dying and death. Certainly, the extent and nature of the reforms of New Zealand health care institutions in the 1990's meant major changes occurred in the provision of health care during the course of the research. The justification for undertaking the research was borne out by the main conclusions of the research even when the limitations are taken into consideration. There are considerable implications arising from the research and possibilities for future directions, which will be addressed later in the chapter.

The research conclusions

The results of the critical analysis indicate that particular NFR social practices were revealed. A key finding, and one that justifies the approach taken, was the discovery that the talk of the researcher herself in conversations with the participants, was a source of repressive power. The effect of this was that those who held more authority and greater rank in the institution were given more opportunity to have their say than those in more junior positions. However, the construction of NFR knowledge in this study was not totally dominated by any one professional discipline. Professional power was exercised in both overt and covert ways. A range of discourses were utilised by doctors, nurses, managers, and policy advisors to exert authority around NFR. These techniques formed a collage in which there were several distinct features ranging from silence and the keeping of secrets to speaking up directly and persuading, and even coercing, others to speak.

Medical repositioning

The individual disciplines exhibited distinct positions. Senior (consultant level) medical disciplinary discourse dominated NFR events in times of crisis, when the senior medical discourse remained cohesive and coherent and therefore powerful. In crises, there was a polarisation effect between senior medical power and less senior medical positions and other disciplines. The positional power of all other professionals was dispersed by crisis situations. When NFR events went well and when there was time for deliberation and reflection there was a likelihood of the emergence of co-operative and accommodating discourses. The findings of this study suggest that some of the ways in which nurses exercise power over NFR are hidden from medical practitioners. This sequestration of nursing NFR knowledge must have an impact on medical NFR practice. If secret nursing practices were revealed to the relevant medical practitioners, there may be a greater opportunity for more open NFR discourses to develop.

Nursing repositioning

Nurses were more likely than other professionals to use colloquial language in their NFR talk as a form of persuasion and they were more likely to use codes to denote an NFR event. Their language was also more dramatic than that of other health professionals, with the exception of the Medical Consultant, Advisory Group Chairperson. Only one nurse, acting as a Charge Nurse, claimed overt power in NFR events. Overall, nurses hold the power to determine what happens to patients but some nurses make that power secret by either using power covertly or by claiming they do not have power. Nurses' NFR practices can have a major impact on patients' experience of dying and their preparation for death.

The earlier critical analysis of the published NFR commentary in Chapter Three and the analysis of nursing discourses in this study indicate that numerous nursing NFR discourses both at practice level and at policy level, remain hidden from policy makers and advisors. This silence is borne out in the revised Ethics Committee Guidelines (1997), which identified three central figures in NFR decision-making: the patient's doctor, the patient and the family/whanau (see Appendix E). Yet, this research revealed that nurses' involvement with patients and their families regarding NFR was significant. Furthermore, the doctors interviewed in the course of the project referred to the involvement of nurses in NFR decision-making processes. This research showed that nurses represented themselves strongly as practitioners in letting people die. An institution that continues to develop policies without taking this power into account will continue to promote covert nursing action or feigned powerlessness among nurses in relation to the process of dying.

Policy repositioning

The investigation of talk relating specifically to the three NFR policies relevant to the institution showed a significant degree of disorder. The contestability of NFR policy discourses was evident in the polarisation of professional positions; those that knew about and supported NFR policies, and those who did not know about them and who, in two cases, actively resisted their utilisation. What was evident throughout the study was the talk of patient NFR events that was wide ranging, from people dying the way they wished, to situations that were uncaring, disorderly and cruel for patients, staff and families. These findings are very sobering, given that the good of the patient and protecting patients' interests and family interests were central and recurring elements of the talk of participants.

It could be argued that policies in an institution may work best to support the institution's purposes when they impose just enough order to give staff guidance but not so much order that staff will ignore or disregard the policies' directions. In the event, the Ethics Committee's policy and guidelines and the hospital's NFR policy were largely ignored, knowingly or unknowingly, by most of the staff involved in the research. It could be argued that these NFR practices were facets of struggle to resist the institutional discourse on NFR and transform it into a more closely patient-aligned discourse. A much more likely explanation might be that NFR discourses in the institution are so diverse that it is difficult to discern the extent to which they affirm or deny patients' needs.

Patient repositioning

The discourses identified in this study reveal that the social practices in the ward and in the hospital ranged from total medical control over NFR decision-making to total patient or consumer control. An example of this is reported by Debbie, the Staff Nurse and Resuscitation Educator, in Chapter Six. The patient was reported to have said, 'I want an NFR order to be documented.' In other words, medical discourses of therapeutic privilege, that is, the maintenance of professional control of NFR possibilities, are present in some cases and represent a modernist practice of protecting patients from the reality of facing their own deaths. On the other hand, NFR practice in the researched ward also includes instances of 'dying my own way', where patients have control of the time and manner of their dying. It is not possible to predict from these findings whether patients making their own arrangements for their death will become a more widespread way for patients in the research ward to die. Whether it occurs or not, depends rather on a number of factors. Patients need to be aware that they are dying. Many patients have no idea that they are near death. Some patients may not wish to involve their families or staff.

Another factor must be the extent to which the health care institution has as its primary purpose the support of patient autonomy. If institutional NFR practices were designed and implemented around patients dying their own way, patients could anticipate their own death and organise, with assistance, how it might be. There is a potential for preparation for death to be sufficiently orderly to satisfy patients' and family needs. On the other hand, the patient may not want to plan or organise anything at all. If preparation for death was orderly for the patient, where possible, it is likely that staff might believe their work has some meaning and therefore be satisfying. It could be argued then, that the personal needs of the institution's patients are paramount; that the institution has been overturned.

Conversely, staff who believe that it is good for the patient to have an orderly death may well find themselves routinising patient care to the extent that the patient's wishes, for an unplanned approach for example, may well be overruled. The result is the usurping of patient autonomy by institutional and professional control. Fairclough (1992) is likewise suspicious:

> While democratisation of discourse and synthetic personalization can be linked to substantive democratisation in society, they are also arguably connected with marketization, and specifically with the apparent shift in power away from producers to consumers, which has been associated with consumerism and the new hegemonies it entails. (Fairclough, 1992, p. 99)

The application of these words to the research findings leads to the consideration that the institution would allow people to die in their own way as long as that does not override the goals of the institution. Fairclough goes on to raise the possibility, citing Jameson (1984), of the effect of marketisation resulting in the dedifferentiation of public and private worlds. He also raises the possibility of the resulting fragmentation of hitherto structured professional practices (Fairclough, 1992). According to this argument, people would be able to receive assistance to die their own way as long as they were prepared to be involved with health professionals, either in an institution or through visits to the home. The 'fragmentation of professional practices' alluded to above throws out another challenge to professions. It suggests that structured professional end-of-life practice is one aspect of routinisation of care; that it is one way for professions to maintain their power and status. Certainly, routine resuscitation in the absence of a patient-initiated NFR request could be seen in this light.

Repositioning autonomy, the market and society

The fragmentation of NFR discourses revealed in this study suggests a loss of medical power and an assertion of nursing and institutional power and by inference, an assertion of consumer power. Are all these reconfigurations of medical power an indication that medicine and its sphere of influence are now subject to the activities and movements of the market place? The findings of this research do not answer that question. Nevertheless, the degree of disorganisation in NFR practices that the research reveals suggests that Turner's (1992) contention that medical education and research needs to take a more interdisciplinary approach is worth considering. However, one of the risks of interdisciplinarity, Turner argues, is that there are unintended consequences in the organisation of research and teaching, which are brought about for reasons which are broadly economic rather than educational. In the context of this study I interpret this to mean, for example, that a medical school might extend their educational services to include a nursing school. Such a collaboration would not, however, be developed to enhance medical and nursing practice and support patients. Rather, it would be developed as a means of ensuring the financial survival of the educational institution, because an increase in the number of students would mean a greater income for the institution.

The freedom of individual autonomy in late capitalist societies is a false promise, at least to a substantial number of individuals. The talk of those involved in NFR policy development and implementation in one health care institution indicates that the promise of patients dying in their own way is quite a long way from fulfilment. The extent to which language practices that support patients dying in their own way resist and transform other practices will probably depend to some extent on the willingness of the institution to include patients and consumers into the development of their policies and practices. The means of doing that is worthy of a different investigation. To some extent, that possibility already exists because of the lay membership of Regional Ethics Committees.

Repositioning post-structural research

This research has demonstrated the usefulness of a post-structural approach to health research. It has done this by raising questions about the taken-for-granted principle in qualitative research that 'reality can be apprehended by capturing the individual's point of view and that this can be represented in language' (Crowe, 1998). The kind of reality addressed in this research takes into account the social elements of reality, including power relations. The approach taken in this research was that there was more to reality than the individual research participant's viewpoint. It assumed that the participant's institutional and professional position would influence the individual's point of view. The participants accepted that their different socio-political positions would influence what they said and I was curious to understand what language they used to represent their recollections and beliefs. Could the participants' conversations constitute an 'expert' knowledge and could the actions described, serve to reinforce that professional 'expertise'? Also of interest was the possibility that expression of this expertise served to gain or preserve status for the members of that profession. This research showed that uncertainty and ambiguity characterised participant conversations. Language aimed at gaining or preserving professional status was evident in individuals but so was language aimed at the protection of patient advocacy.

Repositioning the researcher

Throughout the project I have been aware of the risk of valorising nursing because of my knowledge of nursing and familiarity with its professional agendas. I have also been mindful of the risk of demonising neoclassical economics and market forces because of my personal views on their nature and effects on the health service and New Zealand society generally. As Fairclough says, "a critical discourse analysis must aim for constant vigilance about who is using its results for what, and about whether its critique of certain practices is not helping to naturalise other equally but differently ideological practices" (Fairclough, 1995, pp. 82-83). I can claim authority in this writing only to the extent that the credibility of the project is apparent to the reader.

Research limitations and future directions

There are a number of limitations associated with this investigation, which need to be identified because they have a bearing on the practical outcomes of the research and future research possibilities. These limitations relate to the topic under investigation, the methodology employed, the practicalities of the research and the associated ethical considerations.

The topic under investigation

The decision to involve twelve participants rested on a methodological premise. Discourse analysis assumes an important place for research that focuses on local, specific and detailed data. It is only through such an approach that data are likely to give rise to in-depth understandings of the meaning of social reality in a given situation. Given the depth of data necessary, the talk of twelve participants on two occasions provided sufficient data for analysis. The fact that I talked with people holding a range of positions regarding NFR in the health care organisation is testament to my interest in identifying different professional and institutional discourses and the extent to which they competed with one other.

However, the small number of participants had implications for the research. The Chairperson of the Ethics Committee was the only participant without a professional background in health services. Half of the participants had a nursing background; thus more data emerged from nursing than from any other single discipline. More participants representing a greater variety of positions in the health care institution might have provided greater richness to the data. Any future research would be enhanced by reference to voices in a wider range of settings within the institution, for example, oncology, palliative care and care of the elderly. These settings are of interest because they are likely to be concerned with patients who have the opportunity to contemplate their own deaths because they are receiving treatment and care for identifiable disease conditions. It is also likely that a wider range of settings might reveal distinctive NFR practices because of the specialist professional discourses in those areas. This research also showed that there is a need to investigate NFR practices in areas of the institution where there is less opportunity to discuss NFR plans, for example, accident and emergency departments and intensive care areas. Longterm care institutions are likely to have NFR policies and practices. What bears further investigation in those settings is the cohesion between policy and practice, institutional discourses and resident and family discourses.

This research has been conducted on the premise that localised, specific and detailed analysis of NFR language would reveal realistic and reasonable conclusions. Nevertheless, there is an argument for further research on NFR social practices to be done at a national level. It would be useful to conduct a comparative study of NFR practices in health care institutions throughout New Zealand. The justification for this is the evidence that there is considerable variation in policies and practices not only in the institution where the research was conducted but also throughout health facilities in both the public and private sectors throughout the country (Niven, personal correspondence, 1995; Brown, personal correspondence, 1999). The aim of such research would not necessarily be to provide evidence for the standardisation of practice. Rather, there would be greater relevance in identifying existing practices, making them more widely known so that they can be debated publicly. Such a project might serve to establish and extend populist discourses regarding NFR. There is then the prospect of populist and health consumer discourses cooperating with, or contesting, health policy and professional discourses. The emergence of such discourses may well lead to people having access to a meaningful discourse which will allow them to die in their own way.

The Treaty of Waitangi provisions, particularly those relating to sovereignty and self-determination, demand attention in the area of NFR. This research did not surface talk that indicated a distinctive Maori discourse regarding NFR policies and practices. No role for language constructing a separate Maori reality emerged in the conversations. No participants indicated a personal affiliation with tribal or iwi connections. The formal policy documents reviewed as part of the study do not reflect an understanding of the significance of the Treaty of Waitangi. Any future research in the area of NFR needs to take the possibility of distinct Maori discourses into account. Cultural distinctions in NFR discourse might well apply to other non-Maori groups within New Zealand, for example, Pacific Island peoples, Chinese and other Asian groups.

Reliance on retrospective commentary is a further limitation of this study. There is a greater likelihood of identifying the reality of social practice of NFR if a research method was used which allowed for the study of the actual talk of the staff at work, for example, a discussion between staff about the decision of NFR. Another dimension of such a study could well be a discourse analysis of the talk between patients, family and staff in order to evaluate the extent to which medical, nursing and bioethics discourses influence decisions made. It would be useful to track the discourses from when the issue is first raised through to a point when a decision is reached about NFR. Given the results of this research, the value of such a study would be in identifying the way in which each speaker represents NFR, especially the way that nurses talk with patients and family and then talk to doctors. This would provide a more detailed and telling analysis of how NFR knowledge is constructed in an individual patient's case. It would reveal any distinctions between the way that the nurses converse with the patients and the way that they represent that conversation to the doctor. An analysis of both conversations would reveal any inconsistencies in a nurse's talk as well as the way that professional discourse might be utilised. For example, the words a nurse may use with a patient might not be the words that he or she uses to represent a patient's views to a doctor. Likewise, a doctor may use certain words with a nurse but utilise different language when talking with the patient about an NFR issue.

Another major dimension of NFR worthy of investigation, as indicated in the critical review of the literature, is an examination of the written texts of NFR, that is, the medical records. This could be done as a retrospective study of NFR decisions or it could be incorporated into a more comprehensive study investigating both the written and spoken texts of NFR, including both the patient records of individuals and the guidelines and policies produced by the institution. The value of such a study would be in replicating similar previous studies, for example, those conducted by Aarons and Beeching (1991) and Taylor, Parker, Ramsay and Peart in Dunedin, New Zealand (1996). The findings of these studies point to a greater need for all staff involved with patients for whom NFR is a possibility, to work together and communicate effectively. A subsequent study of written NFR texts would identify the extent to which a seamless and orderly NFR process through effective documentation might result in a better experience for patients and staff.

Critics might suggest, as one research participant (the Medical Consultant) did, that it is not particularly useful to isolate NFR from other treatment decisions. There is an acute need to conduct further and more substantial research into the more general area of end-of-life decision-making in settings as diverse as the intensive care unit and the private home where advance directives may be under discussion. If the social movement of requested death continues to gather momentum, it will be important to conduct social research into every diverse element of it, including euthanasia. The justification for the undertaking of such research arises from an understanding that the requested death movement, a new social movement supporting people's wish to take their own lives, is associated with the belief that people want to die according to their own wishes. By so doing, they are taking the decisions about the timing and character of the experience of dying out of the hands of the experts like nurses, doctors, and bioethicists. Commentators like Walter (1994), Giddens (1991) and Bauman (1992) predict that in the future people are more and more likely to want to die in their own way. Nurses and social science researchers need to investigate whether people are being allowed to die in their own way, particularly in settings other than hospices where such practices are well established although not universal.

It is likely that health care institutions will represent themselves as supporters of patient autonomy even more strongly in the future than they do now. Nurses' work in determining patient resistance to standardised practice regarding CPR and NFR, through private talk at the bedside, needs to be taken into account in the development of institutional policies and practices. Such a project may sound like a contradiction in terms because of the apparent impossibility of streamlining variability in NFR discourse into a written policy text that acknowledges the range of speech and silence techniques shown to be present in NFR talk. Nevertheless, there is undoubtedly a place for nurses to contribute to NFR institutional and professional policies and practices. Finally, they also need to be involved in the development of policies at regional, national and international levels.

Methodological approach

The distinction between critical discourse analysis and discourse analysis provided particular problems. The issues this raised in the research have been discussed in some depth in Chapter Four. The methodological problems I struggled with were a response to the situation that Parker and Burman (1992), in Parker (1992), describe:

> Two important characteristics of the post modern turn in culture are the shift from depth to surface and the shift from a belief in truth to the celebration of the impossibility of truth, to uncertainty. This double shift, the flight from depth and truth, is... the cultural setting for discourse analysis. (Parker & Burman, 1992, p. 164)

This view reflects the assumption that there are multiple realities. It was also enacted in my responsibility in the study to regard all discourses as equal; to avoid privileging, for example, nursing discourses over medical discourses or vice versa. I was dismayed, therefore, to discover through an analysis of the social relations of the data collection process that I had not achieved that. In fact, my treatment of the interview process mirrored the hierarchies of the research institution and the professions working within it. In that sense, as the researcher, I accept that I can be responsible only for my own reading of the data and that other readings of it may well result in a different interpretation.

When this study was undertaken, discourse analysis as a suitable method for the investigation of health care practices was in the early stages of development. Even then, a number of different approaches to discourse analysis were being applied to health research questions (see, e.g., Crowe, 1998; Gastaldo & Holmes, 1999; Lupton & Barclay, 1997; Wicks, 1999). Even though a post-structural analysis proved useful for the research questions, my philosophical position wavered somewhere between depth and surface, somewhere between truth and uncertainty. I did not want to succumb to an "exhausted and passive fatalism and surrender of political vision" (Parker & Burman, p. 168) by taking an extreme relativist position. This position was discussed in Chapter One, including an indication of my commitment to social action. Nevertheless, the opportunity to consider the wider political consequences has been exploited within the research project in a limited way only. Suffice to say here that lack of clarity in understanding led to hesitancy in decision-making, both in the data collection process and in the analysis of data. Limited experience as a researcher contributed to lack of confidence. Undoubtedly, as the researcher, I affected the research participants. They affected me, as indicated in Chapter Five. To some extent that relationship resulted in an enhancement of the project, in another sense, to limitations in the research project. These I have chosen to address below as moral problems.

There is a moral responsibility on the part of the researcher to make plain in the information sheet issued to prospective participants, what the purpose of the research is and what will happen to their transcripts. I believe the participants in this research did participate on an informed consent basis. However, the obscure terminology and concepts of discourse theory and analysis militated against a brief explanation of this approach being included in the information to participants. Moreover, the suggestion that the participants would be constructing or constituting their position and power while speaking to me, might have met with a less obliging response. Research participants' responses to a researcher's interpretation of their discourses do not usually constitute a section of the research report. However, a possibility for future research might be discourse action research in which participants have the opportunity, either as a group or as individuals, to study their own discourses in retrospect and work to utilise new language in order to change what happens. By doing this, they would have the opportunity to consider whether the language they use they would have the opportunity to consider whether the language they use does affect what happens to patients. They would then be able to modify the language to bring about improvements in practice and better outcomes for patients.

Another identifiable limitation was the decision to conduct the research, with management approval, anonymously in the institution where the data was collected. This was motivated by a desire to protect the participants from any negative effects from being involved in the research, a commitment that was spelt out in the information sheet. In retrospect, this was a mistake and did not necessarily ensure that participants would not suffer any ill effects. The result was that it was not clear to staff and patients of the institution who I was or why I was in the hospital and in the ward where several of the participants worked. A formal introduction to the staff in the ward and an opportunity to talk about the research to all staff and answer questions might have resulted in a greater awareness of research generally and of my project in particular.

An impression I gained throughout the data collection process was that medical staff were more comfortable than nursing staff with a research culture. Initially, nursing staff seemed unsure of the value of the research or their potential contribution. The advantages of my position as a nurse researcher have been discussed previously in Chapter Five and include the argument that eventually the reserve was overcome, not because of my position as a researcher but my position as a nurse. At the time of writing, no participant has been disadvantaged by involvement in the research, as far as I am aware. The data collection process may have been made more difficult because of the lack of awareness of research culture among the nurses interviewed and other ward nurses who made the decision not to be involved in the research project.

Field research as an orderly and scientific process, presupposes incorrectly that the field will remain stable long enough for the researcher and participants to achieve what they set out to do. It is difficult to conduct research which involves personal contact with participants over an extended period of time when the circumstances of their working lives mean their positions in the organisation may change radically during the data collection phase and also before the research is written up and published. Organisational arrangements may also have changed radically and this is the case in the organisation researched in this project. A major restructuring of all departments in the hospital was commenced in the middle of the data collection process. At the time of writing, only three of the twelve participants still work in the same area in which they were interviewed. The general manager who approved access to the institution resigned shortly after the research commenced. The Professional Advisory Committee no longer exists. It has been replaced with another form of collective governance with radically different membership. The Ethics Committee membership has changed considerably.

The significant changes in organisational structure subsequent to completion of data collection, suggest that any recommendations to the institution from this research may no longer be relevant. However, my perception is that, while the situation may have changed in many ways, the wider issues of NFR practices and the question of individual patients having a say in their treatment and futures remain an issue for the institution where this research was conducted and for other health care institutions in New Zealand and on other similar countries. This research is a snapshot of NFR practices in a New Zealand health care institution in the mid 1990's, a time of great change in the New Zealand health service. More substantially, I believe the research identifies a number of significant implications, which are detailed later in this chapter.

The practicalities of the research

Just as the setting of the research changed and the positions of the research participants changed, so too did that of the researcher during the duration of the research project. I took up a new employment position at the beginning of the project and then moved to employment in another academic institution half way through. Care needed to be taken that my involvement in the health care organisation was as a researcher only. Otherwise there was a possibility that my views on end-of-life decision-making might permeate the NFR talk of the institution and covertly influence the conversations of the research participants. The method of data collection allowed for my involvement in discussions with participants including an exchange of views. What it did not allow for was informal or formal discussions with other employees in the institution who were not aware that I was undertaking research in their work setting.

Nevertheless, each of the steps I took to gain management approval and access to the research area gave rise to conversations, which deserved inclusion in the data collection because of their relevance to the research goals. It is certainly an area that begs further inquiry into the question 'At what point does data collection begin and at what point does it end?' Another area of inquiry worth investigating, given the dominance of managerialist ideas regarding performance review, financial accountability, competency and leadership in the research site, is the way that performance is reviewed. The transitory nature of professional power and status is another area worthy of investigation, given the rapid rate of change and the way positions of clinical and managerial leadership can appear and disappear. In a sense, this signals another limitation of the research. The research findings do not claim to extend beyond the period of time when the data were collected but any recommendations to the institution may be considered less relevant too.

of time when the data were collected but any recommendations to the institution may be considered less relevant too.

Throughout the project I juggled the obligations of a full time workload with the demands of each aspect of the research design. I was fortunate that each step, including approval by the Massey University Human Ethics Committee and the ethics committee pertinent to the research site, and the gaining of access to the research participants, was straightforward. The confidence in the research project expressed by those involved in approving each of these steps was appreciated and further justified the research being done. The original proposal was to conduct conversations with participants over a six-month period. In reality, the time frame extended to three times that length. Participant convenience and availability was a factor. Also, arrangements to travel to the research site had to be made to fit in with my employment commitments. Given that substantial change was a taken-for-granted aspect of the research environment, I believe no harm was done by the elongation of the data collection phase and the data were, after all, based on retrospective talk. It was after the completion of the data collection that the Regional Ethics Committee reviewed its 1994 NFR policy.

Ethical considerations

Agreement to be involved in a research project like this presupposes an interest in the research outcomes. There is a moral obligation on the part of the researcher to fulfil participants' expectations by carrying out the actions agreed to. In this project, for example, this included returning transcripts to participants for their perusal and correction or amendment. It is also preferable to have the project completed and its published form available to the participants, their organisation and the public at large within a reasonable time frame. The delays in completion of this project are regrettable. However, recent conversations with interested parties at a national forum on NFR issues, suggest to me that the research findings are relevant and do have a contribution to make to future improved care and practices.

My initial commitment to the protection of participants' privacy remains. The identity of the health care organisation is not significant. Of significance is the fact that it is one of a number of New Zealand health care organisation with features and problems in common.

Implications and possible future research

As the critique of published sources in Chapter Three suggests, there is very little research available on the role of language in constructing the reality of NFR in a general hospital setting, or research on how language might shape or even determine what happens at NFR events. Research regarding NFR practices published by the disciplines of medicine and bioethics tend to focus on quantitative approaches without revealing the reported experience of staff especially staff from differing disciplines. This research analysed the language used by a range of speakers, showing a view of how NFR knowledge is constructed. What emerged was not a coherent discourse but one that demonstrated a lot of tolerance, fluidity, contradiction, resistance and duplicity. Particular medical and bioethics discourses shaped the formal policies and guidelines. At this level, the dominance of medicine and bioethics was taken for granted. In the reality of practice, NFR discourses were rich and varied. The research therefore refutes the 'naturalness' of biomedical authority in NFR knowledge.

The findings presented in this research have a number of implications for the social practices of NFR, for the people who work in health care organisations where NFR events happen, and for patients and consumers. These are addressed as follows.

For patients and families

Patients and families were not included as participants in this investigation. Nevertheless, patient and family discourses were represented as part of the NFR social practice of the research site, by the research participants. They reported, that in some instances, patient and family voices were silenced by the exercise of either overt or covert professional power. The implications of these findings are that it is not possible to judge whether the social practices at the research site routinely provided individuals with the kind of death they wanted. Therefore, patients and their families need to take part in NFR research that investigates patient NFR discourses and experiences.

This research suggests that greater planning and participation in decisions about all treatments including CPR and NFR may assist people to achieve the goal of dying in a way that meets their own needs, rather than the needs of a professional group, or an institution, or society at large. Patients and families are more likely to have their voices heard in the institutional, professional and ethical policies and guidelines on CPR and NFR if they are formally included in the processes that create, disseminate, implement and evaluate them.

For nursing, health and policy researchers

In relation to the relevance of discourse theory and analysis, researchers need to question the relationship between structuring of knowledge and appropriate social action, lived experience and represented experience. This research contributes to a growing body of knowledge regarding NFR policies and practices and to some extent offsets the influence of the published commentary, which paints a limited and distorted picture of NFR practices. It offers a new opportunity to consider the various ways in which speech and silence shape NFR practices; it demonstrates the ways in which NFR practice discourses resist institutional discourses. This research has implications for research that has the consumer voice as a central part. There are a number of ways which this could be done. An investigation of the patient records would reveal the part documentation plays in shaping NFR discourses. Another possibility is a study consisting of interviews with patients who have an NFR order completed and documented. Public perceptions of NFR are worthy of further investigation. An action research project could be done of the discussions that take place between staff and patients and staff and families. In addition, the part consumers play in the development of NFR policies could be the subject of research. An investigation of professional organisations' (for example, the New Zealand Medical Association's) policies could be undertaken, to discover whether these organisations invite consumers to contribute to their professional position statements on NFR.

For nurses in practice

This research speaks to a wide audience, though it speaks most particularly to nurses. The study has shown that nurses play an active part in constructing NFR knowledge, through both covert and overt use of language. Further research is needed to investigate more thoroughly how nursing discourses construct NFR knowledge and how that impacts on what happens in practice. This investigation showed that nursing discourse represents itself as a crucial element in mediating between patient and family discourse and medical discourse regarding NFR. The movement towards greater inclusion of patient/family discourses in NFR decision-making has implications for nurses. It is likely that they will continue to represent their discourse as a way of mediating between patient, family and medical NFR discourses. More research in this area might justify increased recognition of nursing influence, which would in turn shape policies. There is also the possibility of considering that NFR decisions in a hospital setting could be co-ordinated by responsible nurse clinicians, in keeping with Yarling and McElmurry's (1983) argument that NFR decision-making requires no greater moral and clinical responsibility than for decision-making about CPR. This research also offers a challenge to nurses to be more open in their NFR practices and to negotiate more transparently with other parties regarding NFR decisions.

The research findings also indicated that some NFR and CPR events were characterised by confused, angry, distressed, and frustrated talk, particularly from nurses. Institutional policy texts, if they exist at all, need to take into account nurses' talk. The development of more cooperative, open and tolerant NFR discourses may serve to reduce the tensions and distress identified in the research data. They may provide the basis for transformative practice by allowing patients to talk about 'dying in their own way', more readily.

For medical practitioners

This research reveals to medical practitioners that NFR events are more complex than they might have considered and that more influences exist than may be apparent in nurses' talk or silences. However, it also raises the possibility of a more tolerant and open NFR discourse, one in which nurses and doctors work together effectively to achieve a good result for the patient. This study exposes the hierarchical nature of medical practice and education. Research into the realities of medical practice and medical education regarding end-of-life practices is needed, along with interdisciplinary investigation into ways of improving end-of-life care. There is a need to fund end-of-life projects in New Zealand, perhaps in the same way that the Robert Wood Johnson Foundation does in the United States (Weisfeld, Miller, Gibson & Schroeder, 2000). Medical involvement in policy development and evaluation should continue, but medical practitioners need to address the discrepancies identified in this research, between institutional policies and individual medical practitioners' NFR practices.

For policy advisors and managers of health care institutions

The potential for transformative change in hospitals would be evidenced through acknowledgment of the variety of practices that occur and an assessment of their effectiveness. The research raises serious questions about the effectiveness of NFR policies and, by association, other institutional policies. People in senior management and advisory positions in hospitals need to turn their attention to the mechanisms that they currently employ for achieving the standardisation of effective professional NFR practice.

The potential significance of the wider socioeconomic context and the extent to which it may influence the events in the health care institution also needs to be noted. In view of the findings of this research, the potential for tension between wider socioeconomic projects such as, for example, the rationing of health services and the professional construction of knowledge of NFR requires consideration. Acknowledgment needs to be made of the possibility of tensions between practice-based disciplines like nursing and medicine and non-applied disciplines like bioethics and sociology. Nursing and medicine are applied disciplines. Therefore, proponents of applied, reality-based policies and practices may regard the positions of more theoretically based disciplines with some scepticism. This tension was referred to in Chapter Three and is confirmed in this study by the way the Medical Consultant, Policy Advisor (Kate) dismissed the role of the Ethics Committee in writing NFR policies.

For ethics committees

This research places ethics committees at the periphery of professional NFR knowledge. It raises questions about the degree of influence ethics committees, and their policies and guidelines, have in health care institutions over which the committees have ethical jurisdiction. An evaluation of the effectiveness of ethics committee policies and guidelines is required. The setting up of the National Ethics Committee (Public Health and Disability Act, 2000) may well be a useful step in pursuing appropriate research activities with, and about, ethics committees around the country. The requirement that each committee must have lay and Maori membership provides the possibility of consumer input into policies and guidelines.

Questioning dominant discourses re death decision-making

The research examined individual professional and institutional discourses on NFR and surfaced a complicated arrangement of speech and silence techniques, which worked either to speak about NFR as a judgement and decision or to remain silent. The conclusions derived from this research lend themselves to further investigation and interrogation through sociological analysis by examining NFR in light of the two kinds of dying identified by Walter (1994). In his argument that death is currently being revived, Walter identifies two assumptions, late modern and post-modern:

> The expert ("late-modern") revivalist asserts the right of the individual to know they are dying and to express how they feel; but the expert goes further and insists that individuals need to express their feelings, or at least talk about them, and that carers need to create an 'open awareness context' with those who are dying. The more radical ("post-modern") revivalist points to the wide diversity in how human beings encounter death; some individuals for example do not want to know they are dying or choose not to express their feelings of grief - this may work for them and must be respected. (Walter, 1994, p. 186)

Walter goes on to argue, that from a post-modern point of view it is possible for people to die in ways that they themselves have chosen. He suggests that the postmodern solution is for individuals to assume authority over their own death (Walter, 1994). Their control over how, when, where and in the company of whom they die is an issue that deserves the attention of social science, nursing and medical researchers because the question of who has authority has only been broached in this research. In his paper on power and subjectivity in therapeutic relationships, May (1992) concludes that there is a possibility that the authority rests with the patient:

> Unlike the 'truth' of the disordered body, visible through examination or biochemistry, the truth of the subject cannot be exposed without the explicit permission of the subject concerned. It cannot be exposed or fixed without positive action on the part of the patient, who may lie or remain silent in the face of such inquiry. The question 'do you want to talk' offers the possibility of answering 'no'. (May, 1992, p. 600)

This research has shown that it is professionals who lie and remain silent as part of a retinue of techniques designed to maintain professional power over NFR. If patients, as May claims, also lie or remain silent, it may mean that they are resisting professional power, in the same way that they are resisting professional power by refusing the invitation to talk. Such resistance, as a compatriot of power, is the basis of a construction of patient NFR knowledge. This study proposes a construction of professional NFR knowledge. My hope is that other investigators may use this research as a basis for exploring constructions of patient NFR knowledge, because such a study may well discover how patients can assume authority over their own dying.

The last word

Critical discourse analysis as research methodology and method allows for multiple realities. This account offers one reading of multiple realities. Other readers and readings may well offer alternative interpretations of those realities. In so doing, different realities may well emerge. Such distinctions in critical discourse analysis can only serve to contribute to people's understanding of health care practices in general and NFR practices in particular. The result will have an impact on the way that people practise their professions in health care. The consequence of this will be an impact on the way that patients experience health care. If this research contributes to changes in NFR practices resulting in more people dying in their own way, then my commitment to social action has been observed.

ADDENDUM

There are some inconsistencies within the thesis regarding the consideration of power. The application of a critical discourse analysis approach required the constitution of power within the critical paradigm and also in the discourse sense. The researcher's stance was that of an insider, with a critical understanding of power structures in the health sector. As a result, the research account, while represented as a discourse analysis, occasionally lapses into a more traditional, taken-for-granted Marxist understanding of power. In subsequent publications it will be important to highlight these inconsistencies and to adopt an approach to power that is more consistent with the research methodology and findings.

I

APPENDIX A

17 February 1993

ETHICS COMMITTEE GUIDELINES FOR DO NOT RESUSCITATE POLICY

Recently, the Ethics Committee was asked by an acute services unit to give an opinion on DO NOT Resuscitate policy. Now the Board has requested that this is circulated to staff throughout its area.

These are **guidelines,** not regulations.

Summary

DNR: POLICY (1)

Resuscitate unless DNR order

DNR order must be recorded in notes with reasons

DNR order, a medical responsibility following consultation with others

Patient or proxy consent is required

DNR orders must be regularly reviewed

II

Defining the issues

Our references are primarily to cardiopulmonary resuscitation but the principles apply to all forms of resuscitation.

The purpose of cardiopulmonary resuscitation is the prevention of sudden, unexpected death. Normally it is not indicated or required in cases of terminal, irreversible illness where death is not unexpected.

"Cardiopulmonary resuscitation should not be used on patients who are likely to succumb to their disease in a short time, or patients who are dying or suffering from intractable pain or on patients who are irreversibly comatose". (2 Jonsen, p. 31).

Imminent death cannot be defined by days or weeks to live but by the futility of other than palliative treatment. "The patient is resuscitated only to die". (3 Jonsen, p. 32).

Who makes the decision?

Who makes the decision for a "do not resuscitate" order? The answer is threefold.

The consultant The chief reason for a "do not resuscitate" order must always be clinical grounds. The consultant weighs the matter up after discussion with medical and nursing staff closely involved with the patient and makes the decision that it would be improper on medical grounds to resuscitate the patient and issues a "do not resuscitate" order.

The patient if competent, must be consulted on a DNR order or, indeed, the patient may initiate the request for a DNR order. The patient's wishes must be taken very seriously and be honoured if they are in accord with medical indications. Even if medical indications indicate further possibilities, the patient, having been informed of these, may still insist that his/her wishes for a DNR order shall be respected.

If the patient having been informed that a DNR order is proposed declares that he/she wishes all efforts to be resuscitate be made the consultant should generally follow the patient's wishes. However, there may come a time when this is no longer medically achievable and the consultant rightly accepts the responsibility for a DNR decision.

The immediate family/whanau of the patient may, and indeed should, be consulted, provided the patient gives consent, about prior decisions to make a DNR order. However, if the consultant and the patient are in agreement then the wishes of the family/whanau may not override the combination of clinical and patient opinion.

Where a patient is not in a position to testify to his/her wishes then evidence may be sought from family members, or close friends where family is not available, as to the patient's general wishes in this matter.

Children

Parents of children under 16, of course should be consulted and their wishes taken very seriously but the ultimate decision rests with the consultants. Two consultants should confer, decide and jointly sign the case note. It is preferable that one consultant is not directly caring for the child.

The patient's right to refuse resuscitation

Lord Donaldson, Master of Rolls, recently declared: refusal of lifesaving treatment would be legally binding if four requirements were met. The patient must have the capacity to make a decision and not be acting, for instance, under the influence of a drug; the decision must not have resulted from someone else's influence, it must cover the actual situation in which the treatment is needed; and the patient must have understood the nature and effect of the treatment proposed. (4)

Recording, communicating and reviewing DNR decisions

The decision having been made, it should be entered very clearly and specifically in the patient's notes and a clear direction made on the patient's chart. The case note must be signed and dated by the consultant.

Everyone concerned with the patient's treatment must be informed of an order to "do not resuscitate".

The order must be reviewed regularly at time intervals specified on the patient's chart. It may be changed if clinical conditions warrant it.

Example of entry into medical notes and on chart. (5)

Not for CPR

Time limit – unlimited

Indication – Terminal malignancy

Duty of continuing care

It is important that everyone be informed that the decision not to resuscitate is a decision not to promote a particular form of therapy, it is not a decision to terminate care. At all times appropriate care must be offered to patients. However, it is ethically permissible for the physician to withhold treatment which would serve mainly to prolong the dying process. Again this is a matter for clinical judgment and discussion with the patient if he/she is competent and for consultation with the family. In the end it remains a clinical decision concerning palliative care.

References

1.The summary is taken, by permission, from a lecture given by Professor Alistair Campbell of the Bioethics Research center, University of Otago, at the Medico-Legal Conference, Auckland, 18-19 August, 1992.

2. & 3. Jonsen, Albert R, Siegler, Mark and Winsdale, William J. Clinical Ethics: A Practical Approach to Ethical Decisions in Clinical Medicine. 2nd ed. MacMillan, New York, 1986.

3. BMJ Volume 305, 12 September 1992, p. 602.

4. Advice on Resuscitation policies: British Geriatrics Society.

CHAIRPERSON
ETHICS COMMITTE

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APPENDIX B

HOSPITAL NFR POLICY

PROCEDURE FOR NO-CPR ORDER

1. PURPOSE

The purpose of this policy is to ensure medical staff follow the correct procedure when applying the no-CPR order.

2. PERSONNEL AFFECTED

All medical staff.

3. PROCEDURE

3.1 A no-CPR order incorporates a brief description of discussions with the patient and/or family members, and:

a) a statement of the patient's wishes (when the patient is competent) or
b) the role of the familywhanau, caregiver (when the patient is incompetent)

3.2 A no-CPR order is recorded as a formal order in the patient's record notes in a clear and unambiguous manner.

3.3 A no-CPR order always involves appropriate members of the health care team (e.g. nurses, allied health professionals, medical staff) in the decision-making, although the final decision remains the responsibility of the senior attending medical officer.

3.4 Where a decision had been made not to involve a patient in discussion regarding resuscitation status, an explanation must be provided in the patient record of the rationale underlying this decision.

3.5 Any no-CPR order includes a statement of medical condition to justify the order.

3.6 Any no-CPR order includes a statement about the scope of the order, specifying the management plan (curative and /or palliative) subsequent to the no-CPR order.

3.7 Any no-CPR order is subject to review on a regular basis and can be rescinded at any time. Any decision is documented in the patient's notes in the manner specified above.

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APPENDIX C

PARTICIPANT CONSENT FORM

Regional Ethics Committee

1. **Project title:** PhD project: A discourse analysis of social practices at work in the development and implementation of 'not-for-resuscitation' (NFR) policies in a public general hospital in New Zealand

2. Investigator's name and details

Joy Bickley
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Wellington
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Dip. Soc. Sci. (Nursing studies), Massey University
Dip.Soc.Sci. (Sociology), Massey University
BA (History), Auckland University
Dip.Tchg (Epsom secondary)
Ophthalmic nursing diploma (Hons) (England and Wales)
Registered general and obstetric nurse and midwife (New Zealand)

3. Venue of study

4. Aims and purpose of the study

See information sheet

5. Inconvenience

See information sheet

6. Confidentiality

In accordance with the conditions set out on the information sheet.

STATEMENT SIGNED IN THE PRESENCE OF THE INVESTIGATOR AND WITNESSED

I have read the consent form and information sheet and have had the opportunity for discussion with the investigator, Joy Bickley. My questions about the study have been answered to my satisfaction, and I understand that I may ask further questions at any time. I know that I can withdraw from the study at any time and I understand that this withdrawal will not adversely affect my employment situation.

I understand that this study has been approved by the Health Authority Ethics Committee and if I have any concerns about the study, I may contact the Ethics Committee, Telephone

I agree to take part in this study

Signed: (Participant) / / (Date)

(Witness) / / (Date)

Witness name: (Print name)

Researcher declaration

I have discussed with (participant's name) the aims and procedures involved in this study.

Signed: (Researcher) / / (Date)

Three copies required: 1 retained by participant; 1 retained by the researcher: 1 for record

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APPENDIX D

INFORMATION SHEET

Regional Ethics Committee

PhD Project

Title: A discourse analysis of social practices at work in the development and implementation of 'not-for-resuscitation' policies at work in a public general hospital in New Zealand.

My name is Joy Bickley. I am currently employed as a lecturer in the Department of Nursing and Midwifery at Victoria University of Wellington. I am also a general and obstetric nurse and midwife with fifteen years' experience. This project comprises part of my work towards the completion of a doctoral thesis in the Department of Social Policy and Social Work, Massey University. Dr Ruth Anderson (Department of Social Policy and Social Work) and Professor Nancy Kinross (Management Systems) will supervise the project.

This study has developed out of an interest in finding out more about the meaning of 'not-for-resuscitation' (NFR) policies. I am particularly interested in what and who influences their development and implementation. I will be examining written policies and other relevant reports. I would also like to interview you about your views and experiences of 'not-for-resuscitation' policies. The information collected in the course of the study will be used solely for the purpose of the PhD and subsequent published papers.

My role in this project is firstly that of an investigator. I acknowledge that I have an ethical obligation as an academic in human subject research. Because I am a registered nurse and midwife I am also bound by the professional ethics of the Nursing Council of New Zealand. This means that I have an ethical duty to act responsibly if, in the course of the interviews, I become aware of any situation where patient safety appears to have been compromised.

If this situation arises I would in the first instance, discuss with you possible courses of action you may wish to take. If the situation were to remain unresolved, I would seek your consent to discuss the situation with appropriate senior staff in the institution. If you did not consent, I would then seek advice from my supervisors.

Your participation in the research would be based on your written consent. If you consent to participating in the research I would like to interview you on two occasions three or more months apart. Each interview would last approximately one and a half hours and be recorded on audio-tape. Information collected during the first interview will be transcribed and analysed. You will be provided with the transcript of the first interview and you may wish to comment. Likewise, you will be provided with a transcript of the second interview so that you can comment. A word processor operator will be employed to transcribe the tapes. You will receive a signed form indicating the transcriber's agreement to respect confidentiality.

As a participant you are asked to talk around the subject of 'not-for-resuscitation' policies and practices. Likely questions are

1. What written policies are being used currently in your work area?
2. What unwritten rules can be identified currently?
3. What part do you play in the construction of 'not-for-resuscitation' policies?
4. How are NFR or DNR policies implemented?
5. Can you describe the part you play?
6. What happens in 'moments of crisis' ?
7. What meaning do these events have for you?
8. Who else do you think I need to talk to about these things?
9. What other questions should I be asking?

The interviews will take place in a place and at a time that is mutually convenient. You have the right to:

refuse to answer any particular question, and to withdraw from the study at any time.

ask any further questions about the study that occur to you during your participation

ask for the taping to be stopped during the course of an interview

provide information on the understanding that it is confidential to me, the investigator, my supervisors and examiners

be given access to a summary of the findings from the study when it is concluded.

The managers of the institution in which you work have given their approval for this study and they will be provided with a summary of the research findings. It is possible that they know the identity of participants because of the limited number of participants in the research sample. The researcher will do everything possible to ensure no harm comes to you through your involvement in the research. You do need to be aware of the possible implications of the research findings for the institution in general and the social practices of the providers in particular.

You will be provided with a summary of the research findings. Should I wish to use information provided by you in related research papers your consent for the information would be sought. All information transcribed from the tapes will be disguised to reduce the likelihood of you and your employing institution being identified in any reports arising from the study.

All tapes, field notes and transcripts arising from the interviews are held by me for five years. At the end of that time you may wish to have the tapes returned to you, or they will be destroyed. You may also be given a transcript of the tapes at your request.

I can be contacted at Victoria University of Wellington at 04 471 5363
Dr Ruth Anderson, my chief supervisor, can be contacted at Massey University at 06 350 5217. Professor Nan Kinross, my second supervisor, can be contacted at Massey University at 06 350 4733.

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APPENDIX E

REGIONAL ETHICS COMMITTEE

NOT-FOR-CARDIOPULMONARY RESUSCITATION GUIDELINES

These are guidelines, not regulations.

Your organisation may already have a NO-CPR policy in place. These guidelines have been prepared to assist clinicians to discuss and address the implementation of NO-CPR orders bearing in mind the range of clinical settings that NO-CPR Orders may be appropriate.[1] As with all goals of patient care NO-CPR guidelines require application in the light of a particular patient's circumstances as well as regular review by health care professionals.

SUMMARY

NO-CPR: POLICY

Resuscitate unless a NO-CPR Order is in place

NO-CPR order must be recorded in notes with reasons

NO-CPR is primarily a clinical responsibility following consultation with the patient and other health care professionals.

Patient consent or consent from family/whanau or guardian is required.

NO-CPR orders should be regularly reviewed together with other goals of patient care.

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[1] The Ethics Committee has a list of references and background material on NO-CPR Orders which may be obtained from the Secretary.

II

Understanding the issue
Our references are primarily to cardiopulmonary resuscitation but the principles apply to all forms of resuscitation.

The purpose of cardiopulmonary resuscitation is the prevention of sudden, unexpected death. Normally it is not indicated or required in cases of terminal or irreversible illness where death is expected.

Resuscitation can be considered medically futile from both a qualitative or quantitative perspective, that is, resuscitation would not improve a patient's quality of life no matter how many times it was repeated.

Who makes the decision?

There are three central figures in a decision for a NO-CPR order.

1. The patient's doctor

Clinical indications form the basis for the majority of NO-CPR orders. The Patients doctor weighs up the matter after a review of the clinical facts and discussion with the patient, if appropriate their family, and other members of the health care team.

2. The patient

Generally speaking, patients with decision-making capacity should be consulted before a NO-CPR order is issued. Respect for patient autonomy requires that a patient's wishes be respected even if the medical indications indicate further viable treatment options.

If, after due process, the patient, being informed that a NO-CPR order is proposed, still wishes al efforts for resuscitation be made, the doctor should follow the patient's wishes. There may well come a time, however, when resuscitation is medically futile and the doctor rightly accepts the responsibility for a NO-CPR order, thereby overriding the patient's wishes/decision.

III

If the patient's patient judges that a discussion for a NO-CPR order is not indicated this should be recorded in the patient's notes and communicated to members of he healthcare team.

3. The family/whanau

The immediate family or whanau should, with the patient's consent, be consulted. However, the patient's decision should be respected. While appreciating the sensitivities involved in dealing with a patient's family their wishes may not override the patient's wishes and clinical opinion.

Where a patient no longer has decision-making capacity his or her wishes should be established through consultation with family and whanau members.

Important legal points to remember

The New Zealand Bill of Rights Act 1990 entitles any person to effuse to undergo any medical treatment. 8.

Proxy decisions cannot be given by family members for patients over 20 years who have lost their decision-making capacity. Attorneys and welfare guardians appointed to make decisions about a person's care and welfare, if not mentally capable of doing so themselves, cannot refuse standard medical treatment or procedures intended to save a person's life.

An Advance Directive (sometimes called a Living Will) can provide evidence of a patient's wishes with regard to a NO-CPR order. 4.

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2. Section 11 New Zealand Bill of Rights Act 1990.
3. Sections 18 (1) (c) and 98 Protection of Personal and Property Rights.
4. Right 8 (5) Health and Disability Services Consumer's Code of Rights.

IV

Recording, communicating and reviewing NO-CPR decisions

Once a decision for a NO-CPR has been made it should be clearly entered in the patient's notes. The case note should be signed and dated by the patient's doctor.

Where a decision has been made not to involve a patient in discussion regarding resuscitation status, an explanation of the decision-making process and rationale of the decision should be recorded in the patient's notes.

NO-CPR orders should be reviewed regularly at time intervals specified in the patient's notes. They may be changed or withdrawn if clinical conditions warrant it.

The duty of continuing care

It is important that everyone be informed that the decision not to resuscitate does not equate with the withdrawal of care of abandonment of the patient.

At all times appropriate goals of care must be offered to patients.

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APPENDIX F

BRITISH GERIATRIC SOCIETY ADVICE ON RESUSCITATION POLICIES

1. The British Geriatric Society advocates that all hospitals and elderly care units should have a locally agreed policy on cardiopulmonary resuscitation which should include:

    1.1 The methods of arriving at a decision on the appropriateness of resuscitation in individual patients.

    1.2 The methods of communication of this decision amongst hospital staff so that it is clearly understood by all who may need to implement it

2. This is necessary to:

    2.1 Enhance clinical care and the dignity of patients.

    2.2 Protect individual practitioners from criticism. No individual practitioner should be subject to personal retribution for having made a decision under duress, which later is suggested, to be inappropriate by other staff.

3. The policy should indicate:

    3.1 The consultation process with patients, relatives, and staff that led to the formulation of a decision.

    3.2 The duration of effectiveness of individual decisions.

    3.3 The seniority of the staff who make and review the decisions.

    3.4 Whether decisions are written in the case record and if so in what format.

    3.5 That decisions can only be made in the light of accurate knowledge of the diagnosis and prognosis for the patient. Age should not prelude resuscitation

    3.6 Preferably in what types of clinical situation resuscitation would be inappropriate

4. The policy should be audited regularly to check on compliance and ensure adequate education of its content. There should also be a regular audit of individual resuscitation attempts not only to check on compliance with the policy but also audit the appropriateness of individual decisions.

5. Legal advice and consultations with Medical Defence Organisations can be helpful in formulation of a policy.

6. Acute hospital policies should as far as possible be common to all specialties within the hospital.

7. Sample policies are available from the British Geriatric Society Office.

REFERENCES

Aarons, E. J., & Beeching, N. J. (1991). Survey of "Do not resuscitate" orders in a district general hospital. *British Medical Journal, 303*, 1504 - 1506.

Aldridge, J. (1993). The textual disembodiment of knowledge in research account writing. *Sociology, 27* (1), 53 – 66.

Alpers, A., & Lo, B. (1992). Futility: Not just a medical issue. *Law, Medicine and Health Care, 20* (4), 327 - 329.

American Heart Association. (2000). *Part 2: Ethical aspects of CPR and ECC, 46,* 17 - 27.

American Hospital Association. (1994). Living wills touted as a means of reducing costs in care. *Hospital Ethics, 10* (1), 4 - 5.

American Medical Association. (1992). Guidelines for CPR: Part viii, ethical considerations for resuscitation. *Journal of the American Medical Association, 268* (16), 2282 - 2288.

Annas, G. J., & Glantz, L. H. (1986). The right of elderly patients to refuse life-sustaining treatment. *The Millbank Quarterly, 64* (2), 95 –149.

Annas, G. J., & Miller, F. H. (1994). The empire of death: How culture and economics affect informed consent in the U.S., the U.K., and Japan. *American Journal of Law and Medicine, 20* (4), 357 - 394.

Ardagh, M. (1997). Preventing harm in resuscitation medicine. *The New Zealand Medical Journal, 110*, 113 - 115.

Ardagh, M. (1999). Resurrecting autonomy during resuscitation - the concept of professional substituted judgment. *Journal of Medical Ethics, 5*, 375 - 378.

Aries, P. (1981). *The hour of our death.* New York: Allen Lane.

Armstrong, D. (1987). Silence and truth in death and dying. *Social Science and Medicine, 24* (8), 651 - 657.

Armstrong, D. (1993). Public health and the fabrication of identity. *Sociology, 27* (3), 393 - 410.

Armstrong, D. (1995). The rise of surveillance medicine. *Sociology of Health and Illness, 17* (3), 393 - 404.

Arnott, S., & Warner, L. (1995). How to stop singing the code blues! *The Journal of Continuing Education, 26* (4), 189 - 190.

Arthur, J., Dorne, A., McHugh, P., Theewis, F., & Welsh, M. (1994). *Ethical dilemmas of resuscitation: An interpretive study into registered nurses' experiences.* Unpublished dissertation, Otago Polytechnic, Dunedin, New Zealand.

Asch, D. A., Faber-Langendoen, K., Shea, J. A., & Christakis, N. A. (1997). The sequence of withdrawing life-sustaining treatment from patients. *Annals of Internal Medicine, 107* (2), 253 – 156.

Asplund, K., & Britton, M. (1990). Do-not-resuscitate orders in Swedish medical wards. *Journal of Internal Medicine, 228,* 39 - 145.

Baggs, J. G. (1993). Collaborative interdisciplinary bioethical decision-making in intensive care units. *Nursing Outlook, 41* (3), 108 - 111.

Baggs, J. G., & Schmitt, M. H. (2000). End-of-life decisions in adult intensive care: Current research base and directions for the future. *Nursing Outlook, 48* (4), 158 - 164.

Barnes, D. J. (1997). No-CPR orders in a teaching hospital. *Australian and New Zealand Journal of Medicine, 27,* 708.

Bauman, Z. (1992). *Mortality, immortality and other life strategies.* Cambridge: Polity Press.

Bedell, S. E., Delbanco, T. L., Cook, E. F., & Epstein, F. H. (1983). Survival after cardiopulmonary resuscitation in the hospital. *The New England Journal of Medicine, 309* (10), 569 - 576.

Bedell, S. E., Pelle, M. P., Maher, I. K., & Cleary, P. D. (1986). Do-not - resuscitate orders for critically ill patients in hospital: How are they used and what is their impact? *Journal of the American Medical Association, 256* (2), 233 - 237.

Best, S. & Kelleher, D. (1991). *Postmodern theory: Critical interrogations.* London: McMillan Press.

Billig, M. (1986). Methodology and scholarship in understanding ideological explanation. In E. G. Mishler, *Research interviewing: Context and narrative* (pp. 199 – 215). London: Harvard University Press.

Birtwhistle, J., & Nielsen, A. (1998). Do not resuscitate: An ethical dilemma for the decision-maker. *British Journal of Nursing, 7* (9), 543 – 549.

Blank, R. H. (1992). Setting policy priorities for allocating scarce resources. In R. H. Blank & A. L. Bonnicksen (Eds.), *Emerging issues in biomedical policy* (pp. 36 – 48). New York: Columbia University Press.

Blank, R. H. (2000). Agenda setting and policy context. In P. Davis & T. Ashton (Eds.), *Health and public policy in New Zealand* (pp. 144 – 158). Auckland: Oxford University Press.

Bloor, M., & McIntosh, J. (1990). Surveillance and concealment: A comparison of techniques of client resistance in therapeutic communities and health visiting. In S. Cuningham-Burley and N. P. McKegany, (Eds.), *Readings in medical sociology*. London: Routledge.

Boston, J. (1991). The theoretical underpinnings of public sector restructuring in New Zealand. In J. Boston, J. Martin, J. Pallot & P. Walsh (Eds.), *Reshaping the State: New Zealand's bureaucratic revolution* (pp. 1 - 26). Auckland, New Zealand: Oxford University Press.

Boston, J., Martin, J., Pallot, J. & Walsh. P. (1996). *Public management: The New Zealand model*. Auckland: Oxford University Press.

Boston, J., Dalziel, P., & St John, S. (Eds.). (1999). *Redesigning the welfare state in New Zealand: Problems, policies and prospects.* Auckland: Oxford University Press.

Boutain, D. M. (1999). Critical language and discourse study: Their transformative relevance for critical nursing inquiry. *Advances in Nursing Science, 21* (3), 1 – 8.

Boyd, K., Terse, D., Rapaport, J., & Lemeshow, S. (1996). The relationship between age and the use of DNR orders in critical care patients: Evidence for age discrimination. *Archives of Internal Medicine, 156,* 1821 -1826

Bradbury, M. (1999). *Representations of death: A social psychological perspective.* London: Routledge.

Brett, D. (1996). *Playing God: The "do not resuscitate" order.* Unpublished dissertation. University of Auckland, Auckland, New Zealand.

Brown, J. R. (1989). Legally it makes good sense. *Nursing 89,* (3), 46.

Bruce-Jones, P., Roberts, H., Bowker, L., & Cooney, V. (1996). Resuscitating the elderly: What do the patients want? *Journal of Medical Ethics, 22,* 154 - 159.

Burr, V. (1995). *An introduction to social constructionism.* London, Routledge.

Burstin, H. R., Lipsitz, S. R., & Brennan, T. A. (1992). Socioeconomic status and risk for substandard medical care. *Journal of the American Medical Association,* 268 (17), 2383 - 2387.

Cameron, M. (1997). Resuscitating clients against their wishes. *Journal of Professional Nursing, 13* (1), 6.

Carr, G. (1996). Themes relating to sexuality that emerged from a discourse analysis of the Nursing Times. *Journal of Advanced Nursing, 24,* 196 – 212.

Cartwright, S. R. (1988). *The report of the committee of inquiry into allegations concerning the treatment of cervical cancer at National Women's Hospital and into other related matters.* Auckland, New Zealand: Government Printing Office.

Charlton, R. (1996). Diagnosing death. *British Medical Journal, 313*, 956 - 957.

Cheek. J. (2000). *Postmodern and poststructural approaches to nursing research.* London: Sage.

Cheek, J., & Rudge, T. (1994). Nursing as a textually mediated reality. *Nursing Inquiry 1,* 15 - 22.

Coalition for Public Health. (1998). New Zealanders 'poorly served' by health system. *Health Review,* (4), 5.

Cobbe, S. M., Dalziel, K., Ford, I., & Marsden, A. K. (1996). Survival of 1476 patients initially resuscitated from out of hospital cardiac arrest. *British Medical Journal, 312,*1633 - 1637.

Cohen, C. B., & Cohen, P. J., (1992). Required reconsideration of "Do-not-resuscitate" orders in the operating room and certain other treatment settings. *Law, Medicine and Health Care, 20* (4), 354 - 362.

Collins, D. (1992). *Medical law in New Zealand.* Wellington, New Zealand: Booker & Friend Ltd.

Cornforth, M. (1965). *Marxism and the linguistic philosophy.* London: Lawrence & Wishart.

Council on Ethical and Judicial Affairs. (1991). Guidelines for the appropriate use of do-not-resuscitate orders. *Journal of the American Medical Association, 265* (14), 1868 - 1871.

Crowe, M. (1998). The power of the word: Some poststructural considerations of qualitative approaches in nursing research. *Journal of Advanced Nursing, 28* (2), 339 - 334.

Cunningham, C., & Durie, M. (1999). Te rerenga hauora. In P. Davis, & K. Dew (Eds.). *Health and society in Aotearoa/New Zealand* (pp. 235 - 254). Auckland: Oxford University Press.

Daly, B. J., Gorecki, J., Sadowski, A., Rudy, E. B., Montenegro, H. D., Song, R., & Dyer, M. A. (1996). Do-not-resuscitate practices in the chronically critically ill. *Heart and Lung, 25* (4), 310 - 317.

Dautzenberg, P. L. J., Toon, C. J. B., Hooyer, C., Schonwetter, R. S., & Duursma, S. A. (1993). Review: Patient-related predictors of cardio-pulmonary resuscitation of hospitalised patients. *Age and Ageing, 22*, 464 - 475.

Davenport, E. (2000). Clinical guidelines and the translation of texts into care: Overcoming professional conflicts concerning evidence-based practice. *Journal of Documentation, 56* (5), 505 – 519.

Davis, A. J., Phillips, L., Drought, T. S., Sellin, S., Ronsman, K., & Herschberger, A. K. (1995). Nurses' attitudes toward euthanasia. *Nursing Outlook, 43*, 174 – 179.

Davis, A. J., & Slater, P. V. (1989). U.S. and Australian nurses' attitudes and beliefs about the good death. *IMAGE: Journal of Nursing Scholarship, 21* (1), 34 – 39.

Davis, P. & Ashton , T. (Eds.) (2000). *Health and public policy in New Zealand.* Auckland: Oxford University Press.

Deber, R. B., Kraetschmer, N., & Irvine, J. (1996). What role do patients wish to play in treatment decision-making? *Archives of Internal Medicine, 156*, 1414 - 1420.

Degeling, P. (2000). Reconsidering clinical accountability: An examination of some of the dilemmas inherent in efforts to bolster clinician accountability. *International Journal of Health Planning and Management, 15*, 3 – 16.

Diem, S. J., Lantos, J. D., & Tulsky, J. A. (1996). Cardiopulmonary resuscitation on television: Miracles and misinformation. *New England Journal of Medicine, 334* (24), 1578 - 1582.

Doyal, L., & Wilsher, D. (1994). Withholding and withdrawing life sustaining treatment from elderly people: Towards formal guidelines. *British Medical Journal, 308*, 1689 - 1692.

Dreyfus, H. L. & Rabinow, P. (1982). Michel Foucault: Beyond structuralism and hermeneutics. London: Harvester Press.

Dzurec, L. C. (1999). The necessity for and the evolution of multiple paradigms for nursing research: A postructuralist approach. In E. C. Polifroni, & M. Welch (Eds.), *Perspectives on philosophy of science in nursing: An historical and contemporary anthology* (pp. 491 – 497). Philadelphia: Lippincott.

Easton, B. (1992). *Is health an economic commodity?* Paper presented as Arnold Nordmeyer Memorial Lecture, Wellington School of Medicine: Unpublished.

Easton, B. (1997). *The commercialisation of New Zealand.* Auckland: Auckland University Press.

Eastwick-Field, P. (1996). Introducing nurse-initiated management of cardiac arrest. *Nursing Standard, 10* (26), 46 - 48.

Eckburg, E. (1998). The continuing dilemma of the do-not-resuscitate order. *American Operating Room Nurses Journal, 67*, 783 - 790.

Eckersley, R. (2001). Culture, health and well-being. In R. Eckersley, J. Dixon, & B. Douglas (Eds), *The social origins of health and well-being* (pp. 51-70). Cambridge: Cambridge University Press.

Eichorn, D. J., Meyers, T. A., Mitchell, T. G., & Guzzetta, C. E. (1996). Opening the doors: Family presence during resuscitation. *Journal of Cardiovascular Nursing, 10* (4), 59-70.

Emanuel, E. J., & Emanuel, L. L. (1994). The economics of dying: The illusion of cost savings at the end of life. *New England Journal of Medicine, 330* (8), 540-544.

Fairclough, N. (1992). *Discourse and social change.* Cambridge: Polity Press.

Fairclough, N. (1995). *Critical discourse analysis: The critical study of language.* London: Longman.

Fairclough, N., & Wodak, R. (1997). Critical discourse analysis. In T. van Dijk (Ed.). (1997). *Discourse as social interaction: Discourse studies: A multidisciplinary introduction Volume 2*. London: Sage. p. 259 - 284.

Felder, S. (1997). Costs of dying: Alternatives to rationing. *Health Policy, 39,* 167 - 176.

Fillingham, L.A. (1993). *Foucault for beginners.* London: Writers and Readers Publishing Inc.

Flax, J. (1990). *Thinking fragments: Psychoanalysis, feminism and post-modernism in the contemporary West.* Berkeley, California: University of California Press.

Foucault, M. (1973). *The birth of the clinic: Archaeology of medical perception.* London: Tavistock Publications. First published 1963.

Foucault, M. (1977). Discipline and punish: The birth of the prison. (A. M. Sheridan Smith, Trans.) London: Tavistock.

Foucault, M. (1984). The order of discourse. In M. Shapiro (Ed.), *Language and politics.* London: Blackwell.

Fougere, G. (1990). Health. In P. Spoonley, D. Pearson, & I. Shirley (Eds.), *New Zealand Society: A sociological introduction* (pp. 136 – 150). Palmerston North: Dunmore Press.

Fox, N. J. (1993). *Postmodernism, sociology and health.* Buckingham: Open University Press.

Frank, A. (1991). For a sociology of the body: An analytical review, in M. Featherstone, M. Hepworth, & B. Turner (Eds.), *The Body: Social Processes and Cultural Theory* (pp. 32 - 56). London, Sage Publications.

Frankford, D. M. (1997). The normative constitution of professional power. *Journal of Health Politics, Policy and Law, 22* (1), 185 - 221.

Franks, A. (1997). Breaking bad news and the challenge of communication. *European Journal of Palliative Care, 4* (2), 61 – 65.

Fryer, N. (1996). Ethics and the law: A right to die. In K. Soothill, C. Henry, & K. Kendrick (Eds.), *Themes and perspectives in nursing* (pp. 95 - 110). London: Chapman & Hall.

Gastaldo, D. & Holmes, D. (1999). Foucault and nursing: A history of the present. *Nursing Inquiry, 6*, 231-240.

Gauld, R. (1999). Beyond New Zealand's dual health reforms*. Social Policy and Administration 33*, (5). 567 – 585.

Gauld, R. (2000). Hospitals and associated services. In P. Davis, & T. Ashton (Eds.), *Health and public policy in New Zealand* (pp. 231 – 236). Auckland: Oxford University Press.

Giddens, A. (1991). *Modernity and self-identity: Self and society in the late modern age.* London: Polity Press.

Gillett, G. (1995). National advisory committee on health and disability services ethics. *Otago Bioethics Report, 4* (1), 8.

Gleeson, K. & Wise, S. (1990). The do-not-resuscitate order: Still too little too late. *Archives of Internal Medicine, 150*, 1057 - 1060.

Glick, S. M. (2000). The morality of coercion. *Journal of Medical Ethics, 26*, 393 - 395.

Godkin, M. D., & Toth, E. L. (1994). Cardiopulmonary resuscitation decision-making in longterm care: A role for the nurse? *Journal of Advanced Nursing, 19*, 97 - 104.

Grace, V. M. (1991). The marketing of empowerment and the construction of the health consumer: A critique of health promotion in New Zealand. *International Journal of Health Services 21*, (2), 329 - 343.

Grant, A. (1993). Questions of life and death. *Canadian Nurse, 14* (4), 31 - 34.

Grant, E. R. (1992). Medical futility: Legal and ethical aspects. *Law, Medicine and Health Care, 20* (4). 330 - 335.

Grossberg, L., & Nelson, C. (1988). *Marxism and the interpretation of culture.* ChiPACo: University of Illinois Press.

Habermas, J. (1991). The philosophical discourse of modernity. Massachusetts: The MIT Press Cambridge.

Hackler, C., & Hiller, C. (1990). Family consent to orders not to resuscitate: Reconsidering hospital policy. *Journal of American Medical Association, 264* (10), 1281 - 1283.

Hague, S, B., & Moody, L. (1993). A study of the public's knowledge regarding advance directives. *Nursing Economics, 11* (5), 303 - 307.

Hall, J. M. (1999). Marginalization revisited: Critical, postmodern, and liberation perspectives. *Advances in Nursing Science, 22* (2), 88 – 101.

Hancock, H. C. (1997). Professional responsibility: Implications for nursing practice within the realms of cardiothoracics. *Journal of Advanced Nursing, 25,* 1054 - 1060.

Hastings Centre. (1987). *Guidelines on the termination of life-sustaining treatment and the care of the dying.* Bloomington: Indiana University Press.

Hayward, M. (1999). Cardiopulmonary resuscitation: Are practitioners being realistic? *British Journal of Nursing, 8* (12), 810 - 814.

Health Research Council of New Zealand. (1998). *Guidelines for researchers on health research involving Maori.* Auckland, New Zealand: Author.

Heller, R. F., Steele, P. L., Fisher, J. D., Alexander, H. M., & Dobson, A. J. (1995). Success of cardiopulmonary resuscitation after heart attack in hospital and outside hospital, *British Medical Journal, 311,* 1332 - 1336.

Henderson, A. (1994). Power and knowledge in nursing practice: The contribution of Foucault. *Journal of Advanced Nursing, 20,* 935 - 939.

Henneveld, L. R. (1994). The long overdue debate: Medical decisions near the end of life. *New Zealand Medical Journal, 27,*157 - 158.

Henry, J. B. (1993). Did you have to call a code? *American Journal of Nursing Hospital Extra, 16,* 16G.

Higgs, R. (1995). Euthanasia: Can we make sense of the issues? *Otago Bioethics Report, 4* (3), 1 - 2.

Honan, S., Helseth, C. C., Bakke, J., Karpiuk, K., Krsnak, G., & Torkelson, R. (1987). Perception of 'No Code' and the role of the nurse. *The Journal of Continuing Education in Nursing, 23,* (2), 54 - 61.

Hosford, I., Brown, E., & Duncan, C. (1995). Formulating a 'Do not resuscitate' policy for a psychogeriatric service: Need for consultation with Maori. *New Zealand Medical Journal,* 108, 226 - 228.

Hulme, J. & Faull. C. (1997). Decisions around the end of life: The views of patients and professionals. *Palliative Medicine, 11,* 59 - 82.

Hunt, G. (1994). Death, medicine and bioethics. *Theoretical Medicine, 15,* 431 – 447.

Hutchinson, S. A. (1990). Responsible subversion: A study of rule-bending among nurses. *Scholarly Inquiry for Nursing Practice: An International Journal, 4* (1), 3 – 17.

Isaak, C., & Paterson, B. L. (1996). Critical care nurses' lived experience of unsuccessful resuscitation. *Western Journal of Nursing Research, 18* (6), 688 - 702.

Ivy, S. S. (1996). Ethical considerations in resuscitation decisions: A nursing ethics perspective. *Journal of Cardiovascular Nursing, 10* (4), 47 - 58.

Jeffrey, K. (1995). Pacing the heart: Growth and redefinition of a medical technology, 1952 - 1975. *Technology and Culture,* 583 - 624.

Jevon, P. (1999). Do not resuscitate orders: The issues. *Nursing Standard 13,* (40), 45 – 46.

Jezewski, M. A. (1996). Obtaining consent for do-not-resuscitate status: Advice from experienced nurses. *Nursing Outlook, 44* (3), 114 - 119.

Jezewski, M. A., Scherer, Y., Miller, C., & Battista, E. (1993). Critical care nurses' interactions with patients and family members. *American Journal of Critical Care, 2* (4), 302 - 309.

Johnstone, M-J. (1999). *Bioethics: A nursing perspective.* (3rd ed.). Sydney, Australia: W. B. Saunders/Balliere Tindall, pp. 363 - 391.

Jordens, C. (1988). Flesh. *Intervention 21/22, Intervention Publications,* 98 – 103.

Jorm, A. F., Henderson, A. S., Scott, R., Korten, A. E., Christensen, H., & MacKinnon, A. J. (1995). Factors associated with the wish to die in elderly people. *Age and Ageing, 24,* 389 - 392.

Jupp, V., & Norris, C. (1993*). Traditions in documentary analysis* (pp. 37 - 51). In M. Hammersley (Ed.). Social research: Philosophy, politics and practice, London: Sage.

Kamer, R. S., Dieck, E. M., McClung, J. A., White, P. A., & Sivak, S. L. (1990). Effect of New York State's do-not-resuscitate legislation on in-hospital cardiopulmonary resuscitation practice. *The American Journal of Medicine, 88,* 108 - 111.

Karetzky, M., Zubair, M., & Parikh, J. (1995). Cardiopulmonary resuscitation in intensive care unit and non-intensive care unit patients. *Archives of Internal Medicine, 155,* 1227 - 1280.

Kellehear, A. (2000). (Ed.). *Death and dying in Australia.* Melbourne, Oxford University Press.

Kelsey, J. (1995). *The New Zealand experiment: A world model for structural adjustment?* Auckland, New Zealand: University of Auckland, p.1.

Kelsey, J. (1997). *Reclaiming the future.* Auckland, New Zealand: University of Auckland.

Kerridge, I., Mitchell, K., & McPhee, J. (1997). Defining medical futility in ethics, law and clinical practice: An exercise in futility? *Journal of Law and Medicine, 4,* 235 - 242.

Kidder, L. H. (1981). *Research Methods in Social Relations.* New York: Holt, Rinehart & Winston.

King, A. (2000). *The New Zealand health strategy discussion document.* Wellington: Ministry of Health.

King. S. (1999). *"Getting on top of pain": A critical analysis of surgical nurses' talk about their work with hospitalised patients reporting pain*. Unpublished MA (Applied) thesis: Victoria University of Wellington.

Kirschbaum, M. S. (1996). Life support decisions for children: What do parents value? *Advances in Nursing Science, 19* (1), 51-71.

Koch, K. A., Meyers, B. W., & Sandroni, S. (1992). Analysis of power in medical decision-making: An argument for physician autonomy. *Law, Medicine and Health Care, 20* (4), 320 - 326.

Komesaroff, P. A. (Ed.). (1995). *Troubled bodies: Perspectives on post-modernism, medical ethics, and the body.* Durham: Duke University Press.

Komesaroff, P.A. (1997). Editorial: No -CPR policies: Have we made any progress? *Australian and New Zealand Journal of Medicine 27,* 369 - 370.

Konishi, E. (1998). Nurses' attitudes towards developing a do-not-resuscitate policy in Japan. *Nursing Ethics, 5* (3), 218 - 227.

Kouwehoven, U. B., Jude, J. R., & Knickerbocker, G. G. (1960). *Journal of the American Medical Association, 173,* 1064 - 1067.

Kuhse, H., Singer, P., Baume, P., Clark, M., & Rickard, M. (1997). End-of-life decisions in Australian medical practice. *Medical Journal of Australia, 166,* 191 - 196.

Kuuppelomaki, M. (1993). Ethical decision-making on starting terminal care in different health-care units. *Journal of Advanced Nursing, 18*, 276 - 280.

Lake, D. F. (1996). No code. *American Journal of Nursing, 96* (2), 38 - 39.

Langslow, A. (1995). 'Not for CPR' orders: Current developments. *Australian Nursing Journal, 2* (10), 36 - 38.

Lather, P. (1991). *Getting smart: Feminist research and pedagogy with/in the post modern.* London: Routledge.

Laugesen, M. & Salmond, G. (1994). New Zealand health care: A background. *Health Policy, 29*, 11 - 23.

Lawler, J. (1991). *Behind the screens: Nursing, somology, and the problem of the body.* Melbourne: Churchill Livingstone.

Lawler, J. (1997). *The body in nursing.* Melbourne: Churchill Livingstone.

Lessey, K. (1996). Life and death decisions. *Health Service Journal*, November 14, 13 - 14.

Levine, C., & Zuckerman, C. (2000). Hands on/hands off: Why health care professionals depend on families but keep them at arm's length. *Journal of Law, Medicine and Ethics, 28*, 5 - 18.

Liaschenko, J. & Davis, A. J. (1991). Nurses and physicians on nutritional support: A comparison. *The Journal of Medicine and Philosophy, 16*, 259 – 283.

Lipton, H. L., (1986). Do-not-resuscitate decisions in a community hospital. *Journal of the American Medical Association, 256* (9), 1164 - 1169.

Liss, H. P., (1986). A history of resuscitation. *Annals of Emergency Medicine*, January, 117 - 124.

Lo, B. (1991). Editorial: Unanswered questions about DNR orders. *Journal of the American Medical Association, 265* (14), 1874 - 1875.

Loveridge, J. (1992). Working with 'Foucault': Exploring the possibilities for a critically reflexive social research. *Sites, 24*, 43-54.

Lowe, J. & Kerridge, I. (1997). Implementation of guidelines for No-CPR orders by a general medicine unit in a teaching hospital. *Australia and New Zealand Journal of Medicine, 27*, 379 - 383.

Lupton, D. (1992). Discourse analysis: A new methodology for understanding the ideologies of health and illness. *Australian Journal of Public Health, 16* (2), 145-150.

Lupton, D. (1994). *Medicine as culture: Illness, disease and the body in Western Societies*. London: Sage.

Lupton, D. (1997). Consumerism, reflexivity and the medical encounter. *Social Science and Medicine, 45* (3), 373 - 381.

Lupton, D., & Barclay, L. (1997). *Constructing fatherhood: Discourses and experiences.* London: Sage.

McCabe, M. J. (1994). The *hospice movement - an alternative to euthanasia.* Pars Dissertatio ad Doctoratum in Theologia Morali Consequendum. Romae: Pontifia Universitas Lateranensis Academia Alfonsiana Institutum Superius Theologiae Moralis.

McClung, J.A. & Kamer, R. S. (1990). Legislating ethics: Implications of New York's do-not-resuscitate law. *New England Journal of Medicine, 323* (4), 270 - 272.

McGrath, P. (1998). Autonomy, discourse and power: A Postmodern reflection on principalism and bioethics. *Journal of Medicine and Philosophy, 23* (5), 516 - 532.

McGraw, K. S., (1998). Should do-not-resuscitate orders be suspended during surgical procedures? *American Operating Room Nurses Journal, 6* (4), 794 - 799.

McHoul, A. & Grace, W. (1993). *A Foucault Primer: Discourse, power and the subject.* New York: New York University Press.

McInerney, F. (2000). "Requested death": A new social movement. *Social Science and Medicine, 50*, 137 - 154.

McLachlan, A. J. (1994). *The prinicples and practice of do-not-resuscitate orders.* A thesis submitted for the degree of Bachelor of Medical Science, University of Otago, Dunedin, New Zealand.

McLunie-Trust, P. (2000). *Body boundaries and discourse practices in life threatening illness: Narratives of the self.* MA thesis, Victoria University of Wellington, unpublished.

McManners, J. (1981). *Death and the enlightenment.* Oxford: Clarendon Press.

McNamara, B., Waddell, C., & Colvin, M. (1994). The institutionalisation of the good death. *Social Science and Medicine, 19* (11), 1501 - 1508.

McNay, L. (1993). *Foucault and feminism: Power, gender and the self.* London: Polity Press.

Macklin, R. (1993). *Enemies of patients.* New York: Oxford University Press.

Madan, T. N. (1992). Dying with dignity. *Social Science and Medicine, 35* (4) 425 - 432.

Maksoud, A., Jahnigen, D. W., & Skibinski, C. I. (1993). Do not resuscitate orders and the cost of death. *Archives of Internal Medicine, 153*, 1249 - 1253.

Manias, E. (1998). Australian nurses' experiences and attitudes in the "Do not resuscitate" decision. *Research in Nursing and Health, 21* (5), 429 - 441.

Manias, E. & Street, A. (2000). Possibilities for critical social theory and Foucault's work: A toolbox approach. *Nursing Inquiry, 7*, 50 – 60.

Manawatu/Wanganui Ethics Committee, Central Regional Health Authority (1994). *Committee Profile.* Unpublished.

Marsh, F. H., & Staver, A. (1991). Physician authority for unilateral DNR orders. *The Journal of Legal Medicine, 12,* 115 - 165.

May, C. (1992). Nursing work, nurses' knowledge, and the subjectification of the patient. *Sociology of Health and Illness, 14* (4), 472 – 487.

May, C. (1993). Disclosure of terminal prognoses in a general hospital: The nurse's view. *Journal of Advanced Nursing, 18,* 1362 - 1368.

May, C. (1995). To call it work somehow demeans 'it': The social construction of talk in the care of terminally ill patients. *Journal of Advanced Nursing, 22,* 556 - 561.

May, C., & Fleming, P. (1997). The professional imagination: Narrative and the symbolic boundaries between medicine and nursing. *Journal of Advanced Nursing, 25,*1094 - 1100.

Mead, G. E. & Turnbull, C. J. (1995). Cardiopulmonary resuscitation in the elderly: Patients' and relatives' views. *Journal of Medical Ethics, 21,* 39 - 44.

Mechanic, D. (1994). Trust and informed consent to rationing. *The Millbank Quarterly, 72* (2), 217 - 223.

Mello, M., & Jenkinson, C. (1998). Comparison of medical and nursing attitudes to resuscitation and patient autonomy between a British and an American teaching hospital. *Social Science and Medicine, 46* (3), 415 - 424.

Menikoff, J. A., Sachs, G. A., & Siegler, M. (1992). Beyond advance directives: Health care surrogate laws. *New England Journal of Medicine, 327* (16), 1165 - 1169.

Meyer, C. (1992). Coming to new terms with death. *American Journal of Nursing,* August, 19 - 20.

Meyer, C. (1993). 'End-of-life' care: Patients' choices, nurses' challenges, *American Journal of Nursing,* February 41 - 47.

Mezey, M., Evans, L. K., Golub, Z. D., Murphy, E., & White, G. B. (1994). The Patient Self-Determination Act: Sources of concern for nurses. *Nursing Outlook, 42* (1), 30 - 38.

Mezey, M. D., Leitman, R., Mitty, E. L., Bottrell, M. M., & Ramsey, G. C. (2000). Why hospital patients do and do not execute an advance directive. *Nursing Outlook, 48* (4), 165-171.

Miles, J. & Burke, L. (1996). Nurses' views of the decision not to resuscitate a patient. *Nursing Standard, 10* (22), 33 - 38.

Miles, S. H. Koepp, R., & Weber, E. P. (1996). Advance end-of-life treatment planning. *Archives of Internal Medicine, 156,* 1062 - 1067.

Miller, D. L., Gorbien, M. J., Simbartl, L. A., & Jahnigen, D. W. (1993). Factors influencing physicians in recommending in-hospital cardiopulmonary resuscitation. *Archives of Internal Medicine, 153,* 987 – 996.

Miller, T. E. (1989). Do-not-resuscitate orders: Public policy and patient autonomy. L*aw, Medicine and Health Care, 17* (3), 245 – 254.

Ministry of Health, (1996). *Healthy New Zealanders: Briefing papers for the Minister of Health.* Wellington, New Zealand: Author.

Mishler, E. G. (1986). *Research interviewing: Context and narrative.* Cambridge, Massachusetts: Harvard University Press.

Momeyer, R. M. (1990). Philosophers and the public policy process: Inside, outside or nowhere at all? *Journal of Medicine and Philosophy, 15,* 391 - 409.

Murphy, D. J. (1988). Do-not-resuscitate orders: Time for reappraisal in long-term care institutions. *Journal of the American Medical Association, 260* (14), 1131 – 1141.

National Advisory Committee on Health and Disability Services Ethics. (1996). *National Standard for Ethics Committees.* Wellington, New Zealand: Ministry of Health.

National Health Committee. (1998). *Social, cultural and economic determinants of health: Action to improve health in New Zealand.* Wellington: Author.

Nessa, J., & Malterud, K. (1998). Tell me what's wrong with me: A discourse analysis approach to the concept of patient autonomy. *Journal of Medical Ethics. 24,* 394 – 400.

New Zealand Medical Association. (1988). *Medical Code of Ethics.* Wellington: Author.

New Zealand Medical Association. (1993). *Guidelines for dealing with patients in a persistent vegetative state.* Wellington: Author.

New Zealand Nurses Organisation. (1995). *Code of ethics for nurses.* Wellington: Author.

New Zealand Nurses Organisation. (1996). *Guidelines for nurses caring for patients in a persistent vegetative state (PVS).* Wellington: Author

Niles, L. (1996). Cardiac arrest: A difficult transition. *Nursing Praxis in New Zealand, 11* (1), 37 - 39.

Nolan, J. (1998). The 1998 European Resuscitation Council guidelines for adult single rescuer basic life support. (Editorial). *British Medical Journal, 316,* 1870 - 1876.

Nuland, S. (1993). *How we die.* London: Chatto & Windus.

Oakley, A. (1981). Interviewing women: A contradiction in terms. In H. Roberts (Ed.), *Doing feminist research* (pp. 30 – 61). London: Routledge and Kegan Paul.

O'Connor, T. (1999). Professional misconduct. *Kaitiaki: Nursing New Zealand, (50)*, 8, 25.

Onions, C. T. (1964). (Ed.). *The Shorter Oxford Dictionary on Historical Principles* (3rd ed.). Oxford: The Clarendon Press.

Opie, A. (1997). Thinking teams thinking clients: Issues of discourse and repesentation in the work of health care teams. *Sociology of Health and Illness, 19* (3), 259 - 280.

Pang, M. S. (1999). Protective truthfulness: The Chinese way of safeguarding patients in informed treatment decisions. *Journal of Medical Ethics, 25*, 247 - 253.

Papps E., & Olssen, M. (1997). *Doctoring childbirth and regulating midwifery in New Zealand: A Foucauldian perspective.* Palmerston North: The Dunmore Press.

Parker, I. & Burman, E. (1992). Discourse, action and the research process. In I. Parker, *Discourse dynamics: Critical analysis for social and individual psychology.* (pp. 155 - 172). London: Routledge.

Parker, J. & Gardner, G. (1992). The silence and silencing of nurses' voice: A reading of the patient's notes. *The Australian Journal of Advanced Nursing, 9* (2), 3 – 9.

Parker, I. & Shotter, J. (Eds.). (1990). *Deconstructing Social Psychology.* London: Routledge.

Paterson, M. (2000). Dealing with life and death decisions. *Kaitiaki: Nursing New Zealand 6* (7), 14 – 16.

Peerson, A. (1995). Foucault and modern medicine. *Nursing Inquiry, 2*, 106 - 14.

Peterson, A., & Bunton, R. (1997). *Foucault, Health and Medicine.* London: Routledge.

Pijnenborg, L., van der Maas, P. J., Kardaun, J.W. P. F., Glerum, J. J., van Delden, J. J. M., & Looman, C. W. N. (1995). Withdrawal or withholding treatment at the end of life. *Archives of Internal Medicine, 155*, 286-292.

Pollack, S. (1996). Detours on the road to autonomy: A critique of the New York State do-not-resuscitate law. *Archives of Internal Medicine, 156,* 1369 - 1371.

Pomare, E., & de Boer, P. (1988). *Maori standards of health.* Wellington, New Zealand: Department of Health.

Porter, S. (1996). Contra-Foucault: Soldiers, nurses and power. *Sociology, 30* (1), 59 - 78.

Potter, J., & Wetherell, M. (1987). *Discourse and social psychology: Beyond attitudes and behaviour.* London: Sage.

Potter, J., & Wetherell, M. (1994a). Analyzing discourse. In A. Bryman & R. Burgess (Eds.), *Analyzing qualitative data* (pp. 47 - 66). London: Routledge.

Potter, J., & Wetherell, M. (1994b). *Discourse analysis.* Paper presented on 24 October 1994. Loughborough University and the Open University.

Powers, P. (1996). Discourse analysis as a method for nursing inquiry. *Nursing Inquiry 3* (4), 207 – 217.

President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioural Research. (1983). *Deciding to forego life-sustaining treatment: A report on the ethical, medical and legal issues in treatment decisions.* Washington, DC: Author.

Prior, L. (1989). The social organisation of death: Medical discourses and social practices in Belfast. London: McMillan.

Puopolo, A. L., Kennard, M. J., Mallatratt, L., Follen, M. A., Desbiens, N. A., Conners, A. F., Califf, R., Walzer, J., Soukup, J., Davis, R. B. & Phillips, R. S. (1997). Preferences for cardiopulmonary resuscitation. *IMAGE: Journal of Nursing Scholarship, 29* (3), 229 - 235.

Purvis, T. and Hunt, A. (1993). Discourse, ideology, discourse, ideology, discourse, ideology. *British Journal of Sociology, 44* (3), 473 - 499.

Rabinow, P. (Ed.). (1984). *The Foucault Reader.* New York: Pantheon Books.

Reid, P. (1999). Te pupuri i te ao o te tangata whenua. In P. Davis & Dew, K. (Eds.), *Health and society in New Zealand* (pp. 51 – 62). Auckland: Oxford University Press.

.

Research Policy Office, Victoria University of Wellington. (2000). *PhD handbook.* Wellington: Author.

Robertson, G. S. (1993). Resuscitation and senility: A study of patients' opinions. *Journal of Medical Ethics, 19,* 104 - 107.

Robinson, J. (1990). Euthanasia: The collision of theory and practice. *Law, Medicine and Health Care, 18,* 105 - 107.

Robinson, J., Avis, M., Latimer, J., & Traynor, M. (1999). *Interdisciplinary perspectives in health policy and practice: Competing interests or complementary interpretations?* Edinburgh: Churchill Livingstone.

Rodriguez, K. F. (1999). Suing health care providers for saving lives: Liability for providing unwanted life-sustaining treatment. *The Journal of Legal Medicine, 20,* 1 - 66.

Rolfe, G. (2000). *Research, truth and authority: Postmodern perspectives on nursing.* London: MacMillan Press Ltd.

Rose, A. (1997*). Submission to the Wellington Ethics Committee: Critique and recommendations of the 'not-for-cardiopulmonary resuscitation' guidelines from a nursing perspective and the ethic of care.* Unpublished.

Rose, A. (1998). *My concern for not-for-resuscitation.* Paper presented at the Hospice New Zealand Annual Conference, 24 – 26 June 1998, Wellington.

Rothman, D. (1991). *Strangers at the bedside.* New York: Harper Collins.

Rudge, T. (1997). In J. Lawler. *The body in nursing*. Melbourne: Churchill Livingstone.

Sale, K., (1994). A perfect enemy. *The Nation*, May 23, 689.

Salmond, G., Mooney, G., & Laugesen, M. (1994). Introduction to health reform in New Zealand. *Health Policy, 29*, 1 - 3.

Savulescu, J. (1995). Rational non-interventional paternalism: Why doctors ought to make judgements of what is best for their patients. *Journal of Medical Ethics, 21*, 327 - 331.

Sawicki, J. (1991). *Disciplining Foucault: Feminism, power and the body.* New York: Routledge.

Sayers, G. M., Schofield, I., & Aziz, M. (1997). An analysis of CPR decision-making by elderly patients. *Journal of Medical Ethics, 23*, 207 – 212.

Schade, S. G., & Muslin, R. H. (1989). Do not resuscitate decisions: Discussions with patients. *Journal of Medical Ethics, 18*, 186 - 189.

Scharf, S., Flamer, H., & Christophidis, N. (1997). Age as a basis for health care rationing. *New Ethicals*, March, 9-13.

Schneiderman, L. J., Kronick, R., Kaplan, R. M., Anderson, J. P., & Langer, R. D. (1992). Effects of offering advance directives on medical treatment and costs. *Annals of Internal Medicine 117*, 599 - 606.

Schneidermayer, D.L. (1988). The decision to forego CPR in the elderly patient. *Journal of the American Medical Association, 260* (14), 2096 - 2097.

Schroyen, B. (1997). Do not resuscitate. *Northland Polytechnic Nursing Journal, 1*, 23 - 31.

Schultz, L. (1997). Not-for-resuscitation: Two decades of challenge for nursing ethics and practice. *Nursing Ethics, 4* (3), 227 - 238.

Scitovsky, A. A. (1994). "The high cost of dying" revisited. *The Millbank Quarterly, 72* (4), 561 - 591.

Scott, C. D. (1994). Reform of the New Zealand health care system. *Health Policy, 29*, 25 - 40.

Scott, C. E. (1987). The power of medicine, the power of ethics. *The Journal of Medicine and Philosophy, 12,* 335 - 350.

Scott, R. (1988). *The body as property.* New York: The Viking Press.

Seale, C. (1995). Heroic death. *Sociology, 29* (4), 597 - 613.

Seale, C. (1998*). Constructing death: The sociology of dying and bereavement.* Cambridge: Cambridge University Press.

Shepherd, E. (2000). Life and death decisions. *Nursing Times 96* (31), 23.

Shorr, A. F., Niven, A. S., Katz, D. E., Parker, J. M., & Eliasson, A. H. (2000). Regulatory and educational initiatives fail to promote discussions regarding end-of-life care. *Journal of Pain and Symptom Management, 19* (3), 168 – 173.

Silverman, D. (1987*). Communication and medical practice: Social relations in the clinic.* London: Sage.

Sloan, A. (1996). Don't resuscitate, lose your job? *Registered Nurse*, 51 - 54.

Slomka, J. (1992). The negotiation of death: Clinical decision-making at the end of life. *Social Science and Medicine, 35* (3), 251 - 259.

Slomka, J. (1995). What do apple pie and motherhood have to do with feeding tubes and caring for the patient? *Archives of Internal Medicine, 155,* 1258 - 1263.

Smart, B. (1985). *Michel Foucault.* London: Tavistock.

Sorum, P.C. (1995). Deciding about cardiopulmonary resuscitation: The contributions of decision analysis. *Archives of Internal Medicine, 155,* 513 - 521.

St John, P. (1998). Ministry not the right body to oversee ethics. *New Zealand Doctor.* 15 April, 17.

Steering Group to Oversee Health and Disability Changes to the Minister of Health and the Associate Minister of Health. (1997). *Implementing the Coalition Agreement on Health.* Wellington, New Zealand: Ministry of Health.

Steinberg, M. A., Najman, J. M., Cartwright, C. M., McDonald, S. M., & Williams, G. M. (1997). End-of-life decision-making: Community and medical practitioners' perspectives. *Medical Journal of Australia, 166*, 131 - 135.

Stenburg, M. J. (1988). "The responsible powerless": Nurses and decisions about resuscitation. *Journal of Cardiovascular Nursing, 3* (1), 47 - 56.

Stewart, K. (1995). Discussing cardiopulmonary resuscitation with patients and relatives. *Postgraduate Medical Journal, 71*, 585 - 589.

Stolman, C. J., Gregory, J. J., Dunn, D., & Levine, J. L. (1990). Evaluation of patient, physician, nurse and family attitudes towards do not resuscitate orders. *Archives of Internal Medicine, 150,* 653 – 658.

Stone, J. (1996). Advance directives, autonomy and unintended death. *Monash Bioethics Review, 15* (2), 16 - 33.

Street, K., Ashcroft, R., Henderson, J., & Campbell, A. V. (2000). The decision-making process regarding the withdrawal or withholding of potential life-saving treatments in a children's hospital. *Journal of Medical Ethics, 26*, 346 – 352.

Sulmasy, D. P. (1995). Managed care and managed death. *Archives of Internal Medicine, 155*, 133 - 136.

Svensson, R. (1996). The interplay between doctors and nurses – a negotiated order perspective. *Sociology, 30* (4), 379 – 397.

Taylor, E. M., Ramsay, M. P., Parker, S., & Peart, N. S. (1996). The introduction and auditing of a formal do not resuscitate policy. *New Zealand Medical Journal, 109*, 424 - 428.

Temkin-Greener, H., Meiners, M. R., Petty, E. A., & Szydlowski, J. S. (1992). The use and cost of health services prior to death: A comparison of the

Medicare-only and Medicare-Medicaid elderly populations. *The Millbank Quarterly, 70* (4), 679 - 701.

Tilley, S., Pollock, L., & Tait, L. (1999). Discourses on empowerment. *Journal of Psychiatric and Mental Health Nursing, 6*, 53 – 60.

Turner, B. (1992). *Regulating bodies: Essays in Medical Sociology.* London: Routledge.

Turner, B. (1995). *Medical power and social knowledge.* (2nd ed.). London: Sage Publications.

Upton, S. (1991). *Your health and the public health.* Wellington: New Zealand Department of Health.

van Delden, J. J. M., van der Maas, P. J., Pijnenborg, L., & Looman, C. W. N. (1993). Deciding not to resuscitate in Dutch hospitals. *Journal of Medical Ethics, 19*, 200 - 205.

van der Arend, A. (1997). *A nurse-ethical perspective on euthanasia and assisted-suicide in The Netherlands.* Paper presented at the Quadrennial Congress of the International Council of Nurses at Vancouver, Canada. Department of Health Care Ethics and Philosophy, University of Maastricht, The Netherlands.

van Dijk, T.A. (1990). The growth of discourse analysis. *Discourse and Society. 1* (1), 5-16.

van Dijk, T. A. (Ed.). (1997a). *Discourse as structure and process. Discourse studies: A multidisciplinary introduction Volume 1.* London: Sage.

van Dijk, T. A. (Ed.). (1997b). *Discourse as social interaction. Discourse studies: A multidisciplinary introduction Volume 2.* London: Sage.

Veatch, R. (1976). *Death,dying and the biological revolution: Our last quest for responsibility.* New Haven and London: Yale University Press.

Volosinov, V. N. (Trans. L. Matejka and I. R. Titunik). (1973). *Marxism and the philosophy of language.* New York: Seminar Press.

Wagg, A., Kinirons, M., & Stewart, K. (1995). Cardiopulmonary resuscitation: Doctors and nurses expect too much. *Journal of the Royal College of Physicians, of London, 29* (1), 20 - 24.

Waitzkin, H. (1984). The micropolitics of medicine: A contextual analysis. *International Journal of Health Services 14* (3), 339 – 370.

Walker, K. (1994). Confronting reality: Nursing science and the micropolitics of representation. *Nursing Inquiry, 1* (1), 15-22.

Walker, R. M., Schonwetter, R. S., Kramer, D. R., & Robinson, B. E. (1995). Living wills and resuscitation preferences in an elderly population. *Archives of Internal Medicine, 155,* 171 - 175.

Walter, T. (1994). *The revival of death.* New York: Routledge.

Ward, P. R. (1997). Health care rationing: Can we afford to ignore euthanasia? *Health Services Management Research, 10,* 32 - 41.

Watson, D. R., Wilkinson, T. J., Sainsbury, R., & Kidd, J. E. (1997). The effect of hospital admission on the opinions and knowledge of elderly patients regarding cardiopulmonary resuscitation. *Age and Ageing, 26,* 429 – 434.

Weatherall, M. & Mathewson, P. (1995). Rest home policy about cardiopulmonary resuscitation and life threatening illness in their residents. *New Zealand Medical Journal, 108,* 462.

Weisfeld, V., Miller, D., Gibson, R., & Schroeder, S. A. (2000). Improving care at the end of life: What does it take? *Health Affairs, 19* (6), .

Wenger, N. S., Pearson, M. L., Desmond, K. A., Brook, R. H., & Kahn, K. L. (1995). Outcomes of patients with do-not-resuscitate orders: Towards an understanding of what do-not-resuscitate orders mean and how they affect patients. *Archives of Internal Medicine, 155, 2063* - 2068.

Wesney, B. (1985). Nurses' feelings about working with the dying. *The New Zealand Nursing Journal, 78* (5), 3 – 7.

Wicks, D. (1999). *Nurses and doctors at work: Rethinking professional boundaries.* St Leonards, Australia: Allen & Unwin.

Wikler, D. (1991). What has bioethics got to offer health policy? *The Millbank Quarterly, 69* (2), 233-249.

Williams, A. (1992). Cost-effectiveness analysis: Is it ethical? *Journal of Medical Ethics, 18,* 7 - 11.

Wilson, D. M. (1996). Highlighting the role of policy in nursing practice through a comparison of "DNR" policy influences and "No CPR" decision influences. *Nursing Outlook, 44* (6), 272 - 278.

Wilson, H. V. (2000). *Surveillance or support: Divergent discourses in Plunket nursing practice.* Unpublished MA thesis, Victoria University of Wellington.

Yarling, R. R., & McElmurry, B. J. (1983). Rethinking the nurse's role in "do not resuscitate" orders: A clinical policy proposal in nursing ethics. *Advances in Nursing Science, 5* (4), 1 - 11.

Yarling, R. R., & McElmurry, B. J. (1986). The moral foundation of nursing. *Advances in Nursing Science, 8* (2), 63 – 73.

Youngner, S. J. (1987). Do-not-resuscitate orders: No longer a secret, but still a problem. *Hastings Centre Report*, February, 24 -33.

Youngner, S. J. (1988). Who defines futility? *Journal of the American Medical Association, 260* (14), 2094 - 2095.

Youngner, S. J., Lewandowski, W., McLish, D. K., Juknialis, B. W., Coulton, C., & Bartlett, E. T. (1985). 'Do-not-resuscitate' orders: Incidence and implications in a medical intensive care unit. *Journal of the American Medical Association, 253* (1), 54 - 57.

Zerwekh, J. (1994). The truth-tellers: How hospice nurses help patients confront death. *American Journal of Nursing, 94* (2), 31 - 34.

Zimbelman, J. (1994). Good life, good death, and the right to die: Ethical considerations for decisions at the end of life. *Journal of Professional Nursing, 10* (1), 22 – 37.

Zoch, T. W., Desbiens, N. A., DeStefano, F., Stueland, D. T., & Layde, P. M. (2000). Short and long-term survival after cardio-pulmonary resuscitation. *Archives of Internal Medicine, 160* (July 10), 1969 - 1973.