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

**A thesis presented in fulfilment of the
requirements for the degree of**

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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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