

It's not (just) about the evidence:  
The discourse of knowledge translation and nursing practice

by

Lorelei Joyce Newton  
BSN, University of Victoria, 1995

A Dissertation Submitted in Partial Fulfillment of the  
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DOCTOR OF PHILOSOPHY

in the Department of Human and Social Development

School of Nursing

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University of Victoria

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## **Supervisory Committee**

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Dr. M. E. Purkis, Dean, Faculty of Human and Social Development  
**Supervisor**

Dr. M. McIntyre, Associate Professor, School of Nursing  
**Departmental Member**

Dr. M. Prince, Lansdowne Professor of Social Policy, Faculty of Human & Social Development  
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## Abstract

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This dissertation advances a reading of knowledge translation and the effects of such a discourse on nursing practice in one setting. Knowledge translation is often put forth as a solution to the ‘problems’ of contemporary Canadian healthcare. Yet to adopt the practices of knowledge translation does not necessarily reflect the inevitable progress of nursing professionalism or legitimacy but instead, is a process that is both engineered and unpredictable. In order to understand nursing practice in a different way, particularly in the era of ‘knowledge translation,’ an ethnographic methodology guided by a feminist poststructural perspective was chosen.

Within the discursive frame of knowledge translation, accounts of nursing practice are narrowly described and often represented as a linear process of delivering particular knowledge (‘evidence’) from experts to users. This contradicts the knowledge translation practices observed in this study as such nursing practice requires a wide and varied knowledge base derived from multiple sources. Thus, it seems the work of successful knowledge translation is the capacity to “move within and between discourses” (Davies, 2000, p. 60) through contextualizing practices. Articulating these contextualizing practices provides an avenue to explain and understand aspects of nursing practice that are essential to sustain the discourse of knowledge translation yet are mostly unaccounted.

The discourse of knowledge translation seems to focus on ‘outcomes’ and the creation of a particular kind of quantifiable evidence by the nurses themselves. Such outcomes not only become evidence of ‘good practice,’ the nurse is also positioned to ‘manage’ the subjective experiences of the patient (i.e. pain) by converting such experiences into quantifiable accounts. The production of such outcomes (evidence) also serves to bring nurses and patients into alignment with (made ‘subjects’ of) the discourse of knowledge translation. In this way, the

discourse of knowledge translation does not seem to be just about the production of evidence (or knowledge); it is about the reorganization of knowledges. This 're-ordering' is accomplished through (re)education and the concurrent use of chart audits that evaluate 'good practice' through the documented use of knowledge translation activities. It is self-referential: documentation of the outcomes of sanctioned knowledge translation activities becomes the evidence that these activities are effective. That is, the evidence *is* the evidence.

While the effects of the discourse of knowledge translation seem to undermine professional judgment and position nurses as the vehicle for organizational surveillance in terms of patient safety (risk) and economic demands, it also serves as a point of resistance. The taken-for-granted contextualizing practices required to enact the discourse of knowledge translation positions the nurse to be influential in expanding the notions of both evidence and knowledge translation. It is the articulation of the multi-dimensional recursive contextualizing practices in concert with the nurses' ability to move between discursive frames that simultaneously allows for and creates knowledge to be translated. In this way, nurses are also being responsive to a new kind of patient who, while rarely discussed in the knowledge translation process, also has an unaccounted for potential to influence and reshape the discursive field of healthcare.

## Table of Contents

<b>Supervisory Committee .....</b>	<b>ii</b>
<b>Abstract .....</b>	<b>iii</b>
<b>Table of Contents .....</b>	<b>v</b>
<b>Acknowledgements.....</b>	<b>viii</b>
<b>Dedication .....</b>	<b>ix</b>
<b>Chapter One: Knowledge (Translation) Practices.....</b>	<b>1</b>
<b>Background.....</b>	<b>3</b>
<b>(Re)considering Nursing History .....</b>	<b>5</b>
Subjectivity and the ‘ideal’ nurse. ....	6
Subjectivity and me. ....	8
<b>‘Moments’ in History of Translating the ‘Ideal’ Nurse.....</b>	<b>10</b>
The modern nurse. ....	11
The regulated nurse.....	13
The scientific nurse.....	14
<b>Knowledge and Ignorance.....</b>	<b>16</b>
<b>The Knowledge Worker: A Knowledge Translation ‘Moment’ .....</b>	<b>17</b>
<b>Research Question.....</b>	<b>18</b>
<b>Organization of this Dissertation.....</b>	<b>19</b>
<b>Chapter Two: Subjectivity-In-Action.....</b>	<b>21</b>
<b>Problems and Promises.....</b>	<b>24</b>
The main problem: ‘the gap.’ .....	25
The solution. ....	27
Solving the patient safety problem. ....	31
The problem of fiscal responsibility.....	36
<b>But Practice is Not Generic... ..</b>	<b>37</b>
<b>Best Practice Guidelines .....</b>	<b>38</b>
<b>The Knowledge Worker .....</b>	<b>39</b>
Doing and knowing.....	40
Not knowing. ....	41
<b>More Promises.....</b>	<b>42</b>
<b>At the Margins.....</b>	<b>43</b>
<b>Conclusion.....</b>	<b>45</b>
<b>Chapter Three: Methodological and Theoretical Considerations.....</b>	<b>46</b>
<b>Ethnography .....</b>	<b>47</b>
Accounting for knowledge translation practice. ....	49
Place and space.....	51
<b>A Feminist Poststructural Accounting of Nursing Practice.....</b>	<b>53</b>
Subject and subjectivity.....	53
Language.....	54
Power/Knowledge.....	55
Discourse. ....	56
Discourse or ideology? .....	58
<b>Overview of Implementing the Study.....</b>	<b>60</b>

Entering the field.....	61
The general setting.....	62
Sample.....	63
<b>The Nurse-run Clinic.....</b>	<b>64</b>
An introduction to some evidence.....	66
<b>Data Collection.....</b>	<b>67</b>
Observations.....	68
Interviews.....	71
Observant Participant.....	72
Collecting documents and materials.....	73
Research Journal.....	74
Descriptive and Interpretive Notes.....	75
Methodological and Planning Notes.....	75
Theoretical notes and journaling.....	76
The writing itself.....	78
<b>Making Sense: Analysis.....</b>	<b>80</b>
<b>Scientific Integrity.....</b>	<b>82</b>
Triangulation.....	82
<b>Research Ethics Considerations.....</b>	<b>84</b>
<b>Conclusion.....</b>	<b>85</b>
<b>Chapter Four: Knowledge-In/Action.....</b>	<b>86</b>
<b>Best Practice Guidelines.....</b>	<b>87</b>
<b>‘Shift’ Work.....</b>	<b>90</b>
Rationalism.....	94
“Resistance is futile.”.....	97
Registered Nursing.....	99
Noticing.....	102
<b>Contextualizing Knowledge Translation.....</b>	<b>103</b>
<b>Contextualizing Practices.....</b>	<b>107</b>
“Something simple is always complex”.....	108
Resistance is fertile.....	112
“A patient is never a symptom.”.....	113
<b>Conclusion.....</b>	<b>114</b>
<b>Chapter Five: “...but...nurses don’t do <i>knowledge translation</i>, do they?”.....</b>	<b>116</b>
<b>The Nurse-run Clinic: A Room of Their Own.....</b>	<b>117</b>
Establishing nurse space/place.....	118
“What are they doing in there?”.....	119
<b>Site of Ideological Struggle.....</b>	<b>123</b>
<b>Best Practice Guidelines and Identity.....</b>	<b>127</b>
Interpellation.....	128
The independent practitioner.....	130
Accounting for the “knowledge worker.”.....	134
Positioning for ‘power.’.....	136
Advanced practice.....	138
<b>Conclusion.....</b>	<b>140</b>
<b>Interrogating the Researcher Conclusions.....</b>	<b>142</b>
<b>Chapter Six: A ‘(re)ordering’ of Things?.....</b>	<b>145</b>
<b>“A Cultural Shift”.....</b>	<b>145</b>
<b>Accomplishing the Reordering.....</b>	<b>153</b>

Surveillance.....	157
<b>Disrupting Knowledge Translation .....</b>	<b>158</b>
<b>The ‘Business’ of Knowledge Translation .....</b>	<b>160</b>
<b>The Work of Knowledge Translation.....</b>	<b>161</b>
<b>Transformation of the Patient.....</b>	<b>164</b>
<b>Conclusion.....</b>	<b>165</b>
<b>Chapter Seven: The Map is not the Territory .....</b>	<b>167</b>
<b>It’s not (just) about the Evidence.....</b>	<b>167</b>
<b>Entering New Territory .....</b>	<b>169</b>
<b>Noticing Nursing Practice.....</b>	<b>170</b>
<b>Establishing Nurse Territory .....</b>	<b>172</b>
<b>Noticing a New Patient.....</b>	<b>174</b>
<b>Implications of such Accounts of Practice .....</b>	<b>176</b>
<b>Disrupting Narrow Accounts of Practice.....</b>	<b>177</b>
<b>Expanding the Territory (not the map) .....</b>	<b>179</b>
<b>References .....</b>	<b>181</b>
<b>Appendix A: Diagram of the causes of mortality in the army in the East.....</b>	<b>205</b>
<b>Appendix B: Hierarchy of Evidence.....</b>	<b>206</b>
<b>Appendix C: KT+ Alerting System.....</b>	<b>207</b>
<b>Appendix D: Documents and descriptions of materials used by nurses observed .....</b>	<b>208</b>
<b>Appendix E: Interviewer Guide.....</b>	<b>209</b>

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## **Dedication**

This dissertation is dedicated to a patient I met one morning in the waiting room before the clinics opened. He was sitting patiently with his child hoping to get chemotherapy early in order that he could drop off his child at school and still get to work on time. His situation helps me remember why nursing research is so important.

## Chapter One: Knowledge (Translation) Practices

As a practice-based profession, it has long been recognized that new discoveries enacted in the routine practices of nurses have the potential to improve both the health of patients and the quality of healthcare environments. Over the past decade, there has been a growing concern that the uptake of research findings by practitioners and policy-makers is not occurring quickly or efficiently enough resulting in a ‘gap’ between the discovery of new knowledge and its appropriate application. This ‘gap,’ theorized about since the mid-twentieth century in many disciplines including nursing (e.g. Conant, 1967; Risjord, 2010), is currently thought to represent inefficient use of resources and/or a lack of knowledge by practitioners and thus, poses a threat to patient safety<sup>1</sup>. In an apparent effort to address this key issue in contemporary Canadian healthcare, the concept of ‘knowledge translation’ has quickly become a focal point of all healthcare related activities.

The Canadian Institutes of Health Research (CIHR), Canada’s primary source of healthcare research funding, coined the term ‘knowledge translation’ in 2000 when the CIHR Act (Bill C-13) was legislated in that same year. Knowledge translation is defined as the

... dynamic and iterative process that includes synthesis, dissemination, exchange and ethically sound application of knowledge to improve the health of Canadians, provide more effective health services and products and strengthen the healthcare system (CIHR, 2011a).

While the concern over moving research into practice is hardly novel, what is new is formalized federal initiatives to support such an endeavour. This active role by a federal body to coordinate

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<sup>1</sup> For example, Sussman, Valente, Rohrbach, Skara and Pentz (2006) estimated that it takes between one to two decades for original research to be incorporated into routine health practices.

and support the efforts of all involved in health research and healthcare delivery has many effects. In keeping with the spirit of a universal healthcare system, a sanctioned mode of knowledge translation is purported to represent an important step to highlight and address the many inequities that exist across Canada in terms of healthcare and access to that healthcare (CIHR, 2011a). Further to this, the creation of an official Knowledge Translation Institute is said to emphasize the complexity of incorporating research findings into healthcare practices to improve the health of all Canadians. The intention of the newly created CIHR Knowledge Translation Institute is to

... increasingly focus on solutions-based research that involves collaborations between researchers and users of research knowledge to increase the uptake of research findings (CIHR, 2011b).

Central to this view of knowledge translation is grounding policy and practice decisions in ‘real science;’ that is, research findings or ‘evidence’ produced through clinical epidemiology and evaluation research in conjunction with randomized controlled trials - the so-called ‘gold standard’ of knowledge production (e.g. Estabrooks, Scott-Findley & Winther, 2004; Pearson, Field & Jordan, 2007; Sackett, Rosenberg, Gray, Haynes & Richardson, 1996). Within the knowledge translation literature, the terms ‘knowledge’ and ‘evidence’ are often used interchangeably and, at times, the meanings of these terms seem to be conflated. Thus, in Canada, the notions of evidence, knowledge and knowledge translation have been institutionalized with formal processes structured to influence researchers and ‘users’ of research products (e.g. practitioners and policy makers) at both national and local levels of healthcare to facilitate a particular mode of knowledge production and dissemination. Yet at the same time, there seems to exist multiple and various activities portrayed as exemplifying ‘knowledge translation,’ of which the evidence (and benefits) to support such knowledge translation activities is not readily

apparent. One purpose of this study is to better understand the effects of the former (that is, the formalized policies and guidelines), while at the same time paying close attention to excavating indications of the latter.

The formation of the Knowledge Translation Institute and other official Canadian knowledge translation organizations has also served to create a new discourse influencing healthcare policy and practices. Particularly since ‘knowledge translation’ became the focus of my studies (over the past four years), the discourse of knowledge translation seems to have become a guiding force for nursing research, education and practice in Canada. I am intrigued with the speed with which this discourse has been taken up by both nursing and Canadian healthcare organizations. I am also very interested by the potential such pervasive efforts to structure and institutionalize processes aimed to address the ‘gap’ problem has on the practice of all involved in healthcare, chiefly nurses. In adopting and incorporating the practices of the discourse of knowledge translation, there is the promise that nursing practice (and the individual nurse) will be somehow enhanced or even transformed. I suggest that the practices involved in promoting and producing such a ‘transformation’ will produce multiple outcomes and effects on the nurse, nursing practice and ultimately, the discipline and profession of nursing. It is these effects of the discourse of knowledge translation that are the focus of this dissertation.

## **Background**

My desire to explore the discourse of knowledge translation is a direct result of my interest in nursing practice environments and the creation of ethical climates for good nursing to proceed. Ethical climate refers to one aspect of an organizational culture and can be understood as nurses’ views of the setting and norms of the organization that either supports or constrains the open discussion of decisions regarding complicated patient care (Olson, 2002). While working with a

group of nurses researching nursing ethics and ethical climate (Storch, Rodney, Varcoe et al., 2009), I discovered a substantial and robust body of ‘gold-standard’ research evidence linking many positive outcomes such as better retention rates, increased employee satisfaction, increased patient safety, decreased patient mortality rates and decreased infection rates to the quality of nurses’ practice environments (e.g. Aiken, Clarke, Sloane, Sochalski & Silber, 2002; Hart, 2005; Sherwin, 2006). Despite this, there seemed (to me in practice) little evidence of these findings being translated into action. Not only that, there also seemed many initiatives claiming an affiliation with knowledge translation readily funded without any ‘evidence’ supporting that project, such as electronic patient records. Turning to the knowledge translation literature for answers resulted in more questions: Why does nursing knowledge and research findings seem to be so difficult to ‘translate?’ Why is the pervasive influence of history, power and politics on nursing practice and healthcare delivery largely unaccounted in research about nursing practice and knowledge translation? What might the implications of this mean to the discipline and profession of nursing?

With such intense focus placed on this notion of knowledge translation in the current academic and healthcare milieu, I originally planned to explore the history of knowledge translation in relation to the history of the discipline of nursing. In this way, I could ‘find evidence’ in my own knowledge translation process to ‘justify’ the inclusion of the discipline of nursing in current healthcare research debates and competitions for funding. I now realize that, just as the concepts of ‘knowledge’ and ‘evidence’ are often conflated, the concept of knowledge translation and the various disciplinary philosophies and theories of knowledge production and dissemination are also conflated. It is not necessarily a universal experience that a particular notion of knowledge translation is so integral to a country’s contemporary imperative in regards

to healthcare policy and practices. In addition, the history of knowledge production and dissemination in the discipline of nursing over the past two centuries is well documented and substantial (e.g. Thorne, 2009).

### **(Re)considering Nursing History**

Although this contemporary notion of knowledge translation and the production of knowledge over the course of nursing history obviously intersect, what is important to me at this point is to further explore the discourse of knowledge translation in relation to nursing practice and not to defend the legitimacy of nursing knowledge. My first inclination as a neophyte scholar was to describe a linear review of nursing history and ‘lay over’ the concept of knowledge translation to demonstrate that the discipline of nursing is as steeped in this particular ‘tradition’ of knowledge production as any other discipline. For example, I feel compelled to point out that Florence Nightingale was actually the first healthcare practitioner to use so-called ‘gold standard’ evidence to inform both policy and practice. In order to do this, she created the elegant diagram from statistics she collected entitled *Diagram of the causes of mortality in the army in the East* (Appendix A). Although such examples please me, I conclude that framing nursing history in terms of the discourse of knowledge translation would only serve to reinscribe the primacy of current conceptualizations of knowledge translation within Canadian healthcare and my own discipline. Instead, I want to account for multiple meanings of what constitutes knowledge, the importance of attending to power and language and consider a different way to understand the nurse and nursing practice. In order to do so, I began exploring a feminist poststructuralist approach.

### **Subjectivity and the ‘ideal’ nurse.**

An interesting thing happened to me as I was immersed in literature regarding both nursing history and knowledge translation while at the same time, developing my understanding of a feminist poststructuralist approach to my inquiry, particularly the notion of subjectivity (which will be explained further in chapter three). Here I use the term not to describe my subjective stance in relation to objectivity, but instead as a way to explore "the conscious and unconscious thoughts and emotions of the individual [the subject], her sense of herself, and her ways of understanding her relation to the world" (Weedon, 1997, p. 32). That is, how the nurse might identify as a knowledgeable nurse within a discourse such as knowledge translation and the possible effects of that. From a poststructuralist perspective, the subject is not static or ‘fixed’ but is instead continually in an iterative process of being both constructed by social practices and discourses as well as constructing those discourses through the way in which the subject takes up (or does not) particular practices and discourses. Such subjectivities can change when new discursive frameworks are introduced and produced within the broader discursive field (Weedon).

Describing something, such as healthcare, as a discursive field is a way to “understand the relationship between language, social institutions, subjectivity and power” (Weedon, 1997, p. 34). Within discursive fields, various “ways of giving meaning to the world and of organizing social institutions and processes” (which I call discourses) are competing and offering a range of subjectivities to individuals (Weedon, p. 34). While some discourses carry more power than others, there are multiple discourses that work to either maintain or challenge the status quo co-

existing in a continuum of sorts rather than being binary<sup>2</sup> in nature. However, discourses that tend to counter the dominant view in organizations are “likely at the margin of existing practice and dismissed by the hegemonic system of meaning and practices as irrelevant or bad” (Weedon, p. 35).

As I read about nursing history with the discourse of knowledge translation in the background, it seems to me that there is a pattern of change in the subjectivities of ‘the nurse’ when new discursive frameworks are introduced to the larger discursive field of healthcare. In particular, I noticed that there appears to be ‘moments’ in nursing history when wide spread and most often legislated (but not always) changes occurred within the discursive field of healthcare that seemed to coincide with a sort of ‘transformation’ of not just the subjectivities of individual nurses, but also seemed to redefine the very nature of what it means to be a nurse. Rafferty (1996) argues that such legislative changes designed to influence how nursing practice is organized are necessary when the profession of medicine restructures its work because even though nursing work can often be considered invisible or not valued, it is essential for the production of medicine. While I agree with this line of thought, I also see that such legislative changes are also the result of broader changes in Canadian healthcare. In this way, I argue that it is not just that nurses are needed to support the practices of physicians, but also the administration and delivery of healthcare within Canadian healthcare institutions. Thus, there also seems to be a new discursive framing of the ‘ideal’ nurse (or preferred subject position) that emerges.

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<sup>2</sup> Here, I refer to ‘binary’ as a way of thinking in which only two positions are considered. In this way, the complexity in which (and in between) those two positions are embedded within is not taken into account (Thorne, Henderson, McPherson & Pesut, 2004).

### **Subjectivity and me.**

The centrality of the feminist conviction that ‘the personal is political’ in both theory and practice is an important link to the view of subjectivity in poststructuralist thought (Weedon, 1997). This foundational assumption not only underpins how I read nursing history but also how I began to understand my own practice and identity<sup>3</sup> as a knowledgeable nurse. It was my shifting subjectivities that provided further clues to the problem I wished to explore. As I was reading nursing history, I recalled an interview I had as a young nurse in the early 1990s. My interviewers were very pleased with me because I could recite all the aspects of the nursing process and used them actively in my practice. I was surprised because other ways of nursing practice were, at the time, completely unknown to me. I was complimented on my ‘scientific’ mind and superior organizational skills and got the job. The interviewers expressed hope that I could somehow influence the older nurses on the unit, as they were ‘resistant’ to education aimed to put the nursing process into practice. As I started practicing alongside these nurses, those comments puzzled me. I did not notice any difference between how I practiced and how the ‘older’ nurses practiced. In fact, as a new nurse, I was somewhat in awe of their organizational abilities and knowledge and learned much from them during my time employed there. In retrospect, however, I recognize that there was undue attention paid to the paperwork/documentation of the nursing process rather than the time and knowledge necessary to address and work through the various components of the nursing process.

After several years away from practicing in urban acute care settings, I then taught a practicum group of nursing students. I was intrigued that the notion of the nursing process was absent from any teaching materials as well as any decision support or organizational resources

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<sup>3</sup> For the purposes of this study, I use identity and subjectivities interchangeably

available to the nurses on the wards where the students were being mentored. Instead, I was tasked with finding ‘evidence’ of the students’ learning and the students were tasked with using ‘evidence’ to inform their practice, usually in the form of guidelines or protocols. Although at that time the nurses on the ward did not seem to recognize the importance of using evidence, they were all familiar with the nursing process. A few administrators and nurse educators I was acquainted with complained to me about such ‘out of date’ practice. It occurred to me that in less than two decades, the way I (now the ‘older’ nurse) structure my own practice has morphed from being an exemplar of how *to* practice to one of how *not* to practice. This fascinates me. I am still a competent and ‘good’ nurse but the way in which I must describe my nursing practice, which I do not believe is substantially different, to account for my knowledge and competence seems to have changed. It seems that I might now be required to ‘translate’ my practice into a new discursive frame. And, when I do that, what effect does this have on my practice and how I think about nursing and myself?

Such ‘translation’ of nursing practices seems to require knowledge practices of individual nurses necessary to both create and maintain the discursive frame regarding how the ‘ideal nurse’ will/should practice. Nursing knowledge seems to have been restructured in such a way as to facilitate and maintain the new flow of expected healthcare practices and activities at an institutional level (provincial and national) within the norms of current ideas of how healthcare should be delivered. Thus, it is my expectation that when there are broad changes to the delivery of healthcare on a large-scale level, the practices of nurses also change to correspond with new institutional processes and delivery systems. In this way, nurses seem to be ‘transformed’ in order that they operate effectively within and, at the same time, participate in the creation of a new discursive frame for effective and professional practice. Examining such subjectivities can

provide insight into the effects the discourse of knowledge translation may have on nursing practice both as individuals and as a collective. Briefly exploring possible examples of transformation or translation of the preferred subject positions (the 'ideal' nurse) of previous historical 'moments' may provide insights into the influences of the traces of previous subjectivities that may become intertwined with new subjectivities and help create conditions for different notions of the 'ideal' nurse to emerge.

### **'Moments' in History of Translating the 'Ideal' Nurse**

My reading of nursing history in light of the discourse of knowledge translation and my own theoretical subjectivities points to how nursing practice is contingent on the circulating political, economic and scientific discourses at that moment in history which contribute to an account of the 'ideal' nurse. Such subjectivities are tied to nursing practices and it is these practices that are a part of the discourses attempting to define (or redefine) the boundaries of nursing knowledge and the preferred manner in which nurses should practice based on that knowledge. From my perspective, it seems that the 'gap problem' at the centre of the discourse of knowledge translation also represents a transitional historical moment in which expected and institutionalized practices are being transformed into something new.

I will briefly review the conditions for such transformations that seem to me to have the effect of so dramatically changing the subjectivities of nurses that nurses came to identify themselves in a different way. The major transformations that I see are the modern nurse, the regulated nurse and the scientific nurse. This is not to imply in any way that history is a linear process or that such 'moments' are not immersed in complex situations that I will leave mostly unaccounted. But I do wish to touch on them because it seems these major moments set the conditions that allow for future transformational moments to occur. There are elements of such

examples that continue to be carried forward in time and influence perceptions of what an ‘ideal’ nurse might mean not just to nurses, but also to others that we work with or care for.

### **The modern nurse.**

I take the first important moment in nursing’s development as occurring through Florence Nightingale’s efforts to modernize nursing. The foundation of this modernization was through specific forms of training of nurses. In *Notes on Nursing*, a book that became the basis for the early nursing schools curriculum, Nightingale (1859/1969) wrote

... every day sanitary knowledge, or the knowledge of nursing, or in other words, of how to put the constitution in such a state as that it will have no disease, or that it can recover from disease, takes a higher place. It is recognised as the knowledge which everyone ought to have – distinct from medical knowledge, which only a profession can have (p. 3).

Nightingale devoted most of her adult life to establishing (and promoting) modern nursing through the proper training of suitable young women. This occurred concurrently with the growing demands for changes to the wider discursive field of healthcare to accommodate the health needs of the poorer classes and population in 19<sup>th</sup> century United Kingdom. Prior to the efforts of Nightingale, as Joan Quixley (from the Nightingale School of Nursing) wrote in the 1974 edition of *Notes on Nursing*, this was

... a time when the simple rules of health were only beginning to be known, when its topics were of vital importance not only for the well-being and recovery of patients, when hospitals were riddled with infection, when nurses were still mainly regarded as ignorant, uneducated persons.

Thus, the introduction of these ‘trained’ nurses transformed the profession from one populated by ‘ignorant, uneducated’ workers to that of a highly trained and reliable work force.

At the same time, such a workforce can be seen as an essential precursor to the creation of a modern healthcare system.

This discursive framing of nursing as the work of 'good' (i.e. Christian) women offered a new range of subjectivities to middle and lower class women at that time. Nightingale boldly rejected the subject position of a woman as basically helpless and whose only purpose was to bear and raise children for her husband/owner. Nightingale defied conventional views of women, stating she believed marriage and children would interfere with her calling (Robinson Scovil, 1916). Through her efforts to promote the ideal professional nurse, women (who were identified as modern nurses) could legitimately travel, work for a good wage and live fairly autonomous lifestyles. In this way, Nightingale could be considered an early English feminist (Selanders, 2010; Showalter, 1981).

This did offer legitimacy to nurses' identity and indeed, it was a remarkable achievement to create a female dominated profession at a time when women were not considered as capable as men in this regard. However, this also changed the discursive field in which nurses could talk about nursing practice. Nursing was then sanitized, cleansed and idealized as the work of ever-giving and selfless practitioners (Davies, 1980). The new knowledge practices to enact this framework involved long hours, uncomplaining hard work and behaviour (at all times) above reproach. Nurses were encouraged to be loyal and subservient to physicians, and practice in ways that demonstrated they were both maternal and chaste. These knowledge practices constructed a new identity for nurses that we still see idealized by contemporary nurses in describing their own practice and in popular culture (e.g. 'angle of mercy' or 'lady with the lamp').

### **The regulated nurse.**

Another important ‘moment’ is the point in history when the regulation of healthcare professions and the ‘registering’ of such professional activities were deemed important and thus, legislated. Against the backdrop of the wider discursive field of healthcare, nursing has been portrayed as going along with the regulation of health professionals mainly because the physicians had done so first, thereby ‘claiming’ a large portion of the healthcare domain as their own (e.g. Coburn, 1994). While nurses are described as scrambling so as to not be left behind, it is important to note that they were still the second group to regulate themselves in Canada. Because of this, nurses also claimed much of the healthcare ‘territory’ while contributing to the exclusion of other healthcare practitioners such as midwives, chiropractors and pharmacists (Coburn). Taking on the newly legislated responsibilities and delimitations of (self) regulation then required a different discursive frame for nurses beyond simply being ‘trained.’ While the construction of Nightingale’s trained nurse set the pre-conditions for acute care style hospitals to become the norm for modern healthcare delivery, this institutionalization required a more consistent and standardized professional nurse to ensure the proper organization and administration of modern hospitals.

The discursive move from ‘un’-registered to registered nurse offered a sort of legal justification and seemed to clear a path to acknowledging and advancing nurses as legitimate professionals. At the same time, nurses then became ‘governed’ and were then (and now) required to offer proof of the legitimacy of their professionalism. Once again, we see a new discursive frame of the professional nurse. The nurse became situated mostly in the hospital (not in private practice) and worked in conjunction with (for) physicians ensuring that physician orders were ‘carried out.’ This dependence required changes to the knowledge practices of the nurse. Thus, while the legislated practices necessary to support the new discursive frame of the

‘registered nurse’ offered new subjectivities for the nurse as an individual (somehow more professional) it also allowed nurses, for the first time, to come together as a large collective and to organize as unions, associations and regulatory bodies to influence change in the wider discursive field. While the knowledge practices of regulated/registered nurses required to construct institutionalized healthcare seem to also position the individual nurse as increasingly dependent on and subservient to physicians and administrators, the knowledge practices of the newly emerging regulated collectives of nurses allowed for nursing to enter academia. This set the stage for nursing to begin theorizing about nursing practice resulting in an overarching concept for professional practice called ‘the nursing process.’

### **The scientific nurse.**

The nursing process, based on a more traditional scientific reasoning process, is a concept developed by leading nurse theorists (mostly from the United States) during the 1960s in attempts to further professionalize nursing. Since that time, it has been “regarded as the key element of advanced, theoretically based nursing practice...becoming the core and essence of nursing practice” (Habermann & Uys, 2005, p. 3). At the centre of the nursing process is a problem-solving cycle based on medical models of patient interactions (Marriner, 1975). It was integrated into healthcare organizations at the same time that these organizations were being transformed through technological advancements. It is generally agreed that the nursing process is inextricably bound to health information and management systems used in acute care today (e.g. Ammenwerth, 2005). In this way, it could be that the extraordinary technological advancements of healthcare science during the last few decades of the 20th century had such tremendous influence on the wider discursive field of healthcare, that healthcare and subsequent delivery of that healthcare was transformed. In order to implement such changes, I suggest that the discursive

framework of nurses was also ‘transformed.’ It is during this time that the notion of the nurse as a scientist emerges.

The expansion of organizational systems to track quality, outcomes and expenses in a mechanistic way occurred concurrently with the active development of NANDA (North American Nursing Diagnosis Association), a system of nursing diagnosis meant to interface with the health information systems in order to describe and account for nursing practice. This was done in tandem with the establishment of the NMDS (nursing minimum data set). The NMDS was an information technology system designed to describe and standardize core nursing knowledge required by new scientifically trained professional nurses in all situations. One intention of this endeavour was to facilitate the production of reports in which nursing’s contributions within the healthcare delivery system could be highlighted (Purkis, 1999). In this way, such a discursive frame not only demonstrated the value of nursing through quantifiable scientific methods, it also further legitimized the nursing profession. On the other hand, by aligning nursing’s identity with traditional science to such an extent, descriptions of nursing practice were limited to purely quantifiable terms. Such discursive framing seems to erase the important contributions of nursing that fall outside the realm of traditional, quantifiable science. Despite this the nursing process, over the course of a few decades, came to redefine what professional nursing means, both in Canada and globally (Kelly, 2005). While the drive for professionalism may be an important aspect of the nursing process (e.g. de la Cuesta, 1983; Latimer, 1995), changes in the discursive framework of what constitutes the ‘ideal’ nurse can, once again, seem necessary to both accommodate the practices of incorporating new technology into the wider discursive field of healthcare as well as somehow essential to the re-creating of a ‘new’ version of modern healthcare delivery and institutions.

## **Knowledge and Ignorance**

There are common themes in the historical ‘moments’ outlined previously in regard to the shifting subjectivities of nurses, as they seem to be transformed from one version of the ideal nurse to the next. An overarching theme is that all of these ‘moments,’ at that particular time in history, seem to offer nursing a new identity that promises to make nursing knowledge and practices legitimate. Another important theme is that nurses who did not adhere to the new discursive framing of their practice and did not exhibit knowledge practices to demonstrate their commitment to this reframing (no matter which ‘moment’ we are talking about) were most often deemed ignorant, unprofessional and lacking in credibility. Ironically, even as the previous preferred subject position became the object of ridicule and scorn, it was most often that the ‘new’ nurse was actually the same person as before (Nelson, 1997), albeit ‘transformed.’

While much of my analysis in this dissertation is rooted in Foucault’s theoretical work regarding knowledge and power as inextricably linked (to be discussed further in chapter three), my reading of nursing history has also lead me to think about the relationship between knowledge and ignorance (or not knowing). Knowledge and ignorance can be seen as “mutually constitutive” within modern discursive frames (Dilley, 2010, p. 175). Within the ‘moments’ of nursing identified earlier, it is not just that a new discursive framing of the ideal nurse was created: the antithesis of this new nurse, the ignorant nurse, also seemed to be created. This may be because when so-called ‘expert’ knowledge is constructed, there also must exist another who is ignorant of this knowledge. Because ‘knowing’ and ‘not knowing’ are important aspects of modern western discourses, particularly in regard to science, any claim of knowledge can “cast a shadow... demarking a domain of ignorance” because of the mutually defining nature of these concepts (Dilley, p.170). Considering who is denied opportunities and possibilities ‘to know’

within various discursive frames can be seen as an effect of a discourse on the division of labour in a hierarchical system (Dilley), such as healthcare.

As stated earlier, I wonder if the problem of the ‘gap’ central to knowledge translation activities is perhaps, for nurses, not so much the translation of research knowledge into practice but the space and time for transition from one preferred subject position (the ideal nurse) to another in order to accommodate changes in how healthcare is being (re)conceived and delivered in the wider discursive field. Knowledge is not just being translated. It is through the discursive framework of the dominant discourse that the very identity of the nurse is being reinvented and in doing so the previous identity is deemed ignorant. During this transition, an important consideration is how ‘ignorance’ is conceptualized within this discourse.

### **The Knowledge Worker: A Knowledge Translation ‘Moment’**

As in previous ‘moments,’ such changes in identity of nurses sometimes occur with changes (often legislated) to the broader discursive field of healthcare. With the CIHR Act (2000) and subsequent restructuring of how it is thought healthcare should now be organized and delivered, I believe that we are once again in the midst of such a ‘transformation.’ There appears to be a discursive move on the part of nurses to reinvent both the discipline and profession as knowledgeable and credible practitioners within the discourse of knowledge translation. In this way, the newly institutionalized practices of the discourse of knowledge translation are supported and established while at the same time, the discursive frame of the preferred subject position (the ideal nurse) seems to be in transition from the ‘scientific nurse’ to the ‘knowledge worker.’

I am not alone in this belief. Within the literature, this transformation is described as not easy and requires that the nurse be flexible, conscientious, willing to change and take risks as well as be a staunch patient advocate (e.g. Strauss, Tetroe & Graham, 2009; Thompson, 1999).

As Slavin (2002) states, there are those who believe that like medicine, other professions will need to be “dragged, kicking and screaming, into the 20th century” (p. 2). Yet, to adopt the practices of the discourse of knowledge translation is not necessarily evidence of inevitable progress of nursing professionalism or legitimacy but instead, can be seen as a process that is both engineered and unpredictable. Therefore, re-thinking how nursing practice is accomplished within the new discursive frame of knowledge translation is one of my aims. I am not looking for the ‘truth’ of knowledge translation but what effects this discourse may have on how nurses (and nursing) are represented, both by themselves and by others, as subjects and the discursive practices that make this representation possible. As Foucault (1969/2006) points out, “discourse itself is practice” (p. 51). In this way, the discourse of knowledge translation, far from being a descriptive account of a knowledge production and dissemination process, is essentially constitutive. That is, efforts currently underway in the discursive field of Canadian healthcare to incorporate knowledge translation into the everyday practice of nurses holds the potential to establish the ‘ideal nurse’ (preferred subject position) as something new: the knowledge worker.

### **Research Question**

The overall research question guiding this study was: what are the effects of the discourse of knowledge translation on nursing practice? In order to conduct the multi-layered analysis required to gain understanding of such effects within a specific context, I required a framework by which to conceptualize the various layers of investigation. Therefore, I undertook an ethnographic methodology to organize my data. I began my study with observations of nurses in practice, asking them to ‘think aloud’ about their nursing interactions with patients and other healthcare professionals; I then went on to interview those same nurses. From there, I focused on the larger context of the healthcare organization and interviewed people from administration and

other disciplines. Concurrently, I used a feminist poststructural perspective to guide the analysis of the data I collected. This view helped me explore how the organization of healthcare in this setting potentially influenced the individual experiences of the nurses and think about nursing practice in a different way. My aim was to explore and illustrate the connections between knowledge translation practices and the subjectivities of nurses both as individuals and as a collective.

### **Organization of this Dissertation**

Having introduced my study and substantive ground in this first chapter, I will now turn to an exploration of the knowledge translation literature. In chapter two, I will examine the literature pertaining to the discourse of knowledge translation and the discursive frame it promises both in terms of the wider discursive field of healthcare and the preferred subject position of the nurse (and how nurses position themselves) implicit in the readings. This is accomplished by paying careful attention to the interrelatedness of power/knowledge (not knowing), discourse, language and subjectivities available to nurses within the discourse of knowledge translation.

Chapter three is an account of my research methodology (ethnography), guided by a feminist poststructural approach. This includes an overview of my methods and how a feminist poststructural approach was important to this investigation, including considerations of my own subjectivity (as a feminist poststructuralist approach demands). In chapters four, five and six I present my key findings of this research. Chapter four introduces a discussion of how I make sense of my observations and interviews with the nurses and the possible effects I attribute to the discourse of knowledge translation. In chapter five I delve into the history of the specific nursing context of this study and consider the effects this may also have on their knowledge translation practices as they come to identify themselves as 'knowledge workers.' In Chapter six, I consider

my findings in light of the broader discursive field of nursing and healthcare in relation to knowledge translation. Finally, in my concluding chapter, I discuss key considerations regarding the significance of my findings as well as further discussion of the implications for nurses and nursing practice.

## Chapter Two: Subjectivity-In-Action

Drawing on the argument from the previous chapter, that nursing is being somehow transformed by the discourse of knowledge translation, the aim of this chapter is to illuminate the ways in which the notion of ‘knowledge translation’ is presently constructed in the literature. As noted in chapter one, I am guided in my approach to my topic by a feminist poststructuralist perspective. That perspective requires me to examine the ways in which, through language, we are constituted as subjects of discourses and how such constitutive efforts, in turn, organize how we understand ourselves in the world. Thus, it is important to explore the current state of ‘knowledge’ regarding the discourse of knowledge translation (often referred to as ‘knowledge-in-action’) as it is organized into written form (i.e. the literature). In exploring knowledge translation in this way, the literature pertaining to the discourse of knowledge translation can be seen as another ‘site’ of research activity. That is, I will engage in what typically would be considered a review of the literature but instead in a more systematic and critical way. I engage in a reading of this literature in the form of a discourse analysis in order to advance some arguments about the ways in which the discourse of knowledge translation in contemporary research literature, first in general and then specific to nursing, defines and delimits knowledge and how it is to be deployed in nursing practice.

One of the commonly referenced underlying aims of the discourse of knowledge translation is to help busy practitioners deal with the “knowledge explosion” (e.g. Choi, 2005; Hamric, 2007, p. 68). It is also important because “organizations concerned with delivering healthcare services are challenged to make [such information] available to professionals for the

benefits of their clients” (Taylor & Renpenning, 2011, p. 202). It is not my intention to negate the importance of such assistance to busy practitioners and my own experience of attempting a conventional review of the literature brings this sharply into focus. There are literally tens of thousands of articles and texts available electronically regarding knowledge translation produced over the past decade<sup>4</sup>. In the past twelve months there have been more than 1400 articles and texts published regarding one knowledge translation activity (best practice guidelines) within the discipline of nursing worldwide. In order to delimit my task, I have restricted my readings to those published in English. Secondly, I have remained mainly within the Canadian healthcare literature, focusing on literature explicitly referring to the notion of knowledge translation within acute healthcare organizations. I have read widely in order to identify areas of the taken-for-granted aspects underpinning the discourse of knowledge translation, paying careful attention to the language used to guide nurses as to the appropriateness of the proposed knowledge translation activities. In this way, I hope to understand how the discourse of knowledge translation contributes to the constitution of current understandings of healthcare, nursing and nursing practice.

In light of this, two aspects of this study can be addressed with such a review of the literature. First, I will examine and question the ‘problems’ that the discourse of knowledge translation aims to answer and the solutions put forth to resolve such problems. Exploring the major premises upon which the discourse of knowledge translation is based will provide background against which the relationship between nursing and knowledge translation can be critically explored. The goal is to ascertain what possible effects these underlying assumptions may have on nurses and nursing practice.

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<sup>4</sup> In 2007, a Google search of ‘Knowledge Translation’ resulted in 340,000 hits. In March 2011, the same search resulted in more than six billion hits. This is meant to be demonstrative, and not any comment on the theoretical basis of Internet searches.

Secondly, a central question informing this review is to excavate from contemporary literature how the nurse is constituted to enact knowledge translation practices and related activities. The aim is to tease out instances where knowledge translation as a ‘new identity’ for nursing has been combined, perhaps covertly, with discussion of knowledge translation as a phenomenon enacted by and through particular forms of knowledge practices.

This review strives to discover those presuppositions underlying the prescriptions for knowledge translation practices and descriptions of that practice. The aim is to explore the conditions that support such prescriptions: that is, practice and more specifically, nursing practice. Nursing practice does not happen randomly or chaotically. It is engineered and much preparation is devoted to making practice ‘happen’ in particular ways (Purkis, 1993). The perspective I bring to my reading of the literature and of the practice of nurses suggests that these ways are accomplished through the subjectivities of individuals that define and limit which actions are emphasized, which are possible and which are to be excluded. In this way, what is written about knowledge translation and nursing practice cannot be separated from the ‘how’ of nursing practice in settings where the discourse of knowledge translation is actively being taken up. Thus, within this project, what is written about nursing practice can be understood as one form of many ways of describing nursing practice. Other ways (of many) to examine and generate understanding of nursing practice include observing practice, documenting verbal accounts of nurses in practice and interviewing nurses about their practice. These forms will be further explored in chapter three. The knowledge translation literature will be examined in terms of the ‘promises’ of the discourse of knowledge translation to ‘solve’ particular problems. It is through the proposed (and perhaps taken-for-granted) solutions, and the seemingly required

knowledge translation practices, that the potential effects on nurses' subjectivities and nursing practice can also be discussed.

### **Problems and Promises**

Overall, when considering literature pertaining to the discourse of knowledge translation, there appear to be three main aims of the knowledge translation endeavour: it is presented as a method to promote fiscal accountability and efficiency (e.g. Dobbins, Decorby & Twiddy, 2004; Edgar, Herbert, Lambert, MacDonald, Dubois & Latimer, 2006; Murphy, Petryshen & Read, 2004); it is said to be the answer to improving health outcomes and patient safety (e.g. Kerfoot, 2005; Straus, Graham & Mazmanian, 2006; Strauss, Tetroe & Graham, 2009; Williams, 2004); and it is a solution to bridging the knowledge-practice gap (e.g. Davis, Evans, Jadad et al., 2003; Lang, Wyer & Haynes, 2007). While these main goals of knowledge translation and related activities, promissory in nature, could not seem more congruent with the common goals of all involved in providing healthcare, a more in-depth examination provides an opportunity to further explore the underlying, and not always so consistent, assumptions of the discourse of knowledge translation. The taken-for-granted assumptions associated with formalized knowledge translation frameworks support particular discursive practices that can work in dynamic ways with effects that are both restrictive and productive, indicating that opportunities for choice and exclusion are offered (Foucault, 1981). That is, the practices associated with the discourses of knowledge translation work to both enable and constrain the subjectivities of nurses involved in such endeavours to address the primary concerns central to the discourse of knowledge translation: the research-practice gap, patient safety and fiscal accountability.

**The main problem: ‘the gap.’**

The overarching premise of the discourse of knowledge translation is that it is an important strategy to address the gap between the knowledge generated by research and the practical application of this knowledge. It is often described as the ‘research-practice’ divide (e.g. Lang, Wyer & Haynes, 2007) or ‘the gap between discovery and delivery’ (e.g. Kerner, 2006). The problem this gap represents is often conceptualized as a lack of willingness or ability on the part of practitioners to actively demonstrate the use of credible research findings (evidence). Therefore, ‘knowledge translation’ is often presented as an educational strategy to address the research-practice gap (e.g. Davis, Evans, Jadad et al., 2003) through efforts to improve uptake of evidence-based practice guidelines (e.g. Armstrong, Waters, Crockett & Keleher, 2007; Davis, 2006; Doran & Sidani, 2007; Edgar, Herbert, Lambert, MacDonald, Dubois & Latimer, 2006; Kirchhoff, 2004; Thompson, McCaughan, Cullum, Sheldon & Raynor, 2005) and inform (educate) policy makers of such evidence (e.g. Davis, Evans, Jadad et al., 2003; Pablos-Mendez & Shademani, 2006). Indeed, in a large randomized study of knowledge translation activities, Armstrong, Waters, Crockett and Keleher assert that not only is it clear that most practitioners “do not consistently use research evidence to inform their practice”, there is also a “clear gap between the positive attitude expressed towards evidence-based [guidelines] and the practitioner behaviour” in adopting evidence-based practice guidelines (pp. 257-258).

Rycroft-Malone (2002) noted that the translation of evidence into practice is more effective when it is meaningful to the practitioner. To make the evidence more meaningful, some researchers have pointed to a simplified and standardized method of reporting randomized controlled trial findings assuming that it is simply a comprehension problem that stops practitioners (‘non-experts of science’) from understanding the complexity of scientific studies

more fully (e.g. Choi, 2005; Davis, 2006; Kerner, 2006; Sidani & Gottlieb, 2007). Choi contends that the basic principles of knowledge translation are the simplification and integration of the volume of complex evidence into practice. In addition, Armstrong, Waters, Crockett and Keleher (2007) advocate the integration of tacit knowledge into guidelines, with the hope that this would improve uptake. Most often, there is an appeal to incorporate various change theories to modify practitioner behaviour in this regard (e.g. Davis, Evans, Jadad et al.; Kerner, 2006). Adhering to evidence-based practice guidelines is purported to decrease an inappropriate variation in practice, support improved quality of patient care and accelerate translation of research into practice (e.g. Kerner).

Similarly, barriers to knowledge translation are generally discussed in terms of lack of adherence to guidelines, wherein this resistant behaviour on the part of practitioners reinforces the gap (e.g. Armstrong, Waters, Crockett & Keleher, 2007; Choi, 2005; Innavaer, Vist, Trommald & Oxman, 2002; Lang, Wyer & Haynes, 2007; Mosely & Tierney, 2005). The identification of lack of adherence initially focused knowledge translation research solely on the personal characteristics of practitioners as predictors of evidence uptake (e.g. Davis, Evans, Jadad et al., 2003; Estabrooks, Floyd, Scott-Findlay, et al., 2004). Concurrently, similar research concluded that compelling research findings alone are not adequate to increase use of those findings (Rycroft-Malone, Harvey, Kitson, McCormack, Seers & Titchen, 2002). For instance, Estabrooks, Midodzi, Cummings and Wallin (2007) identified the need for a better understanding of organizational influences on the knowledge translation process, including organizational characteristics such as opportunity for peer collaboration, responsive administration and relational capacity. Still, most research on organizational characteristics or context remains focused on the organizational processes and structures that can be manipulated or altered to

enhance uptake of evidence-based guidelines (e.g. Bahtsevani, Willman, Stoltz & Ostman, 2010; Francke, Smit, de Veer & Mistiaen, 2008; Harrison, Legare, Graham & Fervers; Nilsson Kajermo, Bostrom, Thompson, Hutchinson, Estabrooks & Wallin, 2010; Wensing, Wollersheim & Grol, 2006). This is sometimes referred to as creating or identifying “environments that are conducive to evidence-based practice” (Doran & Sudani, 2007, p. 4). Thus, there is a focus on developing and improving evidence-based guidelines, and the environment in which such guidelines will be used, to enhance practitioner uptake. Without exception, these so-called evidence-based guidelines are represented as the ‘obvious’ answer to solve current healthcare problems.

### **The solution.**

Evidence-based practice, the term used to describe the practice of healthcare providers who actively use evidence as a foundation of their practice (almost exclusively through the use of sanctioned guidelines), evolved out of a mostly Canadian medical education group started at McMaster University. The original aim, as it is today, was to ground policy and practice decisions in ‘real science’ through clinical epidemiology and evaluation research with randomized controlled trials research designs, the so-called ‘gold standard’ in knowledge production (e.g. Estabrooks, Scott-Findley & Winther, 2004; Sackett, Rosenberg, Gray, Haynes & Richardson, 1996). When this particular style of medical practice gained popularity in the mid-1990s, an influential movement calling for the recognition of evidence-based decision-making as essential to all aspects of the healthcare system was quickly established (Estabrooks, Scott-Findley & Winther, 2004; National Forum on Health, 1997). That is, evidence-based decisions and practices are not only vital to physicians but also to nurses, administrators, policy makers, physiotherapists and all others involved in healthcare. Evidence-based practice remains firmly

grounded in the assumptions and perspectives of evidence-based medicine (e.g. Cochrane Collaboration, 2011). Central to this is a particular definition of what counts as evidence.

Within the discourse of evidence-based practice, and subsequently knowledge translation, evidence is generally described in terms of proof and rationality and is based on what can be independently observed and verified (i.e. randomized controlled trials). A common assumption underlying discussions of evidence is that experts generate evidence, that this occurs within the context of research and that the research is quantitative in design and implementation (e.g. Straus, Tetroe & Graham, 2009). The hierarchy of evidence, a central feature of the discourse of knowledge translation, illustrates the value of various forms of evidence (Appendix B). While there is great debate in the nursing literature regarding the nature of evidence and the limitations of such a partial definition outlined above (e.g. Morse, Swanson & Kuzel, 2002; Murray, Holmes & Rail, 2008; Pearson, Wiechula, Court & Lockwood, 2007; Porter, 2010; Rycroft-Malone, Seers, Titchen et al.; Sellman, 2005; Tarlier, 2008; Thompson, Estabrooks & Degner, 2006; Wall, 2008), it is the evidence at the ‘top’ of the hierarchy that dominates the knowledge translation literature. There have been some moves to acknowledge non-quantitative evidence as holding some ‘value.’ Most often, this is described as important for understanding knowledge translation as an educational strategy (e.g. Davis, Evans, Jadad et al., 2003) or a potential contribution to an empirical study, perhaps through initial explorations of a concept or quantitative instrument development, rather than as documentation of a fact or evidence that might be useful, in and of itself, for healthcare decisions (Centre for Health Evidence, 2008; Cochrane Collaboration, 2011). As Riese (1982) points out, one can be confident in describing a discourse as dominant when critique yields little change.

It is within the arrangement of the ‘hierarchy of evidence’ that the privileging of a

dominant view of evidence within the discourse of knowledge translation is most visible.

Dominant discourses, or those which purport to be the truth, construct the rules in order that they be unchallengeable (Foucault, 1980; Pêcheux, 1975). In this manner, other ways of knowing or understanding (such as understandings emerging from qualitative research and professional experience) are marginalized (i.e. at the bottom of the hierarchy) or excluded. The evidence central to the discourse of knowledge translation and evidence-based guidelines is predominantly medical evidence. This is not always overt, because the language of the discourse of knowledge translation is predominantly disciplinary-neutral. The underlying assumptions seems to be that practice, no matter what discipline, is generic and the same evidence that supports medical practice is integral to the practice of other disciplines (Newton, 2009a). For example, in June 2010 I joined a service called *KT plus*. This service, provided by KT Canada, was intended to inform me (as a practicing nurse) of important new articles regarding good patient care and safety via email. Since that time I have received 84 important new articles all of which, except two literature reviews, were either randomized controlled trials or systematic reviews of randomized controlled trials. Physicians rate these articles based on their perceived usefulness and relevance to their discipline. Occasionally, nurses or pharmacists will also rate these articles. Only one article I received contained information specifically regarding nursing practice and it was entitled *Nurse versus doctor management of HIV-infected patients receiving antiretroviral therapy (CIPRA-SA): A randomised non-inferiority trial* (Sanne, Orrell, Fox et al., 2010) and was not reviewed by a nurse (Appendix C). Findings of this study indicate nurse-monitored ART (antiretroviral therapy) is “non-inferior” to doctor-monitored therapy and lend support to shifting this task from physicians to appropriately trained nurses (i.e. ‘trained’ in the use of supporting evidence-based guidelines).

The privileging of such evidence supports an emphasis on rationality that underpins and perpetuates the discourse of knowledge translation. Foucault (1984) refers to rationality and rational thought as integral to an “attitude” of modernity; That is, “a mode of relating to contemporary reality” (p. 39). Reiss (1982), in *The Discourse of Modernism*, further describes this attitude as “analytico-referential” or rationalism that constructed “an intellectual structure...upon the perceived world” (p. 35). In this way, discourses in which such rationality is central not only maintain that the world can be explained (i.e. using proper evidence), it also imposes meaning on a world conceptualized as ordered and fixed and is central to modern reasoning. Reasoning, as a modernist discursive practice, is characterized by the “visible and describable... organization of signs” (Reiss, p. 9). Such reasoning has become the foundation of the scientific method generating the proper evidence (i.e. the hierarchy of evidence) for use in practice. In this way, this mode of ‘reasoning,’ or ‘attitude of modernity,’ discursively frames that which is ‘rational’ evidence (i.e. authorized and possible) and what is not (i.e. excluded or suspect) (St. Pierre, 2000). This rational reasoning extends out of modernist conceptual frameworks such as ‘knowledge translation’ and can be seen in the practices involved in particular discourses, and the production of texts to support those discourses. An example of this might be the cause-effect assumption regarding the use of evidence-based guidelines as ‘safe’ or ‘efficient’ practice. Another example could be the recent emergence of evidence-based self-care guidelines, generally aimed at individuals categorized as having a chronic disease (e.g. Tilburt, 2008).

While the politics of evidence and knowledge dissemination are rarely discussed in the knowledge translation literature, discussions regarding evidence as outlined previously highlight the political nature of such practices. Using Becker’s (1975) work, the notion of a ‘hierarchy of

evidence' can also be seen as an example of a "hierarchy of credibility" (p. 241). Thus, those who do not defer to the established status of knowledge, evidence and truth can be discredited or at least viewed as disrespectful of the established order (Becker). Those who call the hierarchy of credibility into question may be viewed as problematic because attending to such critiques will, inevitably, involve a shifting of political power. Perhaps an important aspect of the discourse of knowledge translation is the challenge (or perhaps problem) posed by those practitioners who do not readily adopt evidence-based guidelines into their practice. In the knowledge translation literature, such practitioners are overwhelmingly represented as not credible or deficient.

Interwoven into the discourse of knowledge translation is the discourse of the 'deficient practitioner.' That is, the practitioner is somehow defective: as outlined above, they can't read properly; they need more education; they are resistant; they don't understand how to interpret statistics (central to generating 'gold-standard' evidence); and they have narrow fields of practice requiring targeted information in order to make it 'meaningful' to them. From this perspective, within the discourse of knowledge translation, it could be seen as obvious that, in order to compensate for such deficiencies, practitioners must to adhere to evidence-based guidelines. To not do so would perhaps be considered irrational. The main problem posed by these deficient practitioners is that they are a threat to patient safety.

### **Solving the patient safety problem.**

Another important problem identified within the discourse of knowledge translation is patient safety. 'Knowledge translation' is said to represent a potential answer to the challenge of improving patient safety and decreasing adverse affects (e.g. Jensen, 2008; Straus, Graham & Mazmanian, 2006; Strauss, Tetroe & Graham, 2009). In order to achieve this, knowledge translation initiatives aimed at improving the quality of patient care focus on quantifiable health

outcomes and changing the behaviours of both practitioners and patients to achieve this end (Davis, Evans, Jadad, et al. 2003; Lang, Wyer & Haynes, 2007). Fraser (2004) contends that organizational factors do affect patient safety and, to address this, organizational structures need to be put in place to improve adherence to evidence-based protocols and organizational processes with patient safety as a central concern. So how did the issue of patient safety issues also become an important feature of the discourse of knowledge translation?

The driving force behind the focus on patient safety can be traced to the highly publicized release of the *To Err is Human* report by the Institute of Medicine, an American healthcare policy unit that, in a report, detailed the risks to patients of medical errors (Shojania, Duncan, McDonald & Wachter, 2002). In response, US government agencies tasked with addressing this issue commissioned Stanford University Evidence-Based Practice Centre to create comprehensive guidelines, eventually to be titled *Making Healthcare Safer* (Shojania, Duncan, McDonald & Wachter). Upon its release, there was some criticism of the narrow focus of the *Making Healthcare Safer* document; however, general consensus was that the guidelines should not be abandoned but broadened (Leape, Berwick & Bates, 2002). It was argued by some that this document did not represent a complete picture of patient safety because the main emphasis centred on the actions of individuals while excluding consideration of institutional and societal factors. In response, the authors contended that because patient safety represents such an important priority for all groups involved, only the findings from high quality and rigorous research were included in producing the guidelines (i.e. randomized controlled trials and quantitative studies) (Shojania, Duncan, McDonald, & Wachter). Further to this, they assert that basing practice guidelines on non-evidence (i.e. *not* randomized controlled trials and quantitative studies) is contrary to competent and professional practice (Shojania, Duncan, McDonald, &

Wachter).

Despite the complexity of the inter-relatedness of such factors, developing knowledge translation guidelines is largely focused on the individual practitioner's behaviour, methods that isolate practitioners from their organizational context and the prediction of direct causal relationships between individuals and the use of research findings in practice (Rolfe, 2006; Wall, 2008). In doing so, particular management techniques have been (re)introduced to healthcare organizations, sometimes called 'new managerialism' (Davies, 2003). Davies states that these new managerial practices, in conjunction with evidenced-based guidelines, may represent

... the most significant shift in the discursive construction of professional practice and responsibility that any of us will ever experience. It is characterized by the removal of the locus of power from the knowledge of practicing professionals to auditors, policy makers and statisticians, none of whom need know anything about the profession in question (p. 91).

The effect of such overt focus on the individual practitioner seems to have resulted in the construction of a new discursive framework regarding healthcare practitioners (particularly nurses) who, because of deficiencies outlined earlier, require constant surveillance. Davies theorizes that this is a new form of panopticon.

The panopticon (the all seeing eye), was a prison design and mechanism used by Foucault as a metaphor to describe how power operates. The prison design allowed for "relatively few officials to control large numbers of prisoners by foregrounding both hierarchy and visibility" (Schmelzer, 1993, p. 127). Foucault (1984) states that this is "an architecture transparent to the administration of power" which made it "possible to substitute for force or other violent constraints the gentle efficiency of total surveillance" (p. 217). Thus, as Schmelzer points out, such surveillance "became an efficient means of control by authorities" (p. 127). Foucault (1977/1995) put forth that under the gaze of a panopticon, prisoners internalized particular

structures of surveillance to govern their own conduct. Now, however, Schmelzer argues that instead of non-intrusive leaders relying on worker's own internalized gaze to monitor their own work, such as professional standards, there are layers of many gazes. These layers are shaped by "policies and practices emanating from management which infiltrates and shapes the way the work is done" (Davies, 2003, p. 92).

There is little consideration of the actual effects this new panopticism may have, other than to ensure that organizational objectives are being maintained (Davies, 2003). Thus, evaluation of the use of so-called evidence-based guidelines can be used to monitor not just outcomes of quantifiable aspects of practice in terms of patient safety but also the use (and documentation) of evidence-based guidelines by the practitioner. This is inextricably tied to the 'gap problem.' As Needham (2010) stated on the relationship between knowledge translation and patient safety, "the gap clearly affects patient safety and quality of care" (p. 922). Thus, administrators would seem to have the capacity to evaluate healthcare practices (of both individuals and groups of practitioners) within the discursive framework of knowledge translation based on adherence to evidence-based guidelines and documentation of the same. Within the discourse of knowledge translation, 'good practice' that overcomes the 'gap' problem that aims at improving patient safety can be quantified and used to create 'evidence' positioned in the upper levels of the 'evidence hierarchy.' I suggest it is not such a leap to think that this then might become 'evidence' of a practitioner's competence and ability.

Overall, there is a subtle shift of focus from practices of engaging with and caring for patients in the context of their health, family and community to those practices that assess practitioners' ability to work through the various components of an evidence-based practice protocol, often presented as linear and uncomplicated. Thus, organizational reporting patterns can

establish a hierarchy of practice where the primacy of achieving organizational goals more efficiently outpaces specific goals related to patient care. For example, Hakkennes and Dodd (2008), in a systematic review, recommend that health professionals who aim “to improve the quality and safety of healthcare” can assess the barriers to guideline implementation (and thus ‘safety’) through the use of quantifiable process outcomes (i.e. desired changes in practice) and patient outcomes. This again assumes a linear causality between one group of practitioners and patient outcomes. By linking these two quantifiable ‘measures’ *and* assuming linear causality, it is not difficult to take a further step to suggest that, as nurses become ‘subjects’ of the discourse of knowledge translation, the primacy of the discourse of patient safety is introduced to, and monitored through, nursing practice. In this way, nurses are positioned to be the primary instrument for management of risk in contemporary healthcare organizations.

Key to risk management in the knowledge translation literature is reducing variation in practice (e.g. Kerner, 2006). In the nursing literature, this reduction of variability is generally reported to be necessary for routine nursing tasks (e.g. CNA, 2002). But often in the general knowledge translation literature, ‘variation in practice’ seems to be conflated with giving outdated information or conflicting information (evidence) to patients. These two interpretations are very different. While certain routine tasks can be standardized, eliminating variability in nursing practice is impossible because the context and subjectivities of the nurse (and the patient) within a particular practice setting are always shifting and thus can never be reproduced exactly the same, even in the equivalent physical space. Thus, the construction of risk and reduction of variability in practice within the discourse of knowledge translation has the effect of homogenizing nursing practice. The production of quantifiable evidence to improve (or prove) patient safety within healthcare organizations also dovetails with fiscal responsibility and

efficiency. Now knowledge production, and efficient use of these products, is key to a new global economy (e.g. Armstrong 2001).

### **The problem of fiscal responsibility.**

In the majority of knowledge translation literature, knowledge is generally conceptualized as an important commodity in the new global economy that can be transferred in a rational and universal linear process (e.g. McFarlane, 2006; Pablos-Mendez & Shademani, 2006). This commodity is presented as external to the knower, generated by experts (usually researchers) and value neutral (Armstrong 2001; Traynor 1999). Knowledge translation, in conjunction with knowledge management, is prevalent in the business literature, which in turn influences healthcare administration (e.g. BRINT, 2011; Major & Cordey-Hayes, 2000; Wenger, 2004). It is this business language that dominates the knowledge translation healthcare literature locally and internationally (e.g. Ebener, Khan, Shademani, Compennolle, Beltran, Lansang & Lippman, 2006; Landry, Amara, Pablos-Mendes, Shademani & Gold, 2006; Pablos-Mendes & Shademani, 2006). We are told repeatedly that we now live in a knowledge economy, in which healthcare professionals are discursively framed as knowledge managers, knowledge workers and knowledge brokers (e.g. CIHR, 2011c; Change Foundation, 2010; Conrad & Sherrod, 2011; Dobbins, Robeson, Ciliska et al., 2009; Duncan, Langlais, Danyluk-Hall & Simonson, 2008; Nagle & Yetman, 2009). Healthcare professionals are encouraged to attend to knowledge performance: That is, to consider the value of knowledge for the fiscal cost of production (Landry et al.). Fraser (2004) contends that an important aspect of knowledge translation is to translate the impact of intervention costs in order for administrators to determine the ROI (return on investment). Davis (2006) concurs; claiming that failure to take up evidence (i.e. through adherence to evidence-based guidelines) quickly and efficiently will only lead to increased

healthcare costs and poor patient outcomes. In addition, healthcare organizations are encouraged to consider how financial incentives and current healthcare markets affect knowledge translation (e.g. Fraser; Kerner, 2006).

Business models of information and data management based in rationality are integral to the discourse of knowledge translation activities aimed at ‘harnessing’ the resource of knowledge and evidence for decision-makers in all areas of healthcare, particularly in acute care (Hamric, 2007; Davis, 2006; Kerner, 2006). One promise is that using such knowledge management technology in conjunction with knowledge translation activities will improve access to this information. This will, in turn, assist administrators and educators with changing behaviours of both resistant healthcare workers and unknowing patients. Once again, we are brought back to the claim that this will ultimately bridge the gap problem.

### **But Practice is Not Generic...**

Overall, the discursive framing of practice within the discourse of knowledge translation centres on the adherence to evidence-based guidelines. In doing so, it is promised that practitioners will all practice in such a way as to ensure competent practice, enhanced patient safety, improved patient outcomes and fiscal efficiency and responsibility. This also provides a venue for administrators and organizational operatives to both survey and ‘evaluate’ such knowledge translation practices and extrapolate these quantitative findings to concurrently ‘predict’ patient safety and fiscal outcomes. However, when taking up the language of the discourse of knowledge translation, practice is then prescribed and described in terms of traditional scientific rationalities and quantifiable terms. Although the language of the discourse of knowledge translation is generally discipline-neutral, the centrality of medical evidence to practice seems to limit how other healthcare professionals, such as nurses, can account for their

practice.

This is interesting because when we consider the ‘moments’ of nursing transformations as outlined in chapter one, vital to such previous transformations was the concurrent growing body of nursing theories, models and knowledge. Although these theories were mostly entrenched in a modernist perspective, they were nonetheless primarily concerned with *nursing* practice. These models did establish and represent, at least to some degree, a link between nursing academia, research and philosophy to nursing practice. By contrast, the driver of evidence-based guidelines essential to the discourse of knowledge translation is quantifiable medical knowledge and the activities necessary to ‘translate’ that information for use in practice.

And yet, with all this discussion of evidence-based guidelines, what is lost in such translations is that nurses employed in acute care organizations are not really expected to adhere to evidence-based guidelines: The expectation for nurses is to follow ‘best practice guidelines.’ This subtle difference contributes, then, to a different discursive frame for nurses than other healthcare practitioners, primarily physicians.

### **Best Practice Guidelines**

Evidence-based practice and best practices are often used interchangeably; however, they are indeed different. Evidence-based practice guidelines are developed for independent practitioners (i.e. physicians). While ‘best practices’ were first used as a managerial tool in other countries such as Australia and Britain and evolved out of business practices, in Canada best practice guidelines have been developed as an important knowledge translation activity. It is most important to note that the focus of best practice guidelines is not on the individual practitioner; it is on the organizational use of evidence (Driever, 2002). Particular notions of policy, knowledge, patient safety, fiscal responsibility and efficiency are incorporated to a higher degree in these

guidelines. The Canadian conceptualization of ‘best practices’ embodies the ideals of the discourse of knowledge translation and seems to be reconstructed at local levels mainly through various educational pathways. It is this aspect of the nursing literature that I mainly draw from to answer my second question: how is the nurse constituted within the literature to enact knowledge translation practices and related activities?

### **The Knowledge Worker**

Integral to the discourse of knowledge translation seems to be the construction of the nurse as a particular kind of ‘knowledge worker.’ Nurses as knowledge workers are vital to the knowledge dissemination interface with patients. Nurses are only required to understand how to retrieve proper scientific evidence, usually with the aid of technology, and to apply it to patients based on their current health status (Purkis & Bjornsdottir, 2006). The view of knowledge and knowledge dissemination for nurses is portrayed as mostly uncomplicated within the discourse of knowledge translation. The end result is the conceptualization of nurses, to both nurses and to the organizations they work for, as the conduits of expert knowledge rather than creative, knowledgeable practitioners in their own right.

As outlined above, ‘knowledge’ in the discourse of knowledge translation is most often conceptualized as a commodity. While many authors contend that nursing practice is not based on passive transactions of pre-packaged knowledge but instead on the transformative synergy between knowledge and action (e.g. Purkis & Bjornsdottir, 2006; Reimer-Kirkham, Baumbusch, Schultz & Anderson, 2007), this is quite the opposite of how nursing practice is portrayed within the discourse of knowledge translation. What these discursive frames fail to take into account is the complex interplay between the nurse and the patient as the nurse creatively draws from many sources of knowledge in a particular moment and context. Current knowledge translation

activities rely on the dissemination of decontextualized ‘expert’ knowledge by the nurse. Nursing practice, and research which supports it, cannot be reduced to a simple transfer of a commodity. But, as Foucault (2008) predicted, healthcare and particular healthcare practices would likely be the vector for discursive framing of all aspects of our lives in economic terms. If the ‘work’ of nurses becomes discursively framed as the transfer of an important commodity across the ‘know-do gap,’ then the required knowledge translation practices would necessarily centre on standardized acts of distributing pre-packaged knowledge created by others. Thus, bridging this ‘know-do’ gap requires ‘doers’ to transport these important packages from the ‘knowers.’

### **Doing and knowing.**

In the knowledge translation literature, the focus is consistently on the doing and not the knowing and it is the nurse who is constructed as the doer and not the knower. In addition, implicit in the literature is that technology is key to knowledge translation activities (i.e. part of the ‘solution’) and frequently used to manage and direct nursing activities in order to increase efficient uptake of best practice guidelines. In the majority of the exemplars reviewed, nursing merely becomes an extension of medical models. For example, Davis (2006) describes how his (physician) group created an evidence-based guideline by conducting a survey, enlisting key people (no mention of nurses or patients) and incorporating their findings into grand rounds. After these key activities, the interventions employed included educational in-services for nurses, an educational campaign for patients and employees, and a local policy mandating nurses to ask specific questions when assessing patients. The perspective of the nurses is not included in the creation of the evidence however it is the nurses who do the work of both collection and dissemination of evidence to support the original guideline. In this way, nursing practice is constructed as adherence to best practice guidelines and supporting the use and development of

evidence-based practice guidelines in establishing minimum (perhaps maximum) standards of nursing care.

Knowledge produced in such an exclusionary manner may replicate the unexamined values of the dominant discourse to both support the exclusion of alternative discourses and establish a foundation of expertise from which other sources of knowledge can be easily dismissed (Ceci, 2000). In this way, nurse scientists and researchers may be unduly influenced to shift their attention away from generating knowledge based in professional and disciplinary concerns (McNabb, 1999) to instead generating knowledge in relation to evidence-based practice and subsequent knowledge translation activities. Nurses who comply with and advance the evidence central to the discourse of knowledge translation are often rewarded with grants, publications and other forms of recognition. Instead of nurses deciding the boundaries of nursing knowledge, it is groups such as the Cochrane Collaboration<sup>5</sup> that determine what constitutes nursing knowledge and what is superfluous. Thus, it is this privileged empirical medical knowledge that begins to direct nursing clinical activities and patient care within the discursive frame of knowledge translation. As this narrow view of knowledge becomes entrenched within, and perhaps even defines, professional activities, nurses from diverse practice areas and experience may not even be consciously aware of the existence of alternative sources to draw from when making decisions.

### **Not knowing.**

If all practice ‘ought’ to be based on known ‘gold-standard’ evidence, then it would be difficult for the nurse to ‘not know.’ As outlined in chapter one, an important aspect of modern

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<sup>5</sup> The Cochrane Collaboration claims to be “an international, independent, not-for-profit organization...dedicated to making up-to-date, accurate information about the effects of health care readily available worldwide” and is purported to be “an enterprise that rivals the Human Genome Project in its potential implications for modern medicine” (Cochrane Collaboration, 2011).

discursive frames is the mutually constitutive nature of knowledge and ignorance (not knowing). Within the discursive frame of knowledge translation, all the knowledge purported to best inform practice is contained within best practice guidelines. In this way, a nurse cannot acknowledge that there are instances when she does not know because she runs the risk of being deemed incompetent. And because the credible knowledge required is packaged and somehow available to her, this 'not knowing' appears willfully ignorant (and deficient). There is the potential that in such instances, instead of consulting with colleagues, nurses confine their practice to the guidelines. This would also reduce perceived risk by decreasing practice variation while at the same time, reinforcing the importance of such guidelines and the evidence supporting them. In addition, this once again places the focus on the individual behaviours of the nurse and not collective efforts of nurses.

### **More Promises**

Returning to the idea of the panopticon, Schmelzer (1993) points out that under such a gaze, collaboration "that fails to foreground individual accomplishments" is a threat to the power networks (p. 133). This is interesting, as the tasks of nursing are often considered collaborative and can be seen as necessary to accomplish organizational goals. Davies (2003) also notes that through this process, individual practitioners are often "seduced by the rhetoric of efficiency and accountability" in their efforts to appear increasingly knowledgeable and competent (p. 93). Truly, the most seductive aspect of the discourse of knowledge translation is the belief that use of best practice guidelines within the discursive framework of knowledge translation will ultimately legitimize the profession of nursing and establish the discipline as 'real' science (e.g. Pearson, Field & Jordan, 2007; Thompson, 2003). As Winch, Creedy and Chaboyer (2002) explain, it is most appealing to be "able to tap into the highest form of accepted contemporary authority"

called science (p. 159). This can be seen as a way to elevate nursing science to an equal level with other healthcare practitioners (Winch, Creedy & Chaboyer). Equally important is that this also “carries with it the promise to transform not just the professional self but [the nurse’s] personal identity as well” (Winch, Creedy & Chaboyer, p. 159). The similarity between these claims and the claims of historical ‘moments’ outlined in chapter one are striking.

### **At the Margins**

As I consider the literature regarding knowledge translation, I am struck by the lack of mention of two main subjects I thought would be central to such discussions: ethics and the patient. Ethics seems to be implicit within the discourse of knowledge translation: it is assumed that accountable and ethical professional practice is a result of implementing evidence into practice. Is it merely the act of using the best practice guidelines that demonstrates ethical commitment? Since knowledge is presented as objective, neutral and apolitical in this discursive frame, perhaps ethics is viewed as an outside resource (like a protocol or best practice guideline) to be accessed when issues arise with clear legal implications such as Do Not Resuscitate orders. Although most articles quote the CIHR definition of knowledge translation, which includes the phrase ‘ethically sound,’ if ethics is mentioned again it refers to the fact that a human research ethics application has been approved through an external body such as an associated university.

I found the lack of discussion of ethics puzzling until I read Holmes, Murray, Perron and McCabe’s (2008) article regarding how the use of such guidelines creates an ‘ethical void’ in which discussions regarding ethics are ‘evacuated.’ While this certainly helps me understand the lack of ethical considerations in the knowledge translation literature, within the discipline and profession of nursing there exists much conversation regarding the ethical dimensions of nursing practice. In this respect, I do not see the discourse of knowledge translation creating an ethical

void so much as it is contributing to a shrinking or decreasing discursive space in which nurses can legitimately participate in difficult discussions regarding the ethical dimensions of complex patient care.

In the knowledge translation literature, the patient is not a 'subject' but instead a passive 'object' within the discursive field of healthcare. Patients, or their bodies, are the medium through which a particular form of evidence is gathered in order to make 'proper' clinical decisions. The only explicit mention of interactions with patients I could find was in relation to the importance of compliance to treatment plans, including preferences that may assist with such compliance (e.g. Lang et al., 2007; Rycroft-Malone, Harvey, Kitson, McCormack, Seers & Titchen, 2002). In addition, the patient is often portrayed as a consumer of healthcare service commodities. I am not disputing the importance of ensuring patients have current and accurate information to make their own healthcare decisions but overall, these conceptualizations have a decidedly dehumanizing effect. What is most disturbing though, is that the voices of patients and their participation in knowledge translation activities are, for the most part, absent. The construction of certain groups of underserved individuals, such as those who are homeless, in purely medical terms with little attention paid to the social determinants of health also serves to medicalize these social issues. In addition, patients are also constructed as ignorant (not knowing) but in more of a biblical, innocent sense.

An effect of the discursive framework of knowledge translation for the patient seems to be some sort of unspoken agreement in which the patient exchanges submissive behaviour for high quality ('gold standard') care (Timmermans & Berg, 2003). It seems that nurses have a similar sort of *quid pro quo* cooperation in that their cooperation may result in the inclusion of nursing in important organizational programs and goals such as patient safety.

## **Conclusion**

This review points to the major potential effects the discourse of knowledge translation could have on nursing practice that is yet to be explored. The effects of the knowledge practices required to enact this discourse limit and constrain the subjectivities of nurses and subsequently their nursing practice in particular ways. There is a systematic neglect of the nature and effects of power in the constitutional work of the discourse of knowledge translation.

It is therefore my intention to explore and consider the effects of introducing a major knowledge translation activity (best practice guidelines) in a particular practice setting on nurses and their practices. It is my hope that considering such influences at a local level will provide valuable insight into the effects of the overarching discourse of knowledge translation. In order to achieve this, I will undertake an ethnographic methodology that I will now outline in chapter three in which I not only interview practicing nurses (and their colleagues), I also observe those same nurses and consider the various texts they use to accomplish nursing practice.

### **Chapter Three: Methodological and Theoretical Considerations**

As argued in the previous two chapters, the potential transformative effects of the discourse of knowledge translation on nursing practice are largely unexplored. These chapters lay the groundwork for my overarching research question: What are the effects of the discourse of knowledge translation on nursing practice? To address such a line of inquiry, I need to explore the interconnections between nursing practice, knowledge translation practices and the subjectivities of nurses both as individuals and as they enact their roles as nurses within an organizational context – that is, in their collective activities. In order to accomplish this, I will undertake an ethnographic methodology to collect and organize research materials including observations of nurses' practice, interviews with those nurses and interviews with their colleagues and administrators in an organization that is implementing a project described as 'knowledge translation.' In order to make sense of the data collected, a feminist poststructural perspective will guide my analysis. Ethnography is a useful way to document and explore a process of change (and changing practice) within a particular organizational context (Atkinson & Pugsley, 2005; Marcus, 1986; Robinson Wolf, 2007), which also includes the changing subjectivities of the nurses who are the research participants in my study. A feminist poststructural approach to the analysis of such data will enable me to focus on and excavate the possible effects of introducing a major knowledge translation activity (best practice guidelines) in a particular practice setting on the subjectivities and practices of a group (St. Pierre & Pillow, 2000; Weedon, 1997), such as nurses. It is my expectation that through such an examination regarding how the introduction of best practice guidelines influences nurses' practice at a local level (in this case, a nurse-run clinic to be discussed later in this chapter), I will gain insight into

the wider organizational effects of an overarching discourse of knowledge translation.

In this chapter, I will begin by elaborating on my methodological and theoretical choices (ethnography and a feminist poststructural approach). I then describe the more practical aspects of this project as I outline how I involved participants, collected information and analyzed this data. I conclude with considerations of scientific integrity.

### **Ethnography**

The purpose of this study is to explore the possible effects of the discourse of knowledge translation on nursing practice. An ethnographic methodology was chosen because it supports investigating ‘practice’ in a specific context. As outlined above, ethnography offers a helpful way to document and explore a particular change within that context (Marcus, 1986; Robinson Wolf, 2007; St. Pierre & Pillow, 2000). Ethnography offers an approach that can aid in “the exploration and understanding of social settings and social phenomena” (Atkinson & Pugsley, 2005, p. 229). Thus, it is a useful way to explore and understand ‘the social’ enacted in the everyday life and practices of nurses. The contribution of this methodology to nursing is well established (e.g. Latimer, 2000; Purkis, 1994; Robinson Wolf).

The tradition of ethnography has its roots in anthropology and generally consists of extensive fieldwork of which the goal is to uncover the local knowledge of a particular group (Atkinson & Pugsley, 2005; Creswell, 1998). Its starting point is with researchers who wish to explore and make sense of practices that may be different from their own (Atkinson & Pugsley; Robinson Wolf, 2007). Through detailed narrative accounts, researchers have tried to make the common-sense and implicit knowledge of the particular group studied explicit “by revealing what the social worlds mean for the persons within the worlds and what they mean as insiders acting within” those worlds (Robinson Wolf, p. 285). In addition, the researcher studies the sense-

making processes the participants use to “create the social world and its factual properties” (Robinson Wolf, p. 294). Within this, they are seen as reasonable, logical and knowledgeable actors whose actions make sense in their context. In addition, how such knowledgeable actors constitute their social worlds is much more sophisticated than solely attending to verbal accounts would indicate (Atkinson & Pugsley, 2005; Garfinkel, 1967).

Although there is a wide variation in how ethnographies are undertaken, it is generally agreed that ethnographies contain the following elements: the study of a particular group; gathering of diverse forms of data (e.g. everyday conversations, everyday interactions with other group members, documents, interviews), with participant observation a key feature; engagement of the researcher over time; researcher as the research instrument (explored through writing as a method); and with the intention to discover ‘insider’ or local knowledge including how it is used and the consequences of this use (Atkinson & Pugsley, 2005; Gillis & Jackson, 2002). While ethnographers don’t always follow a prescribed set of established methods, integrating the key features can be seen as a sort of commitment that allows the researcher to take part in a larger conversation both in terms of research and the group that is being studied (Britzman, 2000). Such commitments are based on the assumption that the social life of the participants has meaning (Atkinson & Pugsley, 2005). This social life, including the identities of the participants, is seen as a process and “not a matter of fixed entities and structures” in which “meanings are always available for negotiation and reinterpretation” (Atkinson & Pugsley, p. 230). What ethnography offers that is different from other types of qualitative research is an emphasis on the context and local perspective (Robinson Wolf, 2007). And, when generating rich descriptions from ethnographic data, such research offers a way to consider various perspectives of the participants involved (including the researcher). Central to this is the ‘practice’ of the knowledgeable

participants as they accomplish this everyday social life (Atkinson & Pugsley; Purkis, 1994). A feminist poststructural approach offers a means to question the routine or taken-for-granted aspects of everyday practices and to closely examine the organizational or discursive structures that support these practices (St. Pierre & Pillow, 2000; Weedon, 1997).

Within the discursive frame of knowledge translation, the social world of nurses is largely excluded. As Purkis (1994) points out, consideration of ‘the social’ is often missing in nursing research methodologies and methods. In this way, there is little discussion regarding the potential influences and effects of power and knowledge on practice and feminist poststructural thought supports such theorizing and analysis. In order to gain a new understanding of nursing practice and the effects the discourse of knowledge translation may have on nursing practice, I will examine the social world of the nurses in one setting, with particular attention to their every-day practice as they encounter a knowledge translation activity within their social world through a feminist poststructural lens. As Purkis (1993) points out, the social can “never be erased” and thus accounts of practice also need to include the social dimension (p. 55). That is because action and practice, particularly in practice-based disciplines such as nursing, are embedded in the fabric of the everyday (and social) life of individuals and cannot be considered separate from one another (Latimer, 2000). This is supported by an ethnographic methodology because accounts of practice are a central feature.

### **Accounting for knowledge translation practice.**

As mentioned above, discussion regarding ‘the social’ is mostly excluded from accounts of practice within the discursive frame of knowledge translation. Entering the literature of knowledge translation, in order to explicate the ‘how’ of practice, what I mostly find are prescriptive practices. That is, descriptions of best practice guidelines and how to improve

adherence to such guidelines. Thus, nursing practice is represented in this body of literature as ‘outcomes’ and is often linked to notions of accountability and patient safety (e.g. Doran & Sidani, 2007). Here, outcomes, or so-called ‘nurse-sensitive’ outcomes, provide ‘evidence’ of ‘good’ nursing practice. Such accounts of nursing practice are purported to demonstrate ‘accountability’ in that the nurses can ‘prove’ that they are contributing to the provision of safe patient care as well as efficient use of organizational resources (Doran, 2011).

Traces of the nurse subjectivities in this literature are generally described as ‘variation in practice’ and are generally viewed unfavourably (i.e. a problem to be solved). Thus, within this discursive frame such variations are justifiably excluded from the consideration of knowledge translation practices. This is because within the discourse of knowledge translation homogenization of practice is an implicit goal and therefore, differences *must* be excluded or dismissed as instances when nurses are clearly not following the best practice guidelines. However, building on the insight noted above that such practices of exclusion represent the social that is not possible to erase, the analysis will seek out traces left behind of such practices of exclusion.

Thus the methods currently advanced in the knowledge translation literature for gathering and analyzing data regarding knowledge translation practices and nursing practice are constituted by theoretical underpinnings that themselves exclude nursing subjectivities from understandings of nursing practice. Nursing practice is seen as a vehicle to achieve a certain means (outcomes) in which quantifiable elements (mostly assigning a grade to patient symptoms like pain) are used as ‘proxy measures’ of nursing knowledge and action. Within the knowledge translation literature, there is a dominant trend to reconceptualize knowledge as that information necessary to adequately address the steps of a prescribed best practice guideline and action (nursing practice)

is represented by the outcome measure used. While all of this is aimed at making the use of evidence in nursing practice visible, it seems to succeed in doing the opposite. The complexity involved in accomplishing such nursing practice within the discourse of knowledge translation seems to become even more invisible. Not only that, it fails to take into consideration the influence of power on nursing practice. When power, and its effects on practice, is not considered, central features of nursing practice in addition to nurses' subjectivities are treated as marginal and not worthy of discussion. This denies the constituting power of dominant discourses such as knowledge translation on nursing practice. This is because, as I argue, it is the collective work of nurses that produces the discourse of knowledge translation while at the same time, the discourse is reconstituting them and their subjectivities. Such prescriptive and linearly descriptive accounts of nursing practice belies the complexity of institutionalized practice and does not investigate the 'how' of practice and the influences of power on the practices of these nurses and thus, the effects such power and discursive framing has on the nursing subjectivities. Subjectivities are important because it is integral to nursing practice and how this practice is produced and reproduced within particular places and spaces.

### **Place and space.**

Strathern (2002) theorizes about space and place within ethnography by building on her work in which she says we foreground or background particular 'figures' in the research field depending on our philosophical assumptions. The 'figure' often changes within an ethnographic study and, at times, even the researcher can be seen as a 'figure' (Mueller, 1995; Strathern, 2000). Just like reversing the 'figure' and what is perceived to be the background, space and place can be interchanged. Strathern (2002) describes how, in order to quantify something, place can be calculated or measured in space-time coordinates. That is, seeing a particular 'figure' (like an

outcome measure) in terms of its background (knowledge translation), the figure appears to be encompassed by the larger entity. But this figure, instead of being seen as a place in space, can also be seen as a place that “contains space within itself, as it does time, journeys and histories” (p. 91).

From the position of a researcher seeking outcome measures, the setting for my study would seem ideal. In this nurse-run clinic (to be described later), the ‘figure’ (place) can be seen as the nurses’ use of best practice guidelines while the background is the clinic itself (the space). In this way, multiple quantitative accounts of nursing practice could be generated based on the measured outcomes of best practice guidelines. I am not arguing that such accounts do not have value; however, I do argue that such representations of practice do not account for the complexity of nursing practice. In order to account for nursing practice in a different way, I will draw upon the work of Strathern (2002). I put forth that rather than seeing nursing practice as a ‘figure’ in this clinical ‘space,’ I instead use this line of thinking to see practice itself as the ‘space’ to be opened up and examined through ethnographic observation of actions and interviews with a cross section of participants to account for that practice. In this way, as I see nursing practice as a space potentially inhabited by multiple ‘figures’ in various arrangements, this all occurs within a place (the nurse-run clinic) also embedded in a larger organizational place. In this space of practice, I can theorize and account for power, language and subjectivity from a feminist poststructural perspective as I think about the effects of the discourse of knowledge translation on this space. For example, consider that while this nurse-run clinic is also called the “patient support clinic,” it is quite often referred to as the “symptom control clinic.” Occasionally, I heard various individuals within the organization refer to this nurse-run clinic as “the patient control clinic.” Such descriptions of the ‘place’ in which nursing practice occurs points to something interesting

happening in the 'space' of nursing practice.

### **A Feminist Poststructural Accounting of Nursing Practice**

The heart of this study is nursing practice. As Latimer (2000) points out, "nurses' practices can be understood, then, as not simply function or instrumental, moral or spiritual, but also as expressive of identity" (p. 138). In this way, I will examine the 'space' of nursing practice in order to carefully consider the knowledge translation practice that seem to be required to enact the discourse of knowledge translation and how this potentially constrains or limits the subjectivities of nurses in particular ways. An ethnographic approach will help me generate empirical accounts of nursing practice substantial enough to be analyzed using a feminist poststructuralist approach. Through this perspective, I will remain attuned to ways in which nursing practice is accomplished through the subjectivities of individuals (the subject) and how that defines and limits which actions are emphasized, which are possible and which are to be excluded.

#### **Subject and subjectivity.**

As the nurses incorporate the discourse of knowledge translation into their everyday practices, they become the 'subject' of such a discourse. From a feminist poststructural perspective, the taken-for-granted notions of the human subject are completely disrupted. Within the discourse of knowledge translation, the subject is presented as a unified and rational individual capable of producing 'objective' knowledge because reality is outside the individual and can be observed, understood, predicted and controlled (St. Pierre, 2000; Wall, 2007). In this way, outcome measures engineered to account for nursing practice seem 'common-sense.' From a poststructuralist perspective, the subject is not considered 'fixed,' instead the subject is both constructed by social practices and discourses as well as constructed by itself in the manner in

which it takes up those available social practices and discourses (St. Pierre; Weedon, 1997). From such an account of nursing practice, outcome measures are fraught because the individual (subject) is “both a site for a range of possible forms of subjectivity and, at any particular moment of thought or speech, a subject, subjected to the regime of meaning of a particular discourse and enabled to act accordingly” (Weedon, 1997, p. 34). Thus, the experience of the individual has no inherent meaning but is instead, meaningful in that such experiences are “constituted in language” (Weedon, p. 85). This is not to say that individual experiences don’t exist or are insignificant but instead this highlights how the manner in which we both understand and articulate our experiences can not be considered as separate or apart from language (Weedon). In this way, everyday practice is tied to subjectivities and these subjectivities are constructed through language in which the effects of power and knowledge can be observed.

### **Language.**

Language is clearly central to understanding of how nursing practice is constituted from this perspective. From a feminist poststructural perspective, language does not correspond to things or ideas that already exist but instead, language constructs and structures the world “as we know” it (Davies & Gannon, 2005, p. 318). This differs from the dominant scientific discourse contributing to current conceptualizations of knowledge translation, in which words (such as outcomes and evidence) are treated as having no meaning apart from the object they represent. These meanings are often assumed to be universal and universally understood. However, from a feminist poststructural perspective, how constructs such as ‘outcomes’ are defined and taken up by members of a social group are understood to be the effects of language and located in discourse (St. Pierre, 2000; Weedon, 1997). This does not mean that language is transparent: quite the opposite. Words have no ‘fixed’ meaning, only historical and contextual meanings

requiring careful consideration when investigating social networks and power (Arslanian-Engoren, 2001; Weedon). In this way, it is important to have multiple accounts of nursing practice for analysis and not just through the privileging one account such as outcomes or even interviews. Observing the nurses as they talk through their practice decisions will also highlight contradictions between the dominant discourse of knowledge translation and competing discourses also contributing to the subjectivities of the nurses. Such observations also allow for descriptions and analysis of power and knowledge within the space of nursing practice.

### **Power/Knowledge.**

Power and knowledge are not equivalent, they are inextricably entangled: power relations manufacture knowledge and then knowledge generates power (Foucault, 1980; Mills, 1997). Here power is not conceptualized as originating from the top of a hierarchy (Foucault, 1980). Instead, power has a capillary quality and functions in multiple levels and directions of society and institutions in a broad network of power relations. Foucault, like poststructural feminist theorists such as Weedon (1997) and Davies (2000a), was interested in the end results or effects of power at the local sites of action where the capillary networks end (perhaps the space). When inviting poststructuralism into feminist thought, power is not an object but is seen as constituted through multiple, shifting discourses. Foucault (1963/1994) helps us understand discourses, such as the discourse of knowledge translation, as being socially constructed<sup>6</sup>.

Power and knowledge, combined, can be used to conceptualize the relationships between language, social institutions (such as healthcare organizations) and the individual and how these relationships are exercised in relation to resistance (Foucault, 1969/2006; Weedon, 1997). As discussed before, 'knowledge' is generally conceptualized as a commodity generated by experts

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<sup>6</sup> Social constructionism is the perspective in which one "understands human reality as socially constructed reality" (Berger and Luckmann, 1967, p. vii).

within the discourse of knowledge translation. This also supports the notion of ‘outcomes’ somehow representing nursing practice. In contrast, a feminist poststructuralist view of knowledge is that it is socially constructed, fleeting and overwhelmingly associated with power (St. Pierre; Weedon). A feminist poststructuralist perspective does not consider an analysis of knowledge without consideration of power.

In addition, knowledge within dominant discourses such as knowledge translation is organized in such a manner as to marginalize knowledge from other discourses and often operates in an exclusionary manner (Mills, 1997; Pêcheux, 1975). In this way, the knowledge generated to support the dominant discourse establishes an organizational norm in which the particular discourse is seen as self-evident and commonplace. Yet this quality of being the norm is actually a result of excluding other sources of knowledge (Mills; Pêcheux). If a particular form of knowledge is continually privileged and other forms of knowledge are not accessible, this lack of access shapes how the knowledge in the discipline of nursing develops and subsequently how nurses, informed by this knowledge, practice. Knowledge produced in such an exclusionary manner may replicate the unexamined values of the dominant discourse to both support the exclusion of alternative discourses and establish a foundation of expertise from which other sources of knowledge can be easily dismissed (Ceci, 2000).

### **Discourse.**

Foucault (1980) put forth that particular knowledge created by and within established power relations are called discourses. These discourses direct and structure everyday activities and practices (Mills, 1997). Foucault described discourse as a relationship between ideas and ways of being resulting from a particular context/history that is also produced by the discourse itself. Thus, discourses can be seen as a “structuring principle of society, in social institutions,

modes of thought and individual subjectivity” and “can help explain the working of power on behalf of specific interests” (Weedon, 1997, p. 40). In this way, discourses can be seen to represent political interests through which various groups and individuals are in a constant process of “vying for status and power” (Weedon, p. 40).

This is important because the underlying assumptions of the discourse of knowledge translation represent powerful political interests at both local and national levels. It is a site that can be seen as a ‘battle for power’ (Weedon, 1997). As Weedon points out, this battle for power is not just about the subjectivity of the individual: It is a “battle in which the individual is an active but not sovereign protagonist” (p. 40). Therefore, a feminist poststructural approach to analysis offers the opportunity to more fully understand the discourse of knowledge translation at a national level while also understanding the effects of that at the individual level in a particular context.

In light of this, it is important to consider how nurses and nursing are complicit and/or implicated in perpetuating the discourse of knowledge translation in ways that may contribute to their own experiences of oppression. For example, early in my career as a nurse on a medical oncology unit, I was zealous about completing workload measurement tools that described patients’ illness as quantifiable symptoms. Subsequently, I was devastated to learn that, instead of describing the crushing workload of the unit to lobby for increased staffing, the workload measurement system was instead designed to increase efficiency of nurses’ work. By highlighting certain inefficient (i.e. time consuming) nursing activities, such as prolonged (i.e. more than five minutes) patient teaching sessions, this workload tool was used to explain how current staffing levels were adequate. Thus, instead of contributing to the goal of increasing staffing levels to what I believed would be reasonable and safe, I was complicit in collecting data

to maintain and support the dominant discourse of fiscal efficiency. This consideration of participation in such discourses is also important because it is integral to analyzing potential avenues of resistance with a feminist poststructuralist approach (Weedon).

### **Discourse or ideology?**

Within traditional theories of feminism, the concept of ideology is helpful because it is congruent with feminist endeavours that seek to both examine oppression and highlight how to change these conditions. Certain discourses associated with systems of domination and control can also be understood as ideological, particularly if they become enmeshed in discursive practices so that “specific interests are represented as universal concerns” (Pêcheux, 1975; Purvis & Hunt, 1993, p. 497). Yet, I fear I may represent the nurses as a homogenized group (Mills, 1997) and this, combined with the limits of the conceptualization of power within ideology, tends towards the view of nurses as powerless: That discourses such as knowledge translation merely represent an oppressive strategy employed to boost the power of the dominant. The tension here is that, although I do see the nurses as active agents and not victims, I do not want to lose the insights ideological examination can yield. Foucault was quite critical of the use of ideology as a concept yet during his career, he did not outline methods to change dominant discourses that perpetuated oppression or inequities and that can be problematic for feminists (McCormick & Roussy, 1997). Such critiques alone do not change the status quo (McCormick & Roussy). It is, instead, our ideological commitments that make the difference. And it is these ideological effects that make changes to discourses that prove to oppress or create or perpetuate injustice (Mills).

Ethnographic narratives and descriptions can be seen as a way, through a feminist poststructural lens, to uncover how power might circulate (Britzman, 2000) and the possible effects of such power. Through a questioning of taken-for-granted knowledge and practices, it

may be possible to trace the constitutive aspects of dominant discourses. Excavating the possible effects of the dominant discourse is accomplished by examining the everyday practices and knowledge necessary to enact those dominant discourses. In this, the possibilities for resistance and change are highlighted (Weedon, 1997). Through the use of ethnography, I am able to consider how nurses might be somehow 'transformed' by and within the discourse of knowledge translation and the possible effects of this. It also allows for contradictory readings of the data (Britzman, 2000), not just that participants can be in disagreement, but also the importance of considering differences in the data and my own readings of the data necessary to challenge my assumptions. This provides me an opportunity to look at something I am passionate about (nursing practice) in new ways I might otherwise not see.

Undertaking an ethnographic methodology along with an iterative and concurrent feminist poststructural analysis, not only was I be able to challenge taken-for-granted ideas I noticed, my own taken-for-granted assumptions were highlighted through critical self- reflection crucial to the research process. Due to the integral use of reflexivity within ethnographic methodology, the process of ethnography is deeply person (Robinson Wolf, 2007). In addition, reflexivity is a way of further examining and accounting for the artificial divide between research and practice (Britzman, 2000). That is, overt recognition that the researcher is inextricable from the field (Purkis, 1994). In addition, that what research 'accounts for' is part of the constitution of what may be considered practice (Purkis) as well as being constituted by (and the 'product of') the practices of all those involved, including the participants. Perhaps the use of ethnography, the methodological choice that combines the 'doing' and the 'knowing,' can be considered another way to explore and account for the 'know-do gap' central to the discourse of knowledge translation.

## Overview of Implementing the Study

Having laid out the philosophical approach and methodology of the study, I will now detail the more specific aspects. Data collection and analysis occurred concurrently. As data were collected, they were transcribed, stripped of identifiers and checked for accuracy against the digital recordings. Transcripts were read thoroughly to identify recurring, converging and opposing themes, key concepts and exemplars. Both by using multiple data collection methods and an iterative approach to the data analysis, I attempted to meet the ethnographic (and qualitative) objective of providing a ‘thick description’ sufficient to allow for provisional explanations and suggest unintended effects or consequences (Marcus, 1986).

The actual act of collecting data using ethnographic methods guided by a feminist poststructural perspective raised many uncomfortable questions for me as I examined my own subjectivity along with those of the nurses I observed. Participant observation activities create a site of intense self-reflection for those who employ ethnographic methods (Goldbart & Hustler, 2005). This enhances a feminist poststructural approach that demands the excavation of the subjective nature of the primary research instrument: the researcher (St. Pierre, 2000). This assists the researcher (me) to be attuned to the assumptions underlying my own interpretations as well as reminding me that my interpretations are necessarily and inevitably partial and incomplete (Clifford, 1986).

The primary sample was comprised of registered nurses<sup>7</sup> working in a nurse-run clinic in an ambulatory care oncological setting. Data were collected from multiple sources using the ethnographic techniques of participant observations, in-depth interviews, collection/review of documents and a research journal to track important data as well as engage in the integral method

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<sup>7</sup> Registered nurses are referred to as ‘nurses’ in this document

of ‘writing.’ In addition, participants whose practice intersected with that of the nurses working in the clinic (other disciplines, nurse administrators and non-nurse administrators) were also interviewed. Data collection began by interviewing and observing the nurses first and then proceeded to include interviews with the others. The collection of documents and research journaling occurred simultaneously throughout the study.

### **Entering the field.**

Before I had access to the organizational setting and participants for this project, I first had to undertake an extensive ethics review process. Although my home institution approved the human research ethics application within four months, the organizational ethics approval process took in excess of eight months. Initially, this delay was a great source of stress for me. However, when I began to collect data for my dissertation, I saw that in the end, this was actually of benefit for two reasons. First, the necessity of conforming the qualitative research design and language to that of quantitative research over several requests in order to successfully complete ethics forms clearly written from the viewpoint of a quantitative research paradigm provided a window into the dominant views of how research is conducted at this organization. That is, recognizable (or perhaps ‘real science’) is quantitative and, particularly to this institution, the randomized controlled trial is considered the ‘gold standard.’ Secondly, waiting for the ethics approval afforded me the opportunity to be co-investigator on another project investigating the referral processes and activities of the nurses in the nurse-run clinic in which I collected my dissertation data. Working with, and following, two nurses in the first study allowed me substantial opportunities to get to know individuals working and practicing at this location (nurses as well as all those involved in delivering care at that site) through staff meetings, interdisciplinary meetings and socializing on breaks. Of particular interest to the nurses I first encountered was if I

was a 'real' nurse. According to the nurses I talked to, a 'real' nurse is one with adequate practice experience and I had many conversations about my practice experiences during this first project.

I was also awarded a research internship at the same organization and the backdrop to collecting my dissertation data was over 500 hours of fieldwork for a second nursing research project. This second project provided me with an opportunity to interact with and interview colleagues I would have otherwise not had access to. In this way, I was able to ask my dissertation question of these individuals after I had interviewed them for the project on which I was a co-investigator. Although there was some overlap, I did not use all the interview opportunities of the organizational project for my dissertation data and I did interview several participants who were not interviewed for the larger project. When conducting the interviews of individuals who would participate both in the organizational project and my own project, I ensured that they consented to both projects prior to the interviews. This fortuitous internship was not only helpful for my interviews, but was also particularly helpful when arranging interviews and observations with the nurses. Thus, when I started to collect data for my dissertation from my primary group (the nurses I observed), I had established a relationship with many of them and they had an opportunity to get to know me. Subsequently, arranging data collection activities after this first project was remarkably straightforward.

### **The general setting.**

As I entered the field in this particular setting, I became acutely aware of how the field cannot be seen as a neutral site but is instead a contested and political space in which my experiences as a researcher are inextricable (Purkis, 2003). As I began to learn about the organization in which the nurses worked, the physical space in which they practiced stood out for me. First of all, the building is exceptionally clean and odour free. In the lobby and patient

waiting areas, the atmosphere is that of a business. Employees not working in the clinical areas wore business attire. Although the business attire seemed odd to me at first, I soon recognized that there was no real place to get dirty in this building. Although this very rational environment felt reassuring to me as a family member of a cancer patient at the time of my data collection<sup>8</sup> (that is, everyone here knows what they are doing), I also felt that there was no place to be a sick body: That any kind of messiness was somehow not allowed. This is not congruent with my practice experiences as a nurse where the care of the messy and sick body is central.

### **Sample.**

I conducted a total of 28 interviews for my study. My primary sample was six full-time nurses who worked in one nurse-run clinic. These nurses are all Caucasian females between the ages of 25 and 65 with a range of experience from one to 25+ years. All of these nurses are degree prepared, as compared to approximately 37 % of Canadian nurses (CIHI, 2007). Most of these nurse worked in other areas of the organization split their work time between the nurse-run clinic and another area. Two of the nurses also worked in chemotherapy, two in radiation and two were employed fully in the nurse-run clinic. It is these nurses that I also observed. I interviewed two of these nurses twice (at the beginning and towards the end of the study).

My secondary sample contained six nurses who described themselves as clinical nurse leaders. Three of these nurses were nurse educators (two of them being responsible not just this nurse-run clinic but similar clinics in other geographical areas). The other three nurses were directly involved with the practice of the nurse-run clinic in mostly administrative ways. I also interviewed seven administrators. Four of these administrators identified themselves as a nurse. One of the administrators identified himself as a physician while the other two administrators

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<sup>8</sup> My family member did not access treatment at the site where I collected data but in a different geographical site (although the sites had a similar 'feel').

requested that their discipline not be divulged, as they felt they were easily identifiable in the organization. In addition, I interviewed seven non-nurse healthcare providers and others whose work intersected with the nurses I interviewed and observed and who worked for the same organization. This included two physicians, a ward clerk, two individuals involved with the formal research in the organization and two who did not wish their discipline to be identified.

### **The Nurse-run Clinic**

The nurse-run clinic is located adjacent to the chemotherapy suites and across the hall from patient exam rooms used by physicians. Patients come to this area of the organization explicitly to see a physician. The ‘physician clinics,’ that is, times when a specific physician has the patient exam rooms booked with patients they are treating, are organized into two three-hour blocks (from 0900 to 1200 and then from 1300 to 1600). The nurse-run clinic is located between two large patient waiting rooms, each with two ward clerks. Two ‘team rooms’ accompany a particular grouping of patient exam rooms and both team rooms are across the hall from the nurse-run clinic. Another ward clerk and two care aides work out of each ‘team room.’ Each ‘team room’ also contains six dictation cubicles for physicians. Several years ago, before the creation of the nurse-run clinic, the nurses who now work in the nurse-run clinic worked out of the team rooms. While these team rooms were described as very crowded at that time, I had several conversations with care aide’s regarding the current and “intense” lack of space (i.e. not enough patient exam rooms) due to an increase in number of physicians working at one time who are often accompanied by medical students and residents.

Two to four nurses work out of the nurse run-clinic each day, a room slightly smaller than either of the team rooms. There are four cubicles and each cubicle has a computer, a telephone and shelves to hold binders. The computer is used for many activities: it hosts an interactive

scheduling system for each nurse in which other (mostly nurses) can arrange pre-scheduled patient visits with the nurse for specific purposes; the nurses can access a patient's diagnostic tests and information to prepare for patient interactions and monitor patients who require ongoing treatment from their chemotherapy; they have access to the intranet (including organizational email) and the internet for protocols, policies and guidelines; and this system also informs the nurses when patients are in the building. Each cubicle is designed to ensure some privacy while the nurses use the phone. Also included in their on-line schedule is a list of patients requiring telephone call 'check-ins.' Each cubicle also had a bulletin board with a calendar, new organizational policies and information that the nurses wished to share with each other. The binders are filled with protocols, clinical trial information, patient information and various educational materials for both nurses and patients.

On the wall behind the door is a larger and very busy bulletin board filled with: information about new nursing procedures; articles of interest regarding caring for cancer patients; notices about upcoming educational sessions, workshops and conferences; and various organizational events such as volunteer and fund raising activities. The back of the door to the nurse-run clinic is reserved for information regarding current clinical trials. It is a crowded collage of overlapping pieces of paper of various sizes and colours, including emails clarifying various elements of the clinical trials (such as when a trial is 'closed' or 'inclusion criteria' for recently opened trials). At the far wall of the clinic is a bank of large windows. Under these windows is a ledge with several trays. These trays contain paper information about the patients they may see that day, patient charts and educational information commonly given to patients. The nurses I observed (and interviewed) worked out of this nurse-run clinic.

Over my entire observation period, there was a common theme regarding the actual physical place of the nurse-run clinic. There were many comments voiced by the administrators and the other healthcare providers the nurses worked with regarding the ‘usefulness’ of this place/space. Most often, these comments were in the form of questions musing about how many patient exam rooms could be constructed in this same ‘place,’ usually framed within an overarching discourse of ‘patient-centred care.’ It seemed to me that the nurses who worked out of this nurse-run clinic were constantly under the explicit ‘threat’ that such a place to practice could be taken away. I once asked why the hours of the patient clinics could not be expanded to include evenings and weekends like other healthcare organizations in order to more efficiently use this physical place/space and I was told, “we are not allowed to talk about that.”

#### **An introduction to some evidence.**

At the beginning of the observation periods of my data collection, I attended a communication workshop sponsored by the organization with three of the nurses I also observed. The workshop was entitled *Replacing Communication Myths with Research Insights*. A significant portion of the workshop was the overview presented by a few of the co-investigators of a research project investigating how to deliver bad news to patients (Del Vento, Bavelas, Healing, MacLean & Kirk, 2009). The project design involved analysis of videotaped sessions by eight practicing oncologists delivering ‘bad news’ to an actor portraying a cancer patient. At first, I found this session to be very interesting and enjoyable. Soon, however, I realized that there was something else going on and it was framed within the discourse of knowledge translation.

The group of presenters proceeded to ask the entire group to consider and analyze their “medical interactions,” with particular interest in how the group participants would integrate this new “evidence” presented at the workshop into their patient conversations. This was interesting

for two main reasons because: First, the majority of the participants were nurses, counselors and dieticians with only one physician (who arrived late); and, secondly, the emphasis of the researchers theoretical framework was to identify “implicit presuppositions” that healthcare providers might have which direct conversations away from patients interests to the goals of the healthcare provider. When I pointed out that this workshop might involve some “presuppositions” because I do not have “medical interactions” or any expertise in that area, the researcher/presenter was surprised. I further explained that, as a nurse, the only time I have delivered such ‘bad news’ was informing someone they were HIV positive. The bulk of my *nursing* interactions involve the day-to-day experiences of patients trying to integrate ‘bad news’ into the context of their own lives. What struck me as an effect of this project (including CDs, posters and evidence-based guidelines to be included in the local medical school’s curriculum), was that all the other interactions healthcare providers may have with patients regarding ‘bad news’ seemed to be rendered invisible during this workshop. Central to dissemination of this particular research evidence, collected from physician interactions *with actors*, was the representation that this evidence is a universal commodity to be used by *all* healthcare providers, regardless of the context or their profession. In this presentation, it seemed to me there was, just as in the knowledge translation literature, a presupposition that all practice is generic and what is useful to physicians is also highly important to the other professionals in the organization, particularly nurses.

### **Data Collection**

Data were collected over period of six months. Data analysis proceeded simultaneously with data collection (Munhall, 2007). Data were collected from five main sources and also occurred concurrently. Data collection sources included observations of six nurse-run clinic

nurses, followed by interviews of those same nurses and member check with three of them. I also interviewed other professionals whose work intersected with the work of the clinical nurses observed. I discussed findings with an observant participant as well as collected documents and descriptions of materials used by the nurses observed (Appendix D). In addition, I kept a research journal consisting of descriptive and interpretive notes (including ‘participant observations’), theoretical notes, methodological and planning notes, and reflexive journaling/writing (‘researcher observation’). I will now describe these data collection sources and activities in more detail.

### **Observations.**

Participant observation is considered central to ethnographic endeavours (Angrosino, 2005). I conducted observations with nurses working in the nurse-run clinic, following each nurse throughout the organization during the course of her daily work. All participants were informed of my role as a researcher (and a doctoral student) and my intention to observe their practice in light of the notion of knowledge translation and in conjunction with the implementation of the new best practice guidelines. My goals of observation were to observe the nurses in their day-to-day activities and the interactions they engaged in during their practice. Sometimes I had an opportunity to record my observations during the observation period, such as when the nurse took a quick break. Most often, though, I found a quiet spot in the organization and wrote out notes in my research journal immediately after the observation. This allowed me to record conversations accurately as well as reflect on themes and interesting data collected through a feminist poststructural lens.

I usually arranged a time in advance to meet one of the nurse-run clinic nurses at the nurse-run clinic. Most often, as outlined before, I would have to reschedule. Each observation

was a minimum of two hours but usually lasted three hours. First I observed two nurses over six weeks and after a short break in which no participants came forward, I observed four nurses over a period of about five months. I observed each nurse one to three times and completed 18 observations session consisting of 44 hours of direct observation. In addition, I accompanied the nurses on rounds and to workshops, committees meetings, staff meetings and interdisciplinary meetings for a total of 61 hours over the course of six months. I had the luxury of observing the nurses before the implementation of the best practice guidelines and was able to ask them specifically about how they thought their practiced changed (or not) with regards to using the new best practice guidelines.

We began each observation period by reviewing the activities required of the nurse that day including the formal appointment schedule for the nurse as well as any education sessions or meetings that were also scheduled. My initial observation periods could be seen as more rudimentary in that I spent a lot of time asking questions about how things ‘worked.’ For example: how did the patient come to the nurse-run clinic; how did the patient’s paper chart ‘arrive;’ how did the nurses refer patients to homecare or other external organizations; or how did the electronic charting system function. After this, I then began to focus more on the nurses’ interactions with both patients and their colleagues. For the most part, the observations occurred as the nurses moved from the nurse-run clinic in response to requests to see patients. Thus, I observed the initial interaction of the request, followed by the nurse’s interaction with the patient. After the nurse-patient interaction was finished, I then observed the follow-up activities the nurse engaged in, such as consulting with the physician, referring the patient to other services or completing and faxing forms. In addition, I asked them to describe and ‘think through’ the use of the best practice guidelines and how these worked for them (or not). Over time, I was also able to

question variations in practice, use of the best practice guidelines and patterns of interactions that I observed.

What surprised me about observing in the clinic was my difficulty in staying in a strictly ‘observer’ role while not interfering with patient care. One thing that eased my concern regarding interfering with patient care was the knowledge that the nurses were very aware of the vulnerability of these patients and so I felt reassured that patients would come before the research process. As a nurse, this was important to me and a few times I left an observation because I felt, in my professional judgment, that the patient, although initially had consented, was becoming uncomfortable with me there during difficult conversations or procedures. Afterward, the nurses did confirm the appropriateness of leaving the room at those times. I think this afforded me increased credibility and trust with the nurse participants. Several times, I became a second nurse in the room, assisting with procedures (e.g. fetching supplies or passing instruments) or helping the patient in some other way (e.g. directions or finding particular handouts they had requested). So entrenched in my identity as a ‘nurse,’ I have often reflected on how impossible it seemed for me to not participate in this way. However, I believe, as Robinson Wolf (2007) does, that “nurse ethnographers always defer to the therapeutic imperative...when the welfare of the patient is at stake” (p. 295).

A significant, and unanticipated, challenge for me was withdrawing from the field. Over the course of several months, I had developed a trusting and collegial relationship with not just the nurses I observed, but other individuals working in the organization as well. I did not wish to withdraw abruptly, as that seemed somewhat disrespectful. In the end, I organized two informal meetings in which I invited all of the nurse-run clinic nurses, not just those I observed. Many nurses attended to hear about the overall research project I was involved in as well as my own

dissertation work. In this way, I was also able to ask them if my preliminary themes and findings made sense to them in light of their practice in the nurse-run clinic. I also expressed my appreciation to the nurses who participated in the observation period individually. Upon completion of my studies, I would pursue opportunities to work with this insightful group of nurses again.

### **Interviews.**

I conducted all the interviews myself. I used open-end interviews conducted in a reflexive manner to augment data gathered during the participant observations. The following interviews were conducted (in no particular order):

- Six nurses who worked in a nurse-run clinic
- Six clinical leaders (including nurse educators)
- Seven administrators
- Seven non-nurse healthcare providers.

I had an interview guide for each interview (Appendix E) but was flexible in following them depending on the variation of their practice experiences, particularly in regard to best practice guidelines (the knowledge translation activity), and on the activities I observed them doing during participant observations. The interviews with the nurses I observed tended to be more like conversations based on what I had watched them do during the observation period. All of the interviews were audio recorded digitally and transcribed by a professional transcriptionist verbatim. All the interviews took place in the participants work setting during regular working hours. After listening to the recording of each interview, a brief summary was written highlighting my initial impressions of that interview. These summaries helped me keep track of insights and thoughts regarding the specifics of the interview and thus became additional texts to

analyze. My approach to interviewing is to remain open, even as the questions may become more specific.

### **Observant Participant.**

In addition to observing participants, I wished to enhance my own learning and contribute to the trustworthiness of my project by engaging an ‘observant participant’ (Altrichter & Holly, 2005). That is, an individual with broad knowledge of the various practices of different practitioners (including research) as well as an understanding of the overall workings of the study organization. In addition, the observant participant also observed me and gave me feedback on my research practices. Examples include how I might be influencing the data I collected and pointing to my own unrecognized assumptions. This strategy proved very effective assisting me as I became curious about ‘observing myself as I observed others.’ Indeed, I agree with Kouritzin (2002), who stated, “observation reveals as much or more about the observer as it does about the observed” (p. 133). The biggest advantage of routinely interacting with an observant participant is that she allowed me to check my interpretations of events. For example, I was most interested in a clinical trial the nurses I was observing were involved with. This clinical trial required substantial time and effort on behalf of these nurses, yet it was not at all apparent that the data collected was actually useful. After I began questioning the nurses about this, they also started asking each other and their supervisors about the efficacy of the clinical trial. A few months later, the clinical trial was closed. Initially, I had thought that I had had some influence on the decision to close the clinical trial. The observant participant was able to clarify that; actually, the nursing administration was well aware of the issue and had been working towards closing the clinical trial for several months.

### **Collecting documents and materials.**

Qualitative research, such as a feminist poststructural ethnography, often uses existing texts to augment data generated from observations and interviews (Sandelowski, 2003). Such supplementary information contributes to a context for the observations and interview data (Vaughan, 2004). I collected documents pertaining to the nurses' work in the nurse-run clinic as well as information/documents from the organization within which the clinic is situated. I was particularly interested in texts and materials aimed at nursing practice, such as the best practice guidelines, as well as those designed to support the practice environment in which these best practice guidelines are used. These documents arose from diverse sources and include policies, orientation material and educational material as well as documents the clinical nurses considered important (Appendix D).

I also kept track of some materials (or a description of them) as I became interested in the practices that these materials might produce (Sandelowski, 2003). As I observed the nurses frequent use of such 'materials' as the computer and the telephone, I could see how these items might be seen as an "extensions of their hands" and may point to how the nurse constructs reality (Sandelowski, p. 186). Some materials, such as the best practice guidelines, may embody something important like the notion of what is considered acceptable practices. Feminist poststructuralist thought about such materials (and technology) can help question the binary notions of human/non-human and mental/material and open up the blurred division of 'virtual' and 'reality' (Haraway, 2004; Sandelowski). For example, I was struck by how much of nursing practice I observed in the nurse-run clinic involved the telephone. One nurse told me a story about how a family member of a patient was so grateful to have the nurse "there" (i.e. on the telephone) to help the family member address a difficult issue with the patient. I was intrigued.

The nurse wasn't "there," but a computer reconstruction of data across telephone lines (called 'data packets') to represent the nurse's voice was in the patient's house. There was no questioning of the nurse being "present" in this situation and a distinction between the physical nature of the nurse and the virtual reconstruction of her voice did not exist. In this way, the telephone can be seen as a material mediating the practices of the nurse and contributing to a different understanding of nursing subjectivity and practice in this setting.

I must also acknowledge that, because various texts and materials are both products of a culture and help produce it, multiple interpretations are possible (Sandelowski, 2003). For example, I found it interesting that the nurses I observed carried pagers. I struck me as odd because this group is readily available to whoever may need them without being paged. The only times I observed another healthcare provider not having the attention of one of these nurses immediately was when the nurses were either on the phone or in an exam room with a patient. I hypothesized to my observant participant that this could be seen as a form of surveillance of the nurses. Contrary to this idea, the observant participant stated that within the study organization, pagers represent a certain prestige.

### **Research Journal.**

The key to understanding how I observed both the participants and myself observing the participants was to use a 'layered' research journal (Altrichter & Holly, 2005). By creating a research journal with at least four overlapping yet distinct areas of focus, I had an initial avenue for analysis as well as an opportunity to develop reflexivity and reflect on the research process itself. The four layers I used were descriptive/interpretive notes (which could also be called 'field notes'), theoretical notes, methodological/planning notes as well as a journal to engage in reflexivity. In this way, the research became a living (and messy) process that truly became "a

site of discovery and creativity where the terrain becomes an evolving, heuristic map the research draws on in conversation with the ‘facts’” (Altrichter & Holly, p. 29).

### **Descriptive and Interpretive Notes.**

Descriptive and interpretive notes (which are inseparable) were taken while accompanying and observing the clinical nurses. This section of the journal includes descriptive sequences and interpretations of those sequences. I also reflected on some assumptions (e.g. all nurses had heard the term ‘knowledge translation’ before), phrases that caught my attention (e.g. “everyone needs to be on the same page”) and how the nurses interacted with other disciplines (or not). These observation (or field) notes became a primary source of data generation as I reviewed my observations and reflected on their relevance and relationship to the data constructed through/from the interviews.

### **Methodological and Planning Notes.**

Over the course of the research process, the methodological notes became enmeshed in the planning notes and my never-ending to-do lists. Here I recorded my “observations and reflections regarding research strategies, methods, and activities as the research unfold[ed]” (Altrichter & Holly, 2005, p. 26). I also included thoughts about how to improve my interactions and working relationships with the clinical nurses and other practitioners within the organization and the context of their practice. This foregrounded multiple issues that I needed to attend to as well as consider for any future research endeavours that I will be involved in. For example, funds were available to either replace (backfill) any of the participants or pay them overtime in order to participate in interviews. What I did not consider before the project was that by doing so, those wishing to participate in the project would be clearly identified to their immediate supervisors as

well as other administrators in the organization (who were required to approve such expenditures). To offset this, I spent literally hundreds of hours ‘hanging out’ in my designated office space (away from any supervisory office space) waiting to be contacted by potential participants. I also did daily ‘rounds’ of the clinical areas chatting with the nurses and other healthcare providers working with them. In this way, I could identify when the clinic was most likely to be ‘slow’ and take advantage of that for interviews. To augment this, I remained very flexible about observations periods. I would go to the clinic several times a week to see if anyone was available to spend time with me ‘in the moment’ because the clinical nurses often could not know in advance the staffing demands of them. In addition, the nurses who worked in the nurse-run clinic were frequently transferred from the clinic to other areas of the organization to cover sick or holiday calls. Often, they would only find this out on the morning they went to work. One nurse refused to book future observational dates with me, although she was keen to participate in the research. She stated she “never look[ed] more than a day ahead” in the schedule because “it will just change anyway.” Not to imply that she was unpleasant, far from it. This did, however, cue me to an interesting workload function of the nurse-run clinic affecting continuity of care. In future studies of this nature, I will instead arrange for an honorarium so interviews can be held outside of work (if the participant wishes) and minimize inconvenience to participants while still maintaining confidentiality.

### **Theoretical notes and journaling.**

Theoretical notes were kept in separate scribbles during the course of observation and, more intensely, during analysis to assist me to make “connections between data and understanding them” (Altrichter & Holly, 2005, p. 25). Here I noted such realizations as possible relationships between events, clarification of concepts/ideas or connecting what I was

interpreting with feminist poststructuralist readings. These notes became incorporated in my reflective and reflective journaling. Although this section contained mostly personal journaling about my research process, I also included a folder here with ‘miscellaneous entries’, or bits of interesting ‘data’ that may otherwise be lost (such as letters, memos, commentaries, etc.) were kept in a folder. These included newspaper articles, organizational newsletters, and emails sent to me over the course of the project (e.g. Appendix C). These miscellaneous entries help me keep track of organizational issues occurring over time that might affect my understanding of a particular research event. For example, new patient assessment tools were introduced at the very end of this project.

This is also the place where I engaged in reflexive writing. Reflexivity is “the process of reflecting critically on the self as a researcher” and I have also discovered how these aspects of myself, as the human instrument, are in a “constant state of flux” (Lincoln & Guba, 2000, p. 183; Cutcliffe, 2003, p. 140). It has been a bit unsettling to be confronted with the concept that who I am as a person and a practitioner is inextricable from a credible research process (Cutcliffe; LeCompte, 2000). That it is both the research and the researcher that shape the knowledge constructed and I must acknowledge my experiences and locate myself in relation to the researched (Munhall, 2007). This is essential, as I do concur that there is no neutral or final position to conclude with (Clifford, 1986). I do agree that reflexivity is a major route to validity when engaging in feminist poststructural ethnography (Lather, 1991). Indeed, unlike a traditional view of validity in which influences on the researcher are considered threats, a feminist poststructural perspective may view these influences as opportunities or possibilities to provide insight into the practice of doing research (Newton, 2009b).

I also found it interesting that, while reflexivity is central to feminist research, it is problematic to a poststructural approach in that it might be construed as an enlightenment goal. But the goal of feminist theory to enlighten participants about their oppression (and how they participate in the oppression of others) provides an interesting avenue to address the ‘so what’ criticism of poststructuralism. The assumption that the participants are oppressed could be considered paternalistic and such an assumption would greatly influence how I perceived and related to the participants. I do aim to critique larger structures and processes in order to develop knowledge to influence change; however, I have no goal to emancipate the nurses. On the other hand, I do not wish to reject the idea of emancipation so instead of expecting change to occur based on my research process, I came to understand that emancipation could direct me to consider multiple possibilities of change (Lather, 1991). These possibilities for change can occur for individuals and/or in an organizational context. In this tension, I have come to see that combining feminist, poststructural and ethnographic practices pushed the analysis beyond mere description and helps me make sense of it in relation to a broader context. Most importantly, to me, is that it is this struggle to articulate my assumptions and subjectivity in this section of my research journal that I eventually came to see that the writing process itself was an important analytic method during this research process.

### **The writing itself.**

I have always struggled with my writing (Newton, 2010). The irony of my choice of dissertation topic does not escape me: It is connecting my doing with my knowing as a practicing nurse that has always been difficult for me to articulate. For me, writing has become an essential tool to begin this process. When I spend extended periods of time writing, I feel that I am somehow being reconstituted. This makes sense in light of Colyar’s (2009) statement that

“writing shapes and forms the world as we construct meanings” (p. 427). It is also a “means of self understanding” and this is crucial to my reflexivity and future scholarly endeavours (Colyar, p. 432). And because of this ‘doing,’ I ‘know,’ as Elbow (1998) suggests, although it is “sometimes painful... re-drafting is a re-seeing of what you’ve written” (p. 123). This process of writing (particularly combined with ethnographic practices) can be seen as part of my fieldwork because it is, in itself, a “sort of data collection” (Colyar, p. 423). I am guided by the opinion of Richardson & St. Pierre (2005) who said, “...for me, writing is thinking, writing is analysis, writing is indeed a seductive and tangled method of discovery” (p. 967).

Ultimately, what I see playing out in my writing is my own knowledge translation process filtered through my own subjectivity and experiences of nursing practice and influenced by my current situation in which everything I write is framed by academic expectations. It is the merging of the knowledge I am using, my thoughts about such knowledge and how I put that into practice (whether research or nursing practice). I see how seductive it is to believe that randomized controlled trials are the ‘gold standard.’ Producing such ‘evidence,’ purported to be apolitical and value-free, allows the researcher a detached freedom from the messy and irrational effects of that evidence. If I could generate research findings without being philosophically responsible for those findings (Silvia, 2007), I would have finished my dissertation months ago. My research feels ‘risky.’ That is, I will be in a position where my research can be criticized from multiple fronts. Where there are cracks in my constructivist (stated) approach, my humanist and post-positivist tendencies (which I am trying to better understand) will leak out and be obvious to those more sophisticated. The poststructuralist approach can be attacked as relativist and dismissed because of the frequent ‘all or nothing’ arguments levied against such writings and ‘evidence.’ I do agree with Lather’s (1991) summing up of the issue of relativism in that “fears of

relativism and its seeming attendant, nihilism or Nietzschean anger, seem to me an implosion of Western white male, class-privileged arrogance—if we cannot know everything, then we can know nothing” (p.116). But I am still nervous. A feminist approach exposes the researcher (me) to claims of politicizing issues that are represented as apolitical.

My struggle stems, I believe, from the need for me to have the data make sense both within my philosophical approach (and beliefs) as well as in the context of my nursing practice. Yet this is not an easy and linear process. Through my writing, as in my practice with patients, I must come to terms with the incompleteness and limits of all interactions. In some ways, it is unfortunate that my end product (dissertation) will be so tidy and organized because this, in no way, represents the reality of the tremendous learning and growth I have experienced as I have attempted to collate all of this into a coherent, readable document. I am humbled by the difficulty of writing well. And I am encouraged by the results of my hard work and limited only by my own thinking regarding the possibilities before me as I finally stop writing (but never finish). When I started my doctoral studies, I had a burning question I wished to answer. It is through my writing process that I have come to be satisfied that I have answered this question and that I remain excited to continue to expand on the political nature of nursing practice and healthcare (that is the inextricable feminist in me). Every time I return to this document and continue the writing process, I learn something new about ‘knowledge translation’ and myself.

### **Making Sense: Analysis**

As outlined above, I collected data using an ethnographic methodology informed by a feminist poststructural approach to guide the analysis of that data. In order to make sense of the data collected during this feminist post structural informed ethnography, I set about the ‘doing’ of analysis in a systematic way looking for commonalities and differences as well as being open to

new possibilities. In this, I have attempted to remain alert to notions of power, which can be seen as an effect that is carried out through language (Purkis, 1994, p. 14). I chose not to use software intended to assist with qualitative analysis and thus, analyzed the data in the following manner:

- I began with the core sample of registered nurses I observed.
- I listened to the digital recordings and made a summary of my initial thoughts and observations.
- Then I scanned the interviews as a whole, noting any initial insights or connections.
- Then I reread my summaries, the interviews and the observation notes.
- Similarities generated from this analysis were compared within and between transcripts and field note data in order to clarify commonalities of discourses in practice.
- I read and re read the remaining interviews with the nurses in educator and administrative positions in the same manner.
- I then read the non-nurse administrators and healthcare providers in the same manner.
- When I completed an initial construction of themes, I checked these themes with an ‘observant participant’ and three of the nurses I observed.
- I reviewed documents and texts particularly for language and how dominant discourses were reproduced in these supporting texts. This assisted with analysis of the broader context of the study.

Folding together ethnographic methods with a feminist poststructural approach helped me remember that I am constructing a construction (dissertation) of a construction (best practice

guidelines) of a construction (knowledge translation) and that while doing so, I am allowing for certain 'figures' to be foregrounded (the views/observations of nurses) and other aspects to be excluded (for example, the views of patient care aides or even any artistic representation of the discourse of knowledge translation). While thinking within these nested constructions, it is important to understand how the fundamental assumptions regarding language, power/knowledge and subjectivity are key considerations in representations that both convey and construct understanding and the tensions this may highlight within an ethnographic design. It is through this articulation that I also contribute to the scientific integrity of this project.

### **Scientific Integrity**

Prior to consenting to an interview, one healthcare professional (also a researcher), quizzed me for several minutes on the merits of my research. While it is now widely recognized that traditional views of validity and reliability cannot be applied to all research (indeed, they are contested even within their own paradigm), I do agree that strategies to ensure the scientific integrity of research must exist. Thus, having addressed issues of validity and reflexivity, I will explore the ideas of triangulation in terms of my own work.

### **Triangulation.**

In quantitative research, triangulation is usually taken to mean the use of three methods (as in three points of a triangle) to support the so-called validity of a 'fixed' point of truth or fact (Richardson & St. Pierre, 2005, p. 963). Rather than dismissing the notion of triangulation because of the tendency to understand it in such terms, I wish to use the expression as it was originally introduced: not as a literal 'fixing' of the coordinates of 'truth' but instead as a metaphor (Smith, 1975). In the fifteenth century, 'triangulation' became a popular method of navigation in which explorers used existing maps (and landmarks) to establish coordinates in

uncharted or unknown territory. In this way, I used multiple methods to orient myself and my research using known coordinates on my map of nursing practice (and research) to assist me in exploring new and uncharted territory. As Fontana and Frey (2005) point out, “humans are complex and their lives are ever changing” and thus, multiple methods allow for a more complete picture of the complexity of nurses and their practices (p. 722). I do not wish to imply that using multiple methods for data collection is somehow superior to a single method, but rather as Mathison (1988) suggests, triangulation is an import strategy for “the *researcher* to make sense of some social phenomena” (p. 15). My use of triangulation is not a method of ascertaining ‘the truth’ about the discourse of knowledge translation and nursing practice but instead represents my attempts to understand multiple perspectives and open up possibilities in order to add depth to my study (Munhall, 2007).

This is congruent with Purkis (1993), who also points out triangulation does not represent a fixed truth but instead serves to uncover ‘social facts’ that stand for the shared discursive practices supporting a discourse. In order to attend to notions of triangulation, we must recognize that we cannot locate difficulties solely in the experiences of the individuals interviewed. We need to challenge these assumptions through crosschecks (verification) and observations (Purkis, 1994). In this way, credibility can also be established.

Triangulation in this study was achieved by collecting data over many months as well as using various data generating procedures such as interviews, participant observations and collecting numerous texts. Triangulation assisted me to excavate differing viewpoints as well as identify both differences and congruencies in the data. Purkis (1994) underscores the importance of crosschecking observational data with a careful and critical review of other data sources, such

as interview transcripts. This provides both a contextualized account of nursing practice and some sort of ‘evidence’ of triangulation of data (Purkis, 1993).

Triangulation is also an integral aspect of credibility. Strategies I used to enhance the credibility of my research process and findings were “prolonged engagement (with the research participants), persistent observation, peer debriefing...and member checks” (Munhall, 2007, p. 556) as well as crosschecks. I was able to accomplish crosschecks with both my observant participant and my supervisor. In addition, I was able to engage in member checks by returning to three of the nurse participants whom I observed to discuss my findings. I was able to verify my interpretations as consistent with my supervisor, who read all of the transcripts. Triangulation also seems to be an important consideration for bridging the so called ‘research-practice gap’ identified within the discourse of knowledge translation.

### **Research Ethics Considerations**

Prior to entering the field I obtained ethics approval for my project from the University of Victoria as well as the organization in which it took place. The observations and interviews were conducted after ensuring that informed consent was obtained from the participants. In addition, I considered this consenting process to be on-going and checked in with the participants during each observation to ensure their continue consent. Participants were assured verbally and in the written consent form that they could withdraw from the study at any time, refuse to answer particular questions, and/or terminate the interviews or observations at their discretion. Participants were also invited to contact me directly (by phone or email) if, upon future reflection, they wished some of their comments removed from the transcript. Several participants did limit their participation in some of the ways described above and, rather than feeling distressed about this, I feel more confident that the data I obtained was done so in an ethical

manner. All transcripts and field notes were de-identified and coded to ensure confidentiality of the participants during analysis and anonymity of participants in the dissemination of findings (i.e. presentations and manuscripts).

## **Conclusion**

In this chapter, I have outlined my methodology and the concurrent approach to analysis, including the data collection methods I employed to generate my data. I have also highlighted the strategies I have used in order to make sense of this data with attention to scientific integrity (including research ethics considerations). I now turn to the next three chapters, where I present my findings through detailed descriptions of a feminist poststructural analysis of the data pertaining to the discourse of knowledge translation. I will highlight possible effects of the discourse on nursing practice and the wider social context of the discipline of nursing.

## **Chapter Four: Knowledge-In/Action**

From a feminist poststructural perspective outlined in chapter three, I will now present my findings through detailed descriptions of analysis of the ethnographic data collected. My reading of the knowledge translation literature has focused on the discourse of knowledge translation and the promises offered both in terms of the wider discursive field of healthcare and the preferred subject position of the nurse implicit in the readings. In particular, I focus my analysis in terms of the potential effects the discourse of knowledge translation may have on the subjectivities of the nurses in my study. This is accomplished by carefully considering the knowledge translation practices that seem to be required to enact the discourse of knowledge translation and how these practices may limit and constrain their subjectivities and subsequently their nursing practice in particular ways.

In order to gain further understanding of the discourse of knowledge translation, I will first look more closely at a specific knowledge translation activity: best practice guidelines. Best practice guidelines, I argue, embody the ideals of the discourse of knowledge translation and a careful examination of how the nurses in the nurse-run clinic take up the guidelines and the effects of these on their practice will be explored. While there is great debate over the use of ‘evidence’ and great emphasis placed on the importance of adhering to best practice guidelines (as outlined in chapter two), the effects of such constructs in the context of ‘knowledge translation’ on nursing practice are relatively unexamined. The introduction of best practice guidelines in nursing practice can highlight the changing practices and potential points of resistance and possibilities for change. This shift foregrounds ‘rational’ practices (based in current conceptualizations of science and professionalism) and backgrounds the contextualizing

practices of nurses that could be said to be an integral element of the discourse of knowledge translation. I argue that the interplay of such unacknowledged practices could be seen as both essential to the production of the discourse of knowledge translation and the site of opportunities for resistance to it.

### **Best Practice Guidelines**

The best practice guidelines examined in this study were developed internally to the organization by a senior nursing leadership. Several nurses described this to me as an intense and time-consuming endeavour that the nursing leadership group took “very seriously.” Based on national standards, these best practice guidelines were tailored for the specific focus of the organization (cancer care). There were initially fourteen guidelines developed with plans for several more. All guidelines are based on common symptoms or side effects of cancers and chemotherapy treatments and are also referred to as *Symptom Management Guidelines*. Each guideline represents a different patient ‘symptom’ (such as pain, shortness of breath (dyspnea) or diarrhea) and is approximately nine to fourteen pages in length. Each symptom management guideline includes: the definition of the symptom; assessment steps (general, symptom, and physical assessments); a grading scale for the specific symptom; links to resources regarding the specific symptom; and finally, other considerations that may be related to underlying causes of the symptom (such as possible co-morbidities).

What is most striking about the guidelines is the grading system incorporated into the assessment of each specific symptom. Each ‘grade’ (from 0 to 5) is accompanied by specific actions (excluding ‘0’, defined as asymptomatic and ‘5’, defined as deceased). Grade ‘1’ and ‘2’ are “non-urgent” levels of the symptom that outline the “support, teaching & follow up care as required.” Level ‘3’ indicates an “urgent” level, requiring “medical attention within 24 hours”

and level '4' is "emergent" and "requires immediate medical attention." The nurses all received several hours of education regarding the importance of the best practice guidelines, including how to integrate them into current nursing practice from a team of nurse educators. The nurse educators were very emphatic that the best practice guidelines were "just a guideline" not meant to "replace [the] clinical judgment of nurses." However, it was also explicitly stated in interviews with the nurse educators that the overarching expectation was that the best practice guidelines were being used in patient interactions. This was seen as an important link to improving patient care. One administrator concurred, stating that it was also very important from her perspective that "they [best practice guidelines] are being used and that people [the nurses] are incorporating them into their practice and referencing them" in the patient charts. However, the emphasis for this administrator was on the documentation to demonstrate that particular symptoms were being addressed (and resolved) over time.

In other areas of the organization where the nurses worked, such as chemotherapy suites and radiation therapy, nursing practice is structured by detailed and complex protocols related to physician prescribed modes of care. In the nurse-run clinic, prior to the introduction of the best practice guidelines, it was described to me that there was no clear expectation that the nurses practiced in any particular manner as long as they "got the work done." There was, however, much criticism about the documentation of such nursing practice and how this documentation failed to describe or contribute to continuity of patient care and improved patient outcomes. Prior to the introduction of the symptom management guidelines, nursing documentation was described as being sub-optimal by some of the nurse educators. This was echoed in interviews with nurse administrators. As one nurse administrator commented, the nurses "wrote, like, the whole story of the patient and who wants to read that?" Also of great concern was that the

physicians did not read the nurses notes because, as some physicians were purported to explain to an administrator, “Nah, don’t bother, there’s nothing there.” The concern that physicians did not read the nursing notes was also shared by many of the nurse-run clinic nurses interviewed. This was said to be partly due to the difficulty in obtaining the paper chart and the lack of ability of nurses to input into the patients’ electronic record. For the most part, though, I was told multiple times that other disciplines did not read nursing narrative documentation because of lack of time or because “they [the nurses] just did not know how to capture that [the salient details] in a succinct way on paper.” While I did observe all of the nurses writing in the narrative notes of the paper patient record during each observation, I also observed the nurses charting in a ‘miscellaneous’ field in the electronic patient record. Here, the nurses can type in about 30 characters to convey nursing information regarding the patient to their colleagues. I observed the nurses typing in messages such as “febrile-watch” or “follow lab work.”

After the introduction of the best practice guidelines, a nurse administrator explained to me that the “prompts” provided by the guidelines ensured that the nurses “systematically document[ed] what is going on” instead of “something vague.” The expected format of documentation by the nurses following the introduction of the best practice guidelines was to outline the assessments listed in the specific symptom guideline, assign a ‘grade’ to the symptom and record the actions taken to address the symptom as specified in the guideline. This grading system is also integral to clinical trial research data collection performed by physicians and clinical trial nurses in this organization. Concurrent with the introduction of the best practice guidelines, the nurses also underwent education to improve their documentation skills. After this, most nurse educators agreed that documentation had vastly improved. This perception seemed to be shared by the nurse administrators as one said she was happy to report that “they [the nurses]

are really focusing their charting so that it is much more meaningful” within the organization (i.e. the nurses “assigned a grade” to the symptom). The administrative goal is that the ‘grades’ produced by such nurse-patient encounters would be converted into simple histograms for each patient. The intention was that these histograms would become a permanent feature of the patient’s chart and could provide evidence of the effectiveness of nursing care provided in the nurse-run clinic. In this way, it was hoped that healthcare providers could compare the grades of particular symptoms over time and determine if a patient was improving or if further interventions were required. In addition, quantifying patient symptoms was seen as an avenue to ensure that “everyone is speaking the same language” or “is on the same page.”

### **‘Shift’ Work**

Over the course of six months of observation and use of the best practice guidelines, I perceived a subtle shift in the approach of the nurses I observed in regard to interactions with patients as well as other healthcare professionals. At the beginning of my observation period, nurses most often greeted the patient with open-ended questions such as “How are you?” or “How are you doing?” Following this, the nurses addressed the concerns presented by the patient. While these concerns were often related to the symptoms addressed by the best practice guidelines, it was just as likely that the concern was related to family relations (e.g. a patient worried about how their spouse was coping), questions about follow up appointments or questions about how their medical treatment may impact a chronic illness they might have (e.g. several patients I observed were also diabetic). Parking was a prominent concern that the patients wished to talk about with the nurse and when the patient appeared worried about their parking situation, the interaction between the nurse and the patient seemed to be shorter<sup>9</sup>.

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<sup>9</sup> Like many healthcare organizations in Canada, the study organizational also required patients to pay for parking.

Five months after the introduction of the best practice guidelines, I noted that all but one of the nurses I observed instead began their patient interactions by asking, “What symptoms do you have?” While the one more experienced nurse still asked the patients how they were (generally) rather than starting from a specific best practice guideline symptom, she still did ask about a symptom at some point during the interaction. When I asked about this, she told me that she needed to make sure she had a symptom to document otherwise, it would appear she had “done nothing for the patient.” This shift happened gradually and, had I not had an opportunity to observe the nurses as they worked over time, I would have missed it completely. Discussions about patient care with their colleagues also shifted from “holistic care” to the focused attention on the cluster of circumscribed symptoms outlined in the guidelines. Thus, the best practice guidelines seem to be part of a redefinition of the boundaries of nursing practice within this setting.

This shift also permeated interactions with other healthcare providers. I observed the nurses redirecting conversations with other healthcare providers, mostly physicians, to a focus back on the best practice guideline symptoms. For example, I observed a physician enter the clinic and have a detailed discussion with the nurse I was observing regarding the social history of the patient and the plans the physician had made in this regard. The nurse listened attentively to the physician. When the physician finished talking she asked, “And what are [the patient]’s symptoms?” The physician replied, “dyspnea<sup>10</sup>” and the following conversation between them focused exclusively on this symptom. When I asked about the focus on the symptom, another nurse replied, “identifying symptoms early is crucial with these mixed [chemotherapy] protocols.” In this way, it did appear to me that the nurse and the physician were “speaking the

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<sup>10</sup> Shortness of breath

same language.” That is, the conversations regarding patient care became focused on the symptoms and side effects of cancer and subsequent medical treatments experienced by the patients. Further to this, it doesn’t seem that it is just healthcare professionals who need to be “on the same page.”

Patients are introduced to the study organization and nursing through an initial meeting called “group chemo-teach.” Usually a nurse, but sometimes a pharmacist, leads this session. I observed two such sessions, each with approximately six patients. These sessions occurred in a conference room with a large table that patients (and usually an accompanying family member) sat around with the nurse. The nurse described a general overview of how treatment is organized in this setting and then conducted a tour of the facility with a volunteer. The nurses I observed were engaging and made eye contact with each patient as they progressed through the educational material to be shared. The nurses would stop at anytime to answer questions from individuals in the group. The nurse did not provide specific information about any patient’s particular treatment plan because each patient also received an “individualized chemo teach” (by a nurse) when they begin their treatments. In one session, a middle-aged man asked for more specific information about his chemotherapy treatment plan because he had concerns about the side effects. The nurse encouraged the patient to discuss his choices and preferences with his physician. The patient replied softly, “Well, it’s a choice but it’s not a choice so I will just listen.”

In both sessions, the patients were very quiet and attentive. They each received an information package that outlined various resources they can access over the course of their treatment. The bulk of this material is related to the most common symptoms, the same symptoms that the best practice guidelines are based on. In reviewing the symptoms, the need to call a nurse was emphasized because “prevention is easier than treatment.” There was, however,

one symptom reviewed for which there was no guideline: the symptom described as “chemo-brain.” One of the nurses told me that a best practice guideline for this symptom was “in the works.” This was important to this nurse because “we all need to be giving the patients the same information...you know... be on the same page.”

Patient involvement with the best practice guidelines was also described in another way. The following is an excerpt from an interview with a nurse who described a problem she had when using the best practice guidelines. In this interview, the nurse is describing a conversation with the spouse of a patient who is experiencing anorexia (involuntary loss of appetite), a common side effect of chemotherapy treatment.

Nurse: But there was just -- the -- the attitude -- well, not the attitude but the -- the concept that, “No, we’ve already tried everything and we know what works.”

Lorelei: Okay. And -- and was that your sense, that they probably did?

Nurse: Yeah. I mean, he seemed to -- he seemed to know, like, you know, he said, “She has a little bowl of cashews that she snacks periodically” and -- and yet, like, when I said, “Well, it’s probably good that she -- if she’s not around the cooking smells while you’re cooking,” well, then he mentioned steak, and I said, “Oh, good, so you barbecue.” “No, no, I cook inside.” Okay, so how is it that she’s away from the cooking smells then while you’re cooking? You know, but it was very much like he had already kind of gotten what he needed...

...so he wasn’t really...he wasn’t really dedicated to the process himself. So... (long pause)

Lorelei: And that’s required, that the patient has to go there with you?

Nurse: Yeah. Exactly. They have to be sort of engaged in the process of what you’re doing but he had already kind of gotten what he needed and he was also working at the time so he was kind of here trying to deal with things ... whereas yesterday, I had a patient in [a treatment area] who was just there for a CT with contrast, so we had to start an IV and I’d read his chart prior to him coming in and

noticed that he had a lot of problems with dyspnea. That's where I was going with that. And he was very open to hearing more information..."

The nurse seemed to find it difficult to follow the guideline when the patient "was not dedicated to the process" of using the best practice guideline. In contrast, if a patient was "engaged in the process" and was "open to hearing more" about symptom management based in the guidelines, then the encounter was perceived by the nurse to have gone more smoothly. During one observation, one nurse expressed the difficulty of the best practice guidelines when the patient "gets distracted" and doesn't follow the linear progression of the guideline format. If this happened, she was concerned a nurse might "miss something." When I asked her what she might miss, she showed me best practice guideline grid and was concerned that she would not be able to differentiate between something she could address independently and when she would be required to contact the physician. Incorrectly assigning the grade might make it harder to follow up with patients to see if their symptom was improving or not. In addition, she stated she often wanted to assign the grade as '1.5' or '2.5' because it seemed, to this nurse, that a half grade would be more accurate. Later, in an interview, this same nurse explained that if focus can be sustained, she is able to "extract more accurate information" and "get more direct answers from the patient" than before using the best practice guidelines. Thus, it does not appear to be just the nurses who reframe their practice in terms of the best practice guidelines; patients also seem to be cued from their first visit with the nurses to describe their cancer 'journey' in terms of symptoms to be managed.

### **Rationalism.**

Using Reiss' (1982) discourse of analytico-referentiality, or rationalism (as discussed in chapter two), the best practice guidelines seem to be arranged in this way in order to "explain the

world, even impose meaning on the world, a world conceived as set and ordered” (Trueit, 2005, p. 36). Reiss identifies five elements of the discourse of rationalism that influences how certain practices are conceptualized within modern settings, such as healthcare organizations:

Objectivity; the use of metaphor as mechanism of ordering; distanced perspective; “probability” or statistical theory; and a “linear narrative of causation.”

The first characteristic, objectivity, goes hand in hand with the “use of a metaphor as an ordering device” (Trueit, 2005, p. 37). Metaphors help explain or describe the unfamiliar in terms of the familiar and in this way, the familiar becomes the vehicle to normalizing the unfamiliar. As discussed in chapter two, a metaphor of the discourse of knowledge translation is the commodification of knowledge as an extension of 21<sup>st</sup> century global economy. As Reiss points out, objectivity (or the appearance of it) and such metaphors are usually intertwined. Objectivity can be defined as “the ability to consider or represent facts, information, etc., without being influenced by personal opinions” as well as being impartial or detached (OED, 2011). Central to the construction of best practice guidelines is that they represent certain ‘facts’ or symptoms in decontextualized packets of ‘knowledge’ that can be followed by nurses with certainty, despite the situation at hand. Nurse leaders, as well as the practicing nurses, seemed to represent the best practice guidelines as highly rational, or “a ‘pure’ type of description or knowledge that is untainted by the problems of perspective or subjectivity” (Bulloch & Trombley, 2000, p. 604). So, in the example of charting, the need to assign a grade to each symptom may serve to reinforce the rational objectivity of the discourse as well as representing the successful delivery of certain packages of knowledge. In this way, the ‘object’ of this endeavour also seems to be (re)defined within the discursive framework of knowledge translation: the patient.

When Reiss (1982) describes the third characteristic, perspective, he is referring to the “god’s eye view” or a view that is “fixed and whose certainty is ensured by defining” (Trueit, 2005, p. 37). This view is assumed to be all knowing, that is objects (such as symptoms) can be known and described universally. Because of this, adhering to the guidelines then becomes the rational imperative because all that is required to be known at this time can be seen as contained within them. From within the discourse of knowledge translation, it could be seen as irrational to do otherwise. The fourth characteristic, ‘probability theory’ or statistical theory, assumes that the laws of an orderly universe can be known and explained fully. That is, the symptom central to each guideline contains all the pertinent evidence required to successfully address the symptom. And, finally, inherent in this discourse of rationality, is the notion of a linear model of cause and effect. Thus for every effect, there is a cause to be uncovered and applied universally (Reiss). For every symptom, there is the promise of a discrete and complete set of guidelines that, when applied to any patient and regardless of the setting, this application will result in a successful outcome.

These five characteristics order and shape the discursive practices of rationalism (and knowledge translation), in which knowledge is fixed and made finite as demonstrated in the nurses’ use of a best practice guideline. Through this process of objectifying the experiences of people living with cancer, the boundaries of nursing practice and patient care within the context of this organization are delineated. The goal of a discourse framed in objective rationalism, in the incremental generalization as the discourse is produced, is to eventually establish the exclusive form of ‘true’ knowledge with other forms of knowledge being merely contradictions of this true knowledge (Trueit, 2005). Once this exclusivity is established, the nurses could be inscribed within this discursive operation and, thus, perpetuate and reinforce the exclusivity of the

guidelines through repetitive use. Eventually, practices can shift to such an extent that the discursive processes of knowledge translation become ‘taken-for-granted.’

A seemingly innocuous discursive move of how the nurses interacted with their colleagues and patients might not only represent a shift in practice but also, how they may be reconstituted as a different kind of nurse constructed by and through the discourse of knowledge translation: one that is more overtly rational and perhaps, more professional. This effect may be illuminated through the nurses charting practices.

In contrast to the previous narrative nurses notes described earlier, towards the end of my last observation period, I observed two nurses discussing how they would communicate patient information to the patient’s physician as well as another nurse working in the nurse-run clinic that day upon her return from a break. To accomplish this, they entered “11-2” into the patient’s electronic record, in the small ‘miscellaneous’ field the nurses sometimes use to communicate with each other. When the other nurse returned after lunch, she looked at this patient’s electronic chart and said, “11-2? What is that? Oh, pain...I should have known that. Yes, [the patient’s] pain symptom is a grade 2.” When I asked her how she “knew” that, she replied, “well, pain is the eleventh symptom and we have been talking about a way to chart them better.”

**“Resistance is futile.”**

The nurses’ general acceptance of the best practice guidelines, both during my interviews and observations, surprised me. I assumed that I would hear, and observe, far more overt resistance to the use of the guidelines. During my observation sessions, without exception, I observed the nurses referring to and using the best practice guidelines to work through their clinical decisions regarding patient care. In addition, they used the best practice guidelines to guide their charting, particularly emphasizing the grading system and ensuring this ‘grade’ was

somehow accessible to their colleagues (in the electronic record, the patient paper chart or in a note). This observation of the nurses' general acceptance of the guidelines was also expressed to me several times by other individuals I interviewed, mostly nurse educators. As one nurse educator stated, after explaining she had gone to each nurse individually to discuss the new guidelines and to ensure that they knew they could contact her directly if they had any "trouble" using them,

... they said that they would call. I have not had one phone call about the symptom management guidelines.

One administrator expressed the pleasure she felt when she went into the nurses' work areas and "seeing the binders [best practice guidelines] open and the nurses referring to them." During my observations, the nurses themselves described the best practice guidelines as "making assessments more comprehensive," "mak[ing] assessments more well rounded," "improv[ing] charting" and "a great resource" in response to my questions regarding their utility. There was also general agreement amongst the nurses regarding the benefit of best practice guidelines; as such guidelines consolidated massive amounts of information into a useable format. This was important to the nurses because before, as one nurse stated, "we had to go to no man's land [the internet or organizational intranet] and figure out what was best." I observed this timesaving effect frequently after the introduction of the best practice guidelines, particularly when the nurses needed to access patient education information quickly while a patient was waiting. Instead of spending many minutes gathering specific information from several sources needed by a particular patient, the nurses accessed the information required from the best practice guidelines quickly. This also assisted the nurses to spend more time with patients and ensure the patient had the information they needed in that moment. The nurses consistently acknowledged the time, money and physical energy required of the patients to attend their appointments at the

organization and tried to minimize the impact of this. I observed that if the nurse had trouble locating information she needed to give to the patient, and subsequently could not get back to the patient quickly, that most often the patient left the building. Whereas before the nurse would have to retrieve information from potentially multiple sites (e.g. intranet, internet, clerks, care aides or pharmacy), the best practice guidelines offered “one stop shopping” (according to one nurse) and greatly reduced the amount of time the nurses spent looking for information both for themselves and patients. In addition, I observed that the nurses were more likely to end their patient interaction to their satisfaction (i.e. the patient waited for them and did not leave the building). Further discussion during the interviews demonstrated how the discourse of knowledge translation at once situated the nurses as both producing the discourse as well as being produced by it. As one nurse explained, “the more I use them [the best practice guidelines], the more value I see in using them.”

### **Registered Nursing.**

This can also be read as “the more I use them,” the more natural the re-framing of increasingly rational nursing practice appears. As Derrida (2002) explains, “naturalizing always, very nearly at any rate, amounts to neutralizing” (p. 69). In this way, when a practitioner (Derrida is specifically referring to teachers) is required to utilize a particular content as a framework for their practice, the practitioner then becomes merely the representative of that content (Derrida; Bingham, 2008). Thus, as the practitioner becomes ‘neutralized,’ the process of ‘erasure’ of the practitioner is initiated (Derrida). Underlying this is the assumption that the practitioner can “somehow get out of the way of the text, concepts, ideas, narratives, etc.” (Bingham, p. 18). That is, ‘good’ practice by the nurse can mean that she is somehow a conduit of the best practice guidelines as she transfers knowledge to others unchanged rather than co-creating some new

knowledge. Derrida puts forth that if these institutional practices ignore the knowledge of the practitioner, then the organization will often call upon practitioners to act as if they are “complete beginners” or blank slates (p. 77). These ‘beginners’ are seen to require education as not to interfere with the functioning of the content (i.e. best practice guidelines). This correlates with the intensive educational activities directed at the nurses regarding the best practice guidelines. It is interesting to me that I was explicitly told I was not welcome at any of these educational sessions the nurses were required to attend. One nurse leader told me that there was concern that I would somehow “disrupt” the educational process through my presence and interfere with the learning of the nurse I was following and observing. I was also told that these educational sessions represent a “substantial commitment” to the nurse-run clinic nurses by the nursing leadership and those in charge of the sessions did not want anything to “interfere” with that commitment.

The nurses also tried to demonstrate their “commitment” to the organization by memorizing and spending much time during the observation periods reviewing the best practice guidelines. During one particular period of observation, a more experienced nurse told me that her goal was to use the best practice guidelines “smoothly.” The nurses made multiple comments during the observation periods about how they did not like bringing the “pieces of paper” (that the best practice guidelines were written on) into the room with the patients because, as one nurse stated, “I don’t want the patient to think I *don’t know* what to do.” Another nurse also commented to me as we approached an exam room that “the binder [of the best practice guidelines] feels too big to get through the door” as she was learning them. The use of the best practice guidelines is not an inherently individual process, but enmeshed in institutional practices that rest on what Derrida calls an “economy of erasure.” In this way, “erasure” becomes integral to the entire endeavour because the economy of erasure “supplies us with the very currency with which we

critique the economy of erasure” (Bingham, p. 21). That is, within the discourse of knowledge translation, it does not seem feasible to escape the idea of erasure because the content is constructed as central to nursing practice. Indeed, it is impossible to argue that this information is not extremely important to both nurses and patients in this setting. Thus once redefined, how could one accomplish the work of nursing without the best practice guidelines?

One example of this could be how the nurses (re)constructed their nursing notes based on feedback that the physicians (or other disciplines) did not read them. When the nurses charted narrative (non-standardized) notes, it could be that the nurse was too visible in this writing: Her subjective opinions and assessment of the patient was not “meaningful” in the medical or administrative context of the discourse of knowledge translation. Charting in accordance with the new best practice guidelines, with the focus on quantitative evaluation of the patient and specific information regarding certain symptoms, seems to be viewed as optimal. Thus, from within the discourse of knowledge translation, nursing practices required to successfully work through the best practice guidelines are also represented as standardized and, “such standardization achieves an erasure of the extent and scope of nursing work” (Rudge, 2003, p. 163).

This way of looking at the best practice guidelines is useful because it offers another view of the operations of power and knowledge as it works its way through a rational apparatus such as the best practice guidelines to “erase” or render invisible nursing work. It highlights how power is exercised through a specific discursive mode (knowledge translation) to ensure that what counts as ‘truth’ (quantifiable assessment of certain symptoms), remains central as a valid and “meaningful” way to represent patients’ response to cancer treatments. This is important to gain varied understandings of the effects of the discourse of knowledge translation, but unfortunately, it does not offer details of how resistance is possible (Weedon, 1997). As one

nurse commented to me in the hallway on the way to see a patient, “it should be a total patient care, and I think it’s still going to be but it will be symptom driven.” Here we can imagine that while the *representation* of what nurses do may change, the practices that the nurses continue to do may not be fully accounted for or noticed. These practices (although shifting and changing) can never be fully erased. While I did observe the underlying nursing practices of accomplishing the work of best practice guidelines being ‘erased’ from the patient record, I noticed that there was still a lot going on.

### **Noticing.**

This is not to say the nurses acquiesced or simply adopted the discursive frame of knowledge translation, potentially resulting in some sort of systematic erasure of nursing practices. Nor do I mean to imply that *all* the nurses took up the best practices equally, or even at all, as individuals. The multiple discourses at play affected their subjectivity in a variety of ways and in turn, the nurses resisted in multiple ways as they tried to make sense of these new practices and how they fit within their own view of what it means to be a nurse. This struggle will be discussed in more detail in the next chapter. Now, however, I wish to examine my observations of the nurse-run clinic nurses and, in reviewing my research journal writings and data, I can see how my growing assumption of the shift in nursing practice as described above seems a bit superficial. The move to a more rational and technical approach to nursing practice has been noted in similar observations of researchers during implementation of the nursing process and/or nursing informatics systems (e.g. Easen, 1996; Varcoe, 1996). I began to wonder if my focus on this shift in the work of practitioners to an increasing rationalist perspective when new ways to structure nursing practice are implemented could obscure my view of other possibilities for analysis. Upon reflection, at the onset of this project, I did not overtly believe

that I would see such a shift to rationalism but certainly this may be viewed, at some level of my thinking and analysis, as an expected outcome of using poststructural theories and the difficulty of holding multiple perspectives as a neophyte researcher in order to account for the multiple discourses at play.

Reiss (1982) suggests another avenue to considering discourses. He puts forth that when a discourse becomes dominant, it “occultates” other discourses. Occultation, originating from astronomy, describes a situation that occurs when an object passes between the observer and another object, thereby obscuring the view of the original object (OED, 2011; Reiss). Reiss uses this analogy to describe how dominant discourses eclipse other discourses, causing something to disappear from view or notice. Using Reiss’ work, I began to redirect my research gaze with hopes of noticing what is ‘occultated’ by the discourse of knowledge translation. In this I see multiple possibilities, as what has disappeared from casual sight has not necessarily been destroyed or erased, but is waiting to be *noticed*. I began to consider, in more depth, how the nurses were making the best practice guidelines ‘work’ in this setting. What I noticed, and what might seem invisible to others, was the tremendous amount of unaccounted work done by the nurses in the knowledge translation process: activities that I have come to describe as contextualizing practices. What is so intriguing is that, like my own practice experiences in healthcare organizations, these often unnoticed or invisible contextualizing practices are, as Weedon (1997) would describe, at once both integral to the production of the discourse as well as a fertile site of resistance.

### **Contextualizing Knowledge Translation**

Within the discourse of knowledge translation, the concept of context seems to be either ignored or a taken-for-granted ‘background’ of practice. Often, as outlined in chapter two, it is

presented as a problem to be overcome or manipulated in order to achieve an environment where so-called knowledge translation can occur (i.e. the uncomplicated use of guidelines based in evidence). While context can be defined as the connection or “coherence between the parts of a discourse” (OED, 2011), it also stems from the Latin *contextus* meaning to weave or join together (Dilley, 1999). Contemporary meanings imply “the parts which immediately precede or follow a particular passage or text and determine its meaning” (Dilley, p. 4). In retrospect, what struck me as most interesting in my conversations with the clinical nurses was how they all connected the notion of knowledge translation in terms of the context of *the patient*. That is, they spoke of the patient being the focal point of knowledge translation. This is in contrast to the bulk of the literature, in which the aim of ‘knowledge translation’ is to package knowledge in order that *the practitioner* has all the necessary information to follow the guidelines. That is, the guideline *is* the “translation” (e.g. Harrison, Graham & Fervers, 2009, p. 73) and not the translation of knowledge from practitioner to patient. This does seem to be the common understanding of the best practice guidelines, as one nurse-run clinic nurse told me when asked about updating the best practice guidelines

Well...the [best practice guidelines] themselves are quite new and so I think they're -- and they're still struggling with figuring out exactly how people are going to use them, how they should use them, how they can use them...so, you know, they're preoccupied with translating the knowledge right now.

Subsequently, just as in the literature, there seems to be a focus on education and structuring the practice environment in order to facilitate adherence to particular guidelines. In addition to the many hours of education that the nurses received, they were also required to attend meetings to update administrators and nurse leaders regarding the use of the best practice guidelines. During these discussions, there was never any mention of the care of a patient.

Instead, there were intense conversations on how patients were referred to the nurse-run clinic and detailed reviews of this process. The nurses were routinely asked about “barriers” to using the best practice guidelines (that is, as outlined in chapter two, how to make the nurse-run clinic more conducive to the use of the best practice guidelines) which resulted in such activities as providing more paper copies of the best practice guidelines and setting up a direct link to the best practice guidelines electronically on each computer desk top. As well, the importance of documenting the ‘grade’ remained central to these conversations. I also noticed this theme in conversations with the nurse educators, administrators and physicians. Somehow, the quantified decontextualized outcome of the patient can be seen as an indicator of how well the practitioner used the best practice guidelines or some indicator of organizational functioning (such as patient safety), rather than the actual care of the patient.

In contrast, during observations the nurses described their view of knowledge translation in terms of patient care, such as “...putting the knowledge in terms the patient can understand” while also “...taking into consideration the state of the patient in that moment.” One nurse described knowledge translation as “...taking what we formally and informally know and have access to, and using that to assist patient outcomes.” Another nurse, describing how she might use the best practice guidelines as a knowledge translation strategy, stated, “...to me it is your practice...your experience from practice and applying it to the case in front of you” and further to this, while research is one important resource, “you have to take that and what you’ve got and what limited resources you have so you do the melding of both of them *with the patient*...if you can.” Huen (2009) would describe this interaction between the nurse and the patient as “doubly contextual,” in that the language and subsequent knowledge practices of a discourse such as knowledge translation “shape and are shaped by the context of their occurrences” (p. 150). That

is, a dynamic interface is produced between ‘the context’ (the practitioner and specific organizational environment) and ‘the contexted’ (the patient) that transcends the idea that the ‘contexted’ is somehow a part of, or contained within, the circumscribed ‘broader context’ that can be explained and circumscribed (and perhaps even be thought to be predictable) within a dominant discourse (Strathern, 1992). Thus, this notion of context highlights how the contextualizing practices of the nurse cannot be considered background or inconsequential acts. Such practices involve the incremental and unpredictable production of knowledge (Strathern), which not only allow for a greater understanding of the ‘contexted’ (within the discourse of knowledge translation, this is the patient) but also can be seen as essential to ‘bridge the gap.’ Such an incremental production of knowledge requires both “inexhaustible labour” (Huen, p. 152) as well as time.

Many nurses also talked about the need for more than one patient interaction to translate knowledge; that such a process “takes time...it’s impossible to do this in one sitting.” This was especially difficult for the nurses because, as I observed, the nurses were continually trying to ‘fit in’ their nursing practice in the precious few minutes between physician appointments. Although there was not a formal way for the nurses to follow up with these patients in person at the nurse-run clinic, I did observe the nurses continually ‘booking’ these patients in for follow up telephone calls when the nurse was next assigned to the nurse-run clinic. In addition to these insights, there was concern about the discourse of knowledge translation, in that this knowledge translation process was somehow supposed to stop at the “doors of the organization.” That is, most often once the patient finished treatment or were responding well to treatment (i.e. symptoms are a grade ‘0’ or ‘1’) or if they returned to rural areas, the nurses did not have time or resources to continue to work with them. Many nurses discussed the need to extend this notion of translation

out into the community to include the patient's experiences after they finished cancer treatments. This contrast points to an interesting paradox for those involved in activities within the discourses of knowledge translation.

Inherent to the discourse of knowledge translation is the proclivity to make sense of data (to produce 'gold standard' evidence) through 'context stripping.' De-contextualizing in this manner not only precludes understandings of the historical context of the group, it also conflates the group history with that of the individuals (Haggis, 2008; McIntyre, 2003). It is then up to the nurse to re-contextualize the information in the context of a specific patient situation (perhaps many times). Nurses can be seen as playing an active role in re-configuring the patients as symptoms to be managed rather than complex humans with multiple issues to attend to. In this way, patients can be seen as 'contexted.' At the same time, and quite the opposite as laid out in the discourse of knowledge translation, the nurse-run clinic nurses were also actively contextualizing complex medical and organizational information and knowledge for patients, an understanding of which could be seen as essential for patients to negotiate this intense life-threatening episode of the lives.

### **Contextualizing Practices**

Latimer (2000), in *The Conduct of Care*, theorizes that in the traditional, patriarchal settings of contemporary healthcare, certain aspects of nurses' work are often labeled as invisible or, I would also say, unnoticed or unarticulated. This occurs because the important contextualizing work that the nurses do of "observing, exploring, and interpreting a patient's social situation" is effaced in order to support an appearance of the rational work of medical decisions made on a "purely clinical basis" (Latimer, p. 70). This tends to reinforce a notion that nursing work is merely supplementary or less important than physicians' work, instead of being

complementary in nature (Latimer). It also obscures how it is ultimately this information generated by nurses that is used to provide the context in which medical decisions can be made. In addition, it is the contextualizing nursing practices, such as ensuring new patient forms are completed and addressing patient individual fears and concerns before the patient sees the physician, which can construct visible (or noticed) nursing practices as non-clinical in nature (or merely social) rather than based in any particular disciplinary knowledge. Latimer describes these contextualizing practices in relationship to the physicians that the nurses work with. Effacing the contextualizing work does not just conceal how medicine is distributed between doctors and nurses but is an instance of how the “constituting of classes is maintained and circulated” (p. 71). Thus, possibly perpetuating power structures in which physicians may have undue influence over nursing practice.

This conceptualization of contextualizing work can be extended to the discourse of knowledge translation. The nurses observed for this study were not only doing the contextualizing work of reconfiguring the patients as symptoms in order to monitor potentially fatal outcomes of medical treatments in a manner “meaningful” to physicians, they were also recontextualizing patients as quantifiable objects (the ‘contexted’) in order to create the appearance that the organizational operations in patient safety and economic efficiencies are based in rational decision making. In this way, the contextualizing practices of nurses for both physicians and administrators can be seen as essential to the creation and maintenance of the discourse of knowledge translation.

### **“Something simple is always complex”**

The best practice guidelines also seem to be effective in effacing the complex distribution of medical care and organizational imperatives of patient safety and economic efficiency.

Although these guidelines appear linear and straightforward, they belie the nurses' contextualizing work of connecting with, and caring for, the patients in this setting. In one observation, when I asked the nurse what she meant by "nothing is simple," she also attributed this complexity to being "pulled in so many directions at once." That is, juggling the competing demands of care aides, ward clerks, physicians and patients while also attending to the patients who have appointments with the nurse in the nurse-run clinic. In addition, there are multiple considerations in patient care that are unaccounted for within the framework of the best practice guidelines. That is, something complex is represented as something simple (like a single symptom<sup>11</sup>). As one nurse explained the multiple considerations:

Well, so [best practice] guidelines, you know, are the latest sort of guide into assisting with management of symptoms... But there's all kinds of ways ... I mean, you know, just listening to somebody and acknowledging what you're hearing, it's using other resources to help them out which maybe has nothing to do with symptom management guidelines but has everything to do with just physical or emotional help, so it might be home nursing care to help with dressing changes, or monitoring meds, it could be financial assistance from patient family counseling, or emotional assistance, it could be... just practical information regarding teaching and chemotherapy protocol and answering questions ...

... there could be so much... yes, there's so many resources ... and also I think it's trying to tap into people's strengths, and see how they can best utilize the resources that they already have, that they don't realize that they have... family and friends...

None of the patient-nurse interactions I observed could be categorized as "simple." For example, one patient who was in a lot of pain also had a plugged catheter. This required the nurse to change his catheter and, during this procedure, the nurse gained information about his bathing

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<sup>11</sup> No patient I observed the nurses interacting with had a single symptom and three or more symptoms were common. Contemporary mathematics can demonstrate that the outcomes of interactions between three or more variables (such as symptoms) are not predictable and sensitive to conditions of the onset of such interactions (Mitchell, 2009).

habits and proceeded to do teaching regarding this. At the same time, his wife expressed concern about the patient's lack of appetite and the nurse also discussed nutrition with them both. After ensuring the new catheter was draining properly, the nurse and the patient returned to discussions regarding his pain. This, in turn, morphed into a conversation about his last bowel movement and subsequent discussion regarding bowel care. As this retired couple was from out of town, the nurse also gave them information about low-cost accommodations for future visits. The nurse also reminded them to talk to the pharmacist about having future medications dispensed at their local pharmacy (thus, saving this couple a substantial drive). On the way out the door (and taking the nurse aside), the patient's wife expressed concern about her husband's "forgetfulness" and the nurse engaged in a lengthy heart-felt exchange with her. Then the nurse gave the patient's wife some written information that addressed the wife's concerns and included some caregiver resources for her to access. Finally, the nurse asked if it was okay if she (or another nurse) phoned the couple later that week to see how they were doing. The patient's wife agreed, gave the nurse a hug as she thanked her and then left. This entire encounter lasted approximately 20 minutes. Afterwards, the nurse made a referral to the dietician, put the patient in her computerized agenda for a phone call later in the week and then documented the encounter. While the nurse's narrative charting most likely reflected some of the complexity of this encounter, it does appear that the nursing practice necessary in this interaction, within the discursive frame of knowledge translation, could be summed up as '2.'

Many nurses described how they "speak the patient's language" as well as understand the peculiarities of particular physician practices to have insight into what is possible for the patient's medical treatment. As explained to me during one observation, a nurse "really has to have an understanding of co-morbidities such as cardiac disease, diabetes, psychiatric history, etc." The

importance of understanding and explaining how the organization “works” to patients came up over and over again. One nurse said that the best practice guidelines might be “the basics” but when “the nurses have a concern, it is not the basics you are dealing with. You are dealing with something over and above that” requiring careful attention. Yet, when the nurses employ the best practice guidelines, they seem to be reconfiguring such patients, and their social issues, as symptoms to be treated. As Latimer (2000) points out, this is illustrative of an efficient healthcare organization as “it’s not that the patients don’t have problems but they are reconfigured when inappropriate” (p. 71).

Purkis & Bjornsdottir (2006) argue that there is an unacknowledged space in such activities as best practice guidelines where the nurse demonstrates how knowledge can be activated. Here, the complexity of nursing knowledge can be visible and “opened up for examination” (p. 248). These authors assert the use of such guidelines “places primary emphasis on isolating knowledge ‘factors’ at the expense of the nurses’ creative use of that knowledge as a means for going on in her everyday work as a nurse” (Purkis & Bjornsdottir, p. 250). Thus, a conceptualization of context as a central feature of the discourse of knowledge translation is necessary in order to “make claims about knowledge and its relation to nursing practice” (Purkis & Bjornsdottir, p. 251). I am not arguing that best practice guidelines be abandoned but that the partial nature of such information, and the contextualizing practices required to ‘activate’ them, must be acknowledged. Further to this, the contextualizing practices required for the “intelligent creation of context by the nurse that must take place for nursing practice to be ethical and effective” needs to be examined (Purkis & Bjornsdottir, p. 255). This is important because these contextualizing practices can also be seen as a site of resistance to the discourses of knowledge translation.

**Resistance is fertile.**

Using a feminist poststructural approach, those aspects of nursing practice that are ‘taken-for-granted’ (or unacknowledged) are exposed and this offers the possibility of resistance to otherwise unchallenged, and uncomplicated, views about nursing practice. Such points of resistance may also highlight the potential for change (Weedon, 1997). When reviewing literature regarding the concept of resistance in nursing, resistance seems to be framed as resistance to either physicians or administrators (Timmons, 2003). In this particular setting, a nurse-run clinic, it seems to be different. Resistance does not seem to be openly discussed. As one nurse said, “I use [the best practice guidelines] because I don’t want to be seen as resistant.” This may be because of the rational representation of practice in this organization; resistance to the best practice guidelines is seen at best as irrational and at worst dangerous (i.e. endangering patient safety). In this setting, while the nurses were observed as actively involved in contextualizing the patients for physicians and administrators of the organization, they were also observed contextualizing medical and organizational practices for the patient as they tried to make sense of their diagnosis. That is, also viewing these groups and practices as the ‘contexted.’ These contextualizing practices can also be read as resistance to the dominant discourse of knowledge translation. And articulating these contextualizing practices may be an important step to lead to necessary change of recognizing the political nature of best practice guidelines and nursing practice.

Recognizing the political nature of the best practice guidelines is important because it is not that the nurses need to ‘resist’ these guidelines but the rational discursive moves to articulate or represent nursing practice solely in terms of attending to the common symptoms and side effects of medical diagnosis and treatment in this setting. There are severe limits to this

discourse. If nursing practice is seen to be merely an extension of the medical work in monitoring and reporting side effects of various cancer therapies, this uncomplicated description creates a scenario wherein the nurses could be replaced by less qualified employees. The irony of this, however, is that adherence to a mechanized, rational approach without the ability to engage in contextualizing practices will ultimately result in the failure of knowledge translation initiatives, such as best practice guidelines. I see how contextualizing (and recontextualizing) the decontextualized evidence contained within the best practice guidelines is essential to the main aim of the discourse of knowledge translation: it is one way in which the ‘gap’ between research and practice can be bridged. In this sense, the nurses are quite powerful, particularly because they have the potential to resist and reshape things.

**“A patient is never a symptom.”**

According to Foucault (1982), power is not something employed by those who supervise (such as administrators and physicians). It is a series of relationships in a field of possible actions. Thus, those who are supervised (such as nurses) also engage in power through various relationships and potential actions (which includes resistance). Because nurses play such an integral role in the production of the discourse of knowledge translation and are enveloped in these power relations, they are strategically positioned to resist and reshape their practice (Foucault, 1980). Nurses demonstrated resistance in multiple ways, such as placing a follow up telephone call to patients after their first chemotherapy, and contextualizing this experience for them in the context of their home life, rather than giving the patient all potential information upon their first visit as repeatedly requested by many of their physician colleagues. I observed these telephone calls to be mainly guided by patient concerns rather than particular symptoms they may report (although this changed as chemotherapy progressed and symptoms became more

problematic for the patient). In addition, one nurse reported that her approach to the best practice guidelines consisted of “...just picking out pieces that I thought were relevant.” One counselor commented during a meeting that the nurses independently initiated more appropriate referrals to the counselors rather than consulting with physicians first.

Overall, the most overt resistance I observed and discussed with the nurses seemed to be their refusal to “perform handmaid tasks” for the physicians such as putting patients in the examining room, processing orders, retrieving lab work results, etc. During my observation time, the nurses vigorously lobbied to allow the patients to directly call the nurse-run clinic instead of having those telephone calls vetted through a receptionist. (At the time of this writing, the nurses were successful in achieving this goal). The boldest act of resistance on behalf of the nurses was the request that physicians refer symptomatic patients requiring nursing expertise to the nurse-run clinic. Although this act was not completely successful it illuminated, in a very powerful way, the need for the nurses to collaborate and articulate their practice in this setting.

## **Conclusion**

The introduction of best practice guidelines, which I argue embody the ideals of the discourse of knowledge translation, in a particular setting highlighted the changing practices of nurses. Over time, it seemed that these practices moved from a focus on the patient to a focus on the patient’s symptoms (or side effects of medical treatment). However, upon interrogating such researcher conclusions, I noticed that the nurses were engaged in far more complex practices than accounted for within the discourse of knowledge translation. Noticing such practices points to possibilities for change and resistance.

Resistance can also be seen as constituted through description, analysis and discussions (Timmons, 2003, p. 258) that take place in everyday practice. Resistance was not observed as a

binary of simply taking up the best practice guidelines or resisting them. There are multiple layers of subjectivity that influence how such resistance transpires and to the potential that exists for transformation. Nurses are uniquely positioned to have an overview of other disciplines practices and aspects of the organization that makes them able to contextualize knowledge and information for patients in a particularly sophisticated manner. Using best practice guidelines judiciously might optimize this latent power, if nurses are provided legitimate practice space and are able to articulate such practices. Potential exists to foreground these contextualizing practices as essential to the discourse of knowledge translation. Although the ultimate effects of such struggle will undoubtedly be transformative, it is impossible to predict because the interplay of the nurses' resistance and production of the discourse of knowledge translation are so intertwined. The possibilities are endless because, as I will discuss in the next chapter, the nurses are also in the midst of a struggle to articulate who they are and what they do.

### **Chapter Five: “...but...nurses don’t do *knowledge translation*, do they?”**

As outlined previously, I believe the discourse of knowledge translation carries with it the potential to redefine the ‘ideal nurse.’ This new discursive framework, which promises to ‘elevate’ the irrational (perhaps sometimes called intuitive) position of nursing practice to an increased level of professional status akin to those aligned with rational scientific practice based in ‘real’ research and evidence. This is a remarkably similar promise as that offered during the ‘moments’ of transitions between discursive frames presented in chapter one, particularly adopting the nursing process as a practice framework (e.g. Latimer, 1995). In taking up this position, I argue that nurses could come to identify themselves more closely as ‘knowledge workers’ as defined within the discourse of knowledge translation.

In this chapter, I will further explore this avenue of theorizing. But as stated before, such arguments only provide a partial answer when considering the effects of the discourse of knowledge translation on nursing practice. In light of this, I must also interrogate my own interpretations of the nurses’ subjectivity in this setting. In doing so, I find my passion for nursing practice reignited as I explore the possibilities for nursing practice in the taken-for-granted contextualizing practices I observed these nurses engaging in. I recognize the potential for a feminist poststructural perspective to not only highlight such practices as essential to the discourse of knowledge translation but also to how nurses may position themselves to be integral to knowledge translation processes. In order to do so, I will first outline a brief history of the nurse-run clinic, as this heritage is an important consideration.

### **The Nurse-run Clinic: A Room of Their Own**

From a feminist poststructural perspective, the history of organizational structures, and what has emerged out of those previous structures, is an important aspect in considering power and subjectivity in a particular setting (St. Pierre & Pillow, 2000; Weedon, 1997). The organizational structures examined in this study designed to support the delivery of healthcare were developed several decades ago, at a time when the traditional roles of men and women in Canadian culture were well established and translated ‘naturally’ into hierarchical settings where the roles of medicine (men) and nursing (women) were (re)defined. Thus, the cancer care organization in which this study is situated seems to have continued in the historical tradition of functioning like a physician’s private business with patients coming to this setting specifically for scheduled physician appointments. That is, nursing practice was structured to ensure the steady flow of patients through the clinic with an explicit focus on the details and tasks required to create optimal conditions for an efficient fifteen-minute physician-patient interaction. Prior to the introduction of the nurse-run clinic, the study organization consisted of two ambulatory care clinics in which approximately ten physicians collectively saw an average of 80 patients per day. The hub of each clinic was called “the team room” and resembled or functioned like a traditional nursing station with several small dictation cubicles for physicians. In the team room, the nurses were immediately available to the physicians for information and discussion regarding patient concerns although, as one clinical nurse leader interviewed pointed out, these conversations were “collegial but hardly collaborative.”

The smooth running of the clinics was the responsibility of the nurses and included numerous unrelenting non-nursing duties, such as clerical work, described by the clinical nurses (and other colleagues such as care aides and administrators) during observation times and in

*every* interview as “handmaid tasks.” This left little time for the holistic nursing practice envisioned for patients by the nurses in the brief periods between physician activities. This discourse of holistic (and individualized) nursing care was an important development in nursing during the 1960s and 1970s, as nurses moved away from task-based care and can be considered an aspect of the nursing process (Kelly, 2005; Timmons, 2003). These discourses seem to remain central to how nurses define their practice, particularly in this setting and especially in contrast to medicine, “which is perceived by some as being reductionist... concerned only with pathology and body systems” (Timmons, p. 265). According to the nurse-run clinic nurses observed and interviewed, a primary motivating factor for establishing the nurse-run clinic was to allow the nurses time to engage in “real” (i.e. holistic and patient centred) nursing practice. Nurse administrators also agreed that this was an important factor.

### **Establishing nurse space/place.**

Many nurse administrators told me that the nurse-run clinic was never intended to replace medical treatment, but instead to complement the existing medically oriented structure of the clinics while supporting “more holistic” patient care. Most of the non-nurses interviewed referred to the creation of the nurse-run clinic as the time in the organization’s history “when the nurses left the team room.” When the nurses “left the team room,” care aides and additional ward clerks were hired to work in these areas. I observed care aides as they greeted patients, escorted them to examining rooms and measured their weight and blood pressure: all work formally done by nurses before they “left the team room.” Nurse and non-nurse administrators reported that replacing nurses with care aides in certain circumstances “makes sense” because “why would you pay someone \$35/hour to do tasks someone else can do for much less?”

The new nurse-run clinic, in a room literally across the hallway from the “team room,” was designed to provide nurses with the space and time to address patients’ needs (examples given included symptom management and education) apart from scheduled physician appointments. Several non-nurse interviewees stated that, when the nurse-run clinic was first established, the “door was always closed.” This was deemed a problem because both administrators and physicians expressed concern to me during conversations at meetings and during interviews that they did not know “what the nurses were doing in there.” During my time spent in the nurse-run clinic, I observed a conscious effort by clinical nurses to ensure that the door was always open. Towards the end of my observation period, I asked the nurses about the door. From their perspective, the only time the door was closed was when they were concerned about patient confidentiality. It is interesting to note that the nurse-run clinic was never allotted designated space for the nurses to examine or interact with patients. If the nurses require a confidential space to discuss patients, the door to the nurse-run clinic must necessarily be closed.

### **“What are they doing in there?”**

In reviewing the list of activities I saw the nurses I observed doing, their practice does not appear significantly different than that described before the establishment of the nurse-run clinic, with the few exceptions of reception and portering work done by the care aides mentioned previously. I observed that nursing practice with patients while working in the nurse-run clinic still occurred, as before, in the same exam rooms squeezed in between physician appointments. Theoretically, patients are to be referred to the nurse-run clinic nurses by other healthcare professionals (mostly physicians after their assessments), so that nurses can assist patients to manage the side effects of their therapies and cancer symptoms. Such referrals rarely happened. It appeared during my observations that interactions between physicians and nurses occurred much

less frequently than before the nurses “left the team room” (as described to me by the nurse-run clinic nurses). If a patient presented in obvious discomfort, I observed the care aides asking the nurse-run clinic nurses to see the patient immediately as to not interfere with physicians’ schedules. Unless she was busy, the nurse-run clinic nurse attended to that patient right away. A great deal of the nurse’s time was taken up, as before the establishment of the nurse-run clinic, with duties such as data collection for clinical trials, unscheduled nursing tasks requested by physicians (such as injections, dressing changes and removal of peripherally inserted central catheters), referrals to homecare and palliative benefits, chemotherapy education, teaching regarding specific drugs, looking for paper patient charts, checking email accounts (alerts and important organizational communications are distributed through employee email) and follow up from telephone triage patients. As one nurse I observed explained to me when I asked about the forms she was filling out, “sometimes these ‘simple’ forms take us all day to complete—we do it in between all our other stuff.”

While observing the nurses, I noticed that how practice was accomplished in this setting varied among the nurses: this was often described as a “problem.” Such “variations in practice,” according to nurse administrators, were said to be a common source of “patient complaints.” In addition, two nurse educators suggested that this variation contributed to “poorer patient outcomes.” While some nurses did seem at a bit of a loss without specific orders, most of the nurses I observed spent time reviewing the new best practice guidelines and talking about how to apply them in practice. Other nurses used time not spent with patients to re-organize the nurse-run clinic and attempted to attend various interdisciplinary meetings and educational sessions. Especially in light of the few referrals from other healthcare professions, nurses were observed trying to establish nurse specific practice activities in this setting. For example, when the nurses

worked in the chemotherapy room, they booked their patients in the nurse-run clinic schedule for follow up phone calls the next day that nurse worked in the nurse-run clinic. The nurses were frequently observed discussing management of the symptoms (or side effects) experienced by complex patients, as well as reviewing complicated patient treatment and drug schedules in order to anticipate common symptoms of their treatment. Interestingly, the nurses I interviewed had a difficult time articulating the specifics about nursing practice in the nurse-run clinic, stating that it was “evolving” and “developing” at this time. One nurse commented that although nurses need space to “do what nurses do,” trying to “market that and articulate that has been our struggle.” Indeed, an explicit expectation of nurse administrators was that the nurses “more fully develop their role” in this setting but in an “assertive not aggressive” manner. It was the nurse educators’ responsibility to help guide the nurse-run clinic nurses in this “process.” A few months into my observation period, a group of nurses working in the nurse-run clinic were particularly distressed when they were called to a large meeting to explain to a group of physicians and administrators exactly “what nursing is doing” in the nurse-run clinic. As one nurse stated, “Why don’t they get it? This will be the third time we have had to tell them.”

Simultaneously, there were a number of expectations voiced by administrators, nurse educators and other healthcare professionals of these nurses. Every clinical leader interviewed expected nurses to demonstrate “more independence” in this setting. In addition, nurse administrators expressed the expectation that the nurses “cultivate” their own patient group by reviewing the charts of every patient to be seen by physicians each day. The nature of scheduling in the nurse-run clinic is not conducive to this practice because of the unpredictability of patient care required during the physician clinics. Interestingly, one administrator who expressed this view did concede that there “could be 100 patients a day so that may not be realistic?” In fact,

according to the administrator of the nurse-run clinic at the time of the observation period, the physicians with whom these nurse-run clinic nurses work with see more than 140 patients daily. Although the number of physicians has doubled since the “nurses left the team room” to accommodate this increase, the number of nurses has remained the same. What has also remained the same are the expectations of the physicians and administrators in this setting that the nurses “are to be available when needed” by the physicians. I observed multiple instances when a physician came out of an examining room with the expectation that a nurse-run clinic nurse would be available in that moment regardless of what else she might be doing. Part of this may stem from the tremendous pressure placed on the physicians in this setting to attend to all of their patients within a short block of time allotted to them for clinical space. But for the most part, the expectation that a nurse would assist them within their time frame and without regard for the fact that the nurse would have other legitimate work that he or she would need to be drawn away from in order to deal with the physician’s request was prevalent. I observed physicians (or care aides and ward clerks on behalf on a physician) interrupt nurses in order to attend to the physician’s request as quickly as possible so many times, I would consider this to be a common feature of nursing practice in this setting. For example, in one two-hour observation, the nurse was interrupted more than ten times. These interruptions, like most of the other nursing practices observed, seem to be unchanged from descriptions of practice prior to the creation of the nurse-run clinic and so I am struck by the number of the nurses’ colleagues and administrators who claim they “don’t know what the nurses are doing in there.” They seem to be doing almost exactly what they were doing “before” as well as trying to create nursing practices that are separate from, and not requiring, medical direction. Thus, it is my conclusion that this site

represents not just the nurses' struggles to establish nursing practice in this regard but also highlights the competing discourses of what nursing practice *should be*.

### **Site of Ideological Struggle**

Pêcheux built on Foucault's discourse theory by examining the character of discourses and ideology within organizational contexts (Cousins & Hussain, 1986). Pêcheux (1975) argues that an institutional discourse, with its own specific language, can identify and be recognized by the organization within which it is situated and by the groups or individuals who make particular claims within the context of that discourse. According to Pêcheux, fully understanding a privileged organizational standpoint can only occur when explicating its position to other, probably counter, discourses. In other words, discourses do not exist alone but in relation to and in contrast to opposing discourses. Pêcheux (1994) states that the fundamental nature of discourse structure is ideological struggle. When the nurses "left the team room," it seems the *natural order* in this setting was disrupted. It is with this in mind that the nurse-run clinic, itself, can be seen as a site of converging multiple discourses: a site of competing inter- and intra- disciplinary ideologies which challenge and/or support and/or struggle with current discourse(s) around what constitutes nursing and nursing knowledge.

While I was observing the nurses, I was struck by how rooted the nursing practices were in the gender division of labour constructed decades ago: that is, the discourse of nursing as the "handmaid" of medicine. "Handmaid" is defined as "a female personal attendant or servant" (OED, 2011). Without exception, the nurses and their colleagues cited the creation of a nurse-run clinic as a way to "free" nursing from this "role." One physician even commended the nurses for their attempts to do so. Despite this, the frequency with which nurses were asked to justify or explain their new or evolving practices to both physicians and administrators was interesting.

Indeed, I was told by several sources that the physicians often expressed their concerns regarding “the ability of nurses to competently manage care without medical support” to administrators and clinical nurse leaders. Nurses were expected to accept this unquestioningly as, integral to this discourse and stated by one administrator; it was necessary for the nurses to “put up with the difficult behaviour of the physicians” in order for the organization to run smoothly. Although I did not witness a physician-nurse encounter where a nurse refused to do a “handmaid” task for a physician, during interviews nurses described how they felt labeled as “rude,” “disruptive,” “obstructive” and “not pulling their weight” in instances when they did so. Two administrators and a physician, in interviews, explicitly expressed extreme disapproval when nurses told them “that is not my job anymore.” As Weedon (1997) points out, a common strategy employed to maintain levels of patriarchal power is to discredit women challenging that status quo, regardless of how reasonable such challenges may be. For example, I heard physicians in several different meetings request that nurses see *all* new patients, as they did before they “left the team room.” The decision supporting the change to eliminate this practice was based in research (evidence) and feedback from patients that they are too overwhelmed at their first visit to rush through multiple forms and assessments made by a variety of different health professionals. The initial visit is when most patients learn of their cancer for the first time: new patients have overwhelmingly responded that all they want at that first visit is their diagnosis, prognosis and treatment options. Then, they want to leave. As mentioned before, these patients are worried about parking, family members and complained about having to tell their story repeatedly that first day. I also observed this phenomenon: at one point, I spoke with a patient who had been at the organization several days before and had seen a nurse (with me observing her). This patient did not remember me and, upon further conversation, it became apparent that the patient did not

even remember being in the building that day. He said that the difficult information he received that day, his first day ever in the building, “blocked everything else out.” It would seem that patients are much better served by specifically focused group and individual teaching sessions prior to and concurrently with their treatment followed by visits or telephone calls by the nurse-run clinic nurses. Despite the success and positive patient feedback on the new process, I observed many physicians continue to request (and expect) that nurses perform mundane tasks that support physician practice (like ensuring the forms required on the patient’s initial visit are completed) rather than patient care.

While many individuals (including the nurses themselves) interviewed all seemed to expect the nurse-run clinic nurses to become more “independent,” this was in contrast to the structure of work within the organization that made this all but impossible. In addition to the difficulties outlined above, the nurse-run clinic is not staffed to the same level as other areas in the organization in which nursing practice is highly structured around treatment protocols. The nurse-run clinic seems to have become a sort of ‘float pool’ for the organization. I had to reschedule nine observation sessions because the nurse I was to follow that day was re-assigned to another areas. As one nurse pointed out:

How do you explain your value [as a nurse working in a nurse-run clinic] if you are always pulled to a ‘more important’ area?  
[The nurse made quotation marks in the air with her hands].

If there is a lack of consistency in presence and visibility, we will get even fewer physician referrals. And, if the nurses are consistently there, then the physicians know they can rely on the nurses to do the work that needs to be done. As a result, we will have more physicians advocating for increased nursing presence because patients will get better care.

As well as seeming to act as workload replacements for nurses in other areas of the organization, these nurses also assisted the clinical trial group with their workload issues. The clinical trial nurses in this organization were tremendously busy, overseeing many clinical trials at once. As some clinical trials approached completion, the responsibility for collecting the required data was often transferred from the clinical trial nurses to those in the nurse-run clinic. While data collection was described (to me) by an administrator as something the nurses only had to “do a few times a month,” this description was in marked contrast to the significant amount of work I observed the nurses engaged in for this activity. The nurses I followed collected data for clinical trials at every observation session at least once and sometimes as many as three times. Not only did this entail an underlying understanding of the process of clinical trial research, it also required the nurse to review lengthy trial protocols related to the specific trial they were collecting data for (there was significant variation in what and how data collection was accomplished for each trial). This data collection activity (‘doing’) was seen as an important avenue for nurses, as one administrator told me, “to be a part of the research culture” of this organization, and thus, refusal to participate in this highly visible activity was not viewed favourably.

I do not wish to imply that the nurses did not want to collect such data as many of them found it very interesting despite the time consuming nature of such work. What is very interesting to me however, was the difficulty in having the nurses’ questions and concerns regarding the data collection answered in a timely manner. For example, during one observation, the nurse was unsure if the patient’s symptom should be marked ‘other’ or ‘graded’ according to the clinical trial protocol. She wondered if the symptom was “part of the disease process or the treatment” and how classifying this differently might affect the findings of the trial. I thought this was a

good question but the nurse did not receive an answer from those she asked. It seemed that if the nurses questioned the validity of a research project or if they were concerned if a patient did not meet the inclusion criteria for the research, their concerns were mostly dismissed. To me, in this setting, collecting data seems to be an illusion of inclusion in the “research culture” and process. The expectations of nurses within this setting vacillated between an ideology of professionalism, which emphasized independent practice as a key feature, and that of the nurses unquestioningly taking on “handmaid” tasks to ensure the smooth functioning of the organization regardless of the nurses expressed desire to focus on patient care. The difficulty these nurses seem to have articulating the parameters of their nursing practice left them vulnerable to non-nurses definitions based in traditional ideas of how nurses (and perhaps women) should be. In retrospect, then, I should not have been surprised that the nurses were so open to, and even excited about, the idea of best practice guidelines.

### **Best Practice Guidelines and Identity**

During interviews and observations, I asked all the nurses what they thought of the best practice guidelines and if they made sense in the context of their practice. Overwhelmingly, the nurses were very positive about the best practice guidelines. At first, I was puzzled about this because the best practice guidelines seem to represent a way of organizing practice that seems contrary to the holistic or patient-centred care that the nurses professed to strive for. However, in light of the struggles of nurses to describe their practice, it seems that the best practice guidelines offered the promise of some clarity. The key feature of the best practice guidelines was described several times by different nurses as “giv[ing] us an identity.” This intrigued me and so, over the last several weeks of observing the nurses, I became more and more curious about how the nurses came to identify with, and become subjects of, the discourse of knowledge translation. Pêcheux

(1994) argues that the language associated with ideologies exerts a tremendous influence on how individuals structure their identity and reality. And, as the perception of best practice guidelines somehow being the “framework” of nursing practice becomes entrenched within, and perhaps even begins to define, the nurse activities within the organization, it may narrow the view of what is acceptable nursing practice and knowledge. In this way, the nurses may become less aware of the existence of alternative sources to draw from when making decisions. I was told more than once that “everything [the nurses] need to know is in the guidelines.” I began to wonder if, as I observed these nurses in the nurse-run clinic, I was also witnessing the interpellation of the nurses. That is, I became curious about how the nurses, over the course of six months, not only integrated the best practices into their own practice, but also came to identify the practice of nursing so closely with this knowledge translation activity.

### **Interpellation.**

Interpellation is described as a mechanism through which individuals are constructed as subjects of a particular ideology (Cousins & Hussain, 1986). Louis Althusser, a French Marxist philosopher, first put forth the notion of interpellation. He explored the process of how an individual comes to identify so completely with an ideological position that it establishes how their world is represented and structured. Althusser states that through this ideological component, individuals maintain a fundamental belief that they are autonomous or independent rather than operating under particular ideologies which further capitalist agendas (Cousins & Hussain). This is because, according to Althusser, the ideology conceals itself in obviousness, self-evidence and fact (Cousins & Hussain). Pêcheux (1975; 1994) extended Althusser’s work on interpellation and addressed the main criticism of Althusser’s conceptualization of interpellation: agency of the subject (Cousins & Hussain). Pêcheux (1975) stated that there is a tension between

the self-determination and domination of a subject in regards to ideology (and discourse) and thus possibility for change. It is this tension he investigates in the context of organizations, and perhaps the work of establishing a context conducive to the new discursive framework, rather than that of the individual.

Pêcheux (1975) argued that interpellation, which occurs before one is made a subject, ensures the “self-evidence of identity” and “is realized through the complex ideological formations [that] supplies each subject with their reality as a system of evident truths” (p. 113). These ideological formations are a part of the discursive formation of a dominant discourse he also calls “interdiscourse” but that I would call the discursive field (Pêcheux, 1975, p. 113). He suggests it is not simply a matter of constituting individuals as subjects but of establishing within them such an obviousness of their position, that this position is unquestioned and viewed as self-evident. Further to this, Pêcheux (1994) states “ideologies are not made up of ‘ideas’ but of practices” (p. 141). The relationship between these everyday practices and the ideology are concealed by the ideological mechanism or the dominant discourse that brings it to fruition.

What might be integral to any sort of interpellation process of the nurses in this study is the desire to be seen as a legitimate professional group within the study organization. Articulating nursing practice not organized around scientific medical evidence and best practice guidelines, and defending such practices, within the dominant discourse of knowledge translation seems to be quite difficult. Several nurses, including educators and administrators, expressed the value of being able to “measure” nursing practice (by means of the grading system within each guideline explained earlier). In this way, the nurses are “not struggling to justify” nursing practice in the nurse-run clinic and “can finally prove” what it is that “nurses do.” The best practice guidelines seem to promise not only a superior way to organize practice, that is, as “knowledge workers”

using “the best evidence,” they also offer the means with which to “prove” the effectiveness of such nursing practice in order that “nursing will be recognized.” By adopting the best practice guidelines and using them, as several nurses told me during observations, as the “foundation” or “framework” for nursing in this setting, these repeating and perpetual practices of the dominant discourse of knowledge translation serve as the visible and rational basis of nursing conduct. If discursively framing patient-nurse encounters exclusively in the “measured” symptoms patients are experiencing, a trend that I did notice in my observations of nurse-patient interactions, this facilitates the belief that such knowledge is the most valuable and marginalizes other modes of knowing nurses may require. In this way, dominant discourses, such as knowledge translation, appear natural and gain authority through its appeal to common sense and rationality (Weedon, 1997). Reinforcing the best practice guidelines as ‘common sense’ perpetuates the values and assumptions underpinning the dominant discourse (Weedon). Indeed, nurse administrators told me more than once that the best practice guidelines in this setting did represent “common sense.” In addition, the nurse educators sometimes expressed concern that the nurses were not “getting” the basics of the best practice guidelines even though these guidelines were “common sense.” Thus, the legitimacy of nurses as professional subjects in this organization is intertwined with reinforcing the discourse of knowledge translation. It might seem “obvious” that professional nursing practice in this setting is synonymous with use of the best practice guidelines.

### **The independent practitioner.**

Part of what seems to be constructed, in this setting, as legitimate professional practice is tied to the concept of independence. “Independence” is defined as “not depending on something else for its existence, validity, efficiency, operation or some other attribute; not contingent on or conditioned by anything else” (OED, 2011). The nurses I interviewed and observed seemed to

define this *independence* as not being *dependent* on physicians. For example, one nurse described how the best practice guidelines could

...make nurses more independent...you know, where we can have our set of patients that we are following and...manage their symptoms without physicians...looking over us.

Whereas another nurse described the value of the best practice guidelines as

...I guess, just the sense that... okay, I don't need to always refer on to a physician, then. Or, even if I do refer to a physician, there's still more that I can do, non-pharmacologically, so that's definitely, I think, empowered me in my practice so that I can then pass it on to the patient, too.

Further to this, during observations the nurses would point out instances where the best practice guidelines assisted them to achieve 'independent' practice, such as referring patients to the counselors without fear of being "reprimanded" that they made "a silly referral." The guidelines sometimes provided a list of sanctioned non-pharmaceutical recommendations that the nurses could also discuss with the patients "without orders." This identity as an independent practitioner separate from the physician intrigued me. While in this respect, the nurses have positioned themselves in opposition to, rather than somehow connected to, physicians; these same nurses contradict themselves by emphasizing the importance of gaining the physicians' trust and respect for optimal patient care. In addition to this discourse exemplified in the previous excerpts from nurse interviews, many nurses also told me during observations that they incorporated the best practice guidelines so readily into their practice because this will increase "physicians' trust in nursing judgment" and thus enhance "inter-professional collaboration." Weedon (1997) can offer us insight into this contradiction. She also theorizes about interpellation and puts forth that the function of interpellation in positioning the subject within a discourse is dependent on the historically specific subjectivities of the subject. Thus, while the nurses are in

the process of attempting to identify themselves as independent practitioners (i.e. knowledge workers) within the discourse of knowledge translation, there is a pull to previous ideological subjectivities that historically positioned the nurses as subservient to the physicians in this setting or the original “natural order.” Many nurses consistently used language that reflected their belief that both “exam rooms” and “patients belong to the physicians.” A common theme during my observations of nurses with patients is that the nurses were constantly trying to find space to meet with patients that did not “interfere with the physicians’ rooms” and were frequently interrupted during this time with patients because the room needed to be “filled” by a care aide or a volunteer (i.e. a patient must be waiting in a clean exam room when the physician is ready). It did not seem to matter if the physician would be 5 minutes or 20 minutes because what was important to the care aides was that an empty room was “filled and ready.” This is juxtaposed with the perception that, in this setting, the physician mediated the majority of contact between the nurses and the patients (through requested tasks or infrequently, formal referrals to the nurse-run clinic). The best practice guidelines offer a way for nurses and patients to connect independent of the physician. While the independent nature of a rational practitioner is inherent in the discourse of knowledge translation (and professionalism), it strikes me as impossible for physicians and nurses to be ever really independent of each other. Both practitioners are *dependent* on another for the very existence of their practice: The patient.

All of those interviewed, regardless of position or discipline, expressed a great concern for “patient safety.” The best practice guidelines, as a valued activity of the discourse of knowledge translation in this organization, seems to offer the promise of increased patient safety and better treatment (patient) outcomes. Every administrator I interviewed clearly stated this goal as central. Thus, it seemed important for the nurses to be able to position themselves as playing a

part in such an important organizational goal. Being able to visibly contribute to patient safety and improved outcomes seemed to be integrated into their identity and, as one nurse described during an observation, “that confidence building piece” as practitioners. Another nurse-run clinic nurse explained,

...and I can bring that in to my teaching, then. I feel like it supports my practice. I feel like, okay, if I -- if I follow this, maybe not blindly follow, but follow it mostly, then I know that I'm providing patients with the best care, the best teaching, the best knowledge, so that they [the patients] can have the best possible outcome...I feel that it helps support me in just feeling confident.

Here, a partial history of the best practice guidelines (as it has been explained to me by multiple, sometimes conflicting, sources) sheds light on the nurses' hope that the best practice guidelines will increase patient safety. The major impetus for developing the best practice guidelines was the death of a patient from a potentially treatable symptom. Apparently, this patient saw multiple healthcare professionals about the symptom but did not receive timely interventions or treatments to address that particular symptom. I was told that subsequently, nursing administrators decided to develop the best practice guidelines to address the common symptoms and side effects of cancer and cancer treatments. I find it interesting that, although multiple healthcare professionals were involved and could have intervened with the patient described above, it is only the nurses and their practice that was singled out in this setting as requiring remediation. That is, there seems to be a focus on the nurses' need for education and direction in the treatment of such symptoms. Thus, the organizational impetus to improve patient safety seems to have been translated into redefining nursing practice in this setting to monitor and address those symptoms and side effects of cancer and cancer treatments that are identified as the main potential “threats.” While it is impossible to disagree with patient safety being central to all

healthcare endeavours, how the discourse of patient safety, as a part of knowledge translation, seems to have been constructed places the focus of improving patient safety on changing individual practitioners' (mostly nurses') behaviours. In this way, as described in chapter two, patient safety seems to be conflated with some sort of notion of risk management.

As in the knowledge translation literature (outlined in chapter two), the best practice guidelines focus consistently on the *doing* and not the *knowing* and it is the nurse who is constructed as the *doer* and not the *knower*. In one conversation I had with a physician, he seemed bemused by my interest in studying knowledge translation and nurses. At one point he commented, "but...nurses don't do *knowledge translation*, do they?" The assumption by this one practitioner being that nurses somehow transmitted the important knowledge that others had already translated. This focus on nurses' behaviours as opposed to their knowing seems to disregard the multiple sources of knowledge that the nurses may be drawing from. It seems to reinforce the subordination ("handmaid"-ness) of such knowledge in contrast to the knowledge contained within the best practice guidelines. This will be further explored in the next chapter. What I wish to explore at this point is that when the nurses began using the best practice guidelines more consistently in this setting, they were frequently praised for being "knowledge workers" (i.e. effectively used the best practice guidelines).

### **Accounting for the "knowledge worker."**

The nurse as a narrowly defined "knowledge worker" (perhaps more accurately described as an 'evidence worker') seems to be an important aspect of the discourse of knowledge translation because, as discussed in chapter two, within this discourse the dominant view of knowledge is as a commodity. Thus, "workers" are required to move and distribute packages of knowledge (i.e. best practice guidelines).

Based on the “grade” of the symptom, different “packages” of knowledge are required to be disseminated. As discussed in the previous chapter, nurses are vital to the knowledge dissemination interface with patients and, constructed as knowledge workers within this discursive frame, this process is represented as straightforward: Nurses are only required to understand how to retrieve information from the best practice guidelines and apply it to patients based on their current health status. Pêcheux (1975) states that at the heart of the misconception of an individual within an ideology is the belief that reality, in terms of knowledge, is very simple. That is, words such as best practice guidelines and knowledge translation represent universally understood and particular things that are predictable and straightforward. Pêcheux believed that perhaps this belief is ultimately *the* outcome of an ideology. The end result of the conceptualization of nurses as knowledge workers within the discourse of knowledge translation, to both nurses and to the administrators they work for, is that nurses are then the conduits of expert knowledge rather than creative, knowledgeable practitioners in their own right. The best practice guidelines also offer the nurses an opportunity to collate important information and ensure that it is communicated to the appropriate team members. As one administrator told me, a key purpose of the best practice guidelines is

... to help provide a structure for that, help to provide a support for nurses around what is it they should be doing for patients, help as a communication tool about what the team [defined as all disciplines involved directly in patient care, i.e. pharmacists and physicians] should do, -- that the team -- that nurses are doing but also provides a vehicle about -- for the team to discuss about what they could potentially be doing for the patient, so -- I’m glad you led me back to that because my point was, it’s actually been a really great vehicle for bringing the team together and to start talking about patient care.

As discussed in the previous chapter, this view fails to take into account the complex interplay between the nurse and the unique person who is also a patient as the nurse

contextualizes the knowledge in the best practice guidelines and then creatively draws from many sources of knowledge in that particular moment (Purkis & Bjornsdottir, 2006). But what becomes apparent when observing nurses' knowledge translation practices, and research supporting it, is that this process can never be reduced to a simple transfer of a commodity. While adhering to the best practice guidelines may seem to offer nurses a new identity as independent and legitimate knowledge workers, the nurses also then participate in "the removal of the locus of power from the knowledge of practicing professionals" (Davies, 2003, p. 91) to organizational administrators or policy makers who may not have any understanding of nursing yet monitor and comment on their professional behaviours. So as the nurses' position themselves, they are being positioned.

### **Positioning for 'power.'**

In many ways, the nurses can be seen as repositioning themselves within the organization to be perceived as a more powerful group. Several nurses from a variety of roles explained to me that they felt the nurses were often "scapegoated" for incidents that had happened previously in the organization and were actually the shared responsibility of several different groups. Wodak (2009) asserts that, within discourses, scapegoating others is an element of establishing dominant group identity. The incident described as the impetus for the best practice guidelines was offered as one example. Another example occurred during one of my first observation periods in which I twice encountered nicely dressed young people wearing lab coats and holding clipboards. They were part of a patient safety and infection control initiative that involved counting the number of times staff (almost exclusively nurses) washed their hands. I later learned that one 'patient safety' initiative that was rejected involved the nurses wearing pins with "Ask me if I have washed my hands" printed on them.

In addition, I interviewed one physician who was very “frustrated” with “the nurses” for starting projects they did not finish and subsequently left the physicians “holding the bag.” Because I am unaware of such instances (although I do not doubt such instances have occurred), I requested that the physician give me examples. The physician supplied me with three examples and interestingly, none of these examples had anything to do with nurses (and were directly related to the practice of family counselors, radiation support services and management). Having heard these misdirected frustrations, I have a different reading of the few nursing interviews that described how important it was for the nurses to have defined “scope of nurse responsibility.” So, as explained to me by one nurse administrator in an interview, the best practice guidelines are “not so much about what [the nurses] are capable of or what they can do... but their area of responsibility.”

The best practice guidelines, as a vital knowledge translation activity and highly valued within the organization at the time of data collection for the reasons outlined earlier, offered new positions for the nurses within the organization that not only legitimized nursing practice in this setting, but also seemed to define the boundaries of what the nurses are “responsible for,” perhaps contributing to a sense of professional integrity. One nurse administrator explained to me that nursing “took this initiative on” because

... other disciplines were involved, too, but -- there were other people dealing with the other disciplines’ involvement in that case. But what I took away from it was that I don’t think as a nursing group we really were doing...we weren’t delivering evidence-based care. We could be doing better. And so that led us down the path of -- what is it that we do as nurses for patients?

Further to this, the practices of using the best practice guidelines seemed to morph over time. After a few months, I began to notice more comments made in which the best practice guidelines seemed to be synonymous with a more sophisticated style of nursing practice. A part

of establishing nursing practice in this setting involved the nurses consciously “giving away” some “handmaid” tasks. Even though my observation is that this was not as successful as they would like to believe, the nurses did accomplish something extraordinary in the current Canadian healthcare milieu in the pursuit of this goal: They created new positions filled by care aides to carry out those tasks deemed “handmaid” without being replaced themselves. While this may be seen as hierarchical and supporting an increased status of the nurses, most of the nurses I observed (but not all, for sure) treated this arrangement collaboratively. There seemed to be a growing recognition that it was not possible for nurses to take on the new tasks of “knowledge workers” and continue being responsible for all previous tasks. And, through the combination of best practice guidelines and the creation of positions to which the nurses can delegate or assign tasks they no longer are prepared to do, over time this seemed to elevate the “basic care” provided in the nurse-run clinic to some sort of “advanced practice.”

### **Advanced practice.**

In the last two months of my observations and interviews, several nurses from various positions began to characterize the best practice guidelines as “advanced practice.” It is important to note that other nurses, in contrast, claimed that the best practice guidelines represent “basic nursing care only” and quickly dismissed the move to describe the guidelines as representing a sort of advanced or superior practice. One nurse stated that the guidelines were less than basic care because they were “so dehumanizing.” As she explained

... with [the best practice guidelines] you don't engage them as people other than a symptom or a cancer patient...they are a real person who just happens to have cancer right now.

However, when I observed her practice, she followed the best practice guidelines. When I asked about this she replied, “well, I don't have time to go into everything with every patient...there are

too many patients.” For this nurse, it seemed, the best practice guidelines represented an efficient way for her to account for her work and still see all the patients she was required to see. This observation pointed me towards an interesting insight that the nurses in this site did very little care of the actual physical body of the patient and, after the introduction of the best practice guidelines, this seemed even more pronounced. There is something about the discourse of professionalism as a “knowledge worker” and “advanced practice” that seems to move the nurses away from care of the physical body of the patient. The “handmaid” tasks that the nurses had delegated to care aides all involved the care of the patient’s physical body. As Latimer (2000) points out, this is a common phenomenon in the nursing profession. After one conversation in which a nurse could not describe, to me, why a licensed practical nurse would not be able to follow the best practice guidelines, I had an insight into this relationship. There is tremendous angst currently in nursing about registered nurses being replaced by licensed practical nurses (fuelled by the concern or belief that ‘anyone’ could follow ‘the recipe’ of best practice guidelines). However, looking at that ‘problem’ a little differently, I suddenly realized that registered nurses are not being replaced by licensed practical nurses: registered nurses are replacing themselves with “advanced practice nurses” and delegating (giving away) the “handmaid” tasks previously associated with registered nursing to those who are less educated. Similar to some physician concerns that nurse practitioners will replace them, a quick look at medical schools nationally will reveal a similar trend: physicians themselves are replacing family physicians with specialists. And it is ironic that nurses, to position themselves as more professional and legitimate, seem to be distancing themselves from the care of the physical and concrete body of the patient.

## Conclusion

This analysis highlights the importance of attending to history when considering power and subjectivity within this particular setting. In doing so, the contradiction between what was envisioned by the nurses in this new setting and the expectations that they would continue to practice as they had before the establishment of the nurse-run clinic was highlighted. Thus, I put forth that this ‘room of their own’ represented a site of ideological struggle of what nursing practice ought to be. This struggle, with competing discourses such as professionalism, sexism and economic efficiency, contributed to the difficulty these nurses had in articulating their practice. I argue that the nurse-run clinic nurses readily accepted the best practice guidelines because the guidelines seemed to offer the promise of legitimately explaining their nursing practice in a way that was understandable to their colleagues and supervisors. Further to this, use of the best practice guidelines also seemed to promise elevating nursing practice to a more sophisticated or advanced level.

While such promises did seem to provide some clarity regarding nursing practice in this setting, it also had the effect of discursively reframing nursing practice. As the nurses were constructed as subjects of the discourse of knowledge translation, the best practice guidelines seemed to redefine the boundaries of what could be considered ‘good’ nursing practice and reinforced a particular notion of ‘knowledge worker.’ Yet if nurses take up this preferred or ‘ideal’ position that seems to be offered within the discourse of knowledge translation, they could be relegated to the ‘simple’ doing of a knowledge worker who is the disseminator of ‘expert’ knowledge rather than any credible knower in her own right. Further, the practices of such a ‘knowledge worker’ also circumscribes nursing practice as those activities related to medical

treatment (e.g. monitoring side effects of drugs) and/or organizational imperatives (e.g. patient safety) rather than direct practice towards patient care.

As I suggested in chapter four, such possible effects of the uptake and repeated use of guidelines based in rational, scientific knowledge is hardly novel. In reviewing such analysis, I also recognize that arguments such as those made in this chapter somehow seem to portray nurses as unreflective and perhaps easy to manipulate. This is the opposite of what I observed of the nurses (and wanted to say). I did notice a sort of pattern of the nurses re-inventing themselves within a new discursive framework (i.e. the discourse of knowledge translation). That is, by adopting the best practice guidelines so readily, and purposefully repeating and perpetuating these practices, the dominant discourse of knowledge translation seems to serve as a visible and rational framework for nursing conduct. That being said, I must emphasize that upon reflection, much of what I observed could also be attributed to the ‘newness’ of the best practice guidelines. I am certain that if I observed the same nurses now, they would have very different ideas and practices in regard to these guidelines. This is because, while the use of such guidelines appears to be a *fait accompli* in this setting, the identities and subjectivities of the nurses defined as “knowledge workers” most assuredly are not. While Davies (2000a) suggests, “the mobilization of a dominant discourse” [such as knowledge translation] has the potential to “undercut the subject’s capacity to maintain the discourse” previously taken up (p. 62), that does not mean that the other discourses are out of the realm of the nurses in this setting. Although discourses play a central role in constituting subjects, these discourses do not just represent or describe any ‘reality’ or knowledge or identity or practices (Mills, 1997; Pêcheux, 1975). Multiple subject positions are available to these nurses during continual (re)constitutions through their varied discursive practices. As Crowe (2000) rightly points out, discursive effects “only ever partially

fix identities and subject positions” (p. 964). Not only that, because discourses are often contradictory and may be seen as competing with each other, individuals take up various positions at different times (Weedon, 1997). It is these contradictions within the discourse of knowledge translation, which will inevitably appear over time, that create a ‘space’ in which individuals can accept or refuse a subject position. In addition, they are able to consider possibilities for different positions and discourses that seem to address the questions arising out of the contradictions (Davies, 1992). Further to this, Davies (1989) contends that those discursive practices highlight the possible power to “not only create and sustain...but to see how we can change the world through a refusal of certain discourses and the generation of new ones” (p. xi). Thus, I see the nurses in this setting not as ‘fixed’ but instead as “the complex, changing, contradictory creatures that we each experience ourselves to be, despite our best efforts at producing a unified, coherent and relatively static self” (Davies, 1989, p. xi).

### **Interrogating the Researcher Conclusions**

A feminist poststructural perspective also requires that I interrogate my own assumptions. In doing so, I have considered my theorizing about subject position and subjectivity and this highlights a most important discovery for me. Returning to the best practice guidelines gave me a clue. Far from being imposed on these nurses, the best practice guidelines were actually created by nurses in the study organization. In addition, because of the nurses’ practice expertise, these particular symptoms were chosen because they represent the vast majority of suffering experienced by cancer patients. And these symptoms are based in the very concrete physical nature of the patients’ embodied experience. Highlighting the knowledge and skills required to engage patients in a way meaningful to them returns me to the notion of contextualizing practices as both essential to the discourse of knowledge translation as well as a way for nurses to connect

with the physical bodies of patients. In this way, the nursing practices that address and help alleviate such patient suffering cannot be minimized.

When I returned to one of the nurse administrators that I previously interviewed to ask her about the notion of contextualizing practices, she said, “Of course that is what happens when nurses use the guidelines!” But for me, it was not so obvious. These contextualizing practices in regard to the discourse of knowledge translation are taken for granted to such an extent that they seem to be invisible within this discursive framework. As if such practices were simple and merely a way to prepare a package of knowledge created by ‘experts’ for delivery. This intrigued me. Thinking about this further, it is not just about expanding the notion of evidence (while I do agree that this is vital) or how the nurses ‘know’ something. I am curious about how nurses know not only what to ‘know’ but how to activate that particular knowledge at a particular time with a particular patient. This is a complex process that requires a wide and varied knowledge base from multiple discursive frames to know how to even begin to engage in those contextualizing practices. It seems then, that the actual ‘work’ of successful knowledge translation is the capacity, as Davies (2000a) describes, to “move within and between discourses” (p. 60). I think this may be what I observed when I paid careful attention to what I have called the contextualizing practices of the nurses.

Furthermore, I am not suggesting the information in the best practice guidelines is inherently problematic or “wrong.” I merely add to the chorus stating that such discursive frameworks offer only partial truths. I acknowledge that this must be the case for other discourses that nurses value. Thus, what a feminist poststructuralist approach may add as ‘evidence’ for practice is highlighting the potential for nurses to articulate and identify the discursive practices “through which they as nurses are formed so that they can identify similar discursive practices

which work to produce the subject and object of their practice” (Crow, 2000, p. 964). In this way, if nurses are able to see how such discursive frames, as Davies (2000a) suggests, “subject her,” they can then “use the terms of one discourse to counteract, modify, refuse or go beyond” other discourses (p. 60). That is, create a discursive environment where nurses understand the subjectivities, limits and advantages of various discursive structures and are able to articulate their contextualizing practices as they shift between discursive frameworks as required in the incremental moments of ‘knowledge translation.’ This may help them resist the pull to dominant discourses and ideologies as ‘the truth’ (Weedon, 1997). Because dominant discourses maintain power through repetition of approved discursive practices, the ability to shift between discourses and the refusal to operate solely from within one discursive framework may open up new possibilities for nurses and nursing practice. I see nurses, through these contextualizing practices, as constantly shifting between discourses yet not fully able to articulate this. I also put forth that nurses’ ability to more fully explicate these contextualizing practices of knowledge translation may assist with, as Crow (2000) suggests, “an acknowledgement of the nursing work which defies...measurement processes” (p. 967). And, I do agree with Wall’s (2007) conjecture that “if nurses fail to seek and engage with theoretical perspectives that can open up possibilities, they will be perpetually marginalized” (p. 44). Although this is a big challenge, it may also offer considerable opportunities for nursing. This is because, as I explore in the next chapter, the discourse of knowledge translation has broad implications within the discursive field of healthcare.

## **Chapter Six: A '(re)ordering' of Things?**

As outlined in the previous chapters, I argue that the discourse of knowledge translation has the potential to transform nursing and nursing practice. Recognizing, as Foucault (1980) suggests, that power and knowledge can never be separated, I am intrigued by how all the nurses, regardless of position in the study organization, described the best practice guidelines as “what we already know.” If this knowledge is already part of the repertoire of nursing practice, then what is the purpose of changing practice in this setting? I put forth that the discourse of knowledge translation is not just about the production of knowledge (‘the evidence’), it may also have the effect of ‘re-organizing’ knowledge both within this study organization and potentially within the larger discursive field of healthcare. I will discuss the possible effects of such re-ordering in this chapter. I will also return to the contextualizing practices that the nurses engage in to accomplish activities of the discourse of knowledge translation (specifically the best practice guidelines). These practices offer points of resistance to the dominant discourse as well as position nurses to be influential as the notion of knowledge translation can be expanded to include not just different kinds of evidence, but to also be recognized as an incremental contextualizing process requiring time and skill as essential to respond to the 21<sup>st</sup> century patient.

### **“A Cultural Shift”**

During my observations, the decision to use best practice guidelines in this setting was often referred to as a “major culture shift” for nursing by all involved in this endeavour and seems to represent a new way for nurses to organize their practice based in “the best evidence.” During one observation period, when I asked a nurse to talk me through her clinical decisions regarding care of the patient she had just seen, she showed me the best practice guideline and

explained to me how she ‘graded’ the symptom (pain). When I asked her to explain it to me without the best practice guideline because I had just observed her examine the patient without using the guideline, she did so readily. It was apparent to me that she was very knowledgeable about pain and pain management and used this knowledge to create a plan for the patient in the context of his everyday life, most importantly how he could manage his pain without feeling “fuzzy” while working at his place of employment. I asked her how it was different explaining her practice using the best practice guideline and she stated that it demonstrated “practice evolution;” That is, progress to a more evolved form of practice based in research. One administrator described this as an important aspect of the best practices guidelines, in order to bring the nurses “into the research culture” valued in this organization. As one nurse administrator told me, this new “cultural shift” puts the nurses

... on a journey to look at what are the best evidence -- what’s the best evidence out there related to the major symptoms that patients who we know are being treated for cancer care have, and come to us, and demonstrate on a regular basis? And so we developed [best practice guidelines] based on *best evidence*.

The interesting thing is that no one I interviewed could tell me how the best practice guidelines were going to be updated to reflect new “best evidence.” I argue that this is because the focus is not on “evidence” but instead the necessary “cultural shift” in nursing (and subsequent focus on changing nurse behaviour) to be, as described to me by one nurse administrator, able to use this evidence “effectively.” That is, reconstituting the nurse-run clinic nurses as a particular kind of “knowledge worker.” As discussed in chapter five, towards the end of my observation period, the nurse administrators described the new best practice guidelines as a move towards “advanced practice.” This was in contrast to a few of the nurse-run clinic nurses observed and interviewed,

who described the new best practice guidelines as “basic care” and “what we have always done.”

As one nurse stated, although the best practice guidelines are

... packaged up nice and new and shiny...but... [long pause]

... there's nothing new in the [best practice guidelines] and it's probably something -- I shouldn't say that but, truthfully, the [best practice guidelines] are -- it's basic nursing care. You can go through the -- all the [best practice guidelines] and there's nothing in the [best practice guidelines] that is earth shattering. It's all treatment based that we've known for years and years and we know that, yes, truly, it does work, so in that -- it is evidence-based in that respect. But it's not new, it's not cutting edge, it's not...

I was curious about what made the new best practices guidelines “advanced.” The nurse educators who referred to the best practice guidelines as “advanced practice” admitted, upon further discussion, that they could also agree that the best practice guidelines represent activities that nurses have “always done.” If the nurse-run clinic nurses are “already” providing the same care, then I began to wonder why this new framework for practice is now required.

I argue that this is because the discourse of knowledge translation does not just require a more explicit use of certain knowledge (evidence), but instead it represents a re-organization of knowledge within the discursive field of healthcare. Central to this is the construction of the ‘hierarchy of evidence,’ as outlined in chapter two. As Loughlin (2008) points out, at the pinnacle of the hierarchy, the so-called ‘gold standard’ is systematic reviews of randomized clinical trials (i.e. one form of research) while at the bottom is “views of colleagues/peers” (i.e. *professional judgment*). This move seems to discount professional judgment and, as Loughlin argues, has “been accompanied by a reshaping of the politics of the workplace that similarly downgrades the role of practitioners” (p. 666). Previously, it seems written guidelines or protocols in the study organization (such as oncological emergencies) provided, similar to those Manias and Street

(2000) described in their study about protocols, “some consistency and ensure[d] a particular level of patient care [using] a flexible approach [that] allow doctors and nurses to take responsibility in using expert clinical judgment” (p. 1473). Now, however, it seems these new best practice guidelines place particular research evidence central to nursing practice and thus, has the potential effect of supplanting professional judgment. Instead of professional judgment being central to the practice of nursing in this setting, what may instead be valued is the ability of the “knowledge worker,” as defined within the discourse of knowledge translation, to “know” where to find the “best evidence” for dissemination.

I found many examples of this during interviews and observations. For example, during an observation period, a nurse was asked by a care aide to see a patient in distress. The care aide was concerned about the patient because the patient was crying and the physician was unavailable. The nurse responded immediately. I followed the nurse into an exam room and observed the nurse as she began to assess the patient’s pain level. Unexpectedly, the physician entered the exam room after a few minutes. The physician was very polite and asked the nurse-run clinic nurse if she needed a few more minutes to finish her exam and indicated he could come back in ten minutes. The nurse stood up and said, “No, I’m just here giving her some nursing love.” The patient then stated, “Yes, they’re just being kind to me. I am in terrible pain and I need to see you, doctor.” As the nurse left, she gave a quick report to the physician regarding her exam and what medications the patient has already tried and were unsuccessful in treating her pain. The physician responded by turning to the patient and saying, “Okay, let’s review your medications” as we exited the exam room. Outside, I asked the nurse why she didn’t complete her assessment. She responded by saying she could already “tell that the grade would be higher than 3” and so there would be “no point” in having the patient repeat her story over again. I asked her if perhaps

her practice in this instance would be different and she replied, “No, it will be exactly the same as what the physician would do except he will have to prescribe something. There is no point in doing the same thing twice. But, I will phone her later and make sure her pain level is down.” Thus, it seems in this example, if the physician records the ‘grade’ as outlined in the best practice guidelines, then the nurse is not sure what else she has to offer the patient outside that which is outlined in the best practice guideline. Another example is the following explanation given to me by a different nurse-run clinic nurse

Well, so, we’re making the jump, that the evidence is in the interventions and so for following our [best practice guidelines] as per [the organization] they in fact are using evidence-based practice, so not using evidence-based practice would be like what did my mom tell me to do when I was a little girl when I got cold? It might be evidence-based practice, but I doubt it, or you know mitts, or, non-evaluated, non- measured interventions ...

This nurse-run clinic nurse effectively outlines how she is re-evaluating knowledge gained from her own life experiences (i.e. from her mom, not measurable, not evaluated via a randomized controlled trial) and re-ordering it on the ‘hierarchy of evidence’ below that of quantitative research findings. This re-ordering does not seem to be confined to the personal knowing of the nurse-run clinic but also to that of colleagues. For example, as one nurse-run clinic nurse discussed

... I would say an example [of the importance of everyone giving the same information and using the best practice guidelines] came up when a patient that I was seeing in RT Tox actually had one of her side effects in follow-up was vaginal dryness and having really not worked in RT, I really could not give her a great -- this was pre-[best practice guidelines] -- information on that, so I asked if she would just sit tight for a few minutes and I would discuss her situation with my colleagues and come back and give her some advice and so she was fine with that. So I came back and of course I was working with an RT nurse that particular day [who] was able to give me some of that information was in hard to reach places within the [intranet] which is a bit like a black hole, and certainly because it was an area of expertise for her, she was able to rattle off all kinds of...

I mean now I would have to *compare her information to the [best practice guideline]* to see if that was based in the guidelines, or whether that was her own sort of interpretation of what has worked best over the years, or you know...

Some nurse-run clinic nurses seemed to begin questioning not just the practices of their colleagues in relation to the best practice guidelines, they also seemed to be judging their colleagues' practices based on the inherent "hierarchy of evidence." For example, as another nurse describes,

... a nurse who still uses [different protocol] wouldn't like to be told "You have to follow the [best practice guideline]" because she likes to be a little bit more flexible in what she does and she feels that it is a restriction, or she may feel that it is restricting her practice in not allowing her to make informed decisions and utilize, you know, her own thinking processes. But I would say that, if, you know, what you're doing *is* actually wrong [i.e. not based in evidence], then maybe you need a little more guideline guidance.

During one of my observations, one of the nurses in the nurse-run clinic expressed annoyance with another nurse who recommended "chinese plums" to a patient to help treat their nausea. She disapproved because there is no "evidence" that this food item actually helped (other than the practice experience of the nurse in question) and went on to say that the "chinese plums are not even in the practice guidelines." I am not saying that this item is a viable treatment for nausea but I am interested in how such a recommendation is so easily dismissed.

In addition, over the course of the last few weeks of my observations, nurses who did not record the patient 'grade' in the patient chart were actively sought out in order that they complete their charting. In such instances, the nurses seemed to be chastised for such oversight of the vital information, even though they had most often charted the same information in the narrative nursing notes. In this way, we can see some traces of re-ordering of knowledge in how the nurse-run clinic nurses talk about their own practice and the practice of their colleagues (who may

require further *guideline guidance*). This reinforces the ‘hierarchy of evidence’ with randomized controlled trials at the pinnacle, other research evidence potentially relegated to lesser positions and professional judgment relocated *to the bottom*.

I also became curious about how a few of the nurses talked about “the art of nursing” and how this “art” might be lost when the best practice guidelines were fully implemented in this setting. After several careful readings of the transcripts, it is my impression that “the art of nursing” may represent nurses’ professional judgment. For example, let’s consider part of an interview with a nurse educator

Nurse: I think it removes the nurses doing things that aren’t evidence based, that they just think are a good idea... I worry sometimes that it takes away some of the art of nursing.

Lorelei: Mm-hmm. Tell me more about that.

Nurse: There are a lot of things that work for patients that aren’t necessarily evidence-based.

Lorelei: Can you think of an example?

Nurse: ... (laughs) Well, okay, actually, I don’t know, maybe it is evidence-based by now. The sucking of hard candies when you’re nauseated stimulates the salivary glands, mimics the body’s natural response to suppress nausea. I don’t even know, actually, if it’s in the best practice guidelines. I don’t think it is.

Lorelei: There’s no evidence for that?

Nurse: ...and actually, as I say it, I’ve been meaning to look to see if it’s in there. I don’t think it is. But I was telling patients that for years. There are certain little things that you pick up over the years that just work and you...

...know they work. And maybe it’s a placebo effect? Who knows? But they work. And so does it take away from that? I don’t know. I would wonder if...and what we say is that it doesn’t have to limit your practice as a nurse. It’s giving us a baseline...foundation... that we know every nurse is practicing to this...  
[interviewee indicated a high level above her head with hand].

What you do above that level that's bringing in more of the art of nursing is okay, as long as you're not harming the patient, as long as we've got this foundation. So we know nurses -- all patients are receiving this. They may get other, you know, more enhanced care from seasoned nurses but we can say, as leaders and educators, that everybody's receiving X, this -- this level -- this baseline level of care. Minimum standard.

Lorelei: And so what would happen to me, if I was working [in the setting] and I told someone to suck the hard candy to help them?

Nurse: Had you done the other stuff? Have you -- yeah. Have you followed the other? The [best practice guideline] interventions...

Lorelei: Okay, so that wouldn't be a start but it could be...

Nurse: It could be a supplement to, right? ... You have to make sure you've covered all the other -- the other bases...

Lorelei: ...that are in the guidelines?

Nurse: And then you can supplement that with some of your artful nursing.

Lorelei: As long as it's --

Nurse: --not harmful.... But then there's that question of, "How do you know it's not harmful?" Shall we have nurses doing things like that? But I -- I -- I just don't know if we can ever take away that -- that part of nursing.

In this way, we can see how it might be that when "a discourse speaks of phenomena, it reorders them" (Reiss, 1982, p. 29). Foucault (1980) also discusses how knowledges that are disqualified within a particular discursive frame become viewed as inadequate and that it is often "through the re-appearance of ... these disqualified knowledges, that criticism performs its work" (p. 82). Within the discursive frame of knowledge translation, such a re-ordering of knowledge (and disqualified, non-credible knowledges) seems to have the effect of undermining the confidence of nurses in their own practice if the best practice guidelines become the "framework" or "standard of care." Yet, everyone also seems to be in agreement that the best practice

guidelines merely represent a fraction of the knowledge that nurses need to practice in this setting. Upon further thinking, and as discussed in chapter five, it may be that the rewriting of what constitutes “basic” and “advanced” nursing practice in this setting may be required to establish nursing “territory” in the new order of things within this institution.

But this comes at a cost. Not only does this new order of things seem to position nurses as an extension of medical practice—that is, monitoring for side effects and symptoms of medical treatment—the best practice guidelines can also be seen as “threaten[ing] the autonomy” of the nurse-patient relationship (Holmes, Murray, Perron & McCabe, 2008, p. 395). This is ironic, because the best practice guidelines are seen by many of the nurses as a vehicle to connect with patients independent of the physicians. Positioning themselves in opposition to physicians obfuscates the repositioning of the profession of nursing within the wider context of the organization and healthcare. What is also ironic is that this repositioning seems to be accomplished, as Rafferty (1996) also outlined in her study, mainly through nursing education.

### **Accomplishing the Reordering**

The main vehicle for this reorganization of knowledge for nurses in this setting seems to be nursing education. In the study organization, it was the nurse educators who were tasked with ensuring the nurse-run clinic nurses were not only educated regarding the importance of consistently following the best practice guidelines, but also to monitor and ensure that the nurses were, in fact, using them. Not only were the nurse educators very involved with the nurse-run clinic nurses education regarding the best practice guidelines, they also provided other supports such as colour coded reference materials, “cheat sheets” that were condensed versions of the guidelines to write on during patient interactions and laminated symptom assessment cards for the nurses to carry in their pockets. As one nurse educator told me, all of this was necessary to

“reinforce teaching [in order to] standardize [the nurses’] practice.” In this way, the best practice guidelines can be seen as a mechanism to standardize practice (or reduce practice variation) in this setting. For example, as another nurse educator points out,

... because I might have, yeah, different experiences from, say, another nurse and we may each end up having different opinions about something. But that’s where evidence-based practice is supposed to *bring us together, to one.*

In a broader view, the taken-for-granted nature of the best practice guidelines as “obvious” was reflected in the interviews with two nurses who graduated within the past few years. These nurses not only took up the best practice guidelines unquestioningly, they expressed relief to have the guidelines “finally” in place. The best practices guidelines made sense to them because “that was how” they were taught in nursing school.

I’ll refer to the procedures or to the [best practice guidelines], like, well, what does it say there? Because that was sort of really pounded into our heads when we were in school, that, if it’s in the policy and procedure manual, that’s how you do it, that’s how you know...

This example also points to another interesting use of language during observations and in the interviews. The nurse-run clinic nurses consistently conflated the notions of policy, guideline, protocol and standard of practice. As Manias and Street (2000) point out, there is a subtle difference between policies and protocol, in which policy “defines the responsibilities of healthcare professionals, the rights of consumers and their families” while protocols provide details “specific to procedures that enable the implementation of particular policies” (p. 1468). A guideline can be defined as an “indication or outline of conduct” and a standard of practice can be thought of as a “code of professional responsibility” (OED, 2011). While, at first, I found it odd that the best practice guidelines were described in such various ways, it became clear to me that the best practice guidelines, which I argue embody the ideals of the discourse of knowledge

translation, can be seen as a tool that facilitates the dissemination of not just a particular notion of ‘evidence.’ It can also be seen as a mechanism to translate and disseminate the preferred subject position of the ‘ideal nurse’ as well as discourses around notions of science, patient safety and fiscal accountability. As one nurse who worked quite often in the nurse-run clinic pointed out, the best practice guidelines seem to “... *translate as a directive for nursing.*” This observation on the nurse’s part was prophetic because later, and at the time of this writing, the nursing leadership at the study organization is actively involved in creating a policy to direct nurses to use the best practice guidelines as part of ‘good’ practice.

In this way, the best practice guidelines can also be seen to represent a “reframing of the debate about good practice” (Loughlin, 2008, p. 665). As one nurse educator explained to me, “good practice” is when the nurses “put research evidence into practice.” When I asked how she would recognize when this happened, the nurse educator replied, “Through chart audits.” Chart audits are done routinely in this organization as a part of professional development and performance reviews to collect ‘evidence’ of the nurses’ practice. As Strathern (2004) argues, audits go “beyond the regulation of good practice” because “good practice is at once taken as evidence of itself” (p. 10). Through chart audits, the use of best practice guidelines becomes the evidence of their own effectiveness. That is, the evidence *is* the evidence. Inherent in this self-referential process is the promotion of self-management where such external and compulsory control can eventually become motivation generated by the individual practitioner (Snowden, 2005). As one nurse-run clinic nurse told me why she used the best practice guidelines, “... well, I kind of have a sense of obligation towards them.”

Many authors argue that best practice guidelines are put in place to promote the legitimacy and power of medicine (e.g. Holmes, Murray, Perron & Rail, 2006; Wall, 2008).

While I do agree that my observations seem to support such an argument, I also observed a subtle shift in the nurse-physician interactions after a few months. It seems that the *nursing* use of best practice guidelines might also play an important role in standardizing physician practice in the organization. Variation in physician practice is a problem not easily “solved” in this study organization, as explained to me by an administrator, because physicians have the government-sanctioned right to be independent practitioners. Manias and Street (2000) outline how protocols and practice guidelines may “enable nurses to resist orders” given by physicians (p. 1471).

While I did observe this in one interaction where the nurse-run clinic nurse used the best practice guidelines to negotiate a change to a patient’s medications, I also observed something else going on. The most common way in which I observed the nurses “resisting” physician orders was to work around the physician. For example, during one of my first observations, a physician refused a nurse’s request to offer a young patient the option of sperm banking prior to his surgery/chemotherapy. In order to give this patient the option, the nurse approached a physician she had a “good relationship” with and asked this physician to talk with the “non-compliant” physician. In this way, the issue was resolved. In contrast, towards the end of the data collection period, I observed a physician explaining his prescription for anti-emetics to the nurse because the dose fell outside the parameters outlined in the best practice guideline. In this way, the nurse was quite easily (it seemed to me) able to challenge the physician and get the medication she felt was most appropriate for the patient. This seems to be a subtle shift and might demonstrate how the best practice guidelines could possibly serve to not only “decrease variation in practice” of nurses, but can also be seen as a potential avenue to assist with surveillance of the nurse-run clinic nurses as well as their colleagues (including physicians).

### **Surveillance.**

Surveillance seems to be an important aspect of what is going on here in relation to the 'nursing gaze.' While there is much written about the "medical gaze," this gaze seems to be conceptualized as authoritative and outward focusing on claims of dominance (e.g. Foucault, 1963/1994; Latimer, 2004). In contrast, the "nursing gaze," seems to be described more as an inward focus and directed to following protocols (e.g. Cheek & Rudge, 1994; Manias & Street, 2000). That is, nurses observe themselves with the effect of producing "self-policing behaviours" through which nurses monitor themselves in relation to particular standards of care (Cheek and Gibson, 1996; Manias & Street). Those particular standards of care (in this case, the best practice guidelines) can be seen as a normalizing process used to promote conformity and self-regulation. The nursing gaze, then, monitors nurses to ensure that they "demonstrated desirable and expected practices" (Manias & Street, p. 1474). For example, when the nurse-run clinic nurses ensured that their colleagues recorded the 'grade' of symptoms assessed.

Surveillance of the self, not just others, is at the heart of disciplinary power and underlines further internalization of discipline. In this way, the discourse of knowledge translation can be seen as "a discourse that controls in part by obscuring its very own regulatory mechanisms and system of domination" (Holmes, Murray, Perron & McCabe, 2008, p. 395). The best practice guidelines can be seen as not only a "framework" or even a "guide," they also embed the ideals of the discourse of knowledge translation into the everyday thinking of nurses and this, in turn, provides not just the framework for charting and practice but also becomes engrained in everyday nursing practice. In this way, the best practice guidelines have become a disciplinary 'technology' that creates the seemingly voluntary subjects of the discourse of knowledge translation (Foucault, 1977/1995).

As Foucault (1977/1995) points out, power can be activated when systems of surveillance are put into place. While the best practice guidelines could be seen as a disciplinary technology, what I observed as key is the documentation practices of the best practice guidelines. As one nurse-run clinic nurse so poignantly states, this “charting and documentation is about the patient but it’s not.” It seems that the charting and documentation done by the nurse-run clinic nurses then becomes the evidence to support the use of best practice guidelines and other activities framed within the discourse of knowledge translation, such as patient safety initiatives and fiscal accountability. The traces of re-ordering of knowledge outlined above and observed in this setting seems to facilitate both the production of evidence important to the discourse of knowledge translation and the evidence to justify the continued use of such activities. This may be especially important because there is actually very little ‘gold standard’ evidence to support the efficacy of the discourse of knowledge translation and the various formal activities performed in the name of knowledge translation. However, there are many studies to evaluate how to improve uptake of knowledge translation through the use of rational scientific quantitative discursive frameworks (e.g. Brouwers, Makarski & Levinson, 2010). Thus, this self-referential evidence is vital to the ongoing existence of the discourse of knowledge translation.

### **Disrupting Knowledge Translation**

Snowden (2005) suggests that, rather than something like the best practice guidelines dictating “best” or “good” practices, it is more important to have mechanisms that disrupt the established order of knowledge. Incorporating rituals or routines are essential to disrupt ingrained taken for granted thinking. A superficial reading of the discourse of knowledge translation would lead me to believe that this would be a good thing. Such ‘evidence’ is continually produced and thus, knowledge translation activities (such as best practice guidelines) ought to be in a constant

state of change as this new research knowledge is incorporated into practice on a continual basis. Within such a framework, it would seem an imperative that ‘evidence’ be routinely evaluated and updated. Especially in light of the claim of the evolving and rapidly changing nature of such knowledge—as outlined in chapter two, dealing with all this ‘knowledge explosion’ is one of the biggest promises of the discourse of knowledge translation. But in the end, the institutionalized (and very rational) discourse of knowledge translation remains a product of a particular reasoning patterning with a central contradiction: That is, “the aim of the linear discourse of analysis is to be a continuous process providing its user with an eventually ‘complete’ knowledge<sup>12</sup>...but such knowledge would be the negation of its own ordering, for it would put an end to the continuing process.” Thus, discourses such as knowledge translation actually inscribe “stasis as its goal” and can be seen as “aimed, so to speak, at entropy” (Reiss, 1982, p. 159).

Entropy is defined as the quantifiable measure of the level of disorder and efficiency of the components within a closed system. In such a state, there is a tendency towards uniformity, leading to an inevitable and steady deterioration of that system (OED, 2011; Smirnov, 2006). Latour (1987), also theorizing about knowledge and translation, argues that in such a system the actual labour or energy required to translate knowledge, what I have called contextualizing practices, is rarely accounted for. In this way, such energy is often redirected to the maintenance of the system (stasis) rather than the original purpose of the system (e.g. improved patient care). This was most prominent in my observations in that the nurse-run clinic nurses spent vast amounts of their time hunting for, and documenting in, the patient’s paper chart. The continual upkeep and maintenance of this document is so important in this setting, there is a ward clerk whose sole responsibility is to ‘prepare’ charts for physician appointments (i.e. to ensure all of the documentation required is in the chart). In addition, while there is no official place for the

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<sup>12</sup> In 1644, Descartes predicted this should be achieved in not more than a few centuries (Reiss, 1982).

nurses to chart in the patient's electronic records, there is a sophisticated electronic system in place that monitors the location of each patient's chart within the organization. Upon further reflection on the discourse of knowledge translation, which could be described as a closed system, I am struck by how such an implicit focus on entropy (such as variation in practice) seems to have particular effects on the 'business' of knowledge translation and the continued backgrounding of the contextualizing practices of the nurses.

### **The 'Business' of Knowledge Translation**

What seems to be overlooked in the knowledge translation literature is the 'business' opportunities afforded those involved in the sanctioned knowledge translation activities: chiefly, the production of so-called 'gold-standard' evidence and the marketing of evidence-based 'best' practice guidelines. While the Cochrane Collaboration (2011) claims to be an "independent" and "not-for-profit" organization, I cannot help but wonder how this claim can be made when the bulk of research assessed as "accurate" or most valuable is heavily funded by pharmaceutical companies with a vested interest in ensuring this 'order of things' continues. I also wonder about the 'business' of packaging and selling best practices guidelines. While attending the International Council of Nurses Conference in 2009, I was overwhelmed with the number of groups (many of them nursing) marketing copyrighted 'best practice guidelines' to healthcare organizations. Most of these seemed, to me, to be targeted at developing countries in which nurses do not have the healthcare infrastructure or resources that nurses in so-called 'developed' countries enjoy. I did ask one of the American nurses selling such guidelines to explain this to me. She replied, "Because we, in the west, are the experts of healthcare and we share this knowledge with other organizations and nurses -- who are the experts of their culture and can apply them there." In this way, I can see how such a commodity (pre-packaged acontextual

information produced by ‘experts’) is valuable in the global knowledge economy. What I now ‘hear’ in the comments of the nurse above is a lack of acknowledgement or understanding of the complexity of the work of contextualizing these ‘commodities.’ In this way, the discourse of knowledge translation reinforces the notion of nurses as ‘the doers’ engaged in the linear transfer of knowledge on a global level. In addition, as the World Health Organization (WHO) adopts and integrates the Canadian notion of knowledge translation which includes heavy emphasis on economics and reinscribes the primacy of one kind of knowledge or evidence (WHO, 2006), perhaps the international effects of this view of the nurse as a particular “knowledge worker,” as outlined previously, is contributing to the disturbing trend of diminishing nurse representation and leadership at the WHO. Indeed, 2011 is the first year that WHO representatives have decided not to fill the position of chief nursing scientist (CNA, 2011). Despite the overwhelming evidence of the importance of nurses to accessible and equitable healthcare in Canada and internationally, as outlined in chapter one, within the WHO, nurses<sup>13</sup> represent only 0.9 percent of professional staff while physicians (and medical specialists) represent 91.2 percent. As Judith Shamian, President of the Canadian Nurses Association, points out, this “critically low level of nursing representation is counterproductive to its mandate” (CNA, p. 13) and, as I point out, even contrary to so-called ‘gold standard’ evidence.

### **The Work of Knowledge Translation**

Thinking about Latour’s (1987) comment that the energy (or labour) required to translate knowledge is rarely accounted for brings me back to the contextualizing practices I noticed the nurses engaging in, which seem both essential to the discourse of knowledge translation as well as somehow ‘invisible.’ Upon further reflection of what I have called contextualizing practices, it

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<sup>13</sup> In addition, nurses, midwives, nurse practitioners, dieticians and pharmacists are often referred to as NPPs (non-physician healthcare providers) in current WHO literature.

struck me that the setting I am ‘observing’ is similar to traditional ethnographic research before it was influenced by various philosophical approaches such as feminist poststructuralism. This helped me ‘observe’ and think about the broader discursive field of healthcare in this setting in a different way. The original position of the ‘objective observer’ conducting an ethnography, which is now a site of rich philosophical consideration, was thought to have the authority to define a particular context (culture) and discern the ‘truth’ of that group and it does strike me that a similar situation may be occurring in my study.

Through my method of writing, I reflected on the ‘problematic’ issues I observed and/or discussed with interviewees arising from interactions between the nurses and their colleagues (mainly physicians and administrators) where nursing practices were challenged, as discussed in chapters four and five. Such instances seemed to have occurred when the nurses, instead of dismissing context as unimportant or considering context as a problem to be solved, brought it to the fore. That is, groups accustomed to being the ‘objective observer’ determining the context for interpretation became then the “contexted” within a different discursive frame. In this way, it could be seen that multiple and competing possibilities of ‘truth’ and knowledge could be established based on these new contextualizations that may deviate from the ‘gold-standard.’ As Davies (2000b) reminds us, “one form of knowing can be used to trouble another” (p. 169). Building on this, could the discourse of the ‘deficient practitioner’ be seen as not just a disciplinary technique but also a way to keep attention on the individual practitioner’s behaviour rather than identifying the importance of context beyond a problem to be solved? Interestingly, the reverse also seems to show a pattern. In instances where individuals stated they were “on the same page” (and perhaps not deficient), it was when the context was a background ‘problem’ and the patient was positioned as ‘the contexted.’ That is, when the patient’s experience was

represented as side effects or symptoms resulting from their disease process or medical treatment (i.e. 'pain' or 'anxiety'). Further, it seems to me that when the nurses were contextualizing administrative and medical practices, they were being responsive to the requests of the patients they were caring for. For example, trying to arrange medical and treatment appointments around the care necessary for a patient whose child had a disability or discussing how to address a patient's pain without necessarily using narcotics in order that the patient be alert (but as pain free as possible) to spend quality time with family. What seems to be contested here, then, is the 'context' of interpretation and the authority of that interpretation. What this also highlights is just how ambiguous the notion of 'evidence' can be when it is so dependent on context.

Thinking about the importance of context leads me to reflect again on the context of the patient. The patients I observed with the nurses were, for the most part, very well informed and had access to a tremendous amount of previously 'privileged' information. I observed several patients questioning the nurse in regard to the efficacy of a particular chemotherapy drug versus another based on their specific diagnosis. During one observation, the patient showed the nurse printed treatment protocols from an American organization that conflicted with his treatment at this organization. Another patient, in response to the nurse's reluctance to comment on his chemotherapy protocol said, "That's okay. I will google that when I get home." Such interactions between the nurse and these patients prompted me to wonder if the 'problem' the discourse of knowledge translation aims to solve, that we are in the midst of some sort of a 'knowledge explosion,' is really something that needs to be strictly managed. Could focusing on the need to manage such an 'explosion' obfuscate the circumstances in which the general population is also experiencing an unprecedented 'explosion' of ways to access and connect to various ideas and knowledge that previously were either denied or unavailable? It is reminiscent of when the

printing press was invented, providing previously unimaginable access to new knowledge by the average person. In particular, it was the beginning of a challenge to the authority of organized religion as the only avenue to the ‘truth’ (the bible) and formed the bases for new interpretations of the Christian religion. In this way, within the discourse of knowledge translation, what we as healthcare professionals might fail to ‘notice’ (what may be occultated) is not necessarily new healthcare knowledge or new systems to monitor patient outcomes (like ‘safety’) but the emergence of a new kind of patient with different interpretations of healthcare ‘truth’ and subjectivities. For example, I recently read a commentary on-line illustrating this point regarding the new breast-cancer screening guidelines newly recommended by the Canadian Medical Association. The journalist (McMartin, 2011) outlined how the “dispassionately logical” recommendations might be meaningful in a medical context, but in his context such guidelines would have fostered a situation in which his wife, at the age of 51 and in a statistically insignificant patient group, would not have been diagnosed with breast cancer in a timely manner. He concludes with this sentiment,

And if someone in the medical community in favour of the new recommendations feels I am misguided because I happen to think those recommendations are full of crap, and that I don't have the expertise to make an informed judgment, well, sue me.

### **Transformation of the Patient**

It seems to me that the nurses, through contextualizing medical and healthcare delivery information for the patient, are responding to the demands of patients who are more sophisticated in their knowledge about their own bodies as well as increasingly impatient with being ‘the contexted.’ The nurses in the nurse-run-clinic have the opportunity to resist the reframing of nursing as “knowledge workers” as defined in (and by) the discourse of knowledge translation

and they are also in a position to accommodate as well as constrain a great deal of the knowledge translation process. In this way, nurses are tremendously powerful. They could be seen as essential to the context of the patient but, by interacting with patients in this manner, they are also participating in a sort of reshaping of the context of healthcare. I can't help but wonder if such multi-directional contextualizing practices with patients - this ability to move between discursive frames that alternatively and simultaneously allow for different contextualized knowledge - could be articulated and supported, what effect would this have on both the nurses' subjectivities and the discursive field of healthcare?

### **Conclusion**

In this chapter, I have outlined some possible effects of the discourse of knowledge translation within the broader discursive field of healthcare. I was most fascinated by the descriptions of the best practice guidelines by all the nurses involved as "what we already know." If this knowledge is already part of the repertoire of nursing practice, then the purpose of such intense focus to change practice in this setting must be further explicated. In light of this, I argue that the discourse of knowledge translation does not just require a more explicit use of certain knowledge (evidence), but instead it represents a re-organization of knowledge within the discursive field of healthcare. Central to this is the construction of the 'hierarchy of evidence,' as outlined in chapter two. The evidence hierarchy (or perhaps the hierarchy of credibility) central to the discourse of knowledge translation clearly ranks so-called 'gold standard' research evidence at the top while professional judgment is positioned at the bottom. My findings point to the possible effects of this 're-ordering' as establishing nursing 'territory' in the new order of contemporary healthcare while at the same time, undermining the nurses confidence in their own professional judgment.

This 're-ordering' is accomplished through (re)education of the nurses and the concurrent use of chart audits that evaluate 'good practice' through the documented use of the best practice guidelines. Thus, in this setting the use of best practice guidelines become the evidence of their own effectiveness. It is self-referential: the evidence is the evidence. This self-referential evidence is vital to the dominance and maintenance of the discourse of knowledge translation. Through this process of self-referentiality, best practice guidelines offer a means of surveillance not just of nurses but of their colleagues as well. In this way, nurses also become the vehicle for organizational surveillance in terms of patient safety (risk) and economic demands.

While the effects of the discourse of knowledge translation serve to undermine professional judgment and, ironically, seem to reinscribe the 'handmaid' subjectivity of nurses (perhaps even internationally), it also serves as a point of resistance. The taken-for-granted or background contextualizing practices the nurses engaged in to enact the discourse of knowledge translation seems to position the nurses to be influential in expanding the notions of both evidence and knowledge translation. Articulating the multi-dimensional recursive contextualizing practices in concert with the nurses' ability to move between discursive frames that simultaneously allow for and create different contextualized knowledge to be translated is key. In this way, nurses are being responsive to a new kind of patient (also with shifting subjectivities) who, while rarely discussed in the knowledge translation process, also have an unaccounted for potential to influence and reshape the discursive field of healthcare.

## **Chapter Seven: The Map is not the Territory<sup>14</sup>**

This dissertation advances a reading of knowledge translation and the effects of such a discourse on nursing practice in one practice setting. As outlined in chapter one, I argue that we are in the midst of a historical ‘moment’ in which changes to the discursive field of Canadian healthcare, the formalization of the discourse of knowledge translation, have the potential to ‘transform’ or redefine the ‘ideal’ nurse, possibly as a ‘knowledge worker’ or better described within this discursive frame, as an ‘evidence worker.’ Indeed, there does appear to be a discursive move on the part of nurses to reinvent both the discipline and profession as constituted by knowledgeable and credible practitioners and this move is delineated by the discourse of knowledge translation. Yet to adopt the practices of knowledge translation does not necessarily reflect the inevitable progress of nursing professionalism or legitimacy but instead, it is a process that is both engineered and unpredictable. This reading suggests that the knowledge translation practices required to enact the discourse of knowledge translation limit and constrain nurses’ subjectivities and subsequently their nursing practice in particular ways. The analysis reveals interesting possibilities for these nurses as they are strategically positioned within the discourse of knowledge translation to both resist and reshape not just the discursive frame of the ‘ideal’ nurse but also the broader discursive field of healthcare itself.

### **It’s not (just) about the Evidence**

In chapter two, guided by a feminist poststructural approach, I outline current and formalized conceptualizations of ‘knowledge translation’ in the literature with a focus on how such conceptualizations both define and delimit knowledge and how it is deployed in nursing

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<sup>14</sup> (Korzybski, 1933)

practice. 'Knowledge translation' is most often put forth as a solution to the 'problems' of contemporary Canadian healthcare: that is, the main aims are to promote fiscal accountability and efficiency; improve patient health outcomes and safety; and bridge the 'knowledge-practice' gap. The solutions to these 'problems' are explicit. Practitioners are required to adhere to evidence-based or best practice guidelines with an emphasis on medical evidence as essential to guide all activities. In turn, the use of such guidelines (in conjunction with an assumption of linear causality between particular practices and patient outcomes) supports administrative practices that allow for the 'measurement' of certain outcomes that can be used to demonstrate organizational accountability in regard to patient safety and economic efficiency. In this way, nurses as 'evidence workers,' are positioned to be the primary instrument for management of risk through outcome measures of their use of particular 'evidence' in contemporary healthcare organizations.

The effects of the discourse of knowledge translation can be seen as positioning nurses to be a particular kind of 'knowledge worker' (the 'doer' or the evidence worker) who is necessary to transport the important commodity of knowledge from the experts. In this way, the 'ideal' nurse within this new discursive frame seems to be one who is a conduit of expert credible knowledge rather than a creative, knowledgeable practitioner. Overall, in this literature there is a systematic neglect of the nature and effects of power in the constitutional work of the discourse of knowledge translation. Thus, my starting point is that the discourse of knowledge translation, so centred on the uptake and use of proper evidence, is actually not at all about such 'evidence' or knowledge but is instead the vehicle used to drive power relations and the politics of those relations through to the establishment and maintenance of professional 'territory' or political status in the discursive field of healthcare.

## **Entering New Territory**

As outlined in chapter three, the interpretation of the nurses' activities and practice was situated in a feminist poststructural analysis. Observations of practicing nurses in the nurse-run clinic and in particular, their interactions with patients, colleagues and the space in which they practiced, were drawn on as the primary source for my interpretation. These interpretations were crosschecked with interviews conducted with the nurses and the colleagues they interacted with as well as through conversations with an 'observant participant' and three of the nurses observed.

Undertaking a feminist poststructural ethnography was a rich and challenging learning experience. In combination, these theoretical concepts assisted me to understand the interconnectedness between nursing practices, the discourse of knowledge translation and subjectivities of my participants. Not only did ethnography allow for a coherent way to collect and organize my data, it also supported the use of multiple and diverse methods and the triangulation of such methods. In this way, I was able to recognize patterns and incongruencies in the data that added depth to both my learning and analysis.

A feminist poststructural ethnography assisted me to excavate my own assumptions while at the same time, focus on the concepts of subjectivity, power and discourse in this wide-ranging philosophical and theoretical territory. In addition, staying alert to the 'effects' of a dominant discourse at a local level gave me insight into the possible effects in the wider discursive field of healthcare. Such analysis illustrated how power is diffuse and inseparable from knowledge. I now understand how we are complicit in creating and maintaining a discourse while at the same time, being constituted as subjects of that discourse. In the end, I see how it is our ideological commitments, such as my feminist leanings, through which we enter into the messiness of this everyday social world and address the inequities resulting from the taken-for-granted nature of

dominant discourses. Ultimately, such attention to the notion of power and the politics at the knowledge/power nexus within social institutions draws attention to the contested notion of evidence and how inextricable such notions are from ideological concerns within dominant discursive frames.

This reading made of nurses' practice illustrates the possible effects of the discourse of knowledge translation as I observed the nurses reframing their practice in terms of the newly implemented best practice guidelines. While the seemingly autonomous nature of a nurse-run clinic suggests the best practice guidelines would enable the nurses to practice independently and not in the traditional role or image of the nurse as a "handmaid," this was not the case. I observed the remnants of more traditional forms of work that still remained even as the nurses became subjects of the discourse of knowledge translation. Had I relied on interviews alone, I would have been lead to believe that it was possible for the nurses to transcend this history. For example, I observed the expectation that the nurse be available immediately, regardless of what she was doing, when a physician required assistance. While the practice of the nurse-run clinic nurse was still mediated by physician and administrator imperatives, it does not mean that the practices required to accomplish the work in this setting, and the discourse of knowledge translation, were completely erased. Here I will summarize my findings before discussing the implications of this analysis.

### **Noticing Nursing Practice**

In chapter four I outlined how the nurses' use of the newly implemented best practice guidelines, which I argue embody the ideals of the discourse of knowledge translation, foregrounded seemingly rational practices (based in current conceptualizations of science and professionalism) aimed to 'quantify' the subjective symptoms and experiences of the patient

while at the same time, backgrounding the contextualizing practices of the nurses. That is, as the nurses began to incorporate the best practice guidelines into their practice, there seemed to be a subtle shift in how they interacted with both their patients and their colleagues. In this way, the nurses seemed to be reconfiguring (or contextualizing) the patients' illness and experience as symptoms or side effects of medical treatments. Within the discourse of knowledge translation, this seems to be the primary function of the 'knowledge worker.' Such backgrounding of the nurses' practice demonstrated the workings of power and knowledge through the rational apparatus of one knowledge translation activity, the best practice guidelines, with the effect of rendering much of their work invisible. In addition, this also seemed to demonstrate that the nurses' contextualizing practices are required in order to create the appearance that medical and administrative practices are based in rational decision-making. However, reflecting on this line of analysis, I realized that focusing on the shift to a more rational mode of practice might not allow for a satisfactory analysis. While the *representation* of what nurses do may change, the actual conduct of nursing in this setting is not fully accounted for or noticed. These practices constituting the conduct of nursing (although shifting and changing) can never be fully erased.

Following Reiss' (1982) suggestion that dominant discourses 'occlude' (or block from view) other discourses, I examined the space of practice in the nurse-patient interactions more closely so that I might 'notice' what else is going on. Re-examining practice this way assisted me to recognize that nursing practice in this setting has not been erased but is instead, unacknowledged. 'Noticing' such practices is important because it is not that nurses need to resist the best practice guidelines but the discursive move to articulate or represent nursing practice solely in terms of attending to common symptoms and side effects of medical treatment in this setting. In doing so, I began to see that knowledge translation practices occur in the 'space' of the

nurse-patient interactions, rather than in the gap between research and the practitioner as implied within the discourse of knowledge translation. This practice space, then, also seems to offer a site of resistance. While the nurses were observed actively contextualizing patients for the physicians and administrators, they were also observed contextualizing medical and administrative practices for patients as they tried to make sense of their diagnosis. The interplay of these unacknowledged practices can be seen as both essential to the production of the discourse of knowledge translation and a fertile site of opportunities for resistance. In this way, the nurses are quite powerful as they have the potential to resist and reshape things.

### **Establishing Nurse Territory**

In chapter five, my analysis begins with an examination of the history of the nurse-run clinic as an important aspect of considering power and subjectivity within this particular setting. In doing so, the contradiction between what was envisioned by the nurses in this new setting and the expectations that they would continue to practice as they had before the establishment of the nurse-run clinic was highlighted. Thus, I put forth that this ‘room of their own’ represented a site of ideological struggle of what nursing practice ought to be. This struggle, with competing discourses such as professionalism, sexism and economic efficiency, contributed to the difficulty these nurses had in articulating their practice. I argue that the nurse-run clinic nurses readily accepted the best practice guidelines because the guidelines seemed to offer the promise of legitimately explaining their nursing practice in a way that was understandable to their colleagues and supervisors as well as establishing justifiable territory. Further to this, use of the best practice guidelines also seemed to promise elevating nursing practice to a more sophisticated or advanced level. As outlined in previous chapters, this promise has been a siren call to nurses for decades, if not centuries.

While such promises did seem to provide some clarity regarding nursing practice in this setting, it also had the effect of discursively reframing nursing practice. As the nurses were constructed as subjects of the discourse of knowledge translation, the best practice guidelines seemed to redefine the boundaries of what could be considered ‘good’ nursing practice and reinforced a particular notion of ‘knowledge worker.’ Yet if nurses take up this preferred or ‘ideal’ position that seems to be offered within the discourse of knowledge translation, they could be relegated to the ‘simple’ doing of a knowledge worker who is the disseminator or conduit of ‘expert’ knowledge rather than any credible knower in her own right. Further, the practices of this form of ‘knowledge worker’ also circumscribe nursing practice as those activities related to medical treatment (e.g. monitoring side effects of drugs) and/or organizational imperatives (e.g. patient safety) rather than direct practice towards patient care. By adopting the best practice guidelines and using them, as several nurses told me during observations, as the “foundation” or “framework” for nursing in this setting, these repeating and perpetual practices of the dominant discourse of knowledge translation serve as the visible and rational basis of nursing conduct.

While the best practice guidelines might appear to be a *fait accompli* in this setting, the identities and subjectivities of the nurses as ‘knowledge workers’ within the discourse of knowledge translation definitely are not. Once again, I wish to emphasize that I am not suggesting that the best practice guidelines are inherently detrimental, but what is problematic is describing the complexity of nursing practice solely in terms of this discursive framework. Nursing practice requires a wide and varied knowledge base from multiple discursive frames to know how to even begin to engage in those contextualizing practices I observed. Thus, it seems the work of successful knowledge translation is the capacity to “move within and between

discourses” (Davies, 2000a, p. 60) and what I call the contextualizing practices required to enact the discourse of knowledge translation.

I conclude that a discursive environment conducive to nurses’ understanding of their own subjectivities as well as the limits and advantages of various discursive structures is necessary to articulate their contextualizing practices as they shift between discursive frameworks required in the incremental instances of ‘knowledge translation.’ Such understandings of the complexity of nursing practice may help nurses resist the pull to dominant discourses as the main source of ‘truth’ and open up new possibilities for nurses and nursing practice. It is through articulating these contextualizing practices as the nurses continually shift between discourses that may allow nurses to explain and understand the aspects of nursing practice that are required by the discourse of knowledge translation yet are not accounted for in the representations of the nurse and nursing practice within that discursive frame. This challenge may offer considerable opportunities for nursing because the discourse of knowledge translation has broad implications within the discursive field of healthcare.

### **Noticing a New Patient**

In chapter six, I looked more closely at the possible effects of the discourse of knowledge translation on nursing and the wider discursive field of healthcare. I was intrigued that the best practice guidelines were consistently described by all nurses as “what we already know.” If this knowledge is already part of the repertoire of nursing practice, then what is the purpose of such intense focus to change practice in this setting? I put forth that the discourse of knowledge translation is not just about the production of knowledge (or evidence); it is about the reorganization of knowledge. This is most visible in the evidence hierarchy central to the discourse of knowledge translation in which synthesis of a particular research evidence is at the

top and professional judgment at the bottom. My findings point to the possible effects of this 're-ordering' as establishing 'territory' in the new order while at the same time, undermining the nurses confidence in their own professional judgment.

This 're-ordering' is accomplished through (re)education and the concurrent use of chart audits that evaluate 'good practice' through the documented use of the best practice guidelines. Thus, in this setting the use of best practice guidelines, and the subsequent outcomes of this knowledge translation activity, becomes the evidence of their own efficacy. Within this discursive frame, the self-referential evidence *is* the evidence. The production of this self-referential evidence is fundamental to the maintenance and continued dominance of the discourse of knowledge translation. In addition, this process of self-referentiality of the best practice guideline offers a means of surveillance not just of nurses but of their colleagues as well. In this way, nurses also become the vehicle for organizational surveillance in terms of patient safety (risk) and economic demands.

I argue that accounting for the nurses contextualizing practices offers a means to disrupt such a closed system. While the effects of the discourse of knowledge translation serve to undermine professional judgment and, ironically, seem to reinscribe the 'handmaid' subjectivity of nurses, it also serves as a point of resistance. The taken-for-granted or seemingly invisible contextualizing practices required of nurses to enact the discourse of knowledge translation positions the nurse to be influential in expanding the notions of both evidence and knowledge translation. It is the articulation of the multi-dimensional recursive contextualizing practices in concert with the nurses' ability to move between discursive frames that simultaneously allows for and creates different contextualized knowledge to be translated (and activated). In this way, nurses are being responsive to a new kind of patient (also with shifting subjectivities) who, while

rarely discussed in the knowledge translation process, also have an unaccounted for potential to influence and reshape the discursive field of healthcare.

### **Implications of such Accounts of Practice**

Within the discursive frame of knowledge translation, as outlined previously and demonstrated in the nurses' use of the best practice guidelines, the focus is ultimately placed on 'outcomes' and the creation of a particular kind of quantifiable evidence by the nurses themselves. In this way, the nurses can be seen as creating the evidence of a self-referential closed system that will eventually render their practice (once again) invisible. Such production of evidence is privileged over the life world of the nurse and/or the patient. In this way, outcomes not only become evidence of 'good practice' within the discursive frame of knowledge translation, the nurse is also positioned to 'manage' the subjective experiences of the patient (such as pain and fatigue) by converting such experiences into quantifiable accounts to be monitored and measured, thus rendering the social world of the patient invisible. This also reinforces the notion that the patient's physical body is somehow outside the nurses' territory. The 'body' as a site of the production of 'objective' data, in conjunction with so-called 'gold-standard' evidence, belongs to the physician. It is left to the nurse to manage and account for the subjective data and context (so problematic within the discourse of knowledge translation and the discursive field of healthcare), and somehow translate this into 'meaningful' evidence for other healthcare practitioners (especially physicians) and administrators within the discursive frame of knowledge translation. The production of such outcomes (evidence) also serves to bring nurses and patients into alignment with (made 'subjects' of) the discourse of knowledge translation. If nurses do not problematize the effects and contradictions of the discourse of knowledge translation in order to account for the complexity of nursing practice, not only do such outcomes

come to represent accounts of nursing practice, they also represent the patients' subjective experience as well. In this way, it is not just that the map (best practice guidelines) is not the territory (nursing practice); the map "precedes the territory" (Baudrillard, 1995, p. 79).

Baudrillard (1995) uses a specific analogy of a map to illustrate the self-referential nature of modernist discursive frames that claim much of the territory of 'the truth.' In Baudrillard's version of this analogy, a great empire constructed an incredibly detailed map that was the same size as the empire. Through various wars, hardships and prosperous times, the empire grew or shrunk in dimensions. Because of the vital importance of the map to the empire, the map was reconfigured to remain the same actual size as the empire. After a while, the empire and its infrastructure started to deteriorate. Despite this, the map of the territory was maintained in pristine condition to please those in authority. Eventually the empire completely crumbled, leaving only the beautiful map as evidence of its existence. Baudrillard contends that it is this 'map' that hosts modernist thinking and living (somewhat like a simulation) even as the reality is crumbling away. Extending this analogy, it is not just that the best practice guidelines mark the 'territory' of nursing practice but it also serves to (re)establish and (re)define it even as the accounts of nursing practice within the discursive field of healthcare become narrower and narrower. That is, it becomes possible that such best practice guidelines precede the subject position of the 'ideal' nurses and the accompanying narrow accounts of nursing practice.

### **Disrupting Narrow Accounts of Practice**

As described in chapter one, when there are sweeping changes to the discursive field of healthcare, usually through legislation, there also seems to be a concurrent repositioning of the 'ideal' nurse subject. I propose that one aspect of the 'gap' identified within the discursive frame of knowledge translation is the time necessary for nurses to accommodate the new discursive

frame of how healthcare 'ought' to be delivered and, subsequently the new practices required of nurses who are essential to enact such changes. In some way, creating a new map to represent nursing practice. Perhaps our difficulty articulating nursing practice stems from the eagerness with which such new maps are embraced and taken up by the discipline and profession of nursing in order to prove (finally) our legitimate territory in the healthcare terrain. It seems just as we begin to articulate and establish nursing territory through sanctioned accounts of nursing practice that are credible within the current discursive frame, such framing then changes and we are left to re-map and re-establish our legitimacy. Feminist poststructural theories highlight how such knowledge/power networks systematically marginalize nurses, even as we participate in creating it, and define us as 'the other' (such as 'non-physician practitioners' by WHO). In addition, this theoretical position illustrates how the formalization of patriarchal discursive frames such as 'knowledge translation' functions "both institutionally and individually to produce desired subject forms" (Weedon, 1997, p. 171). If the 'accountability' of nurses is continually called into question, then let us use our 'ability to account' for practice in multiple ways as we move between discursive frames rather than restricting our representation of practice and the 'ideal' nurse to one limited account.

Disrupting narrow accounts of nursing practice within the discourse of knowledge translation lies in the practice space with patients. Feminist poststructural thought offers a way to consider this space as a site of struggle over meaning "that has important implications for how we understand" our practice and the possibilities for change open to us (Weedon, 1997, p. 171). In this space, as we move between discursive frames, we can see how best practice guidelines are important but not a framework for nursing practice. We see that so-called 'gold standard' evidence is necessary information to practice effectively but not sufficient to define and sustain

nursing practice and patient health and well-being. And, it is in this space that we see a patient with shifting subjectivities emerging, perhaps as a part of the global phenomena that Luciano Floridi (2010) calls “re-ontologizing.” Floridi theorizes that the human race is undergoing a dramatic shift in how we view our reality largely due to the blurring of the distinction between what we consider ‘on-line’ and ‘off-line.’ If nurses attend to this nascent view of human reality, we could become leaders in knowledge translation if we are able to articulate what I have called contextualizing practices. If nurses could better understand how we shift between various discursive frames necessary to account for the complexity of nursing practice and patient experiences, we could combine this with the care of the physical body that, in this century will have new and expansive discursive limits. While the ‘virtual’ world currently seems to be ordered by rational scientific knowledge, it is morphing into something new, interactive and profound.

### **Expanding the Territory (not the map)**

To engage in and articulate such nursing practice, nurses are required to account for multiple discursive frames and to maintain a balance between innovation and standardization such as the use of best practice guidelines. This balance, both in research and in practice, is essential. I am not advocating the removal of standards of practice because this can lead to a lack of continuity and fragmented, inequitable care (Freeman et al., 2007). In the same way, we cannot allow the emphasis on best practice guidelines to exclude ideas that challenge the contemporary status quo (such as evidence-based practice). For example, it is conceivable that in the near future working with and assessing patients’ virtually will be as mainstream as talking with them on the telephone is now. It is vital that we create and maintain that space for innovation to allow nurses to develop new knowledge and creative ways of practice that can activate that knowledge. Pêcheux (1975) urges us not to ignore organizational ideologies but to

instead examine the manner in which we have been constructed in order to create different ways to exist. This aptly applies to the new discursive environment that is redefining the boundaries of the human body and the nursing practice necessary to be responsive to this new reality. And, this space allows nurses to engage in recursive practices of knowledge translation in which the nurse and patient work together to accomplish a sort of knowledge translation that is optimal for a particular patient's situation. Together, this will be transformative not just for the patient but for the discursive field of healthcare as well. Nurses will soon be engaged in practices in which it will be required to move through various discursive frames, between what is real and what is virtual and what cannot be defined as either. Articulating the strength of this practice is essential to the delivery of quality healthcare, a practice that has underpinned every collective nursing historical 'moment' and every individual practice encounter with a patient, will allow us to confidently move forward into uncharted and exciting territory as the discursive field of healthcare necessarily transforms to accommodate new patient realities of the 21<sup>st</sup> century.

## References

- Aiken, L.H., Clarke, S.P., Sloane, D.M., Sochalski, J. & Silber, J.H. (2002). Hospital nurse staffing and patient mortality, nurse burnout and job dissatisfaction. *JAMA*, 288(16), 1987-1993.
- Alrichter, H. & Holly, M. L. (2005). Research diaries. In B. Somekh & C. Lewin (Eds.) *Research methods for the social sciences* (pp. 24-32). Thousand Oaks: SAGE.
- Ammenwerth, E. (2005). The nursing process and information technology. In M. Habermann & L. Uys (Eds.) *The Nursing Process: A Global Concept*, pp. 61-76. Edinburgh: Elsevier.
- Angrosino, M. (2005). Recontextualizing observation: Ethnography, pedagogy and the prospects for a progressive political action. In N.K. Denzin & Y.S. Lincoln (Eds.) *The SAGE handbook of qualitative research, Third Edition* (729-746). Thousand Oaks: SAGE Publications, Inc.
- Armstrong, P. (2001). Science, enterprise and profit: ideology in a knowledge-driven economy. *Economy and Society*, 30(4), 524-552.
- Armstrong, R., Waters, E., Crockett, B. & Keleher, H. (2007). The nature of evidence resources and knowledge translation for health promotion practitioners. *Health Promotion International*, 22(3), 254-261.
- Arslanian-Engoren, C. (2001). Feminist poststructuralism: a methodological paradigm for examining clinical decision-making. *Journal of Advanced Nursing*, 37(6), 512-517.
- Atkinson, P. & Pugsley, L. (2005). Making sense of ethnography and medical education. *Medical education*, 39(2), 228-234.

- Bahtsevani, C., Willman, A., Stoltz, P. & Ostman, M. (2010). Experiences of the implementation of clinical practice guidelines – interviews with nurse managers and nurses in hospital care. *Scandinavian Journal of Caring Sciences*, 24(3), 514-522.
- Baudrillard, J. (1995). The Map Precedes the Territory. In W.T. Anderson (Ed.), *The Truth About The Truth. De-Confusing and Re-Constructing the Postmodern World* (79-81). New York: G.P. Putnam's Sons.
- Berger, P. & Luckmann, T. (1967). *The social construction of reality: A treatise in the sociology of knowledge*. New York: Anchor Books.
- Bhattacharyya, O. & Zwarenstein, M. (2009). Methodologies to evaluate effectiveness of knowledge translation interventions. In Strauss, S., Tetroe, J. & Graham, I.D. (Eds.) *Knowledge Translation in Health Care Moving from Evidence to Practice*, pp. 249-260. Oxford: Wiley-Blackwell BMJ Books.
- Bingham, C. W. (2008). Derrida on teaching: The economy of erasure. *Studies in the Philosophy of Education*, 27, 15-31.
- BRINT (2011). Resources for Business Technology Management and Knowledge Management. Retrieved March 1, 2011 from the World Wide Web at: <http://km.brint.com/>
- Britzman, D. (2000). "The question of belief:" Writing poststructural ethnography. In E. St. Pierre & W. Pillow (Eds.), *Working the ruins: Feminist poststructural theory and methods in education* (27-40). New York: Routledge.
- Brouwers, M., Makarski, J. & Levinson, A. (2010). A randomized trial to evaluate e-learning interventions designed to improve learner's performance, satisfaction and self-efficacy with the AGREE II. *Implementation Science*, 5(1), 29.

Bullock, A. & Trombley, S. (Eds.) (2000). *The new Fontana dictionary of modern thought* (3rd Ed). London: Harper Collins Publishers.

Canada, Government of (2000). Bill C-13: The Canadian Institutes of Health Research Act.

Retrieved from the World Wide Web Nov 15, 2009 at:

<http://dsp-psd.pwgsc.gc.ca/Collection-R/LoPBdP/LS/362/c13-e.htm>

Canadian Institute for Health Information, CIHI (2007). *Highlights from the regulated nursing workforce in Canada: 2006*. Ottawa: Author.

Canadian Institutes of Health Research, CIHR (2011a). Knowledge Translation. Retrieved March 2, 2011 from the World Wide Web at: <http://www.cihr-irsc.gc.ca/e/39033.html>

Canadian Institutes of Health Research, CIHR (2011b). Health Research Roadmap: Creating innovative research for better health and health care. Retrieved March 2, 2011 from the World Wide Web at: <http://www.cihr.ca/e/40490.html>

Canadian Institutes of Health Research, CIHR (2011c). The Knowledge Broker Model: Knowledge Mobilization for the Social Sciences and Humanities. Retrieved October 4, 2011 from the World Wide Web at:

<http://www.cihr-irsc.gc.ca/e/29506.html>

Canadian Nurses Association, CNA (2011). ICN abuzz with lack of nursing presence at WHO. *Canadian Nurse*, 107(6), 13.

Canadian Nurses Association, CNA (2002). Position statement: Evidence-based decision-making and nursing practice. Ottawa: Author.

Ceci, C. (2000). Not innocent: Relationships between knowers and knowledge. *Canadian Journal of Nursing Research*, 32(2), 57-73.

- Centre for Health Evidence (2008). University of Alberta. Retrieved April 18, 2008 from the World Wide Web at: [www.cche.net](http://www.cche.net)
- Change Foundation (2010). Top lessons from knowledge translation symposium: Bridging the “Know-Do” gap. Retrieved October 4, 2011 from the World Wide Web at: [www.changefoundation.ca/docs/lessonsfromKTSymposium.pdf](http://www.changefoundation.ca/docs/lessonsfromKTSymposium.pdf)
- Cheek, J. & Rudge, T. (1994). Inquiry into nursing as textually mediated discourse. In P. Chinn (Ed.) *Advances in methods of inquiry for nursing* (pp. 59-67). Gaithersburg: Aspen.
- Cheek J. & Gibson T. (1996). The discursive construction of the role of the nurse in medication administration: an exploration of the literature. *Nursing Inquiry*, 3, 83-90.
- Choi, B. (2005). Understanding the basic principles of knowledge translation. *Journal of Epidemiology in Community Health*, 59, 93.
- Clifford, J. (1986). Introduction: Partial truths. In J. Clifford & G. Marcus (Eds.) *Writing culture: The poetics and politics of ethnography* (pp. 1-26). Berkeley: University of California Press.
- Coburn, D. (1994). Professionalization and proletarianization: Medicine, nursing and chiropractic in historical perspective. *Labour / Le Travail*, 34, 139-162.
- Cochrane Collaboration (2011). The reliable source of evidence in healthcare. Retrieved February 15, 2011 from the World Wide Web at: <http://www.cochrane.org/index.htm>
- Colyar, J. (2009). Becoming writing, becoming writers. *Qualitative Inquiry*, 15(2), 421-436.
- Conant, L. H. (1967). Closing the practice-theory gap. *Nursing Outlook*, 15(13), 37-396.
- Conrad, S. & Sherrod, D. (2011). Nurse managers as knowledge workers. *Nursing Management*, 42(2), 47-48.

- Cousins, M. & Hussain, A. (1986). The question of ideology: Althusser, Pêcheux and Foucault. In J. Law (Ed.) *Power, action and belief: A new sociology of knowledge?* (pp. 158-179). London: Routledge & Kegan Paul.
- Cresswell, J. (2007). *Qualitative inquiry and research design: Choosing among five approaches (Second edition)*. Thousand Oaks, Ca: Sage Publications.
- Crowe, M. (2000). The nurse-patient relationship: A consideration of its discursive context. *Journal of Advanced Nursing*, 31(4), 962-967.
- Cutcliffe, J. R. (2003). Reconsidering reflexivity: Introducing the case for intellectual entrepreneurship. *Qualitative Health Research*, 13(1), 136-148.
- Davidson, C., Sochan, A. & Pretorius, R. (2010). Are Cochrane Collaboration systematic reviews relevant resources for evidence-based nursing internationally? *International Journal of Nursing Studies*, 47, 795–797.
- Davies, B. & Gannon, S. (2005). Feminism/Poststructuralism. In B. Somekh & C. Lewin (Eds.) *Research methods for the social sciences* (pp. 318-325). Thousand Oaks: SAGE.
- Davies, B. (2003). Death to critique and dissent? The policies and practices of new managerialism and of ‘Evidence-Based Practice.’ *Gender and Education*, 15(1), 91-103.
- Davies, B. (2000a). *A body of writing, 1990-1999*. Walnut Creek, CA: AltaMira Press.
- Davies, B. (2000b). Eclipsing the constitutive power of discourse: The writing of Janette Turner Hospital. In E. St. Pierre & W. Pillow (Eds.), *Working the ruins: Feminist poststructural theory and methods in education* (pp. 179-198). New York: Routledge.
- Davies, B. (1992). A feminist poststructuralist analysis of discursive practices in the classroom and playground. *Discourse: The Australian Journal of Educational Studies*, 13(1), 49-66.

- Davies, B. (1989). *Frogs and snails and feminist tales: Preschool children and gender*. Sydney: Allen & Unwin.
- Davies, C. (1980). *Rewriting nursing history*. New Jersey: Barnes & Noble Books.
- Davis, D. (2006). Continuing education, guideline implementation, and the emerging transdisciplinary field of knowledge translation. *The Journal of Continuing Education in the Health Professions*, 26, 5-12.
- Davis, D., Evans, M., Jadad, A., Perrier, L., Rath, D., Ryan, D., Sibbald, G., Straus, S., Rappolt, S., Wowk, M. & Zwarensten, M. (2003). The case for knowledge translation: shortening the journey from evidence to effect. *British Medical Journal*, 327, 33-35.
- de la Cuesta (1983). The nursing process from development to implementation. *Journal of Advanced Nursing* 18, 365-371.
- Del Vento, A., Bavelas, J.B., Healing, S., MacLean, G. & Kirk, P. (2009). An experimental investigation of the dilemma of delivering bad news. *Patient Education and Counseling*, 77, 443-449.
- Derrida, J. (2002). *Who's afraid of philosophy? Right to philosophy I*. Stanford: Stanford University Press. (J. Plug, Translator).
- Dilley, R. (2010). Reflections on knowledge practices and the problem of ignorance. In T. H. J. Marchand (Ed.) *Making Knowledge: Explorations of the indissoluble relation between mind, body and environment* (pp. 167-182). Wiley-Blackwell Publications: United Kingdom.
- Dilley, R. (1999). *The problem of context*. New York: Berghahn Books.
- Dobbins, M., Robeson, P., Ciliska, D., Hanna, S., Cameron, R., O'Mara, L., DeCorby, K. & Mercer, S. (2009). A description of a knowledge broker role implemented as part of a

randomized controlled trial evaluating three knowledge translation strategies.

*Implementation Science*, 4(23).

Dobbins, M., Decorby, K. & Twiddy, T. (2004). A Knowledge Transfer Strategy for Public Health Decision Makers. *Worldviews on Evidence-Based Nursing*, 1(2), 120–128.

Doran, D. & Pringle, D. (2011). *Patient Outcomes as an accountability*. In D. Doran (Ed.) *Nursing outcomes: The state of the science* (2<sup>nd</sup> Ed.), pp. 1-27. Mississauga, Ontario: Joans and Bartlett Learning Canada.

Doran, D. & Sudani, S. (2007). Outcomes-focused knowledge translation: A framework for knowledge translation and patient outcomes improvement. *Worldviews on Evidence-Based Nursing*, 4(1), 3–13.

Driever, M. (2002). Are Evidence-Based Practice and Best Practice the same? *Western Journal of Nursing Research*, 24(5), 591-597.

Duncan, C., Langlais, S., Danyluk-Hall, J. & Simonson, K. (2008). Knowledge Translation: Empowering Health Professionals to Take the Lead. *Journal of Continuing Education in the Health Professions*, 28(4), 282–283.

Easen, P. (1996). Intuition and rational decision-making in professional thinking: a false dichotomy? *Journal of Advanced Nursing*, 24(4), 667-673.

Ebener, S., Khan, A., Shademani, R., Compennolle, L., Beltran, M., Lansang, M. & Lippman, M. (2006). Knowledge mapping as a technique to support knowledge translation. *Bulletin of the World Health Organization*, 84(8), 636-642.

Edgar, L., Herbert, R., Lambert, S., MacDonald, J., Dubois, S. & Latimer, M. (2006). The Joint Venture Model of Knowledge Utilization: A guide for change in nursing. *Nursing Leadership*, 19(2), 41-55.

- Elbow, P. (1998). *Writing with power: Techniques for mastering the writing process*. New York: Oxford University Press.
- Estabrooks, C., Midodzi, K., Cummings, G. & Wallin, L. (2007). Predicting Research Use in Nursing Organizations: A Multilevel Analysis. *Nursing Research*, 56(4S), S7–S23.
- Estabrooks, C., Scott-Findley, S. & Winther, C. (2004). A nursing and allied health sciences perspective on knowledge utilization. In L. Lemieux-Charles & F. Champagne (Eds.) *Using knowledge and evidence in health care* (pp. 242-280). Toronto: University of Toronto Press.
- Estabrooks, C., Floyd, J., Scott-Findlay, S., O’Leary, K. & Gushta, M. (2004). Individual determinants of research utilization: A systematic review. *Journal of Advanced Nursing*, 43(5), 506-520.
- Floridi, L. (2010). *Information: A very short introduction*. Oxford: Oxford University Press.
- Fontana, A. & Frey, J. (2005). The interview: From neutral stance to political involvement. In N.K. Denzin and Y.S. Lincoln (Eds.) *The SAGE handbook of qualitative research, Third Edition* (695-727). Thousand Oaks: SAGE Publications, Inc.
- Foucault, M. (2008). *The birth of biopolitics: Lectures at the College de France 1978-1979* (English Translation). New York: Palgrave MacMillan.
- Foucault, M. (1969/2006). *The Archaeology of Knowledge*. London and New York: Routledge.
- Foucault, M. (1977/1995). *Discipline & punish: The birth of the prison*. Toronto: Random House of Canada Limited.
- Foucault, M. (1963/1994). *The birth of the clinic: An archaeology of medical perception*. New York: Random House Inc.

- Foucault, M. (1991). Politics and the study of discourse. In G. Burchell, C. Gordon & P. Miller (Eds.) *The Foucault Effect: Studies in Governmentality* (pp. 53-72). Chicago: The University of Chicago Press.
- Foucault, M. (1984a). Part I: Truth and Method. In P. Rabinow (Ed.), *The Foucault Reader* (pp. 4-120). New York: Pantheon Books.
- Foucault, M. (1984). Part II: Practices and Knowledge. In P. Rabinow (Ed.), *The Foucault Reader* (pp. 121-256). New York: Pantheon Books.
- Foucault, M. (1982). The subject and power. *Critical Inquiry*, 8(4), 777-795.
- Foucault, M. (1981). The order of discourse. In R. Young (Ed) *Untying the text: a post-structural anthology* (pp. 48- 78). Boston: Routledge & Kegan Paul.
- Foucault, M. (1980). *Power/Knowledge: Selected interview and other writings*. New York: Pantheon Books.
- Francke, A., Smit, M., de Veer, A. & Mistiaen P. (2008). Factors influencing the implementation of clinical guidelines for health care professionals: A systematic meta-review. *BMC Medical Informatics and Decision Making*, (8)38.
- Fraser, I. (2004). Translational research: Where do we go from here? *Worldviews on Evidence-Based Nursing*, 1(S1), S78-S83.
- Garfinkel, H. (1967). *Studies in Ethnomethodology*. Englewood Cliffs, NJ: Prentice-Hall Publications.
- Gillis, A. & Jackson, W. (2002). *Research for nurses: Methods and interpretation*. Philadelphia: F. A. Davis Company.
- Goldbart J. & Hustler, D. (2005). Ethnography. In B. Somekh & C. Lewin (Eds.) *Research methods for the social sciences* (pp. 16-23). Thousand Oaks: SAGE.

- Habermann, M. & Uys, L. (2005). *The Nursing Process: A Global Concept*. Edinburgh: Elsevier.
- Haggis, T. (2008). 'Knowledge must be contextual:' some possible implications of complexity and dynamic systems theories for educational research. *Educational Philosophy and Theory*, 40(1), 158-176.
- Hakkennes, S. & Dodd, K. (2008). Guideline implementation in allied health professions: a systematic review of the literature. *Quality and Safety in Health Care*, 17(4), 296-300.
- Hamric, A. (2007). Dealing with the knowledge explosion. *Clinical Nurse Specialist*, 16(2), 68-69.
- Haraway, D. (2004). *The Haraway reader*. New York: Routledge.
- Harrison, M., Graham, I. & Fervers, B. (2009). Adapting knowledge to a local context. In S. Strauss, J. Tetroe & I. Graham (Eds.) *Knowledge Translation in Health Care: Moving from Evidence to Practice* (pp. 73-82). Hoboken, NJ: Blackwell Publishing Ltd.
- Harrison, M., Legare, F., Graham, I. & Fervers, B. (2010). Adapting clinical practice guidelines to local context and assessing barriers to their use. *Canadian Medical Association Journal*, 182(2), E78-84.
- Hart, S. (2005). Hospital ethical climates and registered nurse turnover intentions. *Journal of Nursing Scholarship*, 37(2), 173-177.
- Holmes, D., Murray, S., Perron, A. & McCabe, J. (2008). Nursing best practice guidelines: Reflecting on the obscene rise of the void. *Journal of Nursing Management*, 16(4), 394-403.
- Holmes, D., Murray, S., Perron, A. & Rail, G. (2006). Deconstructing the evidence-based discourse in health sciences: Truth, power and fascism. *International Journal of Evidence Based Healthcare*, 4, 180-186.

- Huen, C. (2009). What is context? : An ethnophilosophical account. *Anthropological Theory*, 9(2), 149-169.
- Innvaer S., Vist, G., Trommald, M. & Oxman, A. (2002). Health policy-makers' perceptions of their own use of evidence: A systematic review. *Journal of Health Services Research and Policy*; 7: 239-244.
- Jensen, C. B. (2008). Sociology, systems and (patient) safety: knowledge translations in healthcare policy. *Sociology of Health and Illness*, 30(2), 309-324.
- Jones, L. & Somekh, B. (2005). Observation. In B. Somekh & C. Lewin (Eds.) *Research methods for the social sciences* (pp. 138-145). Thousand Oaks: SAGE.
- Kelly, D. (2005). Opening new discourses in nursing: the history of the Nursing Process in the UK. In M. Habermann & L. Uys (Eds.) *The Nursing Process: A Global Concept* (pp. 15-30). Edinburgh: Elsevier.
- Kerfoot, K. (2005). The Johnny Appleseeds of Organizational Change. *Nursing Economics*, 23(5), 271-273.
- Kerner, J. (2006). Knowledge translation versus knowledge integration: A “funder’s” perspective. *The Journal of Continuing Education in the Health Professions*, 26, 72-80.
- Kirchhoff, K. T. (2004). State of the science of translational research: From demonstration projects to intervention testing. *Worldviews on Evidence-Based Nursing*, Supplement, S6-S12.
- KT Canada (2011). Knowledge Translation Canada. Retrieved from the World Wide Web on November 30, 2010 at: <http://ktclearinghouse.ca/ktcanada>
- Kouritzin, S. (2002). The “half-baked” concept of “raw” data in ethnographic observation. *Canadian Journal of Education*, 27(1), 119-138.

- Landry, R., Amara, N., Pablos-Mendes, A., Shademani, R. & Gold, I. (2006). The knowledge-value chain: A conceptual framework for knowledge translation in health. *Bulletin of the World Health Organization*, 84(8), 597-602.
- Lang, E., Wyer, P. & Haynes, R. B. (2007). Knowledge Translation: Closing the evidence-to-practice gap. *Annals of Emergency Medicine*, 49(3), 355-363.
- Lather, P. (2000). Drawing the line at angels: Working the ruins of feminist ethnography. In E. St. Pierre & W. Pillow (Eds.), *Working the ruins: Feminist poststructural theory and methods in education* (pp. 284-311). New York: Routledge.
- Lather, P. (1991). *Getting smart: Feminist research and pedagogy with/in the postmodern*. New York: Routledge.
- Latimer, J. (2004). Commanding Materials: (Re)Legitimizing Authority in the Context of Multi-Disciplinary. *Sociology*, 38(4), 757-775.
- Latimer, J. (2000). *The conduct of care: Understanding nursing practice*. Oxford: Blackwell Science Ltd.
- Latimer, J. (1995). The nursing process re-examined: enrolment and translation. *Journal of Advanced Nursing*, 22, 213-220.
- Latour, B. (1986). The powers of association. In J. Law (Ed.) *Power, action and belief: A new sociology of knowledge?* (pp. 264-280). London: Routledge & Kegan Paul.
- Latour, B. (1987). *Science in action: How to Follow Scientists and Engineers through Society*. Cambridge, Massachusetts: Harvard University Press.
- Lavis, J. (2006). Research, public policymaking, and knowledge translation processes: Canadian efforts to build bridges. *The Journal of Continuing Education in the Health Professions*, 26(1), 37-45.

- Leape, L., Berwick, D. & Bates, D. (2002). What Practices Will Most Improve Safety? Evidence-Based Medicine Meets Patient Safety. *JAMA*, 288(4), 501-507.
- LeCompte, M.D. (2000). Analyzing qualitative data, *Theory Into Practice*, 39(3), 146-155.
- Lincoln, Y & Guba, E. (2000). Paradigmatic controversies, contradictions, and emerging confluences. In N. Denzin & Y. Lincoln (Eds.) *Handbook of Qualitative Research* (2<sup>nd</sup> Ed.) (pp. 163-188). Thousand Oaks: Sage Publications, Inc.
- Loughlin, M. (2008). Reason, reality and objectivity – shared dogmas and distortions in the way both ‘scientific’ and ‘postmodern’ commentators frame the EBM debate. *Journal of Evaluation in Clinical Practice*, 14(5), 665-671.
- Major, E. & Cordey-Hayes, M. (2000). Knowledge translation: A new perspective on knowledge transfer and foresight. *Foresight*, 2(4), 411-423.
- Manias, E. & Street, A. (2000). Legitimation of nurses’ knowledge through policies and protocols in clinical practice. *Journal of Advanced Nursing*, 32(6), 1467-1475.
- Marcus, G. (1986). Contemporary problems with ethnography in the modern world system. In J. Clifford & G. Marcus (Eds.) *Writing culture: The poetics and politics of ethnography* (pp. 165-193). Berkeley: University of California Press.
- Marriner, A. (1975). *The Nursing Process: A scientific approach to nursing care*. Saint Louis: CV Mosby Company.
- Mathison, S. (1988) Why triangulate? *Educational Researcher*, 17(2), 13-1.
- Mautner, T. (2005). *Dictionary of Philosophy*. Toronto: Penguin Books.
- Mazurek Melnyk, B. (2006). The Latest Evidence on Factors Impacting Nurse Retention and Job Satisfaction. *Worldviews on Evidence-Based Nursing*, fourth quarter, 201-204.

- McCormick, J. & Roussy, J. (1997). A feminist poststructuralist orientation to nursing praxis. In S. Thorne & V. Hayes (Eds.) *Nursing Praxis: Knowledge and Action* (pp. 267-284). Thousand Oaks: Sage Publications.
- McFarlane, C. (2006). Knowledge, learning and development: a post-rationalist approach. *Progress in development studies*, 6(4), 287-305.
- McIntyre, M. (2003). Moving interpretive inquiry out from under a metaphysics of genius into a worldly repose of things: The contribution of Sally Gadow's work to interpretive inquiry. *Journal of Nursing Philosophy*, 4(2), 111-120.
- McMartin, P (2011). New breast cancer screening guidelines full of crap. *The Montreal Gazette*, November 28, 2011. Retrieved from the World Wide Web on December 2, 2011 at: <http://www.vancouversun.com/health/McMartin+breast+cancer+screening+guidelines+full+crap/5780452/story.html#ixzz1gAqxWi82>
- McNabb, R. (1999). Making all the right moves: Foucault, journals, and the authorization of discourse. *Journal of Scholarly Publishing*, 31(11), 20-41.
- Mills, S. (1997). *Discourse*. London: Routledge.
- Mitchell, M. (2009). *Complexity: A guided tour*. Toronto: Oxford University Press.
- Morse, J., Swanson, J. & Kuzel, A. (2002). *The nature of qualitative evidence*. Thousand Oaks: Sage publications.
- Moseley, A. & Tierney, S. (2005). Evidence-based practice in the real world. *Evidence and Policy*, 1, 113-119.
- Mueller, M. (1995). *Organising participation: An ethnography of 'community' in hospital*. Unpublished PhD thesis: University of Edinburgh.

- Munhall, P. (2007). *Nursing research: A qualitative perspective* (4<sup>th</sup> Ed.). Boston: Jones and Bartlett publishers.
- Murphy, M., Petryshen, P., & Read, M. (2004). Retaining and transferring nursing knowledge through a hospital internship program. *Nursing Leadership*, 17(2), 60-68.
- Murray, S., Holmes, M. & Rail, G. (2008). On the constitution and status of 'evidence' in the health services. *Journal of Research in Nursing*, 13(4), 272-280.
- Nagle, L. & Yetman, L. (2009). Moving to a Culture of Nurse as Knowledge Worker and a New Way of Knowing in Nursing. *Studies in Health Technology and Informatics*, 146, 467-72.
- National Forum on Health (1997). *Canada Health Action: Building on the Legacy. Vol. I: Final Report and Canada Health Action: Building on the Legacy: Vol. II: Synthesis Reports and Issue Papers*. Retrieved November 20, 2010 from the World Wide Web at: [http://www.hc-sc.gc.ca/hcs-sss/com/fed/nfh-fns\\_e.html](http://www.hc-sc.gc.ca/hcs-sss/com/fed/nfh-fns_e.html)
- Needham, D. M. (2010). Patient safety, quality of care and knowledge translation in the intensive care unit. *Respiratory Care*, 55(7), 922-928.
- Nelson, S. (1997). Reading nursing history. *Nursing inquiry*, 4(4), 229-236.
- Newton, L. (2010). Candidacy Exams: Defending myself. *International Network for Doctoral Education in Nursing Newsletter*, 9(2), 3-6.
- Newton, L. (2009a). Knowledge Translation and nursing: What are we translating? In conference proceedings of *Building Connections for the Scholarship of Practice*. Victoria, BC: University of Victoria.
- Newton, L. (2009b). Reflexivity, Validity and Roses. *Complicity: International Journal Complexity & Education*, 6(2), 104-112.

- Nightingale, F. (1860/1969). *Notes on nursing: What it is and what it is not*. Toronto: Dover Publications.
- Nilsson Kajermo, K., Bostrom, A., Thompson, D., Hutchinson, A., Estabrooks, C. & Wallin, S. (2010). The BARRIERS scale -- the barriers to research utilization scale: A systematic review. *Implementation Science*, 5(32).
- Oborn, E., Barrett, M. and Racko, G. (2010). *Knowledge translation in healthcare: A review of the literature*. Cambridge, UK.
- Olsen, L. (2002). Ethical climate as the context of nurse retention. *Chart*, 99(6), 3-4.
- Ontario Nurses Association (2011). Replacement of Registered Nurses by Less Prepared Providers. Retrieved from the World Wide Web at:  
[http://www.ona.org/professional\\_practice/resources/Replacement\\_of\\_RNs.html](http://www.ona.org/professional_practice/resources/Replacement_of_RNs.html)
- Oxford English Dictionary, OED (2011). Retrieved from the World Wide Web at:  
<http://www.oed.com.ezproxy.library.uvic.ca/>
- Pablos- Mendes, A. & Shademani, R. (2006). Knowledge translation in global health. *The Journal of Continuing Education in the Health Professions*, 26(1), 81-86.
- Pearson, A., Field, J. & Jordan, Z. (2007). *Evidence-based clinical practice in nursing and health care: Assimilating research, experience and expertise*. Oxford, UK: Blackwell Publishing.
- Pearson, A., Wiechula, R., Court, A. & Lockwood, C. (2007). A Re-Consideration of What Constitutes "Evidence" in the Healthcare Professions. *Nursing Science Quarterly*, 20(1), 85-88.
- Pêcheux, M. (1975). *Language, Semantics and Ideology: Stating the obvious* (English Translation by H. Nagpal). London: MacMillan Press.

- Pêcheux, M. (1994). The mechanism of ideological (mis)recognition. In S. Zizek (Ed.) *Mapping Ideology* (pp. 141-150). New York: Verso.
- Pillow, Wanda S. (2000). Exposed methodology: The body as deconstructive practice. In Elizabeth A. St. Pierre and Wanda S. Pillow (Eds.), *Working the ruins: Feminist poststructural theory and methods in education* (pp. 199-219). New York: Routledge.
- Purkis, M.E. (2003) Moving nursing practice: Integrating theory and method. In J. Latimer (Ed.), *Advanced Qualitative Research for Nursing* (pp. 32-50). Oxford: Blackwell Science Ltd.
- Purkis, M. E. (1999). Embracing technology: an exploration of the effects of writing nursing. *Nursing Inquiry*, 6, 147-156.
- Purkis, M.E (1994). Representations in action: Reorienting field studies in nursing practice. In P. Chinn (Ed.), *Advances in Methods of Inquiry for Nursing* (pp. 13-41). Gaithersburg, Maryland: Aspen Publishing.
- Purkis, M.E. (1993). *Bringing 'practice' to the clinic: An excavation of the effects of health promotion discourse in a community health clinic*. Unpublished PhD Thesis: University of Edinburgh.
- Purkis, M. E. & Bjornsdottir, K. (2006). Intelligent nursing: Accounting for knowledge as action in practice. *Nursing Philosophy*, 7, 247-256.
- Purvis, T. & Hunt, A. (1993). Discourse, ideology, discourse, ideology, discourse, ideology... *British Journal of Sociology*, 44(3), 473-499.
- Quixley, J. (1974). Preface. F. Nightingale's *Notes on Nursing: What it is and what it is not*. Glasgow & London: Blackie & Son Ltd.
- Rafferty, A. M. (1996). *The politics of nursing knowledge*. London: Routledge.

- Reimer Kirkham, S., Baumbusch, J., Schultz, A. & Anderson, J. (2007). Knowledge Development and Evidence-based Practice Insights and Opportunities From a Postcolonial Feminist Perspective for Transformative Nursing Practice. *Advances in Nursing Science*, 30(1), 26–40.
- Reiss, T. (1982). *Discourse on Modernism*. Ithaca: Cornell University Press.
- Richardson, L. & St. Pierre, E. A. (2005). Writing: A method of inquiry. In N.K. Denzin and Y.S. Lincoln (Eds.) *The SAGE handbook of qualitative research, Third Edition* (959-978). Thousand Oaks: SAGE Publications, Inc.
- Risjord, M. (2010). *Nursing Knowledge: Science, Practice, and Philosophy*. Oxford: Wiley-Blackwell.
- Robinson Scovil, E. (1916). The love story of Florence Nightingale. *The American Journal of Nursing*, 17(3), 209-212.
- Robinson Wolfe, Z. (2007). Ethnography: The method. In P. Munhall (Ed.) *Nursing research: A qualitative perspective*, 4<sup>th</sup> Ed. (293-330). Boston: Jones and Bartlett publishers.
- Rodgers, B. L. (2005). *Developing nursing knowledge: Philosophical traditions and influences*. Philadelphia: Lippincott, Williams & Wilkins.
- Rolfe, G. (2006). Nursing Praxis and the Science of the Unique. *Nursing Science Quarterly*, 19, 39-43.
- Rudge, T. (2003). Words are powerful tools: discourse analytic explanations of nursing practice. In J. Latimer (Ed.), *Advanced Qualitative Research for Nursing* (pp.155-182). Oxford: Blackwell Science Ltd.
- Rycroft-Malone, J. (2007). Theory and Knowledge Translation: Setting some coordinates. *Nursing Research*, 56(4S), S78-S85.

- Rycroft-Malone, J., Seers, K., Titchen, A., Harvey, G., Kitson, A., & McCormack, B. (2004).  
What counts as evidence in evidence-based practice? *Journal of Advanced Nursing*, 47(1),  
81-90.
- Rycroft-Malone, J., Harvey, G., Kitson, A., McCormack, B., Seers, K. & Titchen, A. (2002).  
Getting evidence into practice: Ingredients for change. *Nursing Standard*, 16(37), 38-43.
- St. Pierre, E. (2000). Poststructural feminism in education: An overview. *Qualitative Studies in  
Education*, 13(5), 477-515.
- St. Pierre, E. & Pillow, W. (2000) Introduction: Inquiry among the ruins. In E. St. Pierre & W.  
Pillow (Eds.), *Working the ruins: Feminist poststructural theory and methods in education*  
(1-24). New York: Routledge.
- Sackett, D. L., Rosenberg, W. M., Gray, J. Haynes, R. & Richardson, W. (1996). Evidence based  
medicine: what it is and what it isn't: It's about integrating individual clinical expertise and  
the best external evidence. *British Medical Journal*, 312(7023), 71-72.
- Sandelowski, M. (2003). Taking things seriously: Studying the material culture of nursing. In J.  
Latimer (Ed.), *Advanced Qualitative Research for Nursing*, 185-210. Oxford: Blackwell  
Science Ltd.
- Sanne, I., Orrell, C., Fox, M., Conradie, F., Ive, P., Zeinecker, J., Cornell, M., Heiberg, C.,  
Ingram, C., Panchia, R., Rassool, M., Gonin, R., Stevens, W., Truter, H., Dehlinger, M.,  
van der Horst, C., McIntyre, J., Wood, R. and SIPRA-SA Study Team (2010). Nurse versus  
doctor management of HIV-infected patients receiving antiretroviral therapy (CIPRA-SA):  
a randomized non-inferiority trial. *Lancet*, 376(9734), 33-40.

- Schmelzer, M. (1993). Panopticism and postmodern pedagogy. In J. Caputo and M. Yount (Eds.) *Foucault and the Critique of Institutions* (pp. 127-136). Pennsylvania: The Pennsylvania State University Press.
- Selanders, L. C. (2010). Florence Nightingale: The Evolution and Social Impact of Feminist Values in Nursing. *Journal of Holistic Nursing*, 28(1), 70-78.
- Sellman, D. (2005). Evidence-based practice: panacea or meaningless sound bite? *Nursing Philosophy*, 6, 221-222. Pennsylvania: The Pennsylvania State University Press.
- Sherwin, L. (2006). The relationship between UK hospital nurse staffing and emotional exhaustion and job dissatisfaction. *Journal of Nursing Management*, 13(1), 51-60.
- Shojania, K., Duncan, B., McDonald, K. & Wachter, R. (2002). Safe but Sound: Patient Safety Meets Evidence-Based Medicine. *JAMA*, 288(4), 508-513.
- Showalter, E. (1981). Florence Nightingale's Feminist Complaint: Women, Religion, and "Suggestions for Thought." *Signs*, 6(3), 395-412.
- Sidani S. & Gottlieb, L. (2007). Guidelines for translating RCT findings into practice. *Canadian Journal of Nursing Research*, 39(4), 191-197.
- Silvia, P. (2007). *How to write a lot: A practical guide to productive academic writing*. Washington, DC: American Psychological Association.
- Slavin, R. E. (2002). Evidence-based education policies: Transforming educational practice and research. *Educational Researcher*, 31(7), 15-21.
- Smith, H.W. (1975). *Strategies of Social Research: The Methodological Imagination*. Englewood Cliffs, NJ: Prentice-Hall.
- Smirnov, B. (2006). *Principles of statistical physics: Distributions, structures, phenomena, kinetics of atomic systems*. Berlin: Wiley-VCH.

- Snowden, D. (2005). Managing for serendipity: or why we should lay off “best practice” in KM. *Australian Law Librarian*, 13(5), 19-24.
- Storch, J., Rodney, P., Varcoe, C., Pauly, B., Starzomski, R., Stevenson, L., Best, L., Mass, H., Fulton, T., Mildon, B., Bees, F., Chisholm, A., MacDonald-Rencz, S., McCutcheon, A., Shamian, J., Thompson, C., Schick Makaroff, K., & Newton, L. (2009). Leadership for Ethical Policy and Practice: Participatory Action Project. *Canadian Journal for Nursing Leadership*, 22(3), 68-80.
- Strathern, M. (2004). *Commons and borderlands: working papers on interdisciplinarity, accountability and the flow of knowledge*. Wantage, Oxfordshire: Sean Kingston Publishing.
- Strathern, M. (Ed.) (2000). *Audit Cultures: Anthropological studies in accountability, ethics and the academy*. London: Routledge.
- Strathern (2002). (2002) Abstraction and Decontextualization: An Anthropological Comment. In S. Woolgar (ed.) *Virtual Society? Technology, Cyberbole, Reality*, pp. 302–13. Oxford: Oxford University Press.
- Strauss, S., Tetroe, J. & Graham, I. (2009). *Knowledge Translation in Health Care: Moving from Evidence to Practice*. Oxford: Wiley-Blackwell BMJ Books.
- Strauss, S., Graham, I. & Mazmanian, P. (2006). Knowledge Translation: Resolving the confusion. *The Journal of Continuing Education in the Health Professions*, 26(1), 3-4.
- Sussman, S., Valente, T., Rohrbach, L., Skara, S. & Pentz, M. (2006). Translation in the health professions: Converting science into action. *Evaluation and the Health Professions*, 29, 7–32.

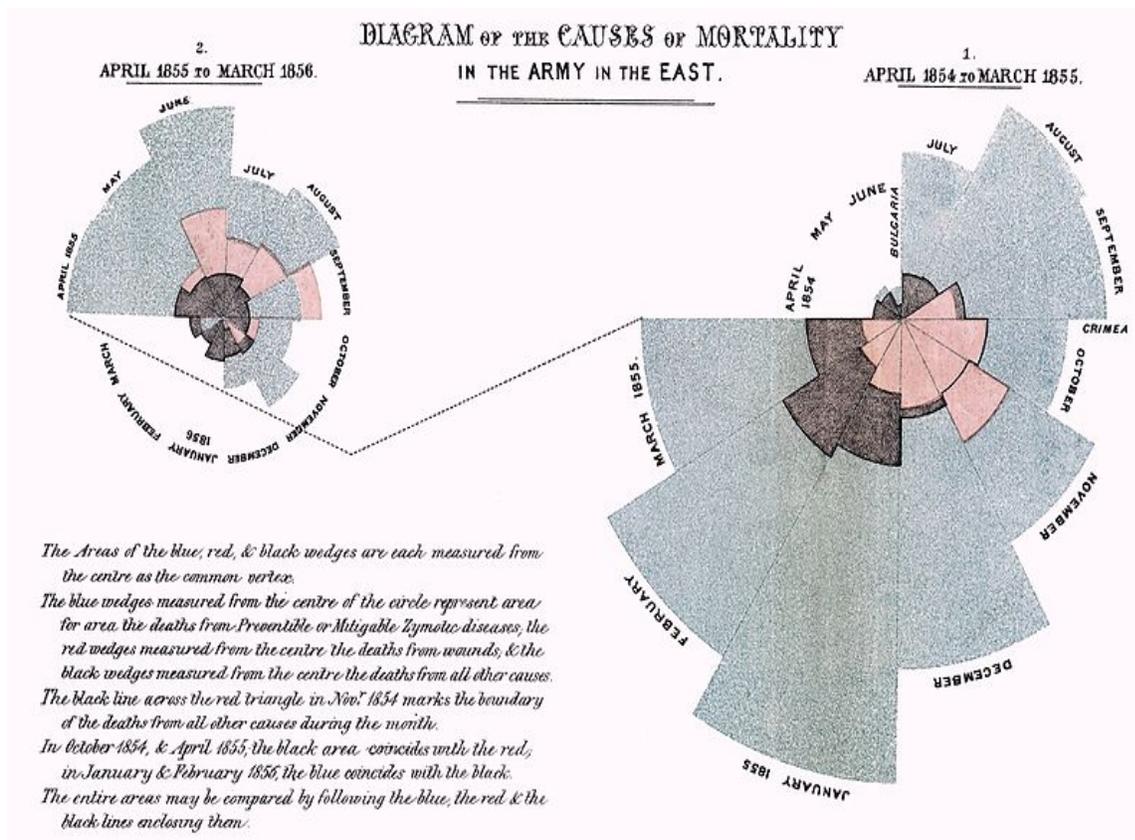
- Tarlier, D. (2008). Mediating the meaning of evidence through epistemological diversity. In P. Reed and N. Shearer (Eds.) *Perspectives on Nursing Theory, Fifth Edition* (365–376). Philadelphia, PA: Lippincott Williams & Wilkins.
- Taylor, S. & Renpenning, K. (2011). *Self-care science, nursing theory and evidence-based practice*. New York: Springer Publishing Company.
- Thompson, P. (1999). Overcoming barriers to research-based practice. *Medsurg Nursing*, 8(1), 59-64.
- Thompson, G.N., Estabrooks, C.A. & Degner, L.F. (2006). Clarifying the concepts in knowledge transfer: A literature review. *Journal of Advanced Nursing*, 53(6), 691-701.
- Thompson, C., McCaughan, D., Cullum, N., Sheldon, T. & Raynor, P. (2005). Barriers to evidence-based practice in primary care nursing- why viewing decision-making context is helpful. *Journal of Advanced Nursing*, 52(4), 432–444.
- Thorne, S. (2009). Ideas and action in a terrain of complexity. *Nursing Philosophy*, 10, 149-151.
- Thorne, S. E., Henderson, A. D., McPherson, G. I., & Pesut, B. K. (2004). The problematic allure of the binary in nursing theoretical discourse. *Nursing Philosophy*, 5(3), 208-215.
- Tilburt, J. (2008). Evidence-based medicine beyond the bedside: keeping an eye on context. *Journal of Evaluation in Clinical Practice*, 14(5), 721–725.
- Timmermans, S. & Berg, M. (2003). *The gold standard: The challenge of evidence-based medicine and standardization in health care*. Philadelphia: Temple University Press.
- Timmons, S. (2003). Nurses resisting information technology. *Nursing Inquiry*, 10(4), 257-269.
- Traynor, M. (1999). The problem of dissemination: Evidence and ideology. *Nursing Inquiry*, 6, 187-197.

- Trueit (2005). Complexifying the Poetic: Toward a *Poiesis* of Curriculum. Unpublished dissertation. Louisiana State University.
- Varcoe, C. (1996). Disparagement of the nursing process: The new dogma? *Journal of Advanced Nursing*, 23, 120-125.
- Vaughan, K. (2004). Total eclipse of the heart? Theoretical and ethical implications of doing post-structural ethnographic research. *Discourse: Studies in the Cultural Politics of Education*, 25(3), 389-403.
- Wall, S. (2007). Nurses' engagement with Feminist/poststructuralist theory: (Im)possibility, fear and hope. *thirdspace*, 7(1), 37-49.
- Wall, S. (2008). A critique of evidence-based practice in nursing: Challenging the assumptions. *Social Theory & Health*, 6, 37-53.
- Weedon, C. (1997). *Feminist practice and Poststructuralist theory*, 2<sup>nd</sup> Ed. Blackwell Publishing: Malden, MA.
- Wenger, E. (2004). Knowledge management as a doughnut: Shaping your knowledge strategy through communities of practice. *Ivey Business Journal: Improving the Practice of Management*, January/February, 1-7.
- Wensing, M., Wollersheim, H. & Grol, R. (2006). Organizational interventions to implement improvements in patient care: a structured review of reviews. *Implementation Science*, 1(2).
- Williams, C. (2004). Preparing the next generation of scientists in translation research. *Worldviews on Evidence-Based Nursing, Third Quarter (Supplement)*, S73-S77.
- Winch, S., Creedy, D. & Chaboyer, W. (2002). Governing nursing conduct: The rise of evidence-based practice. *Nursing Inquiry*, 9(3), 156-161.

Wodak, R. (2009). *The Discourse of Politics in Action: Politics as Usual*. Lancaster: Palgrave Macmillan.

World Health Organization, WHO (2006). *Bridging the “Know–Do” Gap: Meeting on Knowledge Translation in Global Health (10–12 October 2005)*. Geneva, Switzerland: Author

## Appendix A: Diagram of the causes of mortality in the army in the East



Florence Nightingale's 1856 diagram illustrating the causes of mortality of the British army in the Crimean War with different coloured wedges that compared deaths from "Preventable or Mitigable Zymotic disease" (blue), from wounds (red), and from all other causes (black).

Retrieved from: <http://en.wikipedia.org/wiki/File:Nightingale-mortality.jpg>

*Note: This image is in the **public domain** because its copyright has **expired** (copyright is the term of the life of the author plus 70 years).*

## Appendix B: Hierarchy of Evidence

- **Level I:** Evidence from a systematic review or meta-analysis of all relevant randomized controlled trials (RCTs), or evidence-based clinical practice guidelines based on systematic reviews of RCTs
- **Level II:** Evidence obtained from at least one well-designed RCT
- **Level III:** Evidence obtained from well-designed controlled trials without randomization
- **Level IV:** Evidence from well-designed case-control and cohort studies
- **Level V:** Evidence from systematic reviews of descriptive and qualitative studies
- **Level VI:** Evidence from a single descriptive or qualitative study
- **Level VII:** Evidence from the opinion of authorities and/or reports of expert committees

(Mazurek Melnyk, 2006).

## Appendix C: KT+ Alerting System

From: "KT+ Alerting System" <ktplus@mcmaster.ca>  
 Subject: **New Articles From KT+**  
 Date: July 10, 2010 3:56:30 AM PDT  
 To: "Lorelei Newton" <lorelei@uvic.ca>  
 1 Attachment, 3.6 KB

Dear Lorelei Newton

New articles. Your clinical colleagues have found these new articles to be of interest:			
Title	Discipline	R-score*	N-score*
<b>Physician Ratings</b>			
<a href="#">Nurse versus doctor management of HIV-infected patients receiving antiretroviral therapy (CIPRA-SA): a randomised non-inferiority trial.</a>	General Internal Medicine-Primary Care(US)	5/7	5/7
	General Practice(GP)/Family Practice(FP)	5/7	5/7
Powered By 			

\* R-score: relevance to your clinical discipline; N-score: how new is this information?

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Best wishes from KT<sup>+</sup>

Note: if you are unable to access your alert by clicking on the article link, please login directly to KT<sup>+</sup> at <http://plus.mcmaster.ca/KT/> and access the article under 'Alerts' which is listed in the top panel. If you continue to experience difficulties, please contact [ktplus@mcmaster.ca](mailto:ktplus@mcmaster.ca) for further assistance.

**Appendix D: Documents and descriptions of materials used by nurses observed**

1. Best practice guidelines
2. Orientation package (to the organization)
3. Orientation package (for the nursing education session regarding the guidelines)
4. Computer—including electronic patient information records
5. Telephone: each nurse has her own telephone (and computer) in her own cubicle
6. Pager: each nurse in the nurse-run clinic carries a pager
7. Patient education binder and teaching handouts
8. Patient chart
9. Protocols
10. Policies
11. Patient referral form
12. New patient admission form

## **Appendix E: Interviewer Guide**

### **Guide for Interviews with Nurses**

1. Tell me about what ‘knowledge translation’ means to you?
2. How do you decide to use research (as ‘evidence’) in your practice?
3. Do the best practice guidelines make sense in your everyday practice?
4. Tell me about your experiences using the best practice guidelines.
5. Can you give me an example of when you used the best practice guidelines?
6. Have these guidelines been helpful?
7. How so? (Following up from yes or no answer of previous question)
8. What difference have they made in your everyday practice, if any?
9. Do they make sense for how you practice? In what ways (or not)?

### **Guide for interviews with nurses’ colleagues**

1. Tell me about what ‘knowledge translation’ means to you.
2. How do you decide to use research (as ‘evidence’) in your practice?
3. Can you tell me about the new best practice guidelines that the nurses are using?
4. Do you think these guidelines are helpful?
  - a. How so (or not so)?
  - b. How do we know?