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I see and I remain silent

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Table of Contents

Acknowledgements 3
Abstract 4
Methods 6
Theory and Context 8
Ontological Examination of Discourse 10
Epistemology: Clinical Practice and the Discourse of Silence 12
Ethics: The Silencing of the Voice of the Nurse 21
  Silent Advocacy 23
Recommendations for Action 29
Conclusion: The Power Beyond the Silence 32
References 33
Appendix A 41
Appendix B 48
Appendix C 56
Appendix D 58
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Abstract

The discourse of silence in nursing is ubiquitous. This dominant and domineering discourse is insidiously embedded in nursing practice. In this paper, I examine the ontological, epistemological, and ethical constructs of the discourse of silence in nursing, using a feminist lens to guide critical reflection. Select literature, personal reflections, and experiences in the home care nursing environment are incorporated into the discussion. Identification and analysis of the literature follow an integrative review process. Pervasive, insidious, and invisible the discourse of silence arguably constitutes a dominant discourse. Dominant discourses and ideologies entrenched in this discourse are exposed within the examples provided. Questions are posed throughout the paper not to find answers but to stimulate thinking. Suggestions to actively move this discourse in nursing from silence to voice are proposed.
I see and I remain silent

Silence is embedded in the cracks and crevices of all nursing discourse. At times, a discourse of silence exists benignly and functions as a gentle human presence to alleviate suffering (Russo, 2002). This same discourse, however, has another side that emerges as a malevolent force, cloaking our profession in quiet as the voices of nurses are silenced. “I see and I am silent.” This was the mission statement in 1874 for the first Nightingale School of Nursing in Canada located in St. Catharine’s, Ontario. I believe it was a powerful statement that was indicative of the societal expectations of the very first professional nurses in Canada (Rankin, 1988, p. 7). Arguably, this might be the beginning of the silence in the discourse of nursing.

Discourse is fundamental to our everyday lived experience and our understanding of the world; contextual and historical, rough and refined, silent and deafening. Although discourse represents all that we know and understand about a subject, it remains an enigma, defying articulation while being continuously rewritten, embedded as it is within the context of everyday life (Mantzoukis & Wilkinson, 2008). The discourse of silence is linguistically based, invisible, and yet powerful when employed intentionally to provoke response, silence dialogue, or inspire new thinking (Kurzon, 1997). Silence thrives in nursing practice fueled by ideologies grounded in power (Canam, 2008; Ceci, 2003). Silence is also a shelter for power within all discourse (Foucault, 1978). By examining the power inherent in these layers of silence, and using the lenses provided by ontological, epistemological, and ethical frameworks, in this paper, I provide an opportunity for nurses to reflectively analyze this discourse that arguably dominates our profession. Using feminist theory as a perspective by which to explore this discourse, I begin with an examination of the ontology of discourse and the discourse of silence. As a form of
natural progression, the epistemology of the discourse of silence is discussed using select evidence to guide the discussion. Ethics and advocacy in my personal practice environment of home care nursing are then examined in relation to this discourse. Lastly, strategies to mitigate the silence are proposed.

In this paper, I chronicle my personal exploration of a dominant discourse which I believe has impacted nursing practice for generations. As a critical reflection, I encourage active engagement with the on-going conversation on the discourse of silence in nursing to stimulate thinking and provoke voice. Concrete examples provide a stimulus for discussion, with hopes that over time reflection and discussion may pierce the silence. As my purpose is to engage readers in the spirit of critical reflection and inquiry about this pervasive discourse, I present opportunities throughout the following discussion for nurses to reflect on their personal experiences. In order to examine the complexities of this discourse, my methodology includes a non-traditional framework where I use a theoretical lens to de-construct, re-construct, and integrate theory with practice thereby provoking, prodding but not limiting critical thinking. Both methods were used judiciously to develop this discussion.

Methods

The identification of the literature and the consequent analysis of the literature followed an integrative review method. Integrative reviews incorporate theoretical, historical, and empirical data to allow the writer to gain an understanding of a concept, phenomenon, or nursing issue (Whittemore & Knafl, 2005). Consistent with this method, an integrative literature review incorporates data from 2-3 databases (Whittemore & Knafl, 2005). In the literature search, I used two electronic databases, the Cumulative Index to Nursing and Allied Health Literature
(CINAHL) and Medical Literature On-line (MEDLINE). Search words included silence*, silencing*, nursing*, discourse* and nursing practice*. Additionally, an advanced search using Google Scholar was conducted. A total of 28 sources were reviewed. Each article was then examined to determine the frequency that it was cited in scholarly works. I did not place a limitation on the articles identified based on date of publication. Articles of historical relevance to this discourse were included in the dialogue to situate the discussion within the historical roots of the profession. Each article was selected to align with the discussion using a feminist lens (see Appendices A and B for details).

Traditional conceptual frameworks that rely on deductive reasoning seem always to carry the potential to limit analysis. Unlike inductive reasoning, which works toward conclusions (or theories), methodologies using deductive processes work from conclusions which however speculative, are hypotheses ultimately supported or falsified through the research process (Carmen, Profetto-McGrath, Polit & Beck, 2007). With respect to the discourse of silence in nursing, such methods restrict active engagement and critical reflection by excluding information that defies logic (McIntyre & McDonald, 2010). For these reasons, among others, McIntyre & McDonald (2010) proposed a comprehensive framework by which to examine, articulate, and analyze complexities in nursing practice and arguably the discourses and ideologies embedded in nursing discourse. The authors’ use of logic is clearly seen in the framework and yet the logic does not exclude other relevant sources of information such as socio-political variables and contextual variants. Because this framework fits the purpose of this discussion and remains consistent with my intent to foster engagement and inquiry, I use it in what follows to examine the discourse of silence in nursing.
Theory and Context

Nursing is primarily a female profession. A central tenet of feminist theory is that it is “women centered” (Wuest, 1994) examining the experiences of women, not to subjugate men, but to actively advocate for the female gender and for all persons and races (Ceci & McIntyre, 2001; Miller, 1997). As Chinn writes, “Feminism values and endorses women, critiques male thinking, challenges patriarchal systems, and focuses on creating self-love and respect for all others and all forms of life” (Chinn, 1987, p. 23). As such, feminist theory provides an appropriate means of investigating a discourse of silence with roots in the patriarchal domain of western medicine (Bunting & Campbell, 1991; Rankin, 1988). A family of feminist theories exists (Bunting & Campbell, 1991; Hoffman, 1991). As my intent is not to restrict thinking but to incorporate the lived experiences of all, this family of theories provides a perspective from which to view this complex discourse.

Bunting and Campbell (1991) describe feminist theory as a totalizing theory which investigates and considers the lived experiences of women. As a body of social research and a discourse of its own, feminist thinking rejects dichotomies and exclusive ideals focusing on values that exist simultaneously in professional and personal lives, in theory and practice, where the knowing and the doing are the same (Bunting & Campbell, 1991). Valuing the historical and socio-cultural analysis of gender relations, scholars use feminist theories to examine the evolution of experience, knowledge, truth, and relationships (Bunting & Campbell, 1991). Most importantly perhaps, feminist theory when applied in nursing provides an approach to deconstruct power inherent in nursing practice and to build momentum for the creation of a voice within the technical world of clinical practice. Such a voice bridges the gap between the doing or
I SEE AND I REMAIN SILENT

technical discourses and the caring discourses (Canam, 2008). It is that voice which will facilitate change within the health care environment.

Historically speaking, nursing evolved as a gendered profession tied closely to the dominant discourses of femininity, mothering, and patriarchy (Harding, 2007; Wuest, 1994). As such, I believe as others do that these dominant discourses fostered a sense of powerlessness and silence that became entrenched in nursing practice (Bunting and Campbell, 1991; Enns, 2004). And whereas voice is often viewed as a vehicle of self-expression, determination, and confident knowledge, silence is equated with this powerlessness and passivity (Gardezi et al, 2009). Moreover, because a good nurse was seen as feminine, inherently passive and nurturing, she was explicitly powerless and remained silent in her nursing practice (Bunting & Campbell, 1991; Enns, 2004).

In this traditional narrative, nursing has oftentimes been perceived as an oppressed profession subordinate and subservient to a powerful, male dominated biomedical health care model (Bjorklund, 2004; Wuest, 1994). Nurses have been socialized and educated to preserve the status quo and to support the male-dominated system of health care, thus denying their own experiences (Chinn, 1987). Oppression “results from dominating patterns of ideas or structures that characterize, normalize, and perpetuate unequal relationships and role determination within a social system” (Duchsher & Myrick, 2008, p. 194). Such oppression also mends people to certain groups in ways that effect their subordination (Kendall, 1992). For instance, not dissimilar to women who became nuns, nurses were “called” to a vocation. Yet its station as a calling cast nursing and its denizens as altruistic and selfless, a perception that effectively deepened the oppression (Rankin, 1988). Further confounding the situation, nurses unable or
unwilling to articulate the nature of their work, were conditioned and socialized to believe in the subordinate and subservient nature of their work and their role in healing and society in general (Lovell, 1981; Rankin, 1988). I believe that unable to articulate the nature of their work, and socialized to believe in the subordinate and subservient nature of their role in society, the voices of many nurses remain cloaked in silence.

As Bjorklund writes, “Nursing work is invisible not only by virtue of its (gendered location) but also by virtue of its nature and its social valuation” (2004, p. 11). In our inability to articulate the nature of the relational work, the caring that we provide, this work remains uncounted, devalued, and silenced (Bjornsdottir, 2009). This “women’s work” or “caring labor” (MacDonald, 2007; MacKinnon, 2009) has been described as the work of nursing, but it has also been associated with work that is performed in exploitive and oppressive environments (Harding 2007; MacKinnon, 2009). The work that is not seen or counted is not valued (Bjorklund, 2004; Rodney & Varcoe, 2001). Investigating the invisibility of this work without the benefit of feminist theory may further devalue the role of women, objectifying their experiences and silencing their voices (Brown, 2006). But what is discourse and more importantly what is the discourse of silence?

**Ontological Examination of Discourse**

Without ontological definition and the awareness of what *is*, the epistemological process and the evidence it produces has no context; in other words, without registering what *is*, there is no framework, no purpose, for the epistemological question of *how* we know it. What is discourse? What is the discourse of silence? Discourse is embedded in the everyday lived experiences of individuals and society; it extends beyond text, narrative, and discussion to
include those underlying values, beliefs, and assumptions that form our knowledge of the world. Discourses exist in our perception of reality as interactive, engaging elements, which Mantzoukis and Watkinson (2008) have described as the “mouthpieces” of ideologies (p. 130). As a product of the human mind – and, in fact, many human minds converging and diverging – discourse, like the mind, is dynamic and inherently complex. Mantzoukis and Watkinson (2008) gesture toward this complexity by characterizing discourse as a “mechanism for describing daily reality” (p. 129). However, they elide the fact that discourses are systems within systems interacting between and amongst each other. Certainly, as Mills suggests, discourse acts as a “vehicle for communication” (2004). McCloskey (2008) offers a more compelling definition in writing that discourse acts as “a belief, practice, or knowledge that constructs reality and provides a shared way of understanding the world” (p. 24). Although discourse is a form of language use (van Dijk, 1997), I argue that discourse also includes the ideas propagated and constructed by that language, as well as the attitudes and belief systems encompassed in and, most importantly, instituted through it. Ideologies co-exist with discourses and are embedded in discourse.

Ideology, by definition, is “a set of closely related beliefs, attitudes, or ideas characteristic of a societal group or community” (Browne, 2001, p. 119). Discourses provide the “threads from which ideologies are woven” (Browne & Smye, 2002, p. 30).

Power is an inherent part of discourse (Mills, 2004) and certainly power fuels ideology. Language, social interaction, dominant ideas, and beliefs work together to construct a society’s, or a professional discipline’s epistemology, and thus have the capacity to influence individuals and society as a whole (Fejes, 2008; McCloskey, 2008). Power has the capacity to limit discourse through rules and laws, both explicit and implicit, that influence and control everyday
activities. Some of these rules are historically grounded; some are legally enshrined and instituted through social structures like education, religion, and economic systems and still others are insidiously reinforced by our individual attitudes and systems of belief.

An array of discourses have impacted nursing practice (Crowe, 2005). These include medicine and feminist discourses (Crowe, 2005). Interestingly, discourses within nursing influence its practice; the practice, in turn, further influences the discourse (Crowe, 2005). This feedback mechanism is both intentional and subtle. “[T]here is no inside that is not already an operation of the outside” between, among, and embedded in all discourses (Ceci, 2003, p. 69). Arguably, the discourse of silence exists linguistically and relationally within all discourses. This discourse is intentional and visible; unintentional and invisible but always powerful.

The discourse of silence exists as a form of natural pause in language, as a form of interaction, or as a cultural code in the silence of prayer (Kurzon, 1997). The discourse of silence has been defined as a question left unanswered, a whisper, avoidance of a topic in conversation, irrelevant talk, or a frozen gesture (Kurzon, 1997). For my purposes in this paper, the discourse of silence is defined as “a position of not knowing in which the person feels voiceless, powerless, and mindless” (Goldberger, 1996, p. 4). While this discourse exists unintentionally in the powerless silence of those too fearful to speak, it also exists maliciously through intentional silence (Kurzon, 1997; Rankin, 1988). Power is embedded in the unintentional and intentional silence (Kurzon, 1997). Arguably, both forms of silence exist in nursing and are powerful influences in nursing practice. But what is known about this discourse and what is the epistemological foundation of this discourse?

**Epistemology: Clinical Practice and the Discourse of Silence**
Epistemology, in itself, has been described as “the study of knowledge” (Rodgers, 2005, p. 13) and how we come to know what we know. While the study and practice of nursing can, and does boast a growing body of clinical and professional literature, the discourse it represents has a unique quality that distinguishes it from other clinical and disciplinary fields. Nursing has a discourse of silence. What is known about the silence in nursing discourse? An interest in the forces of silence has emerged in the nursing profession—enough so that a growing body of work now constitutes silence as a discourse in its own right. The discourse of silence is linguistically based (Kurzon, 1997). This discourse exists as a “position of not knowing in which the person feels voiceless, powerless, and mindless” (Goldberger, 1994, p. 4). In everyday nursing practice, this discourse exists in the quiet, peacefulness of a healing silence both intentionally and non-intentionally, with words and without, in what is known as an authentic silence (Russo, 2002). By contrast, this discourse also exists much more maliciously in the silence that stifles and smothers thinking, both intentionally and unintentionally, with or without words in all practice areas. In what follows, I examine select discussions emerging in the literature that surround the discourse of silence in the world of nursing practice.

Ann Romano (2009) writes, “The culture of nursing promulgates silence as virtue and speaking out as dishonor to all nurses” (p. 47). The culture of nursing and the practice of silence have deep historical roots. In fact, the first professional nurses pledged to maintain silence (Herman, 1985; Rankin, 1998). This silence may have been innocuous and consistent with what was the only good female deportment of the day, but over time, the swallowing of words and the silent presence of the nurse was preferred and, ultimately, normalized. In fact, silence became both expected and accepted as a dominant discourse in nursing practice (Bradbury-Jones,
Sambrook & Irvine, 2008). If as Mantzoukis and Watkinson (2008) propose, discourses are the mouthpieces of ideology, what ideologies are embedded in a discourse that enshrines silence as a professional code of behavior, much less a personal mark of character and knowledge? The following examples from clinical practice highlight an array of ideological elements that contribute to the discourse of silence.

Faudia Gardezi et al. (2009) examined silence in the operating room, specifically silence as it pertains to behavior and episodes of communication between nurses and surgeons. In this retrospective study, the researchers observed the non-verbal interactions between nurses and surgeons in some 700 procedures over a period of time from 2005-2007. Using a critical ethnographic perspective, Gardezi and her colleague’s analyzed examples of dialogue between nurses and surgeons which remained unanswered, vague or unspoken. Three distinct patterns of silence emerged from the data: “absence of communication; not responding to queries or requests; and speaking quietly” (Gardezi et al., 2009, p. 1390). In observed and documented instances, surgeons chose to not respond when specific questions were posed by nursing staff. In other instances, they responded with barely discernable whispers which were unintelligible and disconcerting in their effect on the nurse trying to function in her role.

In this study, silence in the operating room is linked to powerlessness that results from broader institutionalized power dynamics. The authors suggest that “silence may be a means of exerting power over others, a reflection of relative powerlessness, or a means of resisting power” (Gardezi et al., 2009, p. 1392). In fact, the power of the silence in speech, the usurping of expectation, does not live with the words that are spoken, or not spoken, but rather in the perceived social power of the person involved in the dialogue (Gardezi et al., 2009). The upshot
is that silence becomes an instrument both produced by, and a product of, the power dynamics inherent in the larger institution.

The power gradient also varied dependent on the context of the conversation. For example, power struggles between surgeons and nursing staff were more explicit when nurses pursued institutional rules in the practice environment (Gardezi et al., 2009). In some ways, the nurses were wielding the power vested in institutional rules. Surgeons did not respond favorably, or they did not respond at all. Ultimately, the surgeons relented to the rule but they did not respond to the messenger. For example, the researchers observed and recorded a dialogue relating to a common patient safety protocol in the operating room called a surgical pause. In the surgical pause, the team reviews key details of the case prior to commencing surgery. This is an example of the silence in this environment:

Everyone is in place to begin the surgery.

The anesthesiologist is chatting with the surgeon.

Circulating nurse: [quiet voice] ‘Surgical pause, please’.

Scrub nurse: [repeats, also quiet] ‘Surgical pause, please’

The surgeon relents and responds only when the scrub nurse with scalpel in hand repeats once again ‘Surgical pause’? (Gardezi et al., 2010, p. 1395).

The researchers observed many instances of silence between physicians and nursing staff in interactions seemingly mundane but necessary to maintain professional nursing standards in this environment such as instrument counts, sponge counts and efforts made to maintain sterility (Gardezi et al., 2010). Interaction is by definition dependent on at least two parties exchanging some expected form of communication (usually verbal in a professional practice environment),
without which communication is limited or distorted. The quiet or silent communication of the surgeons, although unspoken, speaks loudly and delivers a myriad set of messages. Quiet is often associated with passivity, and a traditional view of silence (Gardezi et al., 2009). The observers reported that the nurses’ voices were frequently quiet. In this instance, the researchers linked the quiet tone of the nurses’ voices with a sense of subordination and “an actualization of structured power dynamics; those social, historical, cultural and institutional factors that are reproduced on a daily basis” (Gardezi et al., 2010, p. 1397). Thus power brokered through broader institutional structures, historical roles and relationships command silence even in the highly technical environment of the operating room.

Another example of the discourse of silence is evident in the work of Connie Canam (Canam, 2008) who explored the challenges of power dynamics in clinical practice environments through an examination of the roles of clinical nurse specialists (CNS). The clinical nurse specialists in this study worked in specialized areas of pediatric acute care. Yet, it became readily apparent that these advanced practice nurses struggled with articulating the nature of their work. Although, they described their work as primarily relational in nature, this work was usurped by a technical, bio-medical discourse that dominated their particular practice environment. They described feeling pressured to speak a language which did not adequately represent all forms of clinical knowledge. In privileging the objective/technical knowledge, the so-called soft knowledge of subjective/experiential knowing was neglected or marginalized. Regardless of the levels of individual knowledge or experience, when their practice is aligned with this subjective knowledge, the CNS group described feeling disempowered, by both language and, as importantly, their colleagues, who gravitated to the dominant bio-medical discourse.
The official language of health care is the language of medicine (Buresh & Gordon, 2000; Elliot, 1989). This language is linked to the male dominated institutions of health care which discount subjective forms of knowing and sanctify empirical, thus objective forms of knowledge (Buresh & Gordon, 2000; Elliot, 1989; Smith, 1999). Smith (1999) suggests that women are caught in a split relationship with language because subjective forms of knowledge provide evidence of their lived experiences, yet objective knowledge is the language endorsed and recognized by those with power. “Power is maintained and re-produced through knowledge, it is also central to the maintenance and reproduction of power relations” (Canam, 2008, p. 299). I propose from this dialogue that power predicts and enforces which discourses remain dominant.

It has long been recognized that nurses practice in an environment dominated by medical discourse (Bjornsdottir, 1998; Canam, 2008; Kagan & Chinn, 2010). The objective/technical nature of this discourse has fostered a system of nursing practice reinforcing traditional, gender-related values of efficiency and a task orientation over relationships. Further reinforcing a nursing narrative of powerlessness and passivity, the subjective/experiential knowledge is lost in the wake of the quantitatively-derived and technically-driven knowledge readily captured in statistical data. Indeed, the latter is the fuel of an on-going health care debate (Kagan & Chinn, 2010). For nursing practice itself, Canam (2008) proposes that an answer to this conundrum lies in the development of a knowledge-based discourse which for nursing would provide a voice for nurses to articulate the nature of their work. This knowledge-based discourse “shifts focus away from what nurses do to what nurses know by promoting nurses’ practice knowledge as a language for articulating their practice” (Canam, 2008, p. 296). This unique language creates a voice for nursing practice.
A further example, using an ethnographic research design, is that in which Bjornsdottir (1998) examined the patterns of communication between nurses on two general surgical units in an acute care hospital in Iceland. Bjornsdottir (1998) found that the public discourse (documentation, report, meetings) on nursing focused on medical treatments (Bjornsdottir, 1998). This discourse was characterized as mechanical and distant and included sterile descriptions and de-personalization: “the first patient in the bed by the door of 501 is a 62-year old man who was operated on yesterday” (Bjornsdottir, 1998, p. 354). Patients were objectively identified by descriptions of fluid consumption, urinary drainage, medications and treatments in a depersonalized manner. By contrast, the private discourse between nurses focused on changes and transitions in patients’ lives, and responses to health care challenges (Bjornsdottir, 1998). Bjornsdottir questioned why nurses remain silent in the context of their practice, but readily expressed themselves between and among themselves. What were the origins and imperatives of this private discourse?

Bjornsdottir (1998) suggests the answer may lie in looking to the traditional and social context of our work. The public discourse is focused on efficiencies. The private discourse is focused on the concerns of the patient but is not captured in the organizational plan of care. This is a private matter developed collaboratively between the individual patient and nurse. Because the spotlight of objectivity shines on the language and provides for an overriding focus for public discourse, it contrasts sharply where and when subjective experience is the frame for private discourse between nursing staff. Objective data is easily measured, and even hundreds of years post-Enlightenment, quantitative data are the prize of the empiricist values that remain the rock solid foundation of modern-day science and medicine. Subjectively-derived knowledge which
feeds the human and humane aspects of nursing not only defies traditional metrics, but lacks currency where the biomedical paradigm and its reliance on objective data can still reign supreme. But this cultural and professional reality places nursing between two hard places. Nursing embraces the language of science to facilitate the transfer and analysis of biomedical knowledge but the “stuff” of our practice is the caring we provide. Why are we silent about the work of our caring? And what dominant discourses and ideologies propagate that silence? Canam (2008) suggests that the biomedical paradigm which foregrounds our work does not recognize or value the relational nature of our practice. Similarly, Bjornsdottir (1998) asserts that nurses “have found themselves in a system where primary emphasis is placed on technical efficiency, frequently at the cost of human relations” (p. 350).

Human relations form the heart of nursing practice and professional identity (Holmes, Roy, & Perron, 2008). Language is essential in shaping that identity (Bjornsdottir, 1998). The public discourse identified in this study articulated “an instrumental discourse, where objectivity and efficiency are of central value” (Bjornsdottir, 1998, p. 359). But as Bjornsdottir is quick to point out, as a profession, we need to examine all discourses in our practice. In doing so, we should “ask ourselves to what extent these discourses foster and enhance nursing practice that is morally valued” (Bjornsdottir, 1998, p. 359). And what are those ideological elements which empower, and disempower the discourse of nursing?

Kagan and Chinn (2010) discuss those elements that constrain nursing discourse disempowering and limiting the voices of nursing. Specifically, those elements that prevent the voices of nurses “to be listened to and taken seriously, being paid attention to on a sustained basis, and having nurses’ knowledge and expertise be unquestionably valued and influential”
I SEE AND I REMAIN SILENT

(Kagan & Chinn, 2010, p. 42). Passive and voiceless, nurses resist the power that constrains their voices. They do this silently by breaking rules behind the scenes, with “whatever they can get away with” to foster patient care (Kagan & Chinn, 2010, p. 44). Kagan and Chinn (2010) offer a further example of the discourse of silence in practice environments, and it is one that resonates with all nurses when we hear the phrase, “We are all here for the good of the patient.” This phrase silences nursing issues at the point of direct care (Kagan & Chinn, 2010). Nursing-specific issues are rejected or, at least, trivialized by this trite remark. Through this patient-centric focus, which carries with it the unimpeachable interests of the patient, patient issues take precedence over nursing issues, which tend to be invalidated in the process. Moreover, there is an inherent conflict built into the patient-first value proposition. How can a good nurse claim an issue more important than the needs of the patient? But in fact, such a statement is “essentially a power-play to disarm people and deflect their attention away from something that they think is really important to them, but the other party does not want to hear it” (Kagan & Chinn, 2010, p. 41). This trite remark creates a “triangulating dance” (Kagan & Chinn, 2010) whereby the original nursing issue is subversively lost in a dialogue of twists and turns. The needs of the patient are undeniably important, but the abstraction does disservice to the context of the issue at hand. Nursing issues are silenced at the point of direct care when patient issues supersede all dialogue discrediting nursing practice concerns and disempowering the voice of nursing.

A further example of the discourse of silence in clinical practice is the silence of healing or authentic silence (Russo, 2002). Care in the world of medicine has been linked to diagnosis but “nursing care is oftentimes silent expressing itself through gestures” (Russo, 2002, p. 113). A healing silence has been linked to those gestures of care which occur silently in the peaceful
presence of a nurse at the bedside of a palliative patient or those gestures of care evident in the highly technical world of acute care. Are we caught up in those gestures of healing cultivated by our historical roots and the societal expectations of our practice? Or have we forsaken our historical roots caught up in the frenzy of our current practice environments that demand efficiency? Have we forsaken our voices in order to facilitate technology and efficiency and lost those elements historically associated with caring such as human touch?

All examples are mired in the challenges of our ability to use language to voice our issues (Bjornsdottir, 1998; Canam, 2008), and to articulate the relational nature of our work (Canam, 2008). Ideological constraints of gender, medicine, and our historical roots whereby passivity and voicelessness were expected continue to plague our current practice environments. We continue to “play nice” (Chinn, 1987, p. 23) to care for our patients in a system which disempowers our voice. However, “nursing is being controlled for us by forces beyond simply a desire to care” (Wuest, 1994, p. 359). Naughtily, we break rules, in order to provide nursing care (Kagan & Chinn, 2010). But in breaking the rules, we are unable to give voice to those issues that undermine our practice environments. And the system which commands silence propagates silence further deepening the oppression and those ideologies which dominate the discourse. Is the discourse of silence in nursing “voiceless, powerless and mindless” (Goldberger, 1996, p. 4)? We do communicate but who listens? (Elliot, 1998). More importantly, what propagates a discourse of silence in our practice environments and how does this discourse influence the moral and ethical heart of nursing practice.

**Ethics: The Silencing of the Voice of the Nurse**
“Nursing is by nature a moral endeavour” (Sartorio & Zoboli, 2010, p. 687). In nursing practice, ethics are embedded in our code of conduct and in our standards of professional practice. As such, ethics provides for us a moral compass to determine what is and is not acceptable behaviour. Our moral fibre, based as it is on our ethical concerns, finds its voice in the practice of advocacy. Within the discourse of ethics and the practice of advocacy, however, there is another discourse: the discourse of silence. Kurzon (1997) links the discourse of silence to language and communication. As previously defined, if the discourse of silence in nursing is “voiceless, powerless and mindless” (Goldberger, 1996, p. 4), what does our silence suggest about our abilities to communicate our moral agency and more specifically advocacy? How can we advocate for our patients, for society, and our profession if we remain silent? And do we relinquish the power of our collective voices with our silence and in doing so do we give power to others to direct us?

Power means
you take your choice
of exercising
will and voice;
unless, of course,
in mute submission
you wait until
you have permission
In the preceding sections, I examined the ontology of discourse, the discourse of silence and the epistemology of the discourse of silence. In this section of the discussion, I engage in a personal exploration of ethical incongruencies that exist in relation to the discourse of silence in my personal practice environment of home care nursing.

**Silent Advocacy**

The discourse of silence in nursing has strong feminine roots beginning with Nightingale (Rankin, 1988). Nightingale demanded silence from those early nurses. For example, as written by Stanley and Sherratt (2010) “…Florence insisted that nurses were not to speak with medical officers, to speak only soothingly to patients and avoid talking with them unnecessarily” (p. 116). In fact, prior to the 1960’s, “nurses were socialized to work hard, do as they were told and keep quiet” (Lovell, 1981, p. 25). Professional behavior included and encouraged self-sacrifice and dedication. In addition, “to be professional was also to be apolitical” (Lovell, 1981, p. 25). Powerful ideologies seated in a patriarchal health care model that endures today rendered those early nursing voices silent and the silence continues.

Current health care reform has been fueled by equally powerful neo-liberal ideologies based on the system’s ability to meet service demands (Peter, In Press; Varcoe & Rodney, 2009). Neo-liberal ideologies “emphasize the importance of the autonomy and the rights of citizens to decide upon their own destiny” (Bjornsdotir, 2001, p. 5). As such, this view of fair distribution of goods espouses a system whereby “what one puts into the market one gets out” (Peter, p. 250, In Press). Health care is viewed as a source of inefficiency and waste in neo-liberal thinking (Peter, In Press). As above, congruent with globalization, fiscal restraint, and cost recovery, this corporate ideology has taken root in Canada (Rodney, Buckley, Street, Serrano & Martin, In
Press; Varcoe & Rodney, 2009). Our current health care system is fueled by the corporate structures and the messaging I believe it employs. The messaging is relentless and I would argue embedded in the discourse of silence.

An equally powerful ideology born from current health care reform and political conservatism is that of an ideology of scarcity. Nurses are bombarded on a daily basis with the notion that resources are unduly limited (Varcoe & Rodney, 2009). A business model of production, statistical analysis, and efficiency has turned care into a fast-paced assembly line (Bjornsdottir, 2009; Varcoe & Rodney, 2009). Managers govern nursing environments using a business model of tasks, time lines, and cost recovery entrenched in a language previously equated with the business world. Staffing practices and service levels have become more complex as registered nurses are replaced with unskilled and less costly unlicensed care providers (Bjornsdottir, 2001, 2009; Rodney, Buckley, Street, Serrano & Martin, In Press; Varcoe & Rodney, 2009).

All nursing sectors have experienced the influence of the neo-liberal agenda on healthcare, but the influence is felt strongly by those in home care settings (Peter, 2011, In Press). Home care nurses, like their acute care counterparts, are functioning beyond one hundred percent capacity. They have become the gatekeepers of home support services, nursing resources, and equipment (Bjornsdottir, 2009; Purkis, 2001). Home care nurses silently adhere to the rules embedded and artfully crafted by a corporate mantra. Voices are muffled in the corporate ethos of scarcity. I question whether advocacy can survive and at what cost.

I believe that advocacy does exist in everyday ethics but is the advocacy that exists aligned with a discourse of silence. The Canadian Nurses Association Code of Ethics defines an
advocate as someone who “acts or supports a good cause; supports others in speaking for themselves or speaking on behalf of those who cannot speak for themselves” (Canadian Nurses Association, 2008, p. 29). An advocate is a nurse who “actively support[s] patients in speaking up for their rights and choices, in helping patients clarify their decisions, in furthering their legitimate interests, and protecting their basic rights as persons, such as privacy and autonomy in decision making” (Hamric, 2000, p. 94). Might advocacy itself contribute to the overall moral residue, moral distress, and silencing in nursing practice? In our need to be good, and do the right thing, are we punished for those thoughts, actions, and even our inaction (Sartorio & Zoboli, 2010)?

An example of our need to do the right thing, and the moral distress caused by our inability to do so, can be seen in the following example. The costs of caring for a nineteen year old severely handicapped young woman/child, who is transitioning from the child and youth program to the adult program for her complex care needs, offers an example of the human and humane costs of care. Previously cared for at home by her mother and a team of registered nurses for respite, the cost of these registered nurses was considered beyond “the resource capacity” of the adult program. The complexity of the care was significant. However, the funding evaporated when the young woman became an adult. Advocating fiercely for the young woman, the home care nurse’s voice was muffled by the much louder rules regarding the distribution of resources. The home care nurse articulated her recommendations in a report but was questioned by the manager and the director about her decision-making. Who has the right to decide how resources are allocated? As a marginalized, now-adult, individual cared for by her mother since birth, who
now speaks for the patient as an adult and her mother? Justice, fair distribution of resources based on need rather than an arbitrary definition based on chronological age, was denied.

A further example of the limitations imposed by an ideology of scarcity is the funding for wound care products for patients at home. A stringent and restrictive policy exists whereby all wound care products must be purchased by patients and families in the home care environment. These products are available without charge in acute care. Oftentimes, nurses engage in conversations with families about cost. In the dialogue, the care is lost as nurses deal with the anger this policy creates....silenced by the rules. The moral distress created by the battle between cost and care, the injustices in resource allocation between acute care and the home environment further enrich this injustice.

The complexity of care in the community setting is changing rapidly (Bjornsdottir, 2001; Peter, 2011, In Press). Complex palliative and wound care patients prematurely discharged from the hospital increase this complexity (Peter, 2004, In press). The burden of care in the home environment typically falls to women (Bjornsdottir, 2009). Changes to our health care delivery system whereby the expectation is that family members provide the on-going support for patients in the home are the result of societal changes as well as cost recovery measures. However, the impact of these changes does not occur without a human cost and that human cost comes at the expense of women (MacKinnon, 2009). Unappreciated and invisible, the female caregiver role has been argued to be the result of socialization, rigid family structures, and historical patterning of roles and responsibilities. Assumptions and presumptions of the female role in caregiving are often made by families and professional support people (MacDonald, 2010; MacKinnon, 2009). The home care nurse continues to be cast in the role of clinical expert but, once again, the
discursive structures and scarcity of human and material resources restrict the care provided (Hudson, 2004; McDonald, 2010).

Maxwell (2009) contends that the “main commodity that is in short supply in the scarcity paradigm is primary caregivers’ time” (p. 221). Caught between the complexities of justice (equal distribution of health care resources), technical efficiencies, and those variables in healthcare that are quantifiable, professional attributes such as compassion and justice itself are compromised. Intentional rationing of a professional caregiver’s time in a model of cost recovery, foreshadowed by neo-liberal thinking creates a justice deficit. Maxwell (2009) suggests that this deficit of justice results from our inability to meet our professional obligations. Technological efficiencies linked to that which is quantifiable once again trump quality care.

Additionally, out of necessity, and embedded in the scarcity paradigm, the limited caregiver resources promote a model of self care whereby nursing staff teach families to care for those dying in the home. Technological advances in the home setting have further increased the burden for those providing the care (Peter, In Press). Cost fuels the dialogue and restricts practice. Clinical expertise and technical prowess usurps the relational nature of the home care nursing role (Peter, In press). The relational nature of the nursing role is lost to the science of efficiency and cost analysis as the relational nature of the caring, not quantifiable, is lost. Patients in the home setting are increasingly burdened with additional human and financial costs (Bjornsdottr, 2009; Peter, In Press). Advocates of neo-liberal thinking equate this form of thought with equal distribution of resources based on fair market share but, where is the fairness?
I believe that a corporate ideology and an ideology of scarcity, powerful and articulate, have silenced nurses at the front lines.

But in the silence, nurses defy the structures imposed by a system many believe to be punitive and punishing in nature. Silent disobedience, “breaking the rules” in order to provide for patients has been recognized as a silent form of advocacy (Kagan & Chinn, 2010, p. 45). This form of resistance is likened to Gandhi, whose life focused on peaceful resistance (Kagan & Chinn, 2010). Described as “passive and covert”, this form of silent advocacy allows nurses to live their ethical values (Kagan & Chin, 2010, p. 45). For example, in the home care nursing setting, nurses carry a stock of wound care supplies, IV tubing, and common medications to support the care needs of marginalized individuals. All supplies are judiciously hoarded in the trunks of cars. Food drives in my home health office provide sustenance to those in the community unable to access government resources due to addiction, mental health issues, or homelessness. However, this silent form of advocacy is limiting and in itself contributes to the silence in nursing practice as once again, if it is not visible, it cannot be counted (Peter, 2004; Varcoe & Rodney, 2009). Do the many wrongs make this right?

Altruistic and ultimately good, the care provided by home care nurses in the community setting is not always visible. The moral dissonance which is generated in the gap between what is inherently right and the actual care provided assaults a culture already stung by rules and regulations aimed at cost recovery. Political reforms mandated by conservative thinking limit nurses’ abilities to articulate the relational nature of their work (Bjornsdottir, 1998; Canam, 2008), as well as practice issues and concerns (Kagan & Chin, 2010). We need to “stop playing nice” (Chinn, 1987, p. 23) and use the power of our collective voices (Buresh & Gordon, 2000;
I SEE AND I REMAIN SILENT

Peters, 2011; Purkis, 2001) to challenge and change our current health care environments.

Actions oftentimes speak louder than words and if our words have been silenced, our actions will have to speak for us.

**Recommendations for Action**

Patient advocacy in my current practice environment of home care nursing is practiced as a silent form of advocacy. Patients are provided with the resources they require and rules are inadvertently broken in order to support this practice. In this resistant, voiceless form of advocacy, nurses are able to support patient care needs. However, this care/support comes at a significant cost to nursing staff. The additional time to care is borrowed from their personal hours and nurses fund additional resources themselves to meet patient needs and heal the public hurts. But this is not enough to facilitate change at a larger societal level. Where are the voices of the nurses providing care?

Ethical action requires a voice at the bedside with individual nurses, in the boardrooms of those directing the health care dollars, in society, and within the political arena. Micro strategies (individual level), meso strategies (organizational level), and macro strategies (societal level) are required to fuel the collective voices of nurses (Rodney, Harrigan, Jiwani, Burgess & Phillips, In press). By acknowledging and valuing the ethical interplay of each level of practice, nurses as a large social group have an opportunity to influence socio-political changes while continuing to maintain ethical values (Rodney, Harrigan, Jiwani, Burgess & Phillips, In Press).

To begin, at the micro level, the home care nurses in my practice example are maintaining the integrity of their practice by breaking the rules, by providing the supplies, and food necessary for the marginalized patients in their care. But are they aware of other strategies
to promote moral action? Grady et al. (2008) conducted a survey that revealed nurses do not take moral action when faced with ethical and moral dilemmas due to a lack of ethics education. Education focused on both the language of ethics and the language of ethical action provides a venue to develop an ethical voice. Individuals (nurses and patients alike) can appeal directly to the director of their provincial health authority or their member of the provincial legislature in order to receive support beyond that provided through the covert actions of staff. Guerilla tactics (Varcoe & Rodney, 2009) such as the hoarding of supplies is not enough to elicit the required social structural changes. Ethical practice embedded in the incongruencies related to resource distribution requires voice. But where are the voices of nurses? Stories of real nurses can and should be published in nursing magazines, self-help magazines, and in the editorial section of newspapers (Buresh & Gordon, 2000). But I would caution that this is not enough. Whistle blowing provides a voice for those concerns that go unrecognized within the corporate structure (CNA Code of Ethics, 2008). However, whistle blowing is not for the faint of heart but those with a heart of a lion, as whistle blowing often has negative consequences for those personally involved. And still more action is required.

At the meso level, active engagement and dialogue through professional associations, and research can change health policies (p. 275). As Buresh and Gordon (2000) write, “The media, policy makers, and health care administrators all require documented research to demonstrate the importance of nursing care to patients” involved (Hill, 2010). As home care nursing takes place within a social setting, closer examination is required of socio-political factors that influence populations requiring home care, such as those living in poverty, with limited education, with no
or unstable employment, with mental health and addictions issues (Bjornsdottir, 2009; Purkis, 2001).

At the macro level, political engagement at all levels of government can influence neo-liberal policies of corporatization, cost, and scarcity. It is time for nurses to move beyond their apolitical stance and become politically fluent (Peter, In Press). “Unmasking” ideologies of scarcity and corporatization that limit resource allocation “would foreground alternative ideologies (perhaps, ideologies of health, social justice and the common good)” (Varcoe & Rodney, 2009, p. 138).

The voices of a few need to be replaced with the collective voices of many (Peter, 2011). All nurses need to participate in the creation of a strong, moral dialogue. Beyond the discussion of life and death, good and bad, ethical issues underpin resource allocation, socio-political influences, staffing resources, and moral distress. The key to dispelling the silence is to understand why it exists. Education regarding whistle-blowing legislation and specific tools to facilitate clear and concise documentation of the key issues is pivotal to identifying the needs of those involved. These tools include a working knowledge of the CNA Code of Ethics, professional standards and union guidelines (Buresh & Gordon, 2000; Peter, 2011; Rodney & Starzomski, 1993; Varcoe & Rodney, 2009). Site specific ethics committees in the home health environment could lead to social structure changes within the community.

Research is also required to dispel the silence (Buresh & Gordon, 2000; Rodney & Starzomski, 1993; Peter, 2011). Ethical inquiry makes what is invisible in our world of practice, visible (Bjorklund, 2004). The unseen and, I would venture, the unheard, can be measured in a climate that fosters and supports curiosity and ethical inquiry. This includes the work done by
home care nurses to elucidate social problems. Additional funding for social housing, nutritional supplements, and mental health and addiction programs could be obtained if the work we do is made visible and our voices heard.

**Conclusion: The Power Beyond the Silence**

The discourse of silence is ubiquitous, insidiously embedded in nursing. Invisible and yet powerful, this discourse exists ontologically “in a position of not knowing in which the person feels voiceless, powerless and mindless” (Goldberger, 1996, p. 4). From an epistemological perspective, this discourse is known to exist in the operating room silence between surgeons and nursing staff (Gardezi et al., 2009), in the challenges that direct care providers have in articulating the subjective/public discourse in practice (Bjornsdottir, 1998), and in the difficulties advanced practice nurses experience articulating the relational nature of their work (Canam, 2008). Power is a common denominator which propagates silence (Kagan & Chinn, 2010). Silence also exists in the warmth and compassion of nursing care, in what has been called an authentic and healing silence (Russo, 2002). From an ethical perspective, the practice example given from the unique lens of home care nursing illuminates a perspective of silent advocacy I believe mirrors other practice environments. This discourse is indeed everywhere.

Pervasive, insidious and invisible, arguably this discourse constitutes a dominant discourse. My intent in this discussion was not to find answers but to stimulate thinking thereby furthering the discussion. By stimulating thinking and discussion as a unified professional body, we may be able to penetrate the silence. We cannot continue to play nice in a practice environment that suppresses our voice. I see but I will no longer remain silent.
References


References Selected by Cross Referencing CINISL, MEDLINE and Google Scholar

### Appendix A

<table>
<thead>
<tr>
<th>Citation</th>
<th>Discourse</th>
<th>Nursing</th>
<th>Silence</th>
<th>Inclusion or Exclusion Reason</th>
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<tr>
<td>Bjorklund, P. (2004). Invisibility, moral knowledge and nursing work in the writings of Joan Liaschenko and Patricia Rodney. <em>Nursing Ethics, 11</em>(2), 110-149.</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Relevant: links the discourse of silence to discourse and ethics</td>
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<tr>
<td>Bjornsdottir, K. (2001). From the state to the family: Reconfiguring the responsibility for long-term care at home. <em>Nursing Inquiry, 9</em>(1), 3-11.</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Relevant: links the discourse of silence in nursing to ethical inquiry</td>
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<td>Bjornsdottir, K. (2009). The ethics and politics of home care.</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Relevant: links feminist theory to the voice of nursing practice</td>
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<td>Copnell, B., &amp; Bruni, N. (2006). Breaking the silence: Nurses’ understandings of change in clinical practice. <em>Issues and Innovations in Nursing Practice, 1</em>(12), 301-309.</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>Excluded: limited value as not linked to discourse and a very small sample size (12)</td>
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<td>Hart, C. (2009). Silence is stifling. <em>Mental Health Practice</em>, 12(8), 16.</td>
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obstacle to scholarly nursing discourse? *Nursing Philosophy*, 7(2), 100-103.

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<tr>
<th>Author</th>
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<th>Philadelphia: John Benjamins North America.</th>
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References Selected for Focus on Discourse of Silence

Appendix B

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<tr>
<th>Citation</th>
<th>Relationship between discourse, silence and nursing</th>
<th>Cited</th>
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<tr>
<td>Bjorklund, P. (2004). Invisibility, moral knowledge and nursing work in the writings of Joan Liaschenko and Patricia Rodney. <em>Nursing Ethics, 11</em>(2), 110-149.</td>
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<td>Copnell, B., &amp; Bruni, N. (2006). Breaking the silence: Nurses’ understandings of change in clinical practice. <em>Issues and Innovations in Nursing Practice</em>, 1(12), 301-309.</td>
<td>The authors provide an exploration of a research study conducted with a group of 12 critical care nursing staff and their responses to changes in their work environment. The investigators revealed that when confronted with change, the nurses did not react. The author argues that this lack of response to change contributes to their silencing. Limited value as not linked to discourse and a very small study group.</td>
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<tr>
<td>Hart, C. (2009). Silence is stifling. <em>Mental Health Practice, 12</em>(8), 16.</td>
<td>The authors provide a commentary on the silence in nursing in relation to mental health. I believe the article has limited value as the discourse is not clearly articulated.</td>
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<td>Source</td>
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<td><em>Science Quarterly</em>, 23(1), 41.</td>
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<td>Kikuchi, J. (2006). The binary: An obstacle to scholarly nursing discourse? <em>Nursing Philosophy</em>, 7(2), 100-103.</td>
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<td>Lovell, V. (1981). 'I care that VGH nurse’s care!' (1st ed.). Vancouver, British Columbia: In Touch Publications Ltd.</td>
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<td>Written by a sociologist, this book chronicles the experiences in the late 1970’s when a group of administrators at Vancouver General Hospital resigned protesting the lack of nursing voice.</td>
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<td>MacDonald, H. (2006). Relational ethics and advocacy in nursing: Literature review. <em>Journal of Advanced Nursing</em>, 57(2), 119-126.</td>
<td></td>
<td>The author provides an excellent literature review; however, it is not relevant for the focus of this discussion as not directly related to discourse or silence.</td>
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<td>MacKinnon, C. J. (2009). Applying feminist, multicultural, and social justice theory to diverse women who function as caregivers in end-of-life and palliative home care.</td>
<td></td>
<td>An excellent article addressing the relationships between feminist theory and social justice chronicling the experiences of women providing care in the home.</td>
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<tr>
<td><em>Palliative and Supportive Care, 7</em>(4), 501-512.</td>
<td>The authors provide a concise and comprehensive discussion of discourse and ideology.</td>
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<td>Myrick, F., Sawa, R., Phelan, A., Rogers, G., Barlow, C., &amp; Hurlock, D. (2006). Conflict in the preceptorship or field experience: A rippling tide of silence. <em>International Journal of Nursing Education Scholarship, 3</em>(1), 1-14.</td>
<td>The author examines the silence in conflicts that arise in clinical practice environments between faculty, students, preceptors and mentors but the value of this article is limited because of the focus on students and faculty.</td>
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<td>O’Connor, T. (2009). From silence to voice—sure, but when? <em>Nursing New Zealand, 15</em>(8), 2.</td>
<td>The authors provide a commentary written in response to a lack of voice in nursing.</td>
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<td>Peter, E. (2002). The history of nursing in the home: Revealing the significance of place in the expression of moral agency.</td>
<td>This author explores the moral agency of nursing in relation to place. Specifically, it is argued that the place that nursing care is placed in is integral to the expression of moral agency.</td>
<td>44</td>
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<tr>
<td><strong>Nursing Inquiry, 9(2), 65-72.</strong></td>
<td>delivered has the potential to both limit and empower nurses. Excellent article looking at moral agency but of limited value in a discussion of the relationship between discourse, nursing and the discourse of silence.</td>
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<td><strong>Peter, E. (2011). Fostering social justice: The possibilities of a socially connected model of moral agency. <em>Canadian Journal of Nursing Research, 43</em>(2), 11-17.</strong></td>
<td>An excellent article looking at the relationship between the voice of nursing, moral agency and those ideologies that limit our voice.</td>
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<td><strong>Rankin, N. (1988). I see and am silent. <em>Canadian Critical Care Nursing Journal, 6</em>(2), 6-7.</strong></td>
<td>An excellent article whereby the author examines the relationship between power, discourse, and the silence of nursing.</td>
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<tr>
<td>*<em>Russo, M. T. (2002). Care's anthropology: Silence as language. <em>International Nursing</em></em></td>
<td>The authors examine the discourse of silence in relation to nursing care.</td>
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<td>Perspectives, 2(2), 105-114.</td>
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<td>The author provides a commentary examining the silence in practice environments in relation to health care reform.</td>
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<td>NA</td>
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<td>Examines feminist theory in relation to the development of professionalism in nursing.</td>
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Unpublished References Selected in Relation to Discourse of Silence

Appendix C

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<thead>
<tr>
<th>Citation</th>
<th>Discourse</th>
<th>Nursing</th>
<th>Silence</th>
<th>Inclusion or Exclusion Reason</th>
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## Appendix D

### Analysis of Unpublished References Selected for Focus on Discourse of Silence

<table>
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<tr>
<th>Citation</th>
<th>Relationship between discourse, silence and nursing</th>
<th>Cited</th>
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<tbody>
<tr>
<td>Peter, E. (In Press). Home health care: Ethics, politics and policy. In J. Storch, R. Starzomski, &amp; P. Rodney (Eds.) <em>Toward a moral horizon: Nursing ethics for leadership and practice (2nd. ed)</em>. Don Mills, ON: Pearson Education Canada.</td>
<td>This author examines the ethical constraints imposed by neo-liberal thinking and corporate re-structuring on the lives of patients, families and home care nurses. Concrete examples from research conducted in the home care nursing environment are discussed.</td>
<td>N/A</td>
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<tr>
<td>Rodney, P., Harrigan, M., Jiwani, B.,</td>
<td>Excellent article whereby the authors discuss</td>
<td>N/A</td>
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the need for nursing to advocate for ethical change. Links are made between ethics and ideological principles embedded in nursing practice.