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A discourse analysis of nursing diagnosis

Powers, Penny Ann, Ph.D.

University of Washington, 1994

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A Discourse Analysis of Nursing Diagnosis

by

Penny Powers

A dissertation submitted in partial fulfillment
of the requirements for the degree of

Doctor of Philosophy

University of Washington

1994

Approved by Dana G. Allen
(Chairperson of Supervisory Committee)

Deborah Ward

James S. Dunkley

Kristen M. Swanson

Janet M. Michel

Program Authorized
to Offer Degree Nursing

Date June 2, 1994

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Doctoral Dissertation

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University of Washington

Abstract

A Discourse Analysis of Nursing Diagnosis

by Penny Powers

Chairperson of the Supervisory Committee:

Chair and Associate Professor David G. Allen
Department of Psychosocial Nursing

This dissertation is a philosophical analysis of the discourse of nursing diagnosis in nursing literature. It is the general claim that the use of nursing diagnosis extends and reproduces conditions of social domination in our society. Specifically, its use functions in a way that constitutes individuals for themselves and others in an oppressive manner according to race, gender, and class. It is further claimed that the discourse of nursing diagnosis is based on social notions of normality, value and expertise that reflect unfounded notions of science, professionalism, and social agency.

Evidence is provided to support these claims based on the power perspective of discourse analysis from the work of Michel Foucault, and modified with reference to contemporary postmodern critical feminism. The source of text for this analysis is the body of nursing literature concerning nursing diagnosis since 1950.

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CHAPTER ONE: INTRODUCTION

Prologue

"Nursing diagnoses describe actual or potential health problems which nurses, by virtue of their education and experience, are capable and licensed to treat" (Gordon, 1976). The first national conference on the classification of nursing diagnoses was held in 1973 in response to a body of nursing literature that began in the 1950's (Meleis, 1991). The list of nursing diagnoses approved for use in practice by NANDA (North American Nursing Diagnosis Association) is revised on a regular basis at these continuing conferences (see Kim and Moritz, 1982). Nursing research on particular diagnoses provides the evidence NANDA uses to make decisions to revise, delete, or accept a nursing diagnosis.

Each nursing diagnosis has a definition, general principles, etiology, defining characteristics, interventions, and outcome criteria (McFarland and Wasli, 1986). Nursing diagnoses are required in the care plans of the large majority of practice settings for nurses. Nursing diagnoses are assigned to patients by nurses and are written down on care plans in order to guide subsequent nursing actions throughout the duration of the nurse-patient relationship. The subject is taught in both ADN and bachelor's degree programs, and is used as a theoretical

framework for research in nursing and in quality assurance programs (McCourt, 1986). The use of nursing diagnoses by staff nurses is required by JCAHO for the accreditation of hospitals. Nursing diagnosis is used as the curriculum model at Southeast Missouri State University (Webb, 1992). Anderson (1991) reports a hospital orientation based on nursing diagnosis for OR nurses. The discourse of nursing diagnosis therefore has extremely widespread application and influence in the teaching, research and practice of nursing.

The ubiquitous nature of nursing diagnosis does not mean that there is no dissent within the discipline as to its utility. There has been discussion in nursing literature regarding the world view, implications, and scientific basis for nursing diagnosis. The dissent seems to have split the discipline along academic/practicing nurse lines (Gamer, 1979; Thomas and Newsom, 1992; Dickson, 1993). Academics are more likely to be in favor of the continued use of nursing diagnosis, and practicing nurses against its continuation (Mauksch, 1990).

The internal self-talk of a discipline reflects the operation of competing internal discourses that rise and fall in their influence and numbers of adherents over time (Kuhn, 1970). These competing internal discourses themselves contain various themes, stated or unstated, that

may conflict with one another, based on their assumptions, structure, and rules (Foucault, 1972). These competing internal discourses may represent conflicting theories or conceptual frameworks that view the phenomena of concern in the discipline from different perspectives.

Conversely, an external audience is not usually presented with the ongoing internal discussions and differences of opinion within the discipline. It is the unified voice of the dominant perspective that is presented to the lay public in order to provide strong support for the social position of that discipline. A strong social position is an advantage for a health care discipline because of a public service orientation. Elevated social status results in greater public awareness and support, financial and otherwise. Social power is thereby increased, creating a more attentive audience and a wider sphere of influence. The use of a science-based taxonomy further adds to social status in our modern society (Foucault, 1978).

The empirical truth claims of a discourse are more often subjected to close scrutiny in the literature than are the more abstract dimensions. The ethical, ideological, and power-related meta-issues of a discourse commonly receive less attention. Abstract philosophical criteria, however, become as important as empirical criteria when a discipline considers the evaluation of competing internal

discourses (Allen, 1987). Philosophical inquiry in general has an established place in nursing literature along with various other forms of scientific and historical inquiry (Kikuchi and Simmons, 1992; Sarter, 1988; Powers, 1992a).

Considering the wide influence of nursing diagnosis on nursing, its philosophic aspects have been inadequately critiqued. There have been some isolated points made with respect to ethical issues (Mitchell, 1991) and power issues (Kobert and Folan, 1990; Shamansky and Yanni, 1983) but no systematic investigation (Allen, 1987). We have witnessed the rapid dissemination of nursing diagnosis into all areas of nursing. There have been serious questions raised. Given the widespread influence of the discourse of nursing diagnosis, it is necessary that a systematic analysis be conducted.

Purpose

The purpose of this dissertation is to provide a comprehensive, systematic, and in-depth analysis of the discourse of nursing diagnosis from a specific conceptual framework based on the power perspective provided by the work of Michel Foucault, French philosopher and historian.

This analysis is conducted in order to provide further evidence for intra-disciplinary critique. Such critical debate should address whether or not nursing diagnosis constitutes a discursive world view and trajectory that we

as a discipline are willing to continue to disseminate internally, teach to our students, perpetuate in practice, and present to outside audiences.

Method

The conceptual framework for this analysis is constructed largely from my interpretation of the power perspective on modern western civilization from the works of Foucault. He constructs an interpretation of the history of western civilization in terms of changing world views, from the perspective of power. He does not present a theory of power but an analytic of power and its operations. His work suggests that the methods and world view of power have become cultural myths in our social world, requiring no justification.

The purposes of an analytic of power are 1) to identify systematic and/or individual cases of the oppressive effects of the discourse on people or groups of people, and 2) to identify individual and/or group practices of resistance to these oppressive effects. This kind of an analytic of power relations surrounding a discursive worldview highlights several aspects of life in modern western civilization since the 17th century. These aspects include the role of science in modern life, the role of social agents, and the role of knowledge in the maintenance of the dominant view of power. According to

Foucault, modern empirical analytic science informed by foundational assumptions is the major method of maintenance for our dominant view of power, and has become an end in itself (Foucault, 1978).

One key consideration in a power analytic is a focus on the complex social and historical conditions in which agents act and interact. Such consideration is crucial to the analysis of a discourse in the health care field. Foucault's power perspective provides a very large scale world view that helps to highlight these social and historical power dimensions of a discourse. This perspective especially helps to illuminate conditions of social action. Consequently, this discourse analysis must be clearly located historically within nursing practice and the contemporary academic setting. Even more broadly, nursing must be clearly located in its context within the medical and social worlds.

The case for philosophical inquiry in nursing has been variously presented (see discussion in Powers, 1992a). Chapter two presents the conceptual framework and justification for the methodological approach used by this dissertation, and is based on my understanding and informed by my reading of Michel Foucault's historical and discursive approach to the power analytic of knowledge construction and application. To this basic approach is

added some feminist insights into Habermas' communicative ideal, and a prescriptive dimension from critical theory.

The analysis described by chapter two is presented in chapters three, four, and five. The separation of this analysis into three sections is artificial, and utilized only for the purpose of conceptual clarity. The social events, notions, and processes that are referred to in these chapters are closely interrelated.

Chapter three presents a genealogy of the power influences on the history and development of nursing diagnosis. The chapter begins with a history of the general concept of "diagnosis" and proceeds to analyze the influences on early writings in nursing diagnosis from the power perspective described in chapter two. The text for this genealogy consists of all the published works on nursing diagnosis in the nursing literature from 1950 up to the first national conference on nursing diagnosis in 1973. The advantage of hindsight may allow the discovery of some heretofore unacknowledged condition of the development of the discourse, or bring to light some subsequently forgotten motivating force in the early writings, as well as dimensions that may have been lost or rejected.

Chapter four is a structural analysis of the internal rules of nursing diagnosis as it is presented in the nursing literature since the first national conference.

Models identified in chapter three that had major influence on the development of nursing diagnosis are also described as having continuing influence on the internal structure and functioning of the present system.

Chapter five is a power analytic of nursing diagnosis. Potential consequences of the discourse for education, research and practice are identified and analyzed for the possibility of systematic oppressive effects, and to identify the productive effects of the power/knowledge of the discourse. The potential for creating, perpetuating, or extending oppressive conditions is explored. The implications of this power analytic are also evaluated with respect to the place of the discipline in the larger social world when viewed from a power perspective. Ideological implications are evaluated on the basis of potential for the limitation of autonomy and responsibility in individual and group situations. The ideological consequences of a major discourse can be intentional or unintentional. Both types of consequences can serve to sustain the current relations of domination.

The power perspective provides the theoretical justification and focus for further empirically-based studies of oppressive consequences of the functioning of nursing diagnosis. Sources of text for chapter five include contemporary theoretical and practical discussions of

nursing diagnosis in the nursing literature. Chapter six presents discussion, recommendations, and conclusions.

Claims

Based on the above described analysis, this dissertation claims that the discourse of nursing diagnosis is problematic in two ways. First, nursing diagnosis is problematic because of internal contradictions or philosophical tensions between competing influences such as medicine, professionalism, and foundational empirical analytic science on the one hand, and empowerment, patient advocacy, feminism, and caring on the other. The analysis of such tensions from a conceptual framework of power has considerable explanatory utility for issues in the teaching, research and practice of nursing.

Secondly, this dissertation claims that the discourse of nursing diagnosis is problematic because of the potential for creation, perpetuation, and extension of unequal relations of power between nurses and nurses, nurses and patients, nurses and members of other health care disciplines (such as medicine) and between nursing and the health care system.

Conclusion

Discourse analysis is a promising model for inquiry in nursing. An important consideration in this approach is the potential for identification and/or development of

discourses of resistance, in this case, resistance to nursing diagnosis. Such resistance has the ongoing purpose of deconstructing unequal power relations constructed by the discourse of nursing diagnosis that serve to systematically limit the autonomy and responsibility of individuals and groups. Resistance also serves to maintain the discourse it resists, however. A power perspective identifies existing practices of resistance and the potential for limiting or supporting autonomy and responsibility in individual and/or group situations. Nursing, like any discipline, participates in larger trends of the social world. Analysis and evaluation of an influential discourse such as nursing diagnosis is crucial to a discipline concerned with people in social context.

CHAPTER TWO: CONCEPTUAL FRAMEWORK

Introduction

This chapter will describe discourse analysis and provide the justification for this perspective as a conceptual framework for this dissertation. Discourse analysis, as it is performed in this dissertation, is based on the work of Michel Foucault, French philosopher and historian.

To situate this dissertation for the reader, it would be appropriate to note that it is written for academics by an academic who is a white, middle class, middle-aged mother who is interested in overcoming domination in nursing based on race, gender, and class. I teach and study in a university setting, and I also practice nursing in a small rural hospital. The social position and interests of the author are presented explicitly so that the reader may assess, at least partially, the perspective from which this dissertation is written.

To differentiate discourse analysis from other perspectives in scientific and philosophical inquiry, the following philosophical terms pertaining to assumptions will be used. Discourse analysis as it is used in this dissertation is anti-foundational and postmodern. It is a perspective consistent with some of the assumptions in the tradition called critical social theory, which makes it

inconsistent with some other perspectives, such as the dominant form of scientific inquiry in Western civilization today, the empirical analytic tradition.

I will briefly describe modernism, foundationalism, and critical theory as influences on the methodological approach of discourse analysis. Initially, I will discuss the foundational assumptions of the empirical analytic tradition of scientific inquiry in order to show how discourse analysis is anti-foundational. I will then describe modernism in order to show how discourse analysis is postmodern. Finally, I will locate discourse analysis with respect to critical social theory in order to show how discourse analysis participates in the critique of foundationalism by critical social theorists.

Section one will discuss important concepts key to understanding a Foucaultian style discourse analysis. Section two will present theoretical influences on Foucault's methodology of a discourse analysis from a power perspective. Section three will present my approach to genealogy. Section four will discuss my approach to structural discourse analysis. Section five will present my approach to a power analytic. Section six will give examples of discourse analysis in nursing and other disciplines. Section seven describes the process through which this discourse analysis was conducted and

possibilities for generalization of results and recommendations for action. Section eight will conclude the chapter.

In the briefest of terms, this dissertation conducts an analysis of a discourse in nursing literature from a power perspective. Discourse analysis presents a theoretical framework that allows important insights into the nursing diagnosis movement. Discourse analysis is more familiar in Europe, particularly France, than in the U.S. (Seidel, 1993). There is no detailed, cookbook, step by step method for conducting a discourse analysis. We have the complex theoretical assumptions, the goals, the objectives, and the target, which is discourse.

The history of discourse analysis has two major branches. Discourse analysis is used in the discipline of linguistics (van Dijk, 1987) and consists of the analysis of specifically quoted words and phrases from written or spoken language. Some analyses of this type incorporate a power perspective, and some do not.

A Foucaultian style discourse analysis focuses on a larger unit of discourse than the linguistic kind of discourse analysis. A Foucaultian style discourse analysis considers, for example, the entire "discourse" of automotive engineering, instead of a written or verbatim account of words spoken by an automotive engineer. In this

dissertation the unit of analysis is the "discourse" of nursing diagnosis.

The result of this type of discourse analysis has been called a power analytic, a genealogy, an archaeology, critical hermeneutics, or a critical ethnography. Strictly speaking, these approaches are not interchangeable, however, and I have separated the analysis of the discourse of nursing diagnosis into three parts: a genealogy, a structural discourse analysis, and a power analytic. This separation is justified in order to focus on one aspect of the discourse of nursing diagnosis at a time. All three parts analyze the discourse from a power perspective, but they focus on separate ways of analyzing the power relations.

The genealogy focuses on the historical influences on the power relations of the discourse, the structural discourse analysis focuses on the internal logical structure of the discourse, and the power analytic focuses on the power effects of the discourse. All three parts are intimately related to each other, and are separated purely for purposes of conceptual clarity.

In general, the goal of the methodological approach of Foucaultian style discourse analysis is to provide a description of power relations in the context of historically specific situations by the analysis of

discourse. Discourse analysis is conducted in slightly different ways depending on the emphasis given to the different foci of the methodology. Examples of approaches to these different foci are found in section three.

The objectives of a Foucaultian style discourse analysis from a power perspective are to document the historical conditions of the existence of the discourse in a genealogy (Loveridge, 1990), to describe the power relations constructed through the internal rules in a discourse analysis, and to analyze the place and effects of the discourse in the web of social power relations in a power analytic.

The form that this kind of analysis takes varies widely. Instead of discussing the details of the various versions, I will describe the version I have used for the purposes of this dissertation. The basic form of my version of a Foucaultian style discourse analysis comes from my reading of Foucault's work and various commentaries. I have made some modifications to the approach based on critical social theory and feminism. These modifications will be identified as they arise in the discussion of the approaches to the three parts of a discourse analysis.

Section One:

Description of Important Concepts

Discourse, for the purposes of this dissertation, is defined as a group of ideas or patterned way of thinking which can be identified both in textual/verbal communications and also located in wider social structures (Lupton, 1992, p.145). In the notion of discourse is included statements, ideas, rituals, practices and social relations (Loveridge, 1990, p.18).

To understand a basic Foucaultian style discourse analysis, it is helpful to describe several key concepts and processes. These key concepts are power, resistance, bio-power, the repressive hypothesis, confession, the body, and the medicalization clinicalization of social control.

Power

The following is my reading of Foucault's notion of power from all of the sources (both primary and secondary) that are listed in the reference section of this dissertation. The notion of power is the most important notion in Foucault's work because it forms the perspective used to analyze discourse. The main exposition of the notion of power is found in The History of Sexuality, Volume One, Introduction (1980) and this description is mainly drawn from this account.

Firstly, power must be understood as forces that that are goal-driven, relational, and self-organized. Power creates tensions between, within, or among individuals or groups. This is to say that power is not understood as a singular, unidirectional, reified phenomenon with identifiable instances of application. Power is not necessarily viewed as a strategy consciously used by some people over other people. Social life is seen as processes of micropolitics and negotiation.

Secondly, power is a process which operates in continuous struggles and confrontations which change, strengthen or reverse the polarity of the force relations between power and resistance. This means that power is described as a relational process that is embodied in context-specific situations and is partially identifiable through its ideological effects.

Thirdly, power is the support which the force relations or tensions find in one another, forming a web or system of interacting influences, which is to say that wherever power is found, resistance to power is also found. For example, the domination of patriarchy is sustained by the definition of women as not-men. In other words, each is necessary to the other and each one is defined in terms of the other.

Fourthly, power is the contradiction which isolate the tensions from one another. In other words, power can be described within the process relations of force in the form of conflicting goals and objectives of power and resistance.

Fifthly, power is known from the strategies and practices in and through which the force relations take effect. One example of the strategies and practices is the process of marginalization. Marginalization is the process by which non-dominant discourses are not eliminated, but tolerated as alternative speaking positions of resistance that provide the target for the practices of power. This process is necessary because power and resistance are defined in relation to one another. Power and resistance both constitute and are constituted by each other.

The institutional manifestations of these strategies and practices of power mentioned in point number 5) above may be found in, 1) the state apparatus, 2) the laws and, 3) various social hegemonic discourses such as science, medicine, and education. Power is not an ideology in Althusser's sense (1971), although ideology can be said to be one of the strategies seen within individual instances of domination in power relations.

For example, the ideology of capitalism is necessarily dependent on the existence of labor while at the same time

marginalizing the voice of labor away from the process of decision making with respect to the production of capital. Marxist ideology provides a perspective that makes the social order understandable from that perspective. It is also possible to use power relations as a grid of intelligibility, or a conceptual framework, for understanding social order that includes the marxist ideology. The grid of power relations constitutes an interpretation of social order arising from practical concerns instead of from theoretical necessity.

Power is not a group of institutions, or a structure, or a set of mechanisms that ensures the subservience of citizens. Power is not a mode of subjugation functioning by rules instead of by violence. Instead, power functions through strategies and practices without conscious direction. Here Foucault means to distinguish his notion of power from the juridico-discursive notion of power prevalent in western philosophy and based on a notion of a democratically defined person with basic human rights in a sovereign-subject relation (Mish'alani, 1988).

Power is not a physical strength we are endowed with in some essentialist manner. Power does not mean a general system of domination by one group over another. In fact, Foucault emphasizes that situations of domination are embodied as much through the dominators as the dominated.

These individual instances of power usually called domination or oppression are effects, or terminal forms of power, points in the web or grid of power relations.

Power is not thought of as a negative restraint on truth or the rights of individuals or groups. Instead, power is *productive* of truth, rights, and the conceptualization of individuals, through the processes, or discursive practices of the human sciences and other major discourses. Participants in these major discourses are social agents of power.

The truth produced by social science is widely believed to be in the best interests of advancing civilization in the direction of individual freedom of informed choice. However, Foucault argues that the production of truth in this manner serves to decrease or limit options for informed choice by individuals or groups. The options are limited because scientific narratives describe "the way things are" or the "natural categories" which do not change, despite the acknowledged imperfections in any current scientific description. Social agents become responsible for dissemination of the results of truth-producing discourses in a manner that ensures understanding and compliance. Social agents include bureaucrats, police, teachers, nurses, doctors, and other members of disciplines that employ a body of knowledge.

There is no central point from which all power emanates. It is instead the continually shifting web or grid of individual points of tension between power and resistance. Because of the inequality of the tension, local and unstable states of power and resistance are constantly being created, dissolved, reversed and reshuffled. Power is omnipresent not because it consolidates everything as arising from a unified source. It is omnipresent because it is continually produced in every relation from one moment to the next, in one situation to the next.

Power has a different complex strategical existence in the context of each particular manifestation. This strategical existence may be analyzed in its local effects without claims for universal application. Instead, the local strategy is described in terms of the local effects of domination on the individuals and groups involved. For example, the existence of power in an individual case of gender relations may be analyzed in terms of the limits that are found to be placed on the actions of one or both of the participants.

Power is sometimes referred to as power/knowledge by Foucault, because in discourse power and knowledge are joined together in relation to resistance. Discourse may, therefore, be both an instrument and an effect of both

power and resistance. It transmits and produces power, but also can undermine and expose it.

Similarly, positions of silence can enact power, but can also loosen the hold of power and provide obscure areas of tolerance for resistance. The most important level of analysis for power relations is at the level of micropractices, the everyday activities of life, the terminal points of the grid or web.

From this description of Foucault's approach to the subject of power, certain conclusions follow:

1. Power is not a finite entity that is acquired, seized or shared. It is not something that someone can hold on to or allow to slip away. It is embodied through the interplay of non-equal and changing relations of force in a specific context.

2. Power does not exist apart from economic relations, knowledge relations, or sexual relations, but is inherent in them. Power is the immediate embodied effect of divisions and inequalities as they occur in differential distribution. Power has a direct productive role in these relations.

3. Power is not the institutionalized conflict between authorities and target groups. It does not proceed only in a top down fashion. It functions in the machinery of production, in families, groups, institutions, discourses

and relationships. Larger scale lines of force are sometimes created out of the conglomeration of points in the power web that can link them together and bring about redistributions. Major domination is the effect that is sustained when points in the grid are consolidated.

4. Power relations are both intentional and nonsubjective. That is to say that there are directions to the lines of force, but the strategies are not necessarily planned to create oppression of specific people or groups. If power relations are understandable, it is not because they are an example of something that "explains" them, but because they are formed in accordance with specific goals and objectives. These goals and objectives are only rarely identifiable as related to power. More often than not, the goals and objectives that are, or could be, specified with respect to micro-practices that have power effects as unintended consequences. The goals and objectives of an occupational therapist, for example, are not often thought of as related to power, but, instead are thought to function for the social and personal benefit of individual clients.

Therefore, it cannot be said that power relations necessarily result from the choice or decision of an individual person or group of people. In fact, Foucault argues that the modern form of power, bio-power, is not

some sort of conspiracy set up with respect to specific goals of control. He calls bio-power a strategy without a strategist.

The rationality of power is characterized by practices that often seem quite explicit at a restricted level, such as Robert's Rules of Order. Practices can coalesce and form comprehensive systems. The logic of the system can be analyzed, and the aims can be completely understandable, and yet no one can be said to have specifically formulated them. The logic can be said, however, to have been constructed historically, but not intentionally.

.5. Wherever there is power, there is resistance that is implicit to the situation.

Resistance

Resistance plays the role of adversary, target and/or support for power. Analysis of practices of resistance is also crucial to a discourse analysis. Power and resistance both constitute and are constituted by each other. They are each defined by reference to one another, thus power and resistance are found together in all points of the web of power relations. The diversity of resistances is each a special case.

Resistance, like power, can coalesce to form large rebellions, or radical ruptures, or it can remain isolated in specific circumstances. Resistance works against power

to shift the tensions of power and create new alliances and fractures, even within an individual person.

Resistance can be co-opted by power in any force relation. Co-optation of resistance results in the increase of power and the reduction and/or fracturing of the resistance. The possibility of the co-optation of resistances is addressed in a discourse analysis.

Foucault believed it to be instructive to look at marginalized practices and discourse that have escaped exploitation and control strategies as sources of practices of resistance. He suggested looking for practices that have not been co-opted, or localized points of resistance, in order to shed light on the forms of oppression and empowering strategies that may exist in that context.

Feminist discourse, for example, participates in practices of resistance by offering to people competing ways of constituting meaning, competing potential subjectivities. Feminist discourses are currently marginalized by the dominant patriarchal discourse, and thus unavailable to many people as possible speaking positions.

Bio-Power

Foucault's work describes "power" in general, but calls the form of power in our modern discursive epoch, "bio-power" or "power/knowledge". He specifically refers to

bio-power as the increasing social control of all human affairs through "normalizing strategies". According to Foucault, the technical and instrumental rationality of foundational empirical analytic science that was used in such an exploitive and successful manner against the hardships of nature has become the model for all knowledge and truth in modern western civilization. This extension of control to humans and human affairs is an all-encompassing strategy-without-a-strategist that affects everyone.

The major unintended consequence of bio-power is an increase in the amount and scope of power and control at all social levels. The micro-practices of bio-power constitute people at the same time as both meaningful subjects and docile objects (Powers, 1992b). This means that the notion of a person is created to be someone who speaks their experience and does what they are told to do by social agents.

Foucault does not claim to have empirically demonstrated the increasing order of everything by bio-power. His is an interpretation of modernity arising from practical concerns, not theoretical, transcendental concerns. Competing interpretations from other positions are possible and even likely. A discourse analysis aims to point out the practical power aspects of the discourse that contribute to the oppression of people in situated context.

The Repressive Hypothesis

The repressive hypothesis is an unintended, but useful, corollary of bio-power. Foucault's notion of the repressive hypothesis was influenced by "Neitzsche's genealogy of the way power uses the illusion of meaning to further itself" (Dreyfus and Rabinow, 1983, p.xxvii). Neitzsche's work demonstrated how power uses the illusion of meaning to support its own strategies, without the necessity of an appeal to the notion of an organized conspiracy. Foucault called this illusion of meaning the repressive hypothesis. Discourse analysis seeks to uncover the power-related effects of participation in the repressive hypothesis and bio-power.

The repressive hypothesis is the deluding belief that all of the knowledge of science promotes advancement of western civilization by producing truth that has previously been hidden from people by power. This belief has become a cultural myth in western society. The normalizing control of social science is assumed to aid the progress of civilization because the data is supposedly value-free, objective truth that is available to anyone. Faith in science is considered to produce freedom of choice for individuals and groups, where faith in the authority vested in a person or a position is considered to reduce freedom of choice.

Foucault called this notion the repressive hypothesis because it engenders a non-critical attitude among people with respect to the authority of scientific truth. This cultural myth results in a kind of faith people assume about "common sense" notions such as "the truth sets people free" and "the more knowledge we have, the less we can be fooled", and "freely accessible scientific knowledge keeps authorities from having unchecked power" (Dreyfus & Rabinow, 1983; Powers, 1992b).

The repressive hypothesis can be said to function as an ideological strategy of bio-power and is based on the following assumptions: 1) truth is absolute and separate from power. 2) power fears the revelation of truth and so suppresses it, and 3) when truth is revealed, people are less oppressed by power. This ideology can be said to be an instance of belief in the repressive hypothesis because an alternate interpretation might argue that it is ultimately in the interests of the expanding control of bio-power that the repressive hypothesis be widely assumed.

Under bio-power and the repressive hypothesis, technical, instrumental, means-end reasoning has been raised to the level of a social principle (Aronowitz, 1992, p. 302). Radical ideas that advocate resistance to increasing power effects are unfettered but unheard, because they seem so "nonsensical", and "disorderly",

"uncivilized" and "unscientific". Persuasion is not a method, but a content (p. 309). This is to say that persuasion is a discourse, a subject of scientific study in itself. The discourse of persuasion is openly a discourse concerning compliance with the normalized truth of social science.

Confession

Foucault notes one important aspect of the human sciences to be the creation of self-revealing subjects by confession of personal truth to social agents, or authorities. According to Foucault, the confession of personal truth serves a social function that has become an obsession in our modern existence, and has also served as a model for medicine (Dreyfus & Rabinow, 1983) and nursing. The confessing individuals believe this process to be therapeutic because it reveals "truths" which were previously repressed. The revelation of such truth makes someone free of its hold.

The control of bio-power functions by "normalizing" individuals with respect to standards set through the human (social) sciences based on foundational assumptions. Confession creates speaking individuals who can be manipulated by social agents through comparison to the normalized scientific truth. This normalized truth is produced and applied by the social agents to people. For

example, the emphasis on "assessment" in many disciplines, including nursing, makes use of speaking subjects in order to compare what the person being assessed says to the normal version described in the body of scientific knowledge ordered by the discipline. Assessment is performed with the purpose of comparison to normal and intervention to produce movement in the direction of normal.

Confession is thus not a practice limited to religion or psychiatry, but a more general micropractice that can be identified in discourses such as found in education, sociology, government, nursing, medicine, and popular culture in the form of radio call-in shows and self-help manuals.

The Body

A critical characteristic of a discourse analysis in nursing as conducted in this dissertation is to be found in Foucault's description of a notion of the body as the site for the operation of power relations. As examples, consider two discursive strategies "on bodies" which he called the medicalization and the clinicalization of the mechanisms of social control (O'Neill, 1986, p. 353).

Foucault emphasized the human body as the physical "space" for the operation of the social micro-practices associated with the concepts of bio-power, resistance and

the repressive hypothesis such as nursing and medicine. "In the discursive history of strategies for making ourselves visible, knowable, and speakable, we have made great use of the metaphor of the body as a source of health and order, illness and disorder." (O'Neill, 1986, p.352).

Bodies can be considered terminal points in the web or grid of power relations between power/knowledge and resistance (Doering, 1992). This emphasis on the body is especially important when analyzing a nursing discourse, because of our participation in existing discourses on bodies such as medicine and biological science. "Much of the knowledge about human bodies that is represented as universal, value-free, ahistorical truth is more accurately described as a power/knowledge system specific to bodies, relative to historical time, inflected with the values and morals of the time and influenced by existent power structures." (Allman, 1992).

Feminist discourse adds important concepts to Foucault's position on "bodies" with respect to discrimination based on race and gender. Foucault's work does not emphasize the racialization and genderization of bodies as hegemonic dominations. Feminist discourse, however, calls our attention to the important consideration that bodies are always already gendered bodies (Allen, Allman, and Powers, 1991).

Race and gender are seen by this feminist discourse as sociocultural organizations of roles and identities, not simply as natural categories that need to be taken into account (Calhoun, 1992). Female nurses participating in patriarchal discourses on bodies create identifiable tensions within nursing discourse.

A serious approach to racism and sexism in nursing could usefully be based on a feminist perspective on Foucault's notions of power and the body. This approach could begin with the consideration of cultural production and reproduction of race and gender as socially salient power categories and involve basic categorical rethinking, not merely reduction in objective consequences of sorting on the basis of empirical markers such as skin color (Calhoun, 1992, p.251). Such an approach is not widespread in nursing at the present time (Allman, 1991).

In order for nursing to proceed in this direction, a discourse analysis of a specific discourse in nursing literature would have to address race and gender as specific bodily sites for power and resistance relations. Gender might be better understood as a verb, not a noun, because people do not *have* a gender, they *are* gendered. It is an active, social, productive process of power relations, not a static, essential element or thing. It is

something we do to bodies, practices, behaviors, roles, etc.

Medicalization and Clinicalization

Two notions critical to understanding Foucault's approach to discourse analysis are the medicalization and clinicalization of social control. These two notions serve to relate bio-power, medicine, and the body. These connections are crucial to understanding the role of a discourse in nursing as participating in the expanding control of bio-power.

Foucault's concept of the medicalization of social control is that situation that results when the "system" problems of order and deviance in society begin to be addressed in terms of a medical science model of sickness, and thereby bypass other discourses such as those of aesthetics and ethics. Human problems are not seen as issues for discussion and critique, but "problems" to be solved in terms of "adaptation" and "balance".

In the process of medicalization, institutions are reified as "systems" and not as communities of people, interactive human relations become "outcomes", and "diagnoses" replace human situations in social context. Science is then applied for its technical control of these technical problems that are stripped of contextual,

ethical, and human dimensions. Social relations become described in terms of object relations.

This discursive strategy of medicalization uses "body words" in a scientific way that eliminates critique, assumes terms are value-free, promotes control, and assumes the desirability of its own results. Such "body words" include "maladaptation", "minimal brain dysfunction", "hormonal imbalance" and "genetic" causes of alcoholism and violence. Sociobiology is another example of the use of body words for social practices (see Rushton and Bogaert, 1989, with commentary by Leslie, 1990).

The discursive strategy of clinicalization functions alongside that of medicalization within the hegemony of bio-power. If the problems of social order and deviance are phrased in terms of scientific, medical diagnoses, then the "treatment" of such problems must occur on bodies in a physically medical space, a clinical setting ordered by the authority of social agents that include nurses and doctors.

Clinical thinking in medicine thus occurs in the context of medicine's position as a discourse not based on a concept of personal identity, but on the existence of the human body as a space to be acted upon (Scott, 1987).

Foucault argues that medicine arose as a linguistic reorganization of the concept of disease in the space of the body, as seen through the concept of death, utilizing

the "ordering gaze" of the authority, the physician. This analysis constitutes what Foucault calls the historical conditions of possibility for the discourse of medicine (Foucault, 1975).

These closely related processes of medicalization and clinicalization serve to protect and enlarge the status quo of social domination. Time, space, and discourse are not transcendental concepts but inhabit the body directly, creating our perceptions, perceived limits, options and approaches (Scott, 1987). This is to say that the location of these concepts is not viewed by the discourse analyst as external to human bodies. Time and space have important functions in terminal points of the web of power relations, bodies. Nursing participates in the medicalization and clinicalization of social control by reproducing the medical model within expanded applications specific to truth-producing discourse in nursing.

The conceptual ordering of the physical space of the body can be created or dissolved over time for different purposes, such as the creation of new discourses and their related practices. The discourse of nursing diagnosis, it will be shown, orders time and space in a particular way for specific goals, using truth-producing discourse with respect to the power relations specific to bodies.

Section Two: Theoretical Influences

This section will discuss the theoretical influences on the work of Foucault considered to be important for understanding the methodological approach of a power perspective for the analysis of discourse. These theoretical influences will be apparent in the descriptions of the approach I have taken to genealogy, discourse analysis, and power analytic. Given the descriptions of the important concepts from the work of Foucault in the preceeding section, the theoretical influences on the conceptualization of a discourse analysis include the philosophers Neitzsche and Wittgenstein, the tradition of critical social theory, and the philosophical notions of founddationalism and postmodernism

Neitzsche and Wittgenstein

Wittgenstein and Nietzsche are important theoretical influences on Foucault's notion of a discourse analysis. Any definition-producing discourse in philosophy, science, nursing, medicine, or literary criticism, is today faced with the observation that "empirical" definitions change historically and discontinuously, that they do not reflect transcendental subjects, meanings, structures, realities, or processes (Allen, 1986).

Accordingly, Wittgenstein had argued for treating all philosophical problems as manifestations of tensions

between and within discursive practices. When philosophical issues are approached this way, as tensions between discursive practices, without demands for definitions or essences, the analysis includes a description of the tensions in all of their concreteness and situatedness (Mish'alani, 1988, p.4).

Foucault was not only influenced by the notion of historical importance in definitions and definition-producing discourse from Wittgenstein, but also the historical power component of definitions from Neitzsche. For Neitzsche, the very act of definition becomes critically important to philosophical analysis when there is some kind of challenge to the definition of a concept which had been consensually valid up until that time. Any effort towards redefinition is consequently seen as a strategy for access to hegemony or dominance of one discursive mode over others (Mish'alani, 1988). Defining, or re-defining something thus constitutes a move of power.

Neitzsche argued that the current usage of any concept consists of historical conglomerates, borrowings, dominations, plunderings, shifts, displacements, transpositions, and superpositions (Mish'alani, 1988, p.9). This swirling "cotton candy" mix of threads in any discursive formation can be patiently unwound in an analysis that Neitzsche called a genealogy. Foucault also

used the term "genealogy". Following Neitzsche, Foucault agreed that any attempt at analysis must be considered another interpretation, another power domination. The power dimension must be added to the problem with the historical discontinuities of definitions from Wittgenstein.

It follows for Foucault that discourse cannot be analyzed only in the present, because the power component and the historical component cause such a tangled knot of shifting meanings and interests. Consequently, a discourse analysis must be seen at the same time from a genealogical perspective in Neitzsche's sense, a power analytic in Neitzsche's sense, and another historically situated, tension-analyzing discourse in Wittgenstein's sense.

Critical Social Theory

Another important influence on Foucault's notion of discourse analysis comes from the tradition called critical social theory. This tradition has some of its roots in Marxist thought, but other influences include the literary tradition of critique, or literary criticism (DeMarco, et al., 1993). Critical social theory has also been suggested as an appropriate approach for nursing inquiry (Thompson, 1985; Thompson, 1987; Allen, 1985; Hedin, 1986; Dzurec, 1989; Doering, 1992).

What we now call critical social theory arose from the Marxist studies of the Institute of Social Research

established in Frankfurt in 1923, and called the "Frankfurt School" (Held, 1980). The work of authors associated with this Institute does not form a unified body of work, there being major differences between the primary authors:

Horkheimer, Adorno, Marcuse, Lowenthal and Pollock. These differences, fortunately, do not preclude us from stating, in some instances, the "position" of the Frankfurt School. Presently, the name most often associated with critical social theory is Jurgen Habermas, who became an assistant to Adorno in the 1960's and is still extremely influential, albeit more in Europe than in Anglo-American social theory.

Leonard (1990) defines a critical social theory as an analysis that is critical of historically-based social and political institutions that oppress people, while at the same time having a situated practical intent. The practical intent of a critical social theory is to provide people with the tools to change oppressive situations, both perceived and hidden from the participants. A critical theory without the practical dimension is called "bankrupt on its own terms" by Leonard (1990, p. 3). The specific process advocated by critical theory is the bringing about of self-liberating practices in oppressed groups as the groups exist in their own context with respect to the historically-based ideology that structures their experience.

Using the notions of ideology and false consciousness, critical theory seeks to identify ways in which social phenomena might be otherwise less oppressive, looking for possibilities inherent in the value-laden present. The ultimate goal of a critical theory is emancipation of human beings as a consequence of becoming aware of an alternate interpretation which includes an alternative future (Molony, 1993).

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In order to understand the approach of critical social theory with respect to power and oppression that influenced the work of Foucault, I will address the notions of ideology and false consciousness.

Ideology and False Consciousness

Althusser defines ideology as a "representation of the imaginary relationship of individuals to their real conditions of existence." (Althusser, 1971, p. 162). This is to say that ideology is an interpretation of a relationship which creates social meaning. Ideology is a

process that obscures the fact that values are operating to oppress people, because meaning is presented as truth.

Ideology can also be expressed as the existence and functioning of an interpretation that is hidden to the actors, yet one they would recognize if it were presented to them. At the same time, however, it must be noted that it is not necessary to postulate that there exists an absolutely true version of the "real" interpretation, or conditions of existence, to which to appeal in the determination of distortion.

Habermas (1973) argued that ideology in our advanced industrialized society functions unconsciously as a tool of domination which prevents individuals from perceiving that they are the victims of exploitation in increasing areas of their lives (Molony, 1993). For example, marxism postulates the ideological functioning of capitalism that produces domination of the working class by the owning class. In marxist theory this condition is referred to as false consciousness. This ideology functions by fostering a belief in work for personal gain, when it can be demonstrated to the working class that their work functions instead to reproduce the conditions (and relations) of production for benefit not to themselves, but to the owning class. Marxist theory uses the term "false consciousness" because marxist

ideology assumes the existence of a "true" consciousness in which the relations of domination are "revealed".

Foucault does not hold that there is some deep hidden true fact, or meaning, or interpretation within the discourse that is the cause of false consciousness (Dreyfus and Rabinow, 1983). Instead, people may be deluded by one interpretation of reality, only to be convinced of their delusion by another interpretation that seems to be preferable and/or more explanatory in that context. The interpretation may not be any more "true" in a foundational sense, but may indeed be more *preferable* to people in some situated context and at one point in time. In Foucault's work, therefore, the notion of false consciousness is modified and called the repressive hypothesis.

These two notions of ideology and false consciousness influenced Foucault's notions of the operation of power, resistance and the repressive hypothesis in situated discourse. A discourse analysis from a power perspective assumes the operation of these notions in our social world and also within the written product of the discourse analysis itself. Since Foucault's work makes no claims of adopting a position outside of the power relations it is trying to describe, certain questions arise. What kind of inquiry is a discourse analysis? Is it another kind of science? Is it philosophical inquiry? Does a discourse

analysis itself advance the cause of bio-power? The answers to these questions are influenced by 1) the notions of foundationalism and postmodernism within science, 2) the critique of foundationalism by critical social theory, and 3) the postmodernism of Foucaultian style discourse analysis.

Foundationalism and Its Critique

By Critical Social Theory

I will discuss foundationalism in order to demonstrate how a Foucaultian style discourse analysis is anti-foundational because it participates in and extends the critique of foundationalism by critical social theory. This discussion will help to understand how the power perspective of a discourse analysis approaches the problems of its own position in the power relations it describes, and the problems in making conclusions about the repressive hypothesis, and recommendations for action.

The word "foundationalism" describes some of the underlying assumptions of the empirical analytic tradition of scientific inquiry. "Empirical analytic" is to be distinguished from the term "empirical" which means utilizing empirical or observable evidence as data (Lowenberg, 1993). The empirical analytic tradition is a more narrow approach to the description of a pre-existing reality through sense data.

The so-called "natural sciences" are the most commonly cited examples of the empirical analytic tradition and comprise one example of what is labelled "foundationalism" in contemporary writings. The natural sciences include physics, biology and chemistry. The methods of empirical analytic science were originally designed for, and explicitly aimed toward, technical exploitation and control of natural phenomena (Held, 1980; Kusch, 1991).

Habermas observed that human beings have become both the subjects and the objects of the control strategies that had originally been designed for nature (Kusch, 1991). Habermas (1971) argued that science, technology, industry, and administration are intimately connected and require a continually escalating level of technical control over nature and people in order to maintain the assumed value-free goals of predictability and efficiency. The critique provided by critical social theorists addressed the foundational assumptions of the empirical analytic tradition of science as described by the empirical school of philosophical thought called logical positivism.

Logical positivism is the name given by authors in 1931 to the philosophical ideas of the Vienna Circle of mathematicians and philosophers who began meeting informally in 1907, and continued publishing until the mid-1930's (Passmore, 1967). This tradition attempted to set

scientific standards for all significant truth statements in science and assumed that the essence of the concept of scientific knowledge was understood (Mish'alani, 1988). There are four assumptions of foundationalism regarding the relationship of the truth statements in empirical analytic science to a basic uninterpreted reality that are key to understanding the critique by critical social theory.

The first assumption is the existence of a *foundation* of un- or pre-interpreted true facts in an objectively real world that are available to people through sense perception. Second, it is assumed that there is direct correspondence between our sense perceptions and these true facts. Third, it is assumed that fact and value are independent of one another, that facts and values are separate notions, and that empirical analytic science can deal only with facts separated from values. Fourth, the process of empirical analytic science, dealing only with true facts, can discern the essence of concepts and their relationships, such as the causal relationship (Held, 1980).

On the basis of these foundational assumptions, logical positivism claimed complete value-freedom for the empirical analytic tradition. Doing so accorded a position from which to provide value-free critique of other, competing views of science, even though it is logically

difficult to establish a transcendental independent basis for the evaluation of competing value claims.

Assuming the existence of "bare facts" allows an independent basis to which to appeal in distinguishing between theoretical and empirical claims. From such a value-free perspective, any discourse that does not base claims on these "bare facts" can be rejected as illegitimate, or irrational. It is noted in this context that there are critical theorists who reject the separation of fact and value, and reject the value-neutrality of the empirical analytic tradition without rejecting the existence of "bare facts" (for example, see Althusser, 1971).

On the basis of these foundational assumptions, logical positivism claimed that human rationality is limited to the empirical analytic scientific view and denied to all other discourses such as ethics and aesthetics. Science, in this view, is therefore the only mode in which reality can be rationally presented (Held, 1980). It follows that philosophy and ethics have no power to critique scientific claims because these disciplines admit value judgements, whereas empirical analytic science does not.

These foundational assumptions described by logical positivism were also applied by others to the so-called

human sciences, or social sciences. It was argued that these disciplines could be viewed as evolving towards true scientific status on the model of the natural sciences. Critical theorists and Foucault disagreed with the possibility of this extension. Foucault specifically, "was critical of the human sciences as a dubious and dangerous attempt to model a science of human beings on the natural sciences" (Dreyfus, 1987, p. 311).

The authors of the Frankfurt School demonstrated convincingly that foundational claims to true knowledge were not value-free, but were clearly tied to certain social projects, values, interests, genders, races, classes and agendas. They argued that western science had become socially engaged and politically powerful despite (or possibly because of) the claim to value-freedom (Seidman and Wagner, 1992). The authors of the Frankfurt School were skeptical of the existence of any facts purported to lack value and ideological components (Street, 1992).

The critical theory of the Frankfurt School argued that in the name of the foundational assumption of the value-freedom of science, one certain set of unacknowledged, unstated, and unexamined values had become venerated above all others without being subjected to analysis by its own criteria. This set of values includes those of prediction, control, exploitation and efficiency.

Enlightenment naiveté concerning the ability of science to produce value-free truths by value-free methods had failed (Seidman and Wagner, 1992).

The assumption that fact and value can be separated implies that dealing only with facts is *better* than dealing with values because facts provide what is assumed to be an independent basis for distinguishing between theory and truth. This assumption also implies that dealing only with facts will produce outcomes for human society that are *better* than outcomes produced by dealing with facts that are tainted with values.

Since foundationalism regards the world as a domain of neutral objects, foundational science is therefore prevented from examining itself as anything other than another neutral object, i.e. without self-interest, or social origin, or values (Held, 1980). Foundational science submits every activity to causal analysis except its own (Allen, 1992).

In a crucial move, the critical theorists pointed out that the ideals of objectivity, efficiency, prediction, control, and value-freedom are themselves values. The notion that a true judgement (given that there is such a thing) is better than a false one is itself an evaluative statement (Held, 1980, p. 171).

The assumption of value-freedom excludes inquiry into the possibility of the operation, within science, of systematic oppression of people through ideological means, because anything that is free of values must therefore be free of ideological consequences. Foundationalism thereby excludes consideration of the possibility that things might, under different circumstances, be different from how they are presently described (Seidman, 1992, p. 173). This is to say that positivist-based empirical analytic science excludes from rational inquiry the possibility of different meanings being attached to actions by the actors other than the meaning that is constructed by that very same scientific activity.

In order to avoid the possibility of multiple interpretations which would tend to destabilize the concepts under scrutiny, the meaning of concepts is reified. Methodological traditions become reified and held apart from critique by standards of ethical preferability, even when it has become apparent that they embody ideological deception and distortion (Seidman, 1992, p.173).

The critical theorists pointed out that it can be demonstrated that individuals are influenced by social structures, but foundationalism reduces the concept of human agency to that of support or carrier of objective,

measurable, value-free general social structures (Leonard, 1990). Seidman (1992) observes the powerful effect of foundational science on people, saying that it has "unfortunate consequences: it promotes the intellectual obscurity and social irrelevance of theory, contributes to the decline of public morale and political discourse, and furthers the enfeeblement of an active citizenry." (p. 64). In other words, it is disempowering.

Certainly human behavior has become regularized, predictable, controllable to a certain degree, and describable using sophisticated probability statistics (Held, 1980). Under these conditions, social action does indeed appear to be governed by "natural" causal structures. So the use, by the social sciences, of the same approach found in the natural sciences on the "facts" of social life, demonstrate an ironic truth. Instead of making the idea of human agency the subject of critical reflection, foundational methods reify the structured consciousness of their constructed object. The observable is taken to be the only possibility, resulting in loss of context, history, possibility, and situatedness.

As an example of the unintended consequence of foundational science, consider the format of the TV show for preschoolers, Sesame Street. The show's structure is based on research in psychology which demonstrated that

preschoolers learn best under certain circumstances which include very short bursts of colorful, moving, anthropomorphic images that are repeated after a certain amount of time. This research did not focus on the possibility that preschoolers *could learn* in other ways, or *should learn* as they mature, but only how the sample *did learn* when measured by scientific observations. In structuring the TV show, this information was carefully followed, and ignored the possibility of changing the ways that pre-schoolers can learn, i.e. have a longer attention span, etc. Unfortunately, without challenge, pre-schoolers remain at that stage. TV shows for older children began to emulate Sesame Street, then shows for teenagers, then USA Today (Stewart and D'Angelo, 1988). The result will be an entire generation of adults who cannot follow any argument that lasts more than 40 seconds. The point is that the scientific description did not only *describe* the normal, it *produced* the normal without thought for the possible or the desirable.

Foundationalism has provided an extremely useful metaphor to support technical, causal explanations for phenomena in the natural world. It is noted that what counts as the "natural world", however, is itself an ideological decision, and should be recognized as such (Street, 1992). The problem is not with technical reason

itself, but its use as a model for all valid knowledge, and its categorical elimination of critique from any other perspective.

The foundational perspective survives in the natural sciences and the social sciences in various forms despite its own acknowledged and serious difficulties. The logical positivists were unable to determine the meaning of meaning, unable to define the essence of the concepts of verification, evidence, scientific explanation, and analysis, and unable to establish the *a priori* nature of mathematics and logic (Mish'alani, 1988, p.4).

Foucault pointed out the influence of foundational assumptions in the social sciences and how these assumptions influence our social life. Specifically, bio-power uses foundational science to increase control through discursive practices that are productive of truth. The discourse of nursing diagnosis will be shown to participate in this process.

The Influence of Postmodernism

Another important influence on Foucault's notion of discourse analysis is what is called the postmodern perspective. Understanding the assumptions and perspectives of anti-foundationalism and postmodernism are key to descriptions of the parts of this analysis of the discourse

of nursing diagnosis from a power perspective: genealogy, discourse analysis and power analytic.

A modernist approach is one that assumes certain transcendental notions as a basis for theorizing. Foundational science is modernist in that the foundational assumptions include certain transcendental notions such as the existence of "bare facts" and the "epistemological superiority of science as a mode of knowledge" (Seidman, 1992, p. 59). Critical social theory, however, has also been called modernist by Leonard (1990) despite its critique of foundationalism because while it criticizes the foundationalism of science, it makes use of other transcendental notions in the process. This is to say that critical social theory, while critical of the empirical analytic notion of a foundation of unassailable "true facts", believes that some other notions are indeed universal, ahistorical, or transcendental.

The modernist project of critical social theory was designed to eliminate the ideological function of authority by the description of transcendentially valid principles which could produce social reconstruction in emancipatory ways (Seidman and Wagner, 1992). The modernism of critical social theory suffered from two incompatible tasks: "being broad enough to encompass all human activity, and being

specific enough to do this in a non-trivial way"
(Nicholson, 1992, p.83).

The main reason Leonard cites in support of the claim that critical social theory is modernist is the belief of critical theorists that some notions found in some non-dominant discourses of modernity such as marxism are sources of change strategies that can be reified and generalized. The critical theorists criticized marxist theory for universalizing emancipatory interest (and locating it in the proletariat) when they in fact committed a similar error themselves, by insisting that their claims about more general domination, communication, and rationality had to be transcendental to be valid (Leonard, 1990). Anything less was too relativistic to be theoretically useful. Anything more would not be practical enough to be emancipatory. Critical theory can be thus be viewed as another "interested" inquiry claiming universal truths from an unacknowledged situated position, and therefore having the potential for increased unintended ideological consequences (Aronowitz, 1992).

On the positive side, the modernism provided the important emphasis on historicity, possibility and contextuality that was extended even further by the postmodernists, including Foucault. This extension by the postmodernists attempts to avoid postulating transcendental

concepts that have an existence outside of power relations in contextual human situations and assumed to have the logical status of natural laws.

The postmodernists such as Foucault, reject the possibility of a secure, objective, value-neutral foundation of empirical facts or transcendental universal social notions for the social sciences (Seidman and Wagner, 1992). Lowenberg (1993) points out that the postmodern influence has had observable effects across various approaches to inquiry such as phenomenology, hermeneutics, and symbolic interactionism.

Postmodernism rejects totalizing narratives, essentializing definitions, and the existence of a foundation of "true facts" or transcendental, universal, reified concepts for social science such as "domination" or "emancipation". Instead of criticizing society from universal norms, postmodernists criticize universal norms from their context-specific social base (Alexander, 1992, p. 343). The postmodernist position "reconsider[s] the relationship between scientific knowledge, power and society as well as the relation between science, critique, and narrative." (Seidman and Wagner, 1992, p.2).

Methodologically, "postmodernists prefer local stories to general ones, but do not necessarily reject methodologically sophisticated and analytically informed

social analysis but rather invoke a suspicion regarding claims that social inquiry can be grounded in some way that gives it a privileged epistemological status." (Nicholson, 1992). Postmodernists like Foucault, are more likely to do history instead of theory building, and to view moral and political concerns as central issues, but not as transcendentally valid reified entities (Seidman & Wagner, 1992).

Postmodern theory is described as narrative with moral intent (Seidman, 1992, p. 47). Postmodern discourse such as that of Foucault, refuses legitimation of authorities by discussions of "truth". Instead, postmodern discourse seeks to expand the numbers of people who may participate, since the intent is practical and openly moral. Local narratives claim to analyze a general event (AIDS, homelessness, divorce) in a particular social setting, while viewing the power relations inherent in the situation from a historical standpoint, present circumstances, and future possibilities (p. 73).

A Foucaultian style discourse analysis is a power perspective that is postmodern and anti-foundational. The implications of this theoretical position will be pointed out in the descriptions of the three parts of the analysis conducted in this dissertation. Further consequences of this theoretical stance are also visible in the discussion

of the possibilities for generalization of conclusions and recommendations for action.

Section Three: Genealogy

This section will discuss my approach to a genealogical analysis based on a power perspective. The part of a Foucaultian style discourse analysis called genealogy, as the name suggests, emphasizes the historical components of the discourse. Genealogy seeks the conditions that make possible the discursive processes practiced in a specific discourse (Kusch, 1991) as the basis for identifying present power relations. "The best way to see that things might be otherwise is to see that they were once otherwise, and in some areas of life, still are." (Dreyfus, 1987, p. 331).

Because of the importance of the historical formulation of power relations, genealogy gives priority to analysis of social practices (including discursive practices) over the analysis of acontextual theory. Accordingly, Foucault chose to analyze, for example, not the history of the *concept* of punishment, but about the history of the *practice* of confinement that includes the analysis of the discourse surrounding the practices (Mish'alani, 1988). Interesting to note, however, that the discourse of prisoners is not analyzed in Foucault's account.

In keeping with the postmodern perspective, local narratives with moral intent are preferred to generalizing theoretical discourse in a genealogy. This is to say that specific contextualized discussions that describe the ethical issues without assuming a position of disinterested inquiry are preferable. "Genealogies aim to uncover the social processes concealed by hegemonic essentialist discourses and to implicate these discourses in these formative social processes." (Seidman, 1992, p. 70).

From an anti-foundational perspective, Foucault did not posit long-term historical continuity and objective meaning to a discourse. Rather, the genealogist posits that there are rules which determine the regularities of the historical possibility of the existence of a discourse. The influence of non-discursive factors is also considered, and includes such things as institutions, events, practices, politics, economics, demographics, media, gestures, clothing, style, habits, terminology, and the range of roles to be fulfilled by human subjects (Foss and Gill, 1987).

What a discourse chooses to look at, the range of material available, and what the discourse chooses to find acceptable or unacceptable reflects a particular historical situatedness. A genealogy can show the accidental and

historical status of the discourse, and broaden our perspective to include practices still alive that have not been co-opted or removed. (Dreyfus, 1987, p. 331). This is not to imply that we can step outside ourselves or our circumstances in a foundational manner, but instead widens the view from where we are to include a broad picture of the historical contribution to the development of the practices of power and resistance in the discourse under analysis.

According to Rawlinson (1987), a genealogy is an analysis of the historical emergence of a system of notions and rules for the construction of meaningful statements, justifications, and the concrete material realities and procedures for determining truth and falsity in the discourse (p.376). Important here is the historical formation of the authority of the discourse, and how it came to have the right to pronounce truth in some region of experience. In the case of nursing diagnosis, the genealogy demonstrates how the discourse constructed its authority and realm of action. No assumption is made that it can be determined exactly how people came to think and talk and act this way in some objective fashion. A genealogy is an interpretation openly arising from a postmodern, anti-foundational orientation concerning the operation of power.

Section Four:

Structural Discourse Analysis

Foucault's notion of the analysis of the structure of a discourse was based on an earlier version of genealogy, called archaeology (Foucault, 1972). Archaeology has been called a structuralist project (Dreyfus and Rabinow, 1983) and though the analysis of the structure of a discourse remained important in later analyses by Foucault, the assumption that discourse can be viewed as autonomous and not related to other social power-relations did not survive.

Foucault advises (in Dreyfus and Rabinow, 1983, appendix) that in order to conduct a broad discourse analysis, the following general issues within the structure of a discourse must be addressed: 1) the "system of differentiations" or privileged access, 2) The "types of objectives" of one group over another, 3) the "means of bringing power relations into being" that reveals surveillance systems, threats, dismissals, 4) "forms of institutionalization" such as bureaucratic structures, and 5) "degree of rationalization" required to support power arrangements. Foucault believed the purpose of discourse analysis is to describe the connections, contradictions, puzzles, as they become apparent, with the goal of

producing a tool for radical political action (Foucault, 1977, p.205).

Foucault did not conceive of discourse as a unified whole (Mish'alani, 1988). A discourse has inherent, but not random, contradictions. The contradictions are ordered by certain rules, stated or unstated. There is no necessary unity to the set of theoretical concepts that concern a discourse. There is no static repertoire of concepts in a discourse. There is no one style of statement. There is no unaltered set of theoretical strategies. What is important to know about discourse is the *regularity* or the *rules* that govern the array of diversity within the four components of a discourse. These four components are called the subjects, the objects, the styles of statements, and the theoretical strategies.

The objects of a discourse are the assumed entities considered to be external to the discourse that are viewed as the targets for knowledge generation and intervention in a foundational manner. In the discourse of nursing diagnosis, the objects are what are called the "human responses to illness", or the phenomena of concern to nursing. The objects of a discourse are described and thus constructed by the processes of the discourse into its subjects.

The subjects of a discourse are constructed by the discourse from the objects and are manipulated in systematic ways. This is to say that objects are external targets and subjects are internal concepts, sometimes called variables. Subjects are constructed from objects by the social, discursive processes of the discourse focused on what is presumed to be an objectively existing entity. In the discourse of nursing diagnosis, the subjects are the diagnoses themselves.

The styles of statements of a discourse are the form that meaningful statements can take. The theoretical strategies are the form that the processes of the discourse are allowed to take. The style and theoretical strategies are determined partly by assumptions and partly by the discursive practices of the discourse. A Foucaultian style analysis of discourse need not (and does not) make the assumption of foundational objectivity in order to analyze the structure and functioning of a discourse from a power perspective.

The regularity that governs the multiplicity and diversity of the four components can also be described in another way. The multiplicity and diversity of the four components can be said to be described by the implicit order that governs the rules for the appearance,

disappearance, replacement and coexistence of each of the four components in a discourse (Mish'alani, 1988, p. 13).

For example, consider the rules for the formation (appearance) of subjects in a discourse from its objects. There are three dimensions along which objects become subjects in a discourse: 1) surfaces of emergence, 2) authorities of delimitation and 3) grids of specification. The rules for the construction of subjects are explicated by describing the ways these three dimensions are used. Subjects in a discourse multiply because there are rules within the discourse that describe what can count as subjects and objects, what sorts of things can seriously be said about them, who can say them, and what concepts can be used to say them (Dreyfus and Rabinow, 1983, p.71).

A surface of emergence can be thought of as the contiguous edge of a body of discourse that has implications that allow tangential discourses to arise, as it were, on its surface (Foucault, 1975). A discourse arises in relation to other ways of thinking, not in some autonomous manner. For example, the discourse of medicine arose on the surfaces of emergence of natural science and philosophy. An authority of delimitation is viewed as another discourse that sets limits on the identification of subjects for the discourse in question. An authority of delimitation for the discipline of pathology is medicine,

because medicine is the authority that identifies cases for the discourse of pathology. A grid of specification is a systematic discursive ordering of concepts constructed within the discourse. An example of a grid of specification is a taxonomy for subjects in a discourse.

In psychiatry, for example, one of the grids of specification is the DSM-III-R. In this example, the subjects of the discourse are the psychological diagnoses. The objects are the presumed states (and accompanying behaviors) within individuals which are described by the diagnoses. It is assumed that the states (the objects) described by the diagnoses of the discourse (the subjects) actually exist in some objective way in an uninterpreted reality. Within this grid of specification the different diagnoses are divided from one another by definitions, classified, interrelated and placed in a taxonomy. The diagnoses are then used in clinical practice on pre-existing surfaces or physical spaces (in this case, individual human bodies, or groups of bodies like families) which have also been described by the discursive practices of the discourse.

Bodies are the surfaces of emergence in this example, and constitute the context within which people's individual differences, deviations and complaints are noted by the discursive practices of the discipline. Examples of these

individual differences in psychiatry include the family dynamics and the community context. Both grids of specification and surfaces of emergence are coordinated by psychiatry in collaboration with the authorities for the delimitation and identification of cases such as courts, medicine, religious authorities, employers, families, and school officials. Authorities of delimitation may also be termed referral sources.

In these relations between the dimensions of the rules for the appearance of subjects, psychiatry manipulates its constructed subjects using scientific discourse. Scientific work provides the evidence for the manipulation of the diagnoses, forming them, deforming, preserving, deriving, altering, replacing and effacing them. In this one arena of rules (the appearance, construction, or formation of subjects) we can see the interconnectedness of discourse to institutional structures (clinics and hospitals), non-discursive practices (rituals and assumptions), and power relations (professional to professional, and professional to client). The other areas of regularities in the formation of subjects besides the rules for the formation or appearance of subjects are the rules for the formation of styles of statements and the rules for the formation of theoretical strategies.

In keeping with the postmodern, anti-foundational power perspective, Foucault claims that discourse, knowledge and power are so closely interrelated that the field of operation of a discourse is coextensive with a field of power. Since discourse is so closely linked to other social practices, it is easy to see why there can be so many contradictions and tensions between them within a single discourse.

In psychiatry, for example, there is the incommensurability between the discourses of medicine and psychology with respect to the subjects of the discourse of psychiatry - the diagnoses. Competing sub-discourses based on different scientific evidence for, say, the cause of bipolar disorder, gets played out within the discipline. These competing sub-discourses can be identified from a power perspective in a discourse analysis.

The interrelatedness of a discourse to other social discourses, institutions and practices also makes it impossible to totally restrict consideration to one discourse or another. It is also impossible to retreat to a compromise position outside of the discourse under discussion, in order to determine some essence to which to appeal in order to justify conclusions concerning the field of power relations.

To summarize, discursive statements cannot be studied apart from their context. The discursive practices of a discourse produce the subjects from the objects. The subjects of the discourse arise within the "space" or on the "surface of emergence" that was appropriated, named, and made visible by the discursive practices. The discourse combines various practices in a unified way in a certain space, both constituting and being constituted by these practices. This process can also be viewed as the discipline "carving out a turf" for itself among other disciplines, physical spaces, power relations, theoretical orientations, talk, action, and social processes in our society.

Since descriptions of discourse analysis by Foucault and others are fairly vague, I have chosen a specific description of structural discourse analysis that I will use as the basis for chapter four. Rawlinson (1987) elaborates on the explication of Foucaultian discourse analysis and provides a compact summary of the Foucaultian approach. According to Rawlinson, discourse may be conceptualized as the horizon of thought for a participant in the discourse (p.375). The identifying features of this horizon are: the concepts, rules, and authorities that determine the discourse. These must be revealed in part by a historical operation, a genealogy.

According to Rawlinson (1987, p. 377) a discourse analysis is elaborated on three axes. First is the axis of knowledge. This includes analysis of the system of concepts and rules for the formation of statements; and the rules for determining true and false, often called the "method" of the discourse, and thereby accorded the power to produce truth. This is a structural, archaeological analysis that includes the rules of evidence and rules concerning what can be addressed and what cannot be addressed. Rawlinson calls this the closed system of truth.

Second is the axis of authority. To be analyzed in this axis are the rules for the determination of who has the right to speak in the discourse, systems for the preservation, transmission, and general dissemination of the discourse, rules for establishing the relative authority of the discourse vis-à-vis other discourses, and systems of education and association for the reproduction and advancement of members of the discourse. Here is noted how the right to pronounce truth is preserved, exercised, and reproduced. The discourse establishes these things for itself. This is termed the closed system of power.

Third is the axis of value or justification. To analyze this axis the important structures are the systems of regulation, organization, normalization and punishment, and the technologies of power. How is the deployment of the

discourse on the bodies of human beings justified by the discourse?

Not only does the discourse constitute something (the subjects of the discourse) by describing the subjects from the objects in the way it has set for itself, the discourse also produces something else, when viewed from a power perspective. The discourse generalizes its subjects, producing an ideal, a standard, the regular, the normal, through scientific study. Then the discourse functions in a policing role to maintain the range of normal that it has described, by power and control. This is the closed system of value which is necessarily political.

To continue with the example of psychiatry, the discourse defines the normal range of psychological behavior by fixing the dividing line between normal and abnormal. The policing, normalizing, social function of psychiatry arises then with the power to classify behavior as normal or abnormal, and is upheld by social conventions that assign consequences to the social action of diagnosis. Such consequences, in the case of psychiatry, may even include incarceration.

Rawlinson's explication provides for the formulation of questions based on the notion of what is important in the analysis of each of these axes. The questions generated from this conceptualization will be listed at the beginning

of each of the three chapters that address parts of the analysis, and specifically with respect to the three axes.

Section Five: Power Analytic

The process of conducting a power analytic involves careful reading of entire texts and other organizing systems in relation to one another, with a view to discerning discursive patterns of meaning, contradictions, and inconsistencies (Weedon, 1987) that illuminate power relations. The written product identifies and names language processes and social practices that people use to constitute their subjective existences and construct their understanding of social life. These processes either reproduce or challenge the distribution of power as it currently exists. (p.467).

"A power analytic accounts for the social production of identities and institutional orders that frequently are assumed to be natural; they aim to free individuals from essentialist identities that constrain behavior; they strive to unearth submerged alternative languages to describe experiences and open up new possibilities for social identification and behavior." (Seidman, 1992, p.70). Influenced by postmodernism, a power analytic shows how social power is constructed, circulated, and played out (Seidel, 1993, p.175).

A power analytic includes a focus on oppression, how powerless groups are oppressed within power relations, the possibilities of resistance, and how marginalized voices can attempt to challenge dominant discourses. Assuming an anti-foundational perspective, discourse analysis assumes that people can be deceived about what is going on, without assuming that it is possible to know what is "really" going on.

A power analytic may involve identification of several social discourses available to people in a given society at a given time (Gavey, 1989). Seidel's (1993) discourse analysis in section three is an example of this kind of discourse analysis. An analysis of this type will show how the discourse provides alternative speaking positions (Gavey, 1989), and either reproduces or challenges existing power relations.

Some of these alternative speaking positions may be termed marginalized discourses. Marginalized discourses are non-dominant discourses that may or may not represent discourses of resistance. When marginal discourses come under scrutiny by more powerful discourses, the possibility exists that they may be co-opted into the dominant discourse without much alteration, or they may undergo extensive alterations which sometimes render them

completely sterile as alternative subject positions available to people.

A power analytic acknowledges the ability of individuals to recognize power relations and the ways in which their options are limited by a belief in the repressive hypothesis. On the other hand, the capacity of people for activities of resistance and the possibility of co-optation are also acknowledged. Systematic limitations can be brought to light. In some versions of discourse analysis, preferability of speaking positions and practices may be identified. Specific practices of resistance may be openly advocated. Feminist discourse is one such discourse that acknowledges the possibility of the creation of new options, new speaking positions, which, in turn, form new subjectivities, new ideologies with new limits and new possibilities (McIntosh, 1988).

Naming and describing resistance can initiate the process of co-optation and control, using an overt but illusionary goal of emancipation. During such examination as takes place in a power analytic, feminist process variables assume critical importance in the identification of positions of power and resistance in a power analytic of a particular instance of domination. Foucault's work does not address these variables, but they are important in the analysis and discussion of any discourse in nursing.

Feminist Process Criteria

The feminist process variables, or process criteria, are discursive modifications of Habermas's (1984) notion of a communicative ideal. Habermas (1984) had argued that rationality is approached by two goals for the process of discourse: autonomy and responsibility. "Autonomy is the ability and willingness to participate openly in the conversation, and requires being sufficiently self-reflective to understand one's own values, interests, needs, and inhibitions and to take them into account when interacting. Responsibility is ensuring that all participants can function autonomously by attending to group dynamics, knowledge imbalances, power differences, and so forth." (p.6). Rationality, for Habermas, is defined by the confidence one can have in the outcome of the conversation, and is approached by working towards these two communicative ideals.

Some feminists have revised Habermas' notions of ideal speech situations and their relation to rationality. Habermas' notion rests on a transcendental individualistic model and abstract notions of fairness, justice and reciprocity as normatively achievable goals (Calhoun, 1992). Habermas does not consider whether an acceptable form of rationality might begin with relationships rather than individual persons. The very notion of individual is

demonstrated by postmodernists as historically and culturally specific. If the starting point for discourse becomes relationships instead of individuals, then one must necessarily take into account the non-equivalence and non-interchangeability of persons, i.e. their situatedness. Diversity of situations is thus seen as a good thing.

Fraser (1987) critiques Habermas' communicative ideal from the postmodern standpoint of power relations, hegemony and patriarchal society. The determination of a person's right to speak within a discourse is a socially constructed act and an interested move of power. For Habermas, communicative consensus is that of assuring the autonomy and responsibility of speakers in truth claims within ideal speech situations. It is a communicative ideal and is not grounded in practice. It can become a rhetorical exercise that is just as dominant as the one it seeks to replace, unless it examines its own interests, processes, and goals.

Fraser argues that Habermas' criteria for rational discourse ignores women's oppressed group status (Fraser, 1987). The goal of rational consensus assumes that individuals are capable of helping each other to see clearly and working equally toward consensus. Being embedded in a network of power/knowledge would limit individuals' capacity to reason with clarity and to be able to agree to act upon that reasoning due to the possible

consequences in their lives. Individuals are not all equally free to choose. Even the very definitions of individuals who have the potential to become speakers in Habermas' account are definitions based in interested power positions. According to Fraser, Habermas' concepts are transcendental, not located in situated bodies.

Some feminists therefore add to Habermas's communicative goals of autonomy and responsibility the ideas of the connectedness among participants, intersubjectivity, situatedness, and the roles of emotion, diversity, and intuition as supportive of group rationality. Allen (1992) explicates these process variables with respect to nursing inquiry. This situatedness leads to a focus first on values and perspectives and worldviews, then on to the issue at hand. This is not seen as a form a relativism, but a part of the process wherein the speaker explicates their worldview and perspective, instead of making people guess about it, and enabling them to assess how much they share with each other (Allen, 1992).

In order to avoid co-optation of resistance, feminists insist on commitment to participative, communicative, and process ideals (Allen, 1992, p.13). Consciousness-raising peer groups are the model for participation. Typical questions addressed by the postmodern feminist approach

might include the following: Whose voice is being heard? Whose voice is being left out? Do people feel constraints against speaking? Are all voices equally informed? The politics of the research situation can be more important than the research itself (Street, 1992). These questions are critical for the analysis of discourse in nursing.

These process criteria represent an historical shift away from speakers and authors writing to themselves for themselves and then applying their conclusions to other groups. The implication is that in order to assess the rationality of the discourse, the existence of an ongoing reconciled intersubjectivity among the community should be examined.

Consequently, when faced with competing claims, feminists assess the context in which the claim arose, in order to provide evidence with respect to whether or not the process respected autonomy, responsibility, situatedness, interconnectedness, diversity, and emotion and intuition.

Explanations and claims are necessary in order to indicate systematic oppression and how it may be confronted through a discourse of resistance. The role of feminist process criteria in an analysis of discourse in nursing will be discussed in section seven.

Section Six: Examples of Critical Discourse Analysis

This section will describe examples of critical discourse analysis that take slightly different forms, emphasize different key concepts, and come from different academic disciplines. It will become clear that all share a Foucaultian perspective on power, resistance, and the role of discourse. Some of these examples remain at the descriptive level of discourse. Others make recommendations for ways to reduce oppression based on the identification of strategies of resistance. Still others identify, suggest, and follow through with resistance strategies as an ongoing part of the process. Street (1992) is an example of this latter approach in nursing, and will be summarized last.

A Discourse on AIDS

Seidel (1993) produced an analysis of the discourse surrounding HIV/AIDS in sub-saharan Africa. His analysis considers written discourse, behaviors and talk about HIV/AIDS and separates this conglomerate into somewhat overlapping abstract categories of discourse in order to demonstrate systematic oppression, and to identify discourses of resistance to oppressive relations. He identified six separate discourses that have contrasting accounts, different histories, different paradigms,

different power relations, differential access to public policy and funding, and different outcomes. (p.176).

According to Seidel, oppression is created as an unintended consequence of two of these discourses, the medical and the medico-moral. The medical discourse is the approach of medical science. The medico-moral discourse is the Christian moral conclusions based on medical science. In Africa, these two discourses have resulted in "control, medicalisation", "mass harrassment" and "calls for expulsion" of what are termed "high risk groups" of people (p.177).

Seidel notes that the "stigmatising and misleading {phrase} 'high risk groups' has been more widely replaced by 'risk behaviors'", in the medical discourse on AIDS in our northern hemisphere (p.176), but this has not happened in Africa. Of the identified discourses, Seidel characterizes the marginalized discourses of ethics and rights as resistant to the systematic oppression of groups of people by the more dominant discourses. Seidel concludes that, for oppression to be reduced, the discourses of resistance should be examined for strategies that might be adopted by the oppressed groups.

Seidel's analysis contributes an excellent example of the identification of alternative discourses, or speaking positions, within a discourse. This example also

demonstrates the identification of sources of resistance practices.

A Discourse on Pain and Fear

Nettleton (1989) analyzed the discourse on pain and fear in dentistry. The focus of this analysis is the genealogy, the goals, and the unintended consequences of this discourse. The existence of competing discourses was not demonstrated, but Nettleton notes that dentists, "through trying to eliminate the supposed experiences of pain and fear, have paradoxically ensured the existence of these two concepts." (p.1184). This is accomplished by constructing a discourse about them, which legitimizes pain and fear as subjects of the discipline. Discourse has the unintended consequence of keeping the subject alive, even when the intent is to eliminate it.

Nettleton's analysis is based on Foucault's concept of the medical gaze, which creates subjects by identifying a bodily space for them (Foucault, 1975). The gaze is a productive way of looking at a pre-determined space created by the discipline and is invested with power. Thus the meaning of pain, for example, is derived from its spatial location.

In the early years of dentistry, pain was perceived as restricted to the interior space of the physical body as a biological consequence of stimulation of nerve endings.

Control strategies that arise from this perspective are therefore restricted to physical measures like drugs.

In the inter-war years, dentistry, following medicine, acknowledged psychological factors, such as fear, in the description of pain. Dentists looked to psychoanalysis to provide them with the mouth-to-mind link that would help explain dental pain more completely than neural transmission alone. Accordingly, the discourse incorporated the notions of fear, hysteria, oral pleasure and pain, and the "meaning" that these notions have to dental subjects. This shifted pain to the location of "the mind" and described pain as a subjective phenomenon.

Discourse since the 1960's, in Nettleton's interpretation, locates pain within an even wider gaze, a social space that surrounds the patient and includes the environmental context. This has resulted in the creation of knowledge and control strategies at two levels, the micro-level of the individual dental subject and the macro-level of the population. At the micro-level, the practice of history-taking and physical examination become increasingly systematic in order to get the "right" information, including getting the patient to consider themselves speaking subjects and objects of study. This is a scientific process, using scales and indexes for pain and fear. The macro-level of epidemiology has placed the gaze

on constructing fear and pain at the population level and subjecting populations to measures of fear and pain. This construction leads to control at the population level toward the goal of the social construction of a notion of dentistry without pain and fear.

The purpose of the discourse is the elimination of pain, but to eliminate something, you must talk about how this is to be accomplished. Control strategies must be developed. The moves of gaze are productive of a new subject, a person called the dental patient, and new knowledge at two levels. Definitions that change historically are noted as changes, not in the discourse, or the gaze, but in the phenomenon illuminated by the gaze, the pain. "The conception of pain was both the object and effect of the techniques of observation and analysis" (p.1187).

Nettleton concludes that the "functioning of power/knowledge transcends professional and disciplinary boundaries and is a process which is far more subtle and fundamental than one of the accumulation of increasingly sophisticated knowledge or of political manoeuvrings by interested individuals or groups who wish to see a more humane system of health care." (p.1189). The unintended consequences of the discourse on pain and fear in dentistry are that it participates in the increasing control of its

reified subjects, and creates docile patients.

Paradoxically, it creates what it describes, and disallows alternative explanations of the possible.

Nettleton's analysis demonstrates the analysis of the importance of the body to discourse, and the productive function of power/knowledge. This analysis also focuses on the effects of the "medical gaze".

The Discourse of Disneyland

Foss and Gill (1987) analyzed Disneyland as a system of discursive acts that oppresses the patrons in a way that distorts their image of social life. They identified three major discursive practices - design elements, the visitor's role, and the employees' image. Examples of design elements are scale, perspective, architecture, music and inauthenticity. Specific things are left out of the design elements, like pollution, litter, animal manure, and insects. The authors note that what is left out is as important as what is emphasized.

The role assigned to visitors is that of passivity. Choices given to visitors are trivial. Roles available to visitors are very limited, and violations result in removal from the park. Real money is not acceptable in this system, only that which is exchanged for coupons. Interaction of visitors with employees is strictly regulated.

The image of the employees is child-like, asexual, and white. Rules identify to employees what can be spoken and done and what cannot. The non-acceptability of sexuality in the park is not questioned by employees or customers. Hiring practices for employees are very strict, producing a homogeneous pool of people.

Knowledge and power are demonstrated by such things as the non-human and therefore non-interactive physical mechanisms of crowd control. Security is invisible, but surveillance is continuous. Impersonal rope paths control line ups so that there is no identifiable target for aggression or frustration.

This analysis provides a good example of the emphasis on social practices in addition to written discourse. In addition, this analysis demonstrates the emphasis on practices that perpetuate current power relations.

Discourse Analysis in Public Health

Lupton (1992) argues for discourse analysis to be used in public health, but that it is an interdisciplinary field of inquiry. Discourse analysis is different from traditional content analysis, semiotics, and ethnomethodology, because it gives a critical analysis of the use of language and the reproduction of dominant ideologies in discourse (p.145) and looks at rhetorical devices, structure, style, subject matter, how ideology is

reproduced in them. It identifies cultural hegemony and the manner in which it is reproduced.

Lupton quotes Gross (1986) "particular interests are served by every theoretical position and in any textual or discursive system". Lupton reports briefly on two discourse analyses of this type. One is an analysis of the discourse of habitual smokers during the time they were trying to quit. The second is an analysis of doctor-patient communication which explored gender differences between doctor and patient.

This article provides an excellent justification for the approach of discourse analysis as a useful strategy for the health professions.

Discourse on Race and Health

Allman (1992) analyzes the discourses on race, racism, and health in the manner of a power analytic. She dismisses the idea of a grand or master narrative of the progress of science, and analyzes instead the competing discourses on these topics. She calls her approach postmodern (p.37) in that she is concerned with discourse analysis and deconstruction. She also adds a critical element to her analysis, meaning the attempt to provide new ways of seeing that provide the possibility of improving upon past mistakes (p.38).

Allman describes the discourses on race and health and their unacknowledged conditions and unintended consequences, pointing out that the silences in a discourse are as important as the talk. Hers is a critical analysis that identifies the racist consequences and conditions of the discourse.

For example, Allman describes the historical antecedents of modern discourse such as the early 1900's scientific discourse on the red hair of the Irish "race" being causal of a tendency to rheumatic fever. She points out that being presented with another, historical perspective brings insight into the analysis of hidden parts to our own perspective.

Allman talks about the discourse of "naturalism", which presupposes a nature separate from culture and human consciousness (p.40). She lists the advantages of the naturalizing approach to biomedicine and nursing. In its time, the naturalizing approach was thought to lift the blame for a bodily condition away from the moral domain and into the supposedly "neutral" domain of nature where a value-less science could treat and cure it. The political and social "inferiority" of a race is moved from the realm of discussion to the realm of problems to be solved. Unfortunately, the "inferiority" moves with the condition and becomes even more entrenched in a "natural" viewpoint

that is supposedly more solid than the social viewpoint, and less likely to change. This racist view of natural inferiority does not lift the blame but affixes it more solidly and irretrievably.

Allman quotes Yamato's (1990) definition of racism as the "systematic mistreatment of one group of people by another on the basis of racial heritage" (p.22). Allman maintains that racial discrimination cannot be accounted for by separating out analyses of race from those of class and gender, because of the differential opportunity structures organized by race and amplified by class and gender (p.42). Following Foucault, Allman argues that race is not a property of bodies, nor originally extant in human beings. Instead race is a set of effects produced in bodies. The bodies are the site of the technological interventions which produce the effects, only when examined. It is a semiotic apparatus, a system for assigning meaning and value.

Allman cites four problems in research on race and health in medicine and nursing that should be addressed. The first problem is that of race not being represented at all. Secondly, research wherein race is represented as a depersonalized object of experimentation, such as in the Tuskegee experiments on black men and syphilis. Thirdly, the case wherein race is equated with disease as in the

Nazi experiments. Fourthly, Allman names the study of culture without context, as if the researcher does not have a race.

Oppression in Nursing

The emergence of critical scholarship and feminism within nursing and especially nursing education are signs that the profession is beginning to respond to the experiences of nurses (Thompson, 1987; Heinrich & Witt, 1993). Campbell and Bunting (1991) have advocated what they call "text review" which is a critical review of literature that seeks to uncover the contradictions embedded in our society. Doering (1992) supports a feminist postmodern view of power and knowledge in nursing. The annual Conference on Critical and Feminist Perspectives in Nursing provides many examples of critical theory and feminist analyses (see Allen, Thompson, and Rodrigues-Fisher, 1992).

There are, however, few examples of discourse analysis in nursing. I have chosen an excellent recent example of discourse analysis that would fit Leonard's (1990) criteria for a postmodern critical social theory that guides action in a specific context.

Street (1992) does participatory feminist research that she calls a critical ethnography of clinical nursing practice. In Australia, research called "action research" is based on a critical social theory paradigm that analyzes

power relations (p.75). Street chose critical social science because it assumes the ideological nature of self-understanding (p.84). There is much technical knowledge in nursing, causal knowledge that informs practice in predictive ways. Street challenges this as a model for the entire discipline, emphasizing that different kinds of knowledges serve different particular interests.

Street believes that feminist research is a political act (p.11) intended to bring about consciousness raising. This kind of consciousness raising promotes in nurses the realization that conditions of professional autonomy are informed by action-orienting self-understanding among nurses in a shared culture (Hiraki, 1992, p.135).

Street's work is a variant of critical pedagogy that enables nurses to deconstruct the ideological, political, and historical elements of nursing discourse. The researcher's interests are clear from the beginning. Street believes nurses can use metaphoric imagination to reconstruct a collaborative social dream of transformative healthcare based on strategies of consciousness raising and empowerment (p.87).

Clinical practice is viewed as a site of cultural struggle (p.87). She calls her work a critical ethnography because it is *for* nursing and not just *about* nursing. Street argues that traditional empirical analytic research

makes use of self-report of actions and meanings, which ignores false consciousness and leaves the researcher open to the charge of subjectivity. Under the guise of disinterested interpreter of data, the researcher may perpetuate and legitimate forms of cultural oppression as an unintended consequence of foundational assumptions (p.12) .

Street endeavors to maintain respect for the participants while at the same time challenging their assumed world view. Research subjects were encouraged to participate in all aspects of the study because their participation could be used to disclose taken-for-granted actions and contradictions that disclose the power relations that limit their autonomy and responsibility.

For example, the subjects had access to the data in an on-going way, not just at the end of the study. It was the author's original desire for the subjects to be co-authors with her, but she found that the nurses engaged in the same passive resistance with her as they did in their workplace. Street concluded from this that she was using her own power/knowledge to force a research strategy on her subjects, based on her own research design and not the strengths of the discipline. The nurses had an oral tradition, not a written one. To that end, the author removed what was considered pressure on her subjects to

become authors, and worked with them in the verbal way they preferred.

Street emphasizes the importance of not being stuck in strict dichotomies like reproduction vs resistance, or school vs practice. This work treats the production of meaning in its temporal, spatial, cultural, and historical situatedness. Street makes use of the oral culture of the practice environment and the educational environment. The work disavows claims to a master narrative, situates the author's practice and clearly states her own interests in doing the work.

As a critical ethnography, the study assumes false consciousness can be changed in order to promote empowerment and decrease oppression. Such empowerment included consciousness raising with respect to the social consequences of current gendered divisions of labor in health care where hegemonic domination is reproduced based on gender, race, class, and age. Street openly searches for forms of nursing autonomy that refuse to emulate the logic of patriarchal domination. Patriarchal discourses are sometimes hard to detect because they seem "natural" and therefore tend to "disappear" from view (Allman, 1991).

Street critiques Foucault's notion of power/knowledge as deficient for describing women's oppression. She claims that nurses do not fully engage in power/knowledge, but do

participate in what she calls nurturance/knowledge. She said she used feminist critique which exposed some transformative actions that could not be analyzed using power/knowledge. This conclusion leads Street to believe that there are limits to the applicability of critical social science for knowledge in nursing. I was personally not convinced, however, that nurturance/knowledge is anything other than another marginalized discourse that has potential for the production of strategies of resistance.

Street concludes that the dominant discourse of nursing is medicine, and that nursing is basically a moral discipline whose goal is the social production of a docile patient, consistent and parallel to other disciplines of social agents, mainly medicine. The unspoken values of nursing practice are at odds with the values of nursing scholars, and actions with potential for resistance do so by challenging role boundaries between medicine and nursing.

Discourses of resistance were found in marginalized practices such as verbal report, and things not admitted into the knowledge realm, the silences, the avoidances, such as individual pieces of particular patient information that make up "their story".

Nurses who participated in this study reported to Street that they had undergone transformations that had a

significant impact on their practice. They now recognized horizontal violence in their workplace, and oppressive situations between themselves and doctors, and themselves and hospital administrators. They said they now understood the importance of consciousness raising and the rehearsing of empowerment strategies in order to form habits that break the cycle of oppression.

An understanding developed among the participants in Street's study concerning the reasons why nurses do not talk about some aspects of their practice that may seem like resistance to power, while emphasizing others that imitate the dominators. Collaboration and collective empowerment were seen as difficult skills to master because of the history of mutual mistrust between nurses.

Finally, Street identified continuing resistance of nurses to engage in a written culture, even when convinced that this was the way to achieving more power/knowledge. The nurses in this study continued to value the oral nature of what they do as positive and enhancing. Street called this continuing resistance "counter-hegemonic" (p. 271) and insisted that nurses must understand that the development of knowledge from practice depends on written records for analysis. Street was unable to identify any way that practice knowledge could develop from an oral culture.

There is room for continuing research regarding this conclusion.

Section Seven: How This
Discourse Analysis Was Conducted

Given the concepts, the influences, the descriptions, and the examples of discourse analysis above, I will now describe the process I used to perform this analysis. After the dissertation proposal was approved, the literature on discourse analysis was read, or, in some cases, reviewed. Modifications to Foucault's basic approach from critical theory and feminist theory were made.

Given the constructed approach to the task at hand, questions were generated from my reading of the literature on discourse analysis that would be asked of, and answered by, the discourse of nursing diagnosis. Chapters three, four, and five each begin with a set of these questions.

When the approach to discourse analysis seemed clear, the literature on the history of the general concept of diagnosis was sampled as part of the text for the genealogy. Next, the entire body of published work concerning the discourse of nursing diagnosis was collected and read. Some articles and books were skimmed if they seemed redundant to other works. Notes were taken all during this time, guided by the questions I had generated. Everything that I read that had anything to do with the

questions I had generated was noted and organized under the headings provided by the questions.

Finally, after all data had been noted, I wrote the analysis found in each of the three chapters with respect to each of the questions I had asked, and any overall impressions I had had during my reading of the entire discourse of nursing diagnosis while keeping in mind the goals, objectives, and purposes of such an analysis.

This data collection method could have been enhanced by interviewing participants in the discourse of nursing diagnosis. Further insight into the perspectives of the original proponents, and their current opinions would have been useful. However, the sheer enormity of the task precluded, at this time, the addition of interviews to the data collection strategy.

The conclusions of this analysis are not generalized to any other discourse. Alternative interpretations of this data could be generated based on other conceptual frameworks, complete with supporting evidence.

Generalization of Results and Recommendations for action

Foucault was hesitant to make predictions or recommendations for action because of the influence of postmodernism and anti-foundationalism. According to foundational empirical analytic science, any discipline

worthy of the name "science" was required to proceed in a generalizing manner, that is, testing generalizations against experience. However, critical social theory argued that successful prediction does not necessarily lead to truth (Seidman, 1992, p.171). A critical approach to inquiry, as opposed to foundational science, is not necessarily tested by outcomes of prediction. (Held, 1980).

Critical social theory problematized the goals of prediction, efficiency, exploitation, and control because of their systematic functioning in the ideological process of domination. Prediction, efficiency and control are values; they are "vested interests" just as much as any other, more obvious, "vested interests" (Aronowitz, 1992). It is difficult for us to see the operation of these concepts as values or goals because they form the very basis of what we as a society believe to be "common sense" (Weedon, 1987). In this view, successful prediction only reflects the extent to which social phenomena have become controlled by the very processes that are now measuring them. It does not reflect any reality other than the one it has itself constructed both socially and historically.

Methodologically, discourse analysis acknowledges the interpretive, situated nature of observations. Extensive quotations help validate the findings, but no claim is made for universal application (Lupton, 1992). The results of a

discourse analysis as performed in this manner are not necessarily applicable to any or all related circumstances. The interpretations are located within a specific context.

Foucault resisted generalizing statements and recommendations for action based on practices of resistance, fearing that such statements would suffer the fate of other such projects, that is to say, be co-opted and become repressive in and of themselves. Such conclusions have, in the past, served as justification for increased intervention, resulting in the expanded influence of power and control (Foucault, 1978). He was justifiably cautious about positing a better world. Foucault points out that the tools we have for emancipation are based on exploitation strategies, and not empowering ones.

Feminism Addresses the Problem of

Recommendations for Action

Foucault's lack of recommendations for action indicates to Leonard (1990) that the practical intent of critical social theory is being lost. Aronowitz (1992) adds, "We can no longer critically reflect on domination as a generalized social form because we have lost the capacity to distance ourselves from the world we have constructed on the basis of science." (Aronowitz, 1992, p. 294). The problem of a conceptual basis for recommendations for action is addressed by some academic feminist thought.

Feminist discourse successfully adds emancipatory praxis to postmodern discourse analysis (Leonard, 1990). Feminist thought has been suggested as an important perspective for nursing inquiry (Allen, Allman and Powers, 1991; Allen, 1992; Smythe, 1993; Schuster, 1993; DeMarco, et al., 1993; Wuest, 1993b). "One of the strengths of feminist critique is that it presents a model by which bias can be uncovered in a scholarly manner without rancor but with both urgency and compassion." (DeMarco, et al., 1993, p. 30).

Weedon (1987) defined feminist postmodernism as "a mode of knowledge production which uses poststructuralist theories of language, subjectivity, social processes and institutions to understand existing power relations and to identify areas and strategies for change" (pp. 40-41). Feminist postmodernism is concerned with disrupting and displacing dominant (oppressive) knowledges (Gavey, 1989, p.463).

Emancipatory feminist research is sensitive to its own interests, and prescriptive resistance is not based on a reactionary opposition to a dominant, patriarchal, hegemonic discourse (Fraser, 1987, p.80). Charges of relativism notwithstanding, feminism can draw theoretical prescriptive strength from diverse stories and does not need grand narratives (Nicholson, 1992).

Thompson (1992) discusses the importance of identity politics in feminism to nursing inquiry in a way that emphasizes difference and diversity. Identity politics, according to Thompson, links the personal and the social by attempting to create political alliances across differences. These attempts are viewed as historical and social constructions which assumes common (or collective) concerns for situated people. Identity politics attempts to find ways to build these alliances without marginalizing differences or glossing over the complexities of people's multiple identities (p.25). Prescriptive knowledge in nursing is viewed as socially and politically constructed, and closely related to power (Gavey, 1989; Doering, 1992).

Recommendations for action are not a problem for feminist theory, because of the assumption that certain positions that are opposed to racism, sexism, and classism are contextually *preferable* to those that are not so opposed (Allen, 1992, p.1). Feminist writers in nursing inquiry have good reasons to worry about substituting the researcher's explanation for that of the persons being researched. Then the following question arises: how can we as feminist nurse researchers proceed to ask and answer questions that both promote knowledge generation and protect against its oppressive potential or the

perpetuation of already existing oppression? (Allen, 1992, p.2) .

There are two important points to consider when identifying such "preferable" conclusions to inquiry, according to Allen. These two points are the rules of evidence and the problem of explanation. What kinds of evidence are acceptable? Sensory data are not without problems, but are not useless. Allen argues that we must support our recommendations for action by understanding the social conditions in which they are debated, and by an examination of kinds of evidence we find acceptable in making such claims.

The important issue is the one that asks: On what grounds to we prefer one explanation over another? What grounds the preferability of explanations? Interpretive knowledge that posits meaning, and analytic knowledge of structures are both important, but both neglect the idea of false consciousness. "To give up the notion of "cause", especially in favor of interpretive traditions that ascribe meaning-creation to individuals) leaves the process of *change* - what inhibits it, makes it happen, etc. - unexamined, untheorized and unsituated." (Allen, personal communication, 1994).

Allen addresses this problem of ideology and false consciousness, which for feminist postmodernism includes the

notion of critique as well as preferability. Feminist critique claims that oppressive ideologies are systematic misrepresentations or distortions (Thompson, 1984) without an assumption that there is some objective reality that is being distorted. In this sense, then, feminist postmodern theory addresses the repressive hypothesis instead of a false consciousness.

The feminist postmodern perspective is therefore justified in posing recommendations for action based on attention to process variables and the notion of situated preferability. All data may consist of interpretation, but that is not to say that there cannot be deception or self-delusion by one interpretation over an alternate, hidden interpretation, that when revealed, becomes preferable to the participants.

Section Eight: Conclusion

Nursing could have a pivotal role as an academic and practice discipline due to its unique circumstances. It is composed mainly of women and has been understood historically as a female occupation. It was formed and has existed primarily for the purposes and under the direction of the most powerful profession that exists in modern times - medicine. Therefore nurses know the oppression of themselves as women, and of their discipline as subordinate to medicine both in its long history and its contemporary

everyday practices. Nursing discourse in general could participate in the extension of bio-power or could become a source of discourses of resistance.

Nursing as a recognized discipline is taking its place in universities around the world without a long history of allegiance to any established philosophical perspective or social theory for its own research, having participated in the research of many other disciplines in a positive way. Nursing contains marginal discourses that could add considerable strength to positions of resistance to domination effects. At this point in time, nursing has the enviable position of a widely informed choice among philosophical approaches as models for research, teaching and practice. The question, "Is nursing a science?" has become irrelevant. The question will now be asked of us, "What kinds of science do nurses do?".

The diversity of methodological approaches to inquiry available to nursing has the further advantage of including discourse analysis, which was not widely available until about 10 years ago. The philosophical perspective of discourse analysis would orient the discipline to address such important notions as the context and situatedness of nursing, its history, the power relations, the social position, the long term goals and values, the vested interests of participants, the conditions of autonomy and

responsibility of speakers, the process used to formulate and structure discussions, the rules of evidence used to produce explanations, and the rules by which subjects are ignored or dismissed. The philosophical perspective of a discourse analysis helps break the tenacious hold of materialism/realism/foundationalism, and equally important, individualism, that so dominate our thinking (Allen, 1994).

Nursing has the opportunity to demonstrate the operation of a discipline that does not reflect a limited, traditional philosophy of science that is oriented toward prediction and control of phenomena with the unfortunate unintended consequence of oppression of people. Through a belief in alternative futures, nursing could become a source of potential subjectivities that produce situated practices of resistance to the ideology of nursing diagnosis. These subjectivities, though constructed out of different contextual ideologies, might describe preferable situations of reduced oppression.

CHAPTER THREE: GENEALOGY OF NURSING DIAGNOSIS

Introduction

This chapter will examine the history and early development of the discourse of nursing diagnosis in the nursing literature up to the first national conference, from a power perspective. This is the first of three chapters that comprise the analysis of the discourse of nursing diagnosis. Genealogy provides the historical perspective by identifying key influences on the development of the participation of the discourse of nursing diagnosis in present power relations. Some of these influences are assessed directly, and some are identified in a retrospective manner from the standpoint of the proceedings of the first few national conferences.

These key influences continue to inform the discourse of nursing diagnosis through its structure, functioning, and position within present power relations. The influences identified in this chapter have implications that are further referred to in the succeeding two chapters, because it is difficult to separate the historical influences from the present functioning and power arrangements.

Section one of this chapter describes the origin and development of the concept of "diagnosis" in the English language with respect to medicine. This section provides the basis for analysis of the contribution of the discourse

of medical diagnosis to the development of the discourse of nursing diagnosis. The discourse of medical diagnosis is a crucial consideration in a genealogy of the power of nursing diagnosis.

Section two describes the early writings, definitions, and influences on nursing diagnosis up to the time of the first conference. Section three answers questions specific to the genealogical perspective of a discourse. These questions are listed at the beginning of section three and arise from the description of the methodological perspective of a discourse analysis in chapter two.

On the basis of the evidence presented in this chapter, the following claims are made. First, the *development* of the discourse of nursing diagnosis was influenced by the social models of power and social agency from medicine and foundational science. Second, the development of the discourse of nursing diagnosis can be viewed as consistent with the description of discourse development from Foucault's power perspective. Third, the development of the discourse of nursing diagnosis can be shown to have restricted the options for the structure and functioning of the present discourse in a systematic manner according to dominations already inherent in the models used. Section Four concludes the chapter and shows how the evidence presented by the analysis supports these claims.

Section One:

History of the Word Diagnosis

Recall from chapter two that a genealogy provides a historical perspective on the development of the discourse and its position within present power relations. Consequently, there are certain general questions based on an anti-foundational, postmodern power perspective that deserve consideration. What discourses provided models that influenced the worldview of the discourse of nursing diagnosis? What words in the discourse have a history to them that is significant for assessing the role of the discourse within current power relations? The answers to these questions provide a basis for the analysis in chapter four. Systematic oppressive effects can then be identified as being perpetuated, extended, or created by the discourse. Discourses of resistance can also be situated in their historical context.

The most important word in the entire discourse of nursing diagnosis is clearly "diagnosis", followed closely by the word "nursing", and then an array of words such as "human response", "problems", "etiology", "defining characteristics", and so on. Definitions and re-definitions constitute a move of power (Allen, 1986). The most important discourse in the development of nursing diagnosis is that of the discourse of medical diagnosis.

The implications of the choice of the word "diagnosis" for the discourse of nursing diagnosis are far-reaching in their effects. The sub-discourses and models implied by the choice of this word continue to inform the structure and functioning of the discourse of nursing diagnosis within present power arrangements. This section presents a history of the word "diagnosis" and describes one problem in the functioning of the idea of diagnosis in the practice of medicine today. This problem can be identified within the discourse of nursing diagnosis as well. Describing this problem underscores the imitation of medical diagnosis by nursing diagnosis. In dealing with the resulting conceptual difficulties, the discourse of nursing diagnosis will be shown to imitate the authority of medicine at the expense of patients and their families.

The Oxford English Dictionary defines the word "diagnosis" as follows: Greek, noun, meaning "of action" from the Greek word "to distinguish, or discern" which comes from two other Greek words, one meaning "thoroughly asunder" and the other meaning "to learn to know or perceive". 1. In medicine it is the determination of the nature of a diseased condition; identification of a disease by careful investigation of its symptoms and history. 2. The opinion resulting from the investigation.

Diagnoses are therefore not immutable entities in an absolutely knowable reality, but dynamic social and historical constructions (Bynum and Nutton, 1981). It must be noted that this definition of diagnosis reflects an Indo-European world view and may be incommensurate with other world views, such as Asian or African.

Furthermore, note that to diagnosis is not to decide between health and non-health states, but involves the discerning of the conceptual label of a non-healthy state. The purpose of the action of diagnosis is the discerning of *what kind* of non-health a person is experiencing, not whether the person is healthy or not healthy. The action of diagnosis has, therefore, the social discursive power of naming.

The importance of the Greek period for the discourse on medical diagnosis is reflected in the relationship between causes, symptoms, and treatments. The conceptual correspondence of cause, symptom and treatment reflects a social belief that the same thing that happened once to one person can happen to another person at another time. In other words, there is assumed to be a certain degree of predictability in a foundational sense.

Two important notions made their appearance in ancient Greece: the ontological theory of disease, and the reactive theory of disease. The ontological theory of disease

implies that diseases can grow and mature inside a person and/or move to another person (Matlock, 1975; Grmek, 1989). The myth of the diseases in Pandora's box is based on this notion.

Some modern English words that are based on the ontological theory are "catching" a cold, being "attacked" by the flu, and the ideas of contagion and immunity (Nutton, 1983). This notion implies that there are different species of disease based on their assumed essence or nature.

The second important notion to arise in ancient Greece is the reactive theory of disease (Taylor, 1979). This theory holds that disease is the body's reaction to a noxious agent. The pathological changes and bodily reactions are the disease. Therefore, the words that reflect this kind of classification focus on the bodily reaction as the disease entity and not a noxious agent: cerebral tumor, gastric ulcer, mitral stenosis. The writings of Plato, Aristotle, and Hippocrates all reflect the existence of both theories (Taylor, 1979).

The major purpose of the Hippocratic corpus, however, was not the provision of a *diagnosis*, but the provision of a *prognosis* for an individual case (Hudson, 1983). The detailed descriptions of symptoms corresponded directly to estimates of trajectory, not indirectly to a determination

of the name of a disease which is conceptually attached to recommendations for treatment.

For example, white pus from a wound was considered a good sign for prognosis. Yellow pus, however, was a bad sign for prognosis (Hudson, 1983). The purpose of describing white or yellow pus was not to come to a conclusion about what is the name of what is going on, in order to discriminate between that name and the name of something else that could be going on, but to *directly* judge the trajectory. Yellow pus means the patient will die in 14 days. White pus means the patient will have fever for three days, vomit red bile, and recover in 5 more days. Treatments were classified by their effect on symptoms, which might change the prognosis, if the treatment changed the bad symptom to a better symptom.

In the practice of Hippocratic medicine, changing the prognosis of a patient was more important than naming the phenomenon, when it came to applying treatments. Naming and classifying diseases were considered a philosophical enterprise, not a clinical enterprise.

The other approach to diagnosis in ancient Greece is less well known. Hippocrates belonged to the Cos school of thought (Galdston, 1981). The other approach was the Cnidus, and the chief physician of that school was Euryphon. This view of diagnosis concentrated on the

classification of specifically named diseases according to minute individual variations of signs and symptoms, each variation being productive of another species of disease.

Both schools of thought had advocates and critics. The Cos physicians prescribed treatments according to symptoms and criticized the Cnidus physicians for "multiplying types and assigning essential importance to accidental details." (Galdston, 1981, p.55). The Cnidus physicians prescribed treatments according to named and classified disease entities, accusing the Cos physicians of being more concerned with individual clinical circumstances instead of advancing general knowledge.

These two orientations to diagnosis have continued to influence various factions in medicine to this day (Galdston, 1981). Galdston emphasizes the difference between the perspectives as follows:

To diagnose a disease as a distinct entity is a more primitive function. It requires but a moderate mental discipline. It can frequently be accomplished by using inanimate instruments. It offers only a narrow and none too stable foundation for effective therapy....Diagnosis practiced as the definition of a clinical problem affecting a given individual, to be solved therapeutically, is by far the superior and more difficult function. (p.56)

These two approaches also differ in another way. The abstract classification of disease entities was based in the study of causes of death and morbid anatomy and physiology (Galdston, 1981; Taylor, 1979). The treatment of individual clinical manifestations, on the other hand, was based on the study of anatomy and physiology among healthy people. These conflicting approaches survive in their emphasis on health or non-health states, especially notable in nursing discourse. The practicing physician today is faced with both problems in clinical diagnosis, provision of an abstract concept, and treatment of a specific individual.

Taylor (1979) proposes a solution to this ancient problem for medicine. He traces the history of the ontological and reactive disease theories forward through many authors unchanged into modern medicine. He contends that the notion of disease is an abstract one, amenable to classification schemes. He then distinguishes this notion of disease from that of illness, which he defines as the individual clinical manifestation, necessarily causally overdetermined by conceptual disease entities.

Taylor then proposes the notion of "morbus" to designate a unifying concept that has both an illness and a disease component. Since it has become clearly impossible to classify diseases in terms of a single causal entity,

Taylor maintains that effort should be expended to classify morbi in a taxonomy of single causal mechanisms, specific to clinical situations. Taylor concludes that further research in the biological sciences holds the hope for the discovery of the single objective causes for single objective morbi.

These two different approaches to diagnosis which have informed medicine for over two thousand years, have also had a profound effect on the general discipline of nursing, and the discourse of nursing diagnosis in particular. The tension between these two approaches to medical diagnosis has been recreated in the discourse of nursing diagnosis by the choice of the word "diagnosis" without acknowledging the extensive history and problems associated with the notion.

One important effect of this re-creation is that foundational assumptions have continued to inform the discourse of nursing diagnosis in the same way as they inform the discourse of medical diagnosis. That is to say that the tension between the two approaches to diagnosis obscures the operation of the assumptions that underlie both the medical and nursing concept of diagnosis that 1) the entity diagnosed has an objective existence apart from our understanding of it, and 2) that the name given to the

entity somehow captures the essence of that entity as it exists within people in an objective world.

The history of this problem within the discourse of medical diagnosis has further implications for the discourse of nursing diagnosis when I consider the discourse of expert clinical practice as a possible discourse of resistance in nursing. This discussion takes place in chapter five. Noting the tension between the opposing goals of adding to general knowledge and treatment of individual clinical circumstances helps illuminate the power relations between academic and practicing nurses, and between nursing and health care.

Section Two: Early Context and Influences on Nursing Diagnosis

Given the foregoing discussion of tension within the conceptualization of "diagnosis" in modern medicine, I will move to begin discussion of "diagnosis" in nursing by providing a perspective on the early social context of the discourse. This section will also answer the following questions related to the genealogy of the discourse: What other discourses (besides medicine) and what historical context influenced the development of the discourse of nursing diagnosis? What physical, bodily space was created by being described by the discursive practices of the discourse of nursing diagnosis? What surfaces of emergence

and conditions of possibility were acknowledged and appropriated and made visible by this discourse? By what process did the discourse of nursing diagnosis come to have the right to pronounce truth in some region of experience?

The word "diagnosis" comes to nursing from medicine as it has been described in the previous section of this chapter. When nurses use the singular term, "diagnosis", it is the medical diagnosis to which we refer. Hornung (1956) argued that occupational health nurses do indeed make medical diagnoses because often there is no physician in attendance to do so. These she called "nursing diagnoses" (p. 29). The term "nursing diagnosis" came to be redefined from a nursing perspective, however, and began its own separate history. Recall from chapter two that any definition or re-definition is a move of power.

Historical Considerations in the

Development of the Discourse of Nursing Diagnosis

It is important to understand the social context of the discipline of nursing at the time the concept of "nursing diagnosis" was being raised in the 1950's in the United States. This is important because it illuminates the social position of nursing at the time, and the range of options available as models for discipline's goals. There were very few nurses with advanced degrees, and these degrees were predominantly in other disciplines. Medicine

was the pre-eminent model of a profession in U.S. culture. The empirical analytic tradition was the only model of science generally available, marginalized discourses such as critical theory and phenomenology notwithstanding.

In post-WWII America, nurses returning from military service had increased their skills of treating medical diagnoses in conjunction with physicians. Now, returning to peacetime practice, nurses faced renewed domination from physicians and social pressure to return to traditionally defined female roles.

Consequently, nurses felt increased pressure to define their unique status and value. This goal had been articulated in various forms since 1900 (Turkowski, 1992), but now the drive intensified and many nurses went back to school. The discourses of medicine, science, and professionalism constituted the desirable discourses available to nursing (and anyone else) in the 1950's that could be used to describe value, power, and status in the modern post-war social world.

McManus (1951) and Virginia Fry (1953) advocated the discipline-specific term "nursing diagnosis" in nursing literature and suggested care plans to guide nursing practice, based on a model of human needs. This development was not reflected in the ANA's Model Practice Act of 1955, but Abdellah (1957) also defined and used the term nursing

diagnosis. There were few articles published in the 60's on nursing diagnosis and they used differing definitions (See summary in Edel, 1982). During the 1960's, the terms "problem" and "need" were more prevalent than the term "diagnosis", but all three terms referred to an "independent" function of nursing, the use of which, it was felt, would cause "vague descriptions of the patient's condition {to} disappear from our vocabulary" (Hornung, 1965).

During this same time period that saw the beginning of the term "nursing diagnosis", the late 50's and early 60's, the term "science" was also applied to nursing, and has had an equally important influence on the discourse of nursing diagnosis. The first mention of the term "nursing science" in nursing literature is found in the work of Martha Rogers, published in 1963. She argued that nursing constituted a unique body of knowledge and the application of this body of knowledge constitutes the practice of nursing. Abdellah (1969) also called nursing a science and argued that the ability to make diagnoses is fundamental to the development of any science. Jacox (1974) described the classification of concepts as one of the first steps in theory development in any science.

McFarland and McFarlane (1993) emphasize the importance of this decade in the development of the

discourse of nursing diagnosis, noting that an article published by a doctor in the Journal of the American Medical Association in 1967 defined diagnosis in general terms, not specific to medicine. This article (King, 1967) defines criteria or components that must be present to make a diagnosis: 1) there must be a preexisting series of categories or classes that provide a reference for the diagnosis, 2) there must be a particular entity that is to be diagnosed, and 3) there must be a deliberate judgment that the assessed phenomenon or response belongs in a particular category or class.

McFarland and McFarlane (1993) imply that this article was the impetus for the first NANDA conference. Douglas and Murphy (1990) noted that an article with respect to the concept of scientific classification by Sokal in Science in 1974 was also an early influence on efforts towards the classification of nursing diagnoses (p. 17).

With hindsight, Gebbie (in foreword to Carlson, et al, 1982), co-chair of the first national conference, identified other influences on the historical development of the discourse of nursing diagnosis, stating that:

No group of health care providers could expect increased public support, increased professional respect, or increased monetary reward unless that group was known to have a direct impact on the health

of the nation's citizens and was able to demonstrate clear quality control on the care provided....A concise universal language of nursing diagnoses could provide a frame for the needed demonstration. (Gebbie, foreword to Carlson, et al, 1982, p. vii).

The major discourse, the language, of the *practice* of nursing has been, and remains, medical (Street, 1992). The concept of a nursing diagnosis had the social appeal of combining the socially desirable and powerful discourses of medicine, science and professionalism that were major models of social authority, power, and meaning in the 1950's and 1960's, and remain so in the 1990's.

Nursing has historically vacillated between highlighting differences and highlighting similarities between itself and medicine, according to the ideological purpose served by each position in a specific historical moment. The concept of nursing diagnosis had the advantage of being able to emphasize both the similarities and the differences at the same time. "...medical and nursing diagnoses differ in as much as medicine and nursing differ and are similar in as much as medicine and nursing are similar." (Edel, 1982, p. 7). Nursing practice remains defined by its relation to medical practice.

The Influence of the Nursing Process
on the Discourse of Nursing Diagnosis

The concept of nursing diagnosis was subsequently incorporated into a component of the nursing process, which was incorrectly perceived at the time to be a variant of the foundational empirical analytic scientific method (Douglas and Murphy, 1990; Hiraki, 1992).

The nursing process was first advocated in nursing literature by Hall (1955). The four-step nursing process consists of assessment, planning, implementation and evaluation of nursing care (Yura and Walsh, 1973). Nursing diagnosis was added in the 1970's and is usually placed at the end of the assessment phase or the beginning of the planning phase (Stelzer and Becker, 1982; Douglas and Murphy, 1990). The five-step nursing process adds the step of nursing diagnosis between the assessment and planning phases. Early proponents of the five step nursing process were Roy (1975), Aspinall (1976) and Munding and Jauron (1975).

Nursing diagnosis and the nursing process were viewed as the means to mediate between theory and practice. Nursing used the discourse of nursing process to standardize the concept of nursing care in the curriculum, hoping thus to earn professional status (Gebbie and Lavin, 1975, p.23; Hiraki, 1992, p.130). McFarland and McFarlane

(1993) argue that nursing diagnosis is the critical link in the nursing process because "the symptoms of conditions diagnosed can be alleviated or modified by nursing actions." (p.11). Nursing diagnosis has also, however, been called the weakest component of the nursing process (Aspinal, 1976; Andersen and Briggs, 1988).

Original Purposes of the Discourse of Nursing Diagnosis

Many purposes have been cited for the original development of the discourse of nursing diagnosis. The array of purposes clearly shows the tension between the two views of the diagnostic process, the provision of generalized knowledge and guidance in individual practice situations. One of the purposes for developing the language of nursing diagnosis has been identified as the provision of a precise language for practice (Levine, 1989), and for theory development (Edel, 1982). In the proceedings of the third and fourth conferences (Kim & Moritz, 1982) offer the following assessment of the original impetus for nursing diagnosis: "The conferences... proceed on the assumption that nurses diagnose as part of their professional activity and that nurses are seeking guidance in clearly and accurately articulating the nursing diagnoses they make and in further understanding the theoretical framework on which these diagnoses are based." (p. xviii). This claim that the

development of the discourse of nursing diagnosis was initiated and influenced by "nurses seeking guidance", was questioned in later conferences and will be discussed in chapter five with respect to the domination of academics over practitioners.

Another original purpose for the development of nursing diagnosis was identified at the first conference by Gebbie and Lavin (1975). They pointed out that the increasing influence of hospital computers demanded a standardized language from nurses. The demands of hospital bureaucracy and accreditation are as important as the medical influence. Levine (1989) argues further that the process of creating this standardized nursing language was meant to be accomplished through clinicians sharing real-life clinical experiences (p.5).

Efficiency, standardization, and accountability (Edel, 1982, p. 8) plus ease of computerization (Saba, 1989) are also cited as influences on the development of the discourse of nursing diagnosis. Nursing diagnosis was seen as the approach that could provide the "frame of reference from which nurses could determine (1) what to do and (2) what to expect." in a clinical practice situation (Edel, 1982, p. 9).

Nursing diagnoses were also intended to define nursing's unique boundaries with respect to medicine

(Pridham and Schutz, 1985; Douglas and Murphy, 1990). Harrington (1988), for example, argued that nursing diagnosis is a defining characteristic of nursing practice because the definition of nursing in the ANA's social policy statement (1980) states that nursing is the diagnosis and treatment of human responses. "The issue of validity of nursing diagnoses holds the key to verifying nursing practice and therefore to fulfilling the profession's social responsibility to render effective, cost-effective care." (Derdiarian, 1988, p.140). On the basis of this judgement, NANDA meant the standardization of nursing language to be the first step towards having insurance companies pay nurses directly for their care (Gebbie and Lavin, 1975, p. 23; Edel, 1982; Gordon, 1982a, p. 284; Carpenito, 1989; Webb, 1992).

Early Definitions of Nursing Diagnosis

In order to demonstrate the tension between the social discourses of the times as models of power for the development of nursing diagnosis, consider the following early definitions of nursing diagnosis, before the first NANDA conference:

1. McManus (1951) "nursing diagnosis is the identification of the nursing problem and the recognition of its interrelated aspects." (p. 54).

2. Abdellah (1957) "The determination of the nature and extent of nursing problems presented by the individual patients or families receiving nursing care."

3. Chambers (1962) "a careful investigation of the facts to determine the nature of a nursing problem". A problem was defined as a specific patient need, so the diagnostic process produced a linguistic statement of need for the patient.

4. Komorita (1963) "a conclusion based on scientific determination of an individual's nursing needs, resulting from critical analysis of his behavior, the nature of his illness, and numerous other factors which affect his condition. This conclusion should then serve as a guide for nursing care."

5. Durand and Prince (1966) defined nursing diagnosis as "a statement of a conclusion resulting from a recognition of a pattern derived from a nursing investigation of the patient."

6. Abdellah (1969) said "Nursing diagnosis is determination of the nature and extent of nursing problems presented by individual patients or families receiving nursing care" (p.39).

These definitions variously present the phenomena of concern to nursing as problems, needs, and/or patterns. The result of the diagnostic process is called a conclusion or

a judgement or a nursing diagnosis. In the time since these definitions were generated, the description of the phenomena of concern to nursing has still not been clarified, despite the ANA's provision of the term, "human responses". Tension between the goals of general knowledge provision and clinical practice are clearly represented in the words used to describe what it is that concerns nurses. The style of statements in the discourse is addressed in chapter four.

Section Three: Genealogical Questions

Surfaces of Emergence

From a Foucaultian genealogical perspective, surfaces of emergence and conditions of possibility are important considerations in the emergence of subjects from objects within the discursive practices of a discourse, and at the same time are considered important in the description of how it is that whole discourses emerge within power relations. A surface of emergence can be thought of as the contiguous edge of a body of discourse that has implications that allow tangential discourses to arise, as it were, on its surface (Foucault, 1975). Discourses emerge on the surfaces of other discourses in a symbiotic way as mold grows on the surface of old bread. The conditions of possibility in this example would be the existence of spores, warmth, and moisture.

As any discourse does, the discourse of nursing diagnosis arises in a social context utilizing both surfaces of emergence and conditions of possibility that were acknowledged and appropriated and made visible by the emerging discourse on nursing diagnosis.

One surface of emergence for the discourse of nursing diagnosis was the social change in modernity from an emphasis on illness care to health care, which is the focus on health as a life goal, and not simply a physical state consisting of the absence of disease (Foucault, 1985).

This surface of emergence, the changing emphasis of health care, has also been termed the medicalization of social control (O'Neill, 1986) as discussed in chapter two. This orientation becomes one of the surfaces on which the discourse of nursing diagnosis can arise and have some kind of social meaning, power, and value.

Another surface of emergence is the body of required hospital accreditation documentation. In the 1950's, trained efficiency experts were analyzing the industrial work environment in order to reduce inefficiency and increase productivity. Similarly, hospital accreditation procedures began to require written documentation for assessment of quality of care. When asked how nursing could demonstrate their contribution to the quality of care, what kind of answer could be proffered? A discourse of nursing

diagnosis, with scientific foundations and processes, could answer these questions. For example, "Automated record keeping" was cited in the first conference as one of the changes in health care that necessitated a specific nursing language (Gebbie and Lavin, 1975, p. 1).

Conditions of Possibility

What conditions of possibility were appropriated by the discourse of nursing diagnosis? Conditions of possibility consist of those physical, social, and discursive circumstances that make the language of the discourse possible. One condition of possibility for the discourse of nursing diagnosis is that the physician is not always immediately available in the practice environment. The nurse becomes the person with whom the patient has the most contact, and nurses spend more time with other nurses than they do with physicians. In the 1950's hospitals were attracting nurses to work with claims of reduced patient assignments and the provision of unit clerks in their recruitment advertising (Powers, 1988). This is to say that nurses spent increasingly more time talking with each other about their day to day practice, more time in direct patient care, and less time in administrative tasks such as answering phones.

Another condition of possibility was the advanced education of increasing numbers of nurses within the post

WW-II science and technology boom. This produces nurses who teach nursing, who create journals in which to publish, who function in networks, and who can speak academic language. The discourse of nursing diagnosis is in large part an academic project. The first conference on nursing diagnosis was held at the St. Louis University School of Nursing and Allied Health Professions. Nursing diagnosis was expected to "facilitate research and education" (Edel, 1982, p. 8).

The surfaces of emergence and the conditions of possibility create an environment conducive to the creation of a discourse specific to the circumstances. Combined with the motivation of educated nurses in post-WWII America to re-define nursing practice in the social context of power and status, discursive practices arise. According to Foucault, an important step in this process is the definition of a physical space within which to assert the right to pronounce truth.

The Physical Space and the Right to Pronounce Truth

The discourse of nursing diagnosis, in keeping with the task of any discourse, linguistically constructs the description of a physically-based, socially described, space of action on bodies, using discursive elements. The physical space that is created by the discourse of nursing diagnosis could be termed the "clinical encounter". Before

the development of the discourse of nursing process which includes the component of nursing diagnosis, the meeting of a nurse and patient could be said to be determined and described by discourses other than nursing. The "nurse-patient relationship", for example, was conceived of in terms of principles from social psychology.

The discourse of nursing diagnosis in some way represents the attempt of the discipline of nursing to construct and take control of the clinical encounter, physically and conceptually, in order to carve out a "turf". Within this turf, or territory, or domain, the discourse claims the right to describe what is, and should be, going on. The discourse assumes that carving out such a territory for itself can proceed without reference to other disciplines, other territories, when, in fact, any power in the clinical encounter that the practice of nursing has is purely derivative of the relationship it has with medicine. Bypassing discussion of this relationship creates another tension within the present discourse of nursing diagnosis that will become apparent in the next chapter.

Section Four: Conclusion

To summarize this chapter, it might be said that the discourse of nursing diagnosis claims the right to pronounce truth in some region of social experience in the following manner. By utilizing conditions of possibility,

appropriating surfaces of emergence, identifying influential and socially desirable discourses (or models), and constructing and naming a physical space, nursing diagnosis constructs specific discursive practices. These practices create a perceived need for pronouncing truth in a move of power to further long-standing professional goals. The justification of this move using the power of redefinition was phrased in terms of the scientifically verifiable language of patient benefit and fiscal and social responsibility.

This chapter has presented evidence for the claims listed in the introduction. Evidence has been presented to support the claim that the models of power and social agency from medicine and foundational science influenced the development of the discourse of nursing diagnosis. By choosing the word "diagnosis", nursing claimed social power and status from the turf of medicine without considering the dilemmas inherent in that choice. Furthermore, it is not clear what it is that nurses diagnose, but it is clear what nurses do not diagnose. By choosing the word "science", nursing claimed expertise within the clinical encounter based on discursive practices of our own construction. It was assumed that these choices would provide the long-sought goals of independent professionalism and social power and status.

The next chapter will analyze the discursive practices of the present discourse of nursing diagnosis, in order to see how the choices made in the development of the discourse influenced the structure and function of the discourse.

The second claim of this chapter, that the development of the discourse of nursing diagnosis is consistent with the description of discourse development given by Foucault, has also been addressed. I have indicated the conditions of possibility and the surfaces of emergence. I have shown how the discourse of nursing diagnosis, given the long-standing goals and the right circumstances, used the available models to begin constructing discursive practices for itself. No claim is made that this interpretation is the only possible alternative.

The third claim of the chapter is that these choices made in the development of the discourse of nursing diagnosis have limited the options available for the discourse. The evidence provided by this chapter has shown that, from a power perspective, the discourse of nursing diagnosis chose imitation of the most powerful social models of knowledge and action (science and medicine) available in the 1950's. This choice means that we dismiss discussion of models that are not science-based or status-

based. We define and value this discourse only insofar as it conforms to these choices.

Chapter four will demonstrate how the influences on development described in this chapter played out in the consolidation of the discursive practices of the discourse itself.

CHAPTER FOUR: DISCOURSE ANALYSIS

Introduction

This chapter will analyze the structure and internal rules of the present discourse of nursing diagnosis from a power perspective. Section one will present an overview of the NANDA conferences from one through nine because the internal rules of the present discourse of nursing diagnosis are largely determined by the discursive practices constructed by and through these conferences.

Section two will present other classification schemes which have been suggested for the NANDA diagnoses, other than NANDA's Taxonomy I. These other classification systems are presented for two reasons. First, these alternate classification schemes demonstrate the power relations between NANDA and other authorities that might claim their own right to pronounce truth in the clinical encounter based on another grid of specification. Secondly, these other classification schemes demonstrate the manner in which the choice of the word "diagnosis" structures all attempts to determine a grid of specification on the model of medicine and foundational science.

Section three analyzes the present discourse of nursing diagnosis along the three axes as presented by Rawlinson (1987) and discussed in chapter two: the axis of

knowledge, the axis of authority, and the axis of value or justification.

Each of these axes suggests specific questions that address the power relations of a discourse. The questions generated from Rawlinson's work will be listed at the beginning of each of these sub-sections. This section uses questions generated from Rawlinson's work in order to describe the discourse in terms of Foucault's terminology. Genealogical and power implications may be apparent in this description, because of the intimate nature of the connections between a genealogical analysis, a discourse analysis, and a power analytic. However, the major power implications of the discourse will be saved for discussion in chapter five.

Section four discusses the influence of the dominant discourses of medicine, foundational science, and professionalism, on the internal rules of the discourse of nursing diagnosis. This discussion is related to the influences of medicine and foundational science on the *development* of the discourse and its original purposes, as presented in the genealogy of chapter three. These discussions are related in that the influences on the early development of the discourse can be seen to become *more pervasive* but *less visible* in the discursive practices constructed by the conferences.

Section Five concludes the chapter, presenting the evidence based on the analysis presented in the other sections. In general, the evidence in this chapter justifies the following claim: The present discursive practices of nursing diagnosis continue to be influenced by the three models: medicine, professionalism, and foundational science identified in the genealogy chapter. The influence of these discourses identified on the *development* of the discourse continue to influence the internal structure of the discursive practices. In section five it will be shown how the evidence presented in this chapter supports this claim.

Section One: The NANDA Conferences

Gebbie and Lavin co-directed the first national conference on the classification of nursing diagnoses. It was held in October, 1973, in St. Louis, Missouri. The purpose was "to initiate the process of preparing an organized, logical, comprehensive system for classifying those health problems or health states diagnosed by nurses and treated by means of nursing intervention." (Gebbie and Lavin, 1975, p. 1).

Several classification systems were discussed at the conference, including a needs framework and a problem list framework, but none were selected. One hundred nurses were present. One hundred diagnoses were proposed and described

at that conference. Seventeen months later, in March, 1975, the second conference was held. There were 119 nurses present at this conference. Nineteen more diagnoses were recommended for consideration at future conferences, making a total of 119 (Gebbie, 1976). Taxonomy issues were postponed until the third and fourth conferences, held in 1978 and 1980 (Kim & Moritz, 1982).

Around the time of the third conference, 14 nurse theorists met for the purpose of reaching consensus on a framework to be used to place diagnostic terms into a taxonomy. No taxonomy came from the third conference, but the agenda included the presentation of theoretical and practical perspectives concerning the classification and use of nursing diagnoses. At the fourth conference, three clinical specialists worked with the theorists "in order to integrate the views of practitioners into the theorists' framework." (McFarland and McFarlane, 1993).

The formal organization of NANDA happened at the fifth conference in April 1982, which was the last invitational conference. The bylaws of the association were accepted by the members later that year. The purpose of the association as described in the bylaws is "to develop, refine, and promote a taxonomy of nursing diagnostic terminology of general use to professional nurses" (Kim, et al, 1984, p. 574) At the fifth conference (1982), the nurse theorists

presented their work. Despite disagreements and reservations among the participants, the nine patterns of "unitary man" were chosen as the organizing principle for the phenomena of concern to nursing. These are also called concepts inherent to the diagnostic framework. The name of the organizing principle was changed to the nine central human response patterns at the eighth conference (Carroll-Johnson, 1989), but the pattern names remain the same.

These patterns are:

- 1) Exchanging
- 2) Communicating
- 3) Relating
- 4) Valuing
- 5) Choosing
- 6) Moving
- 7) Perceiving
- 8) Knowing
- 9) Feeling

These pattern names continue to organize the diagnoses into categories of responses, but not without reservations and discussion with respect to their appropriateness and usefulness (Carroll-Johnson, 1991). The patterns received official definitions at the ninth conference (Fitzpatrick, 1991, p. 25).

The sixth conference was held in 1984, and the seventh in 1986. These conferences were organized around ongoing development of a taxonomy and the presentation of research studies on identification and validation of new nursing diagnoses. Taxonomy I was presented at the seventh conference (1986) and was approved by the members later. No new diagnoses were presented at the sixth conference, and 22 were presented at the seventh. Twenty-one of these were accepted and added to the list. Fifteen more diagnoses were presented for inclusion in 1988 at the eighth conference, plus two revisions of previous diagnoses. Fourteen of these were accepted.

Taxonomy I was revised at the eighth conference. The ninth conference was held in 1990 and a working draft of Taxonomy II was presented. Two new diagnoses were presented and accepted at this conference, bringing the total approved for use in practice to 100. At this conference, the board of directors presented a clarification of terms used in relation to nursing diagnoses, and the nursing diagnosis submission guidelines and diagnostic review process were refined (Carroll-Johnson, 1991).

The ninth conference (Carroll-Johnson, 1991) also approved the following definition of nursing diagnosis: "Nursing Diagnosis is a clinical judgment about individual, family, or community responses to actual or potential

health problems/life processes. Nursing diagnoses provide the basis for selection of nursing interventions to achieve outcomes for which the nurse is accountable." (Fitzpatrick, 1991, p. 25).

On the other hand, nursing diagnosis is defined in the Standards of Clinical Nursing Practice (ANA, 1991) as "a clinical judgment about the client's response to actual or potential health conditions or needs" and outcomes are "derived from the diagnoses". The collaborative efforts between NANDA and the ANA were reported at the ninth conference, including a presentation of the revised version of Taxonomy I that was presented to International Classification of Diseases - Tenth Edition (ICD-10) of "Conditions that Necessitate Nursing Care" by the ANA with the input of NANDA. This version was presented to the WHO in 1989 but was not included in the ICD-10 (NANDA, 1992).

Present work on Taxonomy II continues around several issues: levels of abstraction of diagnoses (including the possibility of axes), the form and placement of wellness-related diagnoses, methods for testing the taxonomic structure and classification scheme, use of the taxonomy in practice, and revision or deletion of diagnoses that do not meet the criteria specified by NANDA. Other issues include the specification of syndromes in nursing practice, and population-specific diagnoses (Carroll-Johnson, 1991).

Section Two: Alternate Classification

Schemes for Nursing Diagnoses

There are other classification systems for NANDA's nursing diagnoses besides the NANDA Taxonomy based on human response patterns. In 1983, the ANA's committee established to monitor developments in classification systems and develop a taxonomy for nursing practice concluded that nursing is "too rich in data to settle on a single classification system of taxonomy at this time" (American Nurse, 1983, quoted in Douglas and Murphy, 1990, p. 21.) Levine (1989) points out that the American Nurse Foundation proposed, without success, a convening of the diverse groups that could help construct a taxonomy. Then, in 1986, the ANA Board of Directors approved policies related to the development of a classification system for nursing practice (Griffith, 1989). The policies state (p.4):

1. The professional association will facilitate the classification of nursing practice within the categories of assessment, diagnoses, interventions and outcomes.
2. The professional association is committed to the development of a single comprehensive system for classifying nursing practice.
3. This uniform classification system for nursing will be designed for use in all nursing practice situations.

4. The professional association will collaborate with intradisciplinary groups involved in the development of classification systems in nursing.

5. The professional association will promote the consistent use of the classification system in nursing education and in the delivery of nursing services.

6. The professional association will promote the integration of nursing information with health care data systems.

7. The professional association will encourage and actively work toward an international classification system of nursing practice.

8. The professional association will collaborate with interdisciplinary groups in the development of classification systems for health care.

These policies were reported to the sixth national conference in 1986 by Lang (1986) who spoke to the conference in her capacity as a member on the ANA's Steering Committee on Classifications of Nursing Practice Phenomena, and as a member of NANDA. She reported on the history of the relationship between the ANA and NANDA, and advocated increasing collaboration through what were called "consensus conferences" (p. 21).

At the fifth national conference, Kathryn Barnard, one of the members of the ANA committee who generated the

Social Policy Statement, presented the keynote address (Kim, et al, 1984). In this address, Barnard emphasized the similarities between the work of the ANA and the work of NANDA. One of the comments given at the end of the address suggested that the work of the two organizations, and the group of nursing theorists, were at cross-purposes. Barnard responded that in diversity of opinions the movement will find strength, saying, "In the marketplace the clarity and point of view that is most important in practice will emerge." (p.11).

Also at the fifth national conference, Kritek (1984) warned against choosing a classification scheme too quickly. She analyzed twelve possible classification schemes for nursing diagnoses, including the proposed unitary man framework, for overlap and inconsistencies. She advocated tolerance for ambiguity and the use of further critique and analysis in order to determine possible prejudices and problems that would reveal themselves. Her call went unheeded, and the unitary man framework was chosen for the basis for Taxonomy I at that conference.

In December of 1986, ANA submitted a working classification schema for nursing practice to the head of the World Health Organization Center for Classification of Diseases for North America. The schema incorporated the work of NANDA, the project of the Visiting Nurses of Omaha,

and the work of the ANA Council on Psychiatric and Mental Health Nursing (ANA, 1989). The purpose of this move, according to the ANA, was to "help assure a coordinated approach to the eventual development of an internationally accepted classification of nursing practice. It is envisioned that a classification of nursing practice would be a family of classification in the World Health Organization International Classification of Diseases" (ANA, p. 4). In the ANA report of this project, Kritek (1989) again recommended the examination of many classification schemata in order to "get closer to the whole" (p. 9).

Warren and Hoskins (1990) report that as a result of the collaborative meetings and liaisons between ANA and NANDA, some of the ANA's diagnoses were placed within the NANDA taxonomy in brackets. The authors state, "As a result.....ANA stopped supporting the development of multiple nursing diagnosis taxonomies and endorsed NANDA's work on the classification of nursing diagnoses as the official nursing diagnosis taxonomy." (p. 166).

There are several examples of alternate approaches to classification of the NANDA diagnoses which are not disputed officially by NANDA at the present time. Marjory Gordon's 11 Functional Health Patterns (Gordon, 1982a) have been used to classify NANDA nursing diagnoses:

- 1) Health Perception - Health Management Pattern
- 2) Nutritional and Metabolic Pattern
- 3) Elimination Pattern
- 4) Activity - Exercise Pattern
- 5) Sleep - Rest Pattern
- 6) Cognitive - Perceptual Pattern
- 7) Self-Perception - Self-Concept Pattern
- 8) Role - Relationship Pattern
- 9) Sexuality - Reproductive Pattern
- 10) Coping - Stress Tolerance Pattern
- 11) Value - Belief Pattern

Another organizing framework, for community health settings, was developed by the Visiting Nurse Association of Omaha (Martin, 1989). It uses the four domains representative of community health nursing practice: environmental, psychosocial, physiological, and health behaviors.

A framework for diagnoses related to home health Medicare patients was developed in order to predict the need for nursing and other home health services. In this scheme, the nursing diagnoses are divided among 20 components considered to be complete for home health care patients (McFarland and McFarlane, 1993).

A framework for organizing responses of concern for psychiatric and mental health nursing practice was

developed by a task force of the ANA in 1984 (ANA, 1989). This framework was supported by the ANA's executive committee of the division of psychiatric and mental health nursing practice, saying that "the defining characteristics of the NANDA nursing diagnoses and the diagnostic criteria of the DSM-III psychiatric diagnoses are actually human responses." (Loomis, et al, 1987). The ongoing work on another classification system for nursing diagnoses to be used by pediatric nurse practitioners is reported by Burns (1991).

Many textbooks, handbooks, and guides have been written using nursing diagnosis as a framework or an organizing principle for the contents. An excellent annotated bibliography of these and early works is to be found in Gordon (1982a). Bulechek's (1987) annotated bibliography also includes filmstrips, videotapes, audiotapes, and computer software. The newest textbook for the teaching and use of nursing diagnosis is McFarland and McFarlane (1993).

The broadest classification system in nursing is the Nursing Minimum Data Set (NMDS) which was designed to establish uniform standards for the collection of minimum essential nursing data (Werley, 1987; Werley and Zorn, 1989, p. 50). It is patterned after the Uniform Minimum Health Data Set (UMHDS) and is defined by the U.S. Health

Information Policy Council as any health data set that meets the needs of multiple data users. This classification includes the NANDA nursing diagnosis classification, the nursing interventions, the nursing outcomes, and a measure of intensity of nursing care in the nursing care elements section.

These classification schemes, or alternative frameworks for the nursing diagnoses, reflect the internal dialogue within the discourse. As such, they are presented here in order to appreciate the diverse positions within the discourse with respect to the structure of a taxonomy. The key point, however, is their similarity, not their difference. All of these frameworks share the assumptions and goals of the dominant discourse informed by medicine, professionalism, and foundational science. These frameworks share a commitment to the objective validity of the diagnoses, the concept of a taxonomy, and the use of the diagnoses as guides for practice. Engaging in discussions of the merits of competing frameworks inadvertently diverts effort away from analysis of underlying assumptions and philosophical perspectives.

Section Three: Discourse Analysis

Part One: On The Axis of Knowledge

Given the above overview of the conferences, and the historical influences on the development of the discourse

presented in the genealogy, this section will proceed in three parts. The discursive practices of nursing diagnosis as presented in the conferences and the literature coincidental with the conferences will be analyzed. In part I, on the axis of knowledge, the following questions generated from chapter two will be answered:

- What are the objects and subjects of the discourse?
- What does the discourse do to the resulting subjects?
- What are the rules of evidence in the discourse of nursing diagnosis?
- What grids of specification are there?
- In the rules for the formation of subjects from objects, what and where do individual differences, deviations, and complaints emerge?
- How is it specified that these subjects are to be used on pre-existing surfaces, constructed spaces, or bodies?
- What authorities of delimitation exist?
- What order governs the multiplicity and diversity of the subjects, objects, concepts, styles of statements and theoretical strategies of nursing diagnosis?
- What order governs the appearance, disappearance,

replacement, and coexistence of the subjects, objects, concepts, styles of statements and theoretical strategies of the discourse of nursing diagnosis?

The answers to the questions in the three parts of this structural discourse analysis will be analyzed with respect to the claim of this chapter. Based on the answers to these questions about the discourse, substantial evidence can be provided to support the claim.

What Are The Subjects and
Objects of The Discourse?

The discourse defines as its objects of concern what are termed in the later conferences the human responses (or response patterns) to illness. The subjects of the discourse, the variables for manipulation that are constructed by the discourse from the objects, are the nursing diagnoses. Rasch (1987) argues that the ANA's Social Policy Statement declares the human responses and the nursing diagnoses to be the same entities, but they are logically differentiated in a discourse analysis.

Rasch (1987) suggests that the true nature of what it is that nurses diagnose has yet to be elaborated. This confusion was evident at the seventh conference, when Newman (1987) argued that nurses diagnose "patterns" of human responses and not "singular" human responses.

Subsequent to this argument, the name of the organizing framework for Taxonomy I was changed from "unitary man" to "human response pattern" (Carroll-Johnson, 1989).

According to the discourse of nursing diagnosis, human responses (the objects of the discourse) are assumed to be universal objective entities that exist in a pre-interpreted reality and are detectable by scientific research. The diagnoses, on the other hand, are acknowledged by the discourse to be scientific constructs that linguistically represent the objective entities.

The nursing diagnoses, the subjects of the discourse, are viewed as the *names* of the objects in the same way that psychiatric diagnoses are often thought to be the *names* of conditions assumed to exist in humans and described by empirical research. From a Foucaultian perspective, both the diagnoses and the human responses (the objects and the subjects) are reified entities, statistically associated with other reified entities called causes, etiologies, determining characteristics, etc.; all done in the manner of foundational science. The process of reification fixes the description of an entity as an unchanging thing that is assumed to exist apart from its description in a pre-interpreted reality.

The majority of diagnoses presently take the form of an "alteration" or a "deficit" of something, such as

alteration in family processes, or fluid volume deficit. It was suggested at the first conference that there should be diagnoses of patient strengths as well as weaknesses (Gebbie and Lavin, 1975, p. 43), but as of this writing, there are only two diagnoses of this type.

The words "situation", "condition" and "human response" are often used interchangeably for the objects of the discourse in the nursing diagnosis literature, and in the conference proceedings. They have been called the focus of nursing or nursing's unique domain (Wooldridge, et al, 1993). Carpenito (1993), for example, reports that she has come to prefer the terms "situations that necessitate nursing care" instead of "nursing diagnoses". The objects of the discourse of nursing diagnosis, the human responses, are clearly not diseases.

The Rules for Emergence of Subjects

This section explains the rules of the discursive practices that specify how a diagnosis is recognized as worthy of consideration by the discourse. The time/space ordered by the discourse of nursing diagnosis is called the clinical encounter. There are several unacknowledged conditions inherent in the rules for the recognition of potential subjects (diagnoses) by the discourse that I have identified in this analysis.

Nursing practice is in large part an oral culture, and nursing routines take place in the bureaucratically constructed time/space of a shift, and the thinking of practice is organized that way (Street, 1992). For example, practicing nurses use the phrases "being way behind" or "being caught up" with respect to their work at a given point in the shift. The discourse of nursing diagnosis, arising on the surface of the discourse of the nurse-patient relationship in the clinical encounter, leaves unacknowledged the oral nature of practice in the time/space of a shift. Nursing diagnosis is a written practice meant to guide events within the clinical encounter.

The subject of power is also unacknowledged in nursing discourse in general, and nursing diagnosis in particular. References to power are rare, based on outdated definitions, and often mis-applied (Allen, Allman, & Powers, 1991; Powers, 1992b). Nursing theorists have not addressed the notion of power in any systematic manner. Nursing discussion of power has been limited to specific issues wherein power is conceived as personal power, political power, union power, or professional power (Sweeney, 1990). The most common perspective of power in these references comes from early sociology or

organizational literature, based on a political model (Sweeney, 1990).

Another unacknowledged condition is the dependence on medical diagnoses. Clearly the objects of the discourse, the "human responses to illness", are tied directly to conditions defined by medicine, such as illness and disease. The nursing diagnosis is, therefore, constructed socially upon the existence of medical diagnoses that identify the "illness" to which the patient will have a "human response". This connection remains unacknowledged.

Given these unacknowledged conditions, there are specific structural rules for the recognition of potential subjects in the discourse. At the first conference it was stated that "A major task of all nurses is to locate those diagnoses that were neglected, to test and develop them and to present them to the profession so that they might be included in future listings." (Gebbie and Lavin, 1975, p 57-58). It is not apparent that all nurses took this as their major task, because until 1982 the diagnoses were obtained through the members of NANDA and the work of a small group of nursing theorists within NANDA.

Diagnoses are authorized in the following manner. Since 1982, it is specified that diagnoses are proposed to a review committee which follows a specific procedure in order to come to a conclusion to accept or reject the

application for consideration. The recommendation is forwarded to the Task Force. Acceptance of the application means preliminary acceptance for further clinical testing. This clinical testing has been done by nurse researchers, sometimes in collaboration with clinicians.

Fawcett (1986) also encouraged each nurse interested in nursing diagnosis to select a theoretical strategy and continue the work of developing and validating new nursing diagnoses. Derdiarian proposed that practicing nurses should be taught to formulate, test, and evaluate new nursing diagnoses (Derdiarian, 1988, p.139). Gebbie and Lavin (1975) claim that, "There is no category here that might not be rejected by nurses at a second or subsequent conferences, nor is there any claim that these categories cover the entire domain of nursing. Any rejection should be based on clinical evidence that the diagnosis provides no basis for nursing intervention." (pp. 57-58). Carpenito (1993) disagrees, saying we should be spending more research time on the diagnoses we already have, not on making new ones. These tasks, however, would seem to be extremely difficult for nurses in practice settings, and this difficulty is not acknowledged.

Submission guidelines were revised and published in the proceedings of the ninth conference. Considering the amount of work involved in the submission procedure, it

seems highly unlikely that practicing nurses could undertake this task. Furthermore, the acceptance and placement of the diagnosis into the taxonomy is done by the Taxonomy Committee and is not open to scrutiny by the General Assembly. Porter (1986) notes that this procedure is in contrast to accepted taxonomic science, because the general membership does not have the final vote.

Avant (1990), on the other hand, maintains that voting is "unwise and scientifically unsound as a method of choosing" (p. 54) and recommends teams of scientists and clinicians make decisions regarding the presentation of adequate evidence for a nursing diagnosis. It is unclear how disagreements between the members of such teams would be handled.

Rules of Evidence

After a diagnosis is recognized as worthy of consideration, it is subjected to the rules of evidence specified by the discourse in order to determine approval and integration into the grid of specification. Guidelines for submission of nursing diagnoses to NANDA were first published in 1982 (Gordon, 1982b) in the proceedings of the third and fourth conferences. Constipation and diarrhea were cited as examples of nursing diagnoses. The guidelines consisted of five sections of information required for consideration. The categories of information are:

A. The category label (or title). In this section, applicants are asked to identify the "label refers to an identifiable clinical entity".

B. Common etiological factors. This section requires the identification of the etiological sub-category.

C. The defining characteristics of the diagnostic category. These are to be the "observable signs and symptoms that are present when the health problem is present."

D. Supporting materials. This category consists of literature to support the category label, the etiological categories, and the defining characteristics.

E. Rating of independent nursing involved in treating the health problem. The rating in this category is to be identified as high, medium, or low, depending on degree of independent nursing therapy commonly involved in treating the diagnosis. (p. 340).

Until 1980, approval of a nursing diagnosis was by majority vote of conference participants (Kim & Moritz, 1982). The term "accepted nursing diagnosis" was defined specifically at the fourth national conference (Kim & Moritz, 1982) as that which is, "in the opinion of the National Group, a health problem amenable to nursing intervention which has been sufficiently defined for clinical testing." (p. 6).

After 1980, diagnoses were reviewed by small groups of conference participants. Group recommendations were then forwarded to the Task Force Planning Committee which made the final decision on the basis of conformity with guidelines and format. Presently, the Diagnosis Review Committee receives submissions and processes them with respect to the published guidelines (Carroll-Johnson, 1991).

The submission guidelines were refined and published again in the proceedings of the seventh conference (McLane, 1987). "Etiology" was changed to defining characteristics, major and minor, and supplemental information became optional (McLane, 1987). The last revision took place at the ninth conference, and requires a new diagnosis to be submitted complete with a label, a definition, defining characteristics, related factors, and literature/clinical validation support (Carroll-Johnson, 1991). There is a list of "To-Be-Developed Diagnostic Concepts and Definitions" that were published in McFarland and MacFarlane (1993) and include diagnoses such as "Ineffective Management of Therapeutic Regimen (Families)" and "High Risk for Loneliness" (p. 766).

After a diagnosis is accepted, tested and approved, it is fit into the Taxonomic structure and given a number with respect to its position in the structure of Human Response

Patterns. For example, the diagnosis of Altered Protection has the number of 1.6.2. Gordon's Functional Health Patterns Taxonomy does not have numbers. In the classification scheme for home health care, the self-concept component has the sub-category of Meaningfulness Alteration, which is given the number 42. Foucault refers to taxonomies as grids of specification.

Grid of Specification

Once identified and accepted according to the rules of evidence, the diagnoses are integrated into a grid of specification. NANDA's Taxonomy I is a grid of specification similar to that previously described in chapter two for psychiatry, because the taxonomy divides the diagnoses from each other, relates them, and places them under a classification scheme. As described in chapter two, discourses identify defining characteristics, quantify definitions, arrange subjects in a taxonomy, attribute causal mechanisms, and give rules for the application of the diagnoses (in this case) to the individual bodies of nurse and patient. The use of the phrase "grid of specification" emphasizes the process of constructing a taxonomy and applying the grid in practice situations.

At the fifth conference, Webster presented a paper on classification schemes within scientific inquiry and recommended to the conference participants that nursing

diagnoses remain an alphabetical listing at that point (Webster, 1984). He emphasized that since nurses deal with both the general and the specific, the most important point about the process of diagnosing is the *manner* in which the diagnosis is assigned to the patient (Webster, 1984, p. 24).

From a Foucaultian perspective, however, the grid of specification provided for diagnoses *embodies* the power/knowledge, or the discursive technology. The grid *structures* the interventions. The grid is not a neutral tool. Arguing that the important issue is that of *how* a nurse uses a diagnosis deflects attention away from the possibility that the reified concept of diagnosis itself influences the perspective with which the nurse approaches the clinical encounter in the first place.

At the first conference, it was evident to the participants that entities in classification systems were not supposed to overlap and yet they recognized that some of the diagnoses did just that. This overlap was attributed to lack of scientific knowledge, and not to anything about the diagnostic entity or the classification scheme (Gebbie and Lavin, 1975, p. 59). This overlap continued to be discussed as a problem at succeeding conferences. Kritek (1986) suggested to the sixth conference that hierarchical, mutually exclusive sorts of classifications schemes may be

too limiting for the concepts of human responses, but the work on the previously described unitary man/human response pattern framework continued.

Currently, there is work proceeding to expand the grid of specification beyond the diagnoses. McCloskey et al (1990) identify needs to standardize language about nursing treatments, address the links among diagnoses, treatments, and outcomes, facilitate the development of information systems, facilitate the teaching of decision making, assist in the determination of costs for nursing services, assist in planning for resources, provide a language to communicate the unique functions of nursing, and articulate with classification systems of other health care providers. McCloskey et al (1993) have presented their ongoing work on a taxonomy of nursing interventions.

The Disappearance of Subjects

If subjects in the discourse arise in a certain manner, are there rules for their dismissal, as well? What order governs the disappearance of a subject? Consider two examples of diagnoses that have been suggested as candidates for removal from the grid of specification. Jenny (1987) argued that knowledge deficit is not a human response or a nursing diagnosis. By using the criteria of appropriate conceptual focus, necessary diagnostic attributes, theoretical validity and clinical utility, she

concluded that the diagnosis is not legitimate and suggested that it be dropped from the taxonomy.

Jenny (1987) argues that knowledge deficit is more properly a risk factor, contributing factor, etiological factor, or defining characteristic of some other diagnosis. Pokorny (1985) agreed with Jenny, and found no critical defining characteristic of the diagnosis of knowledge deficit, although the data suggested that an important indicator of the diagnosis was the patient's verbal statement of a need for information or clarification. Jenny (1987) argued that "the continued use of the diagnosis Knowledge Deficit perpetuates the false assumption that knowledge is the sole and/or automatic determinant of human behavior." (Jenny, 1987, p.185).

Following Jenny's theoretical conclusions, further clinical support for eliminating the nursing diagnosis of knowledge deficit was provided by Dennison and Keeling (1989). Based on clinical data, these authors concluded that knowledge deficit falls outside the boundaries of the discipline and that the label encourages nurses to focus attention on the promotion of knowledge as an entity rather than addressing a behavior related to the patient's lack of information (p. 142).

Despite these significant arguments, knowledge deficit has remained in the grid of specification, although it was

recommended at the ninth conference that the diagnosis be either revised or deleted (Carrol-Johnson, 1991, p. 28).

As another example, consider the diagnosis of non-compliance. Keeling et al (1993) argue that the diagnosis of non-compliance should be abandoned by NANDA. They reason that it is not congruent with nursing ethically, historically, or philosophically, has doubtful clinical utility, and is inherently pejorative. The authors suggest that the diagnosis of non-compliance should be replaced with a diagnosis phrased variously as "need for commitment to treatment, or inability to adapt to treatment regimen, or self-care deficit, or potential for client participation in cure." (p.96). Despite such attempts, non-compliance also remains in the grid of specification.

The perseverance of diagnoses despite evidence that they do not meet NANDA's own published criteria for acceptability suggests that the discourse itself has attained a certain degree of momentum that carries itself along because of its participation in power/knowledge. The participation of the discourse in the dominance of modern bio-power by alliance with modern science and professionalism, confers a stability to the constructs that carries conceptual permanence with or without external justification. Scientific labeling is justification enough. The struggle to remove homosexuality from the DSMIII-R

faces the same conceptual momentum. Recall the permanence of the concept of "fear" in dentistry analyzed by Nettleton (1989) and described in chapter two.

As an example of conceptual momentum, consider that Carpenito (1993) argues that all clinical research should now be framed in terms of nursing diagnosis. She justifies this by saying that if a study is not phrased in terms of nursing diagnosis all you have is a nice little story about nursing in your town, but if the language of nursing diagnosis is used, you are expanding nursing knowledge (Carpenito, 1993). Foucault has addressed this same phenomenon with respect to psychoanalysis and other disciplines (Powers, 1991).

Authorities of Delimitation

The action of applying the power/knowledge of the discursive practices is ordered by a grid of specification. The diagnoses are applied to the individual bodies of nurses and patients influenced by a time/space structured in part by authorities of delimitation. Diagnoses prescribe the behavior of the nurse as well as the patient because it is the nurse who identifies the diagnosis on the basis of a specified procedure called assessment. Assessment is prescribed by the grid of specification because the nurse is directed to observe for the signs and symptoms of the possible diagnoses. As described in chapter two, the

authorities of delimitation are the disciplines that control the existence and limits of the pre-existing spaces for the action of the discourse. In the case of nursing diagnosis, these authorities are largely physicians, hospital administrators, and insurance companies, because they determine the entrance to the health care system. This entrance is also subject to the petition of an individual patient, or family, or concerned other, and is sometimes accomplished without the consent of the patient.

It is clear that the construction of the clinical encounter by the discourse of nursing diagnosis is not an autonomous act, but the authorities of delimitation are unacknowledged in the discourse. The bodies to which we apply the discourse of nursing diagnosis are those identified by medicine, in the case of the patient, and the education, licensing and hiring criteria in the case of the nurse. The sub-disciplines of nursing that do not fit this model exactly are public health, and nurse practitioners who provide primary care.

Once the authorities of delimitation identify the bodies to which the discourse is applied, there exist rules for the application of the diagnoses in the space/time of the clinical encounter.

How The Discourse Is Used On the
Pre-existing Surfaces of Emergence

Recall that the surfaces of emergence identified in the genealogy for the emergence of the discourse of nursing diagnosis were 1) the change from illness care to health care and 2) the documentation demands of the hospital accreditation process. The discourse acts on these surfaces of emergence, making use of the conditions of possibility to construct a time/space called the clinical encounter. Within the clinical encounter, truth is pronounced and applied to human bodies through the directed action of social agents, using power/knowledge. According to Foucault, discourses that participate in the web of power/knowledge that describes our modern form of power pronounce truth in a self-described region of space/time with respect to human bodies (Powers, 1991).

In general, what happens in the clinical encounter is conceptualized by the Social Policy Statement (1980) as follows: "A nurse's conceptualization or diagnosis of a presenting condition is a way of ascribing meaning to it." (p.11). Ascribing meaning to a situation is a very goal-oriented move of power by a discourse. Used on the surfaces of emergence, the act of ascribing meaning serves to constitute the individuals involved, in this case the nurse and the patient, for themselves and others in prescribed

ways, according to the existing power relations (Allen, 1986) assumed by the rules of the discourse. Ascribing meaning to a situation assumes that the situation had no meaning before the discourse described it. This action is an interested move of power, but discussions of interests and/or power are nowhere represented in the discourse.

Specifically, the diagnoses are used on the bodies of the nurse and patient to determine treatments and predict outcomes. "Nursing diagnosis should devise a way to engineer the uncertainty out of patient care situations and thus minimize the number of incorrect inferences" (Shamansky and Yanni, 1983, p.48; see also Kritek, 1985). Note that this quote uses the instrumental (or technical) word, "engineer".

The discourse specifies the behavior of the nurse by prescribing the proper assessment procedures, the array of acceptable diagnoses, the interventions that are appropriate to the diagnoses, and the outcomes that indicate success. The discourse also specifies the behavior of the patient by assuming compliance with the process of disclosing data to the nurse (confession), and by assigning outcome behaviors that are considered acceptable. These specifications assume a hierarchical power relation of the nurse as a social agent, and the patient with less power/knowledge. This assumption of hierarchy is not

referred to specifically, because science is assumed to be value-free, and its application by social agents is not appropriately questioned by ethical discourse. The result is a technical, mechanical discourse of prediction and control of social effects consistent with current power relations.

Acknowledgement of

Individual Differences

Where in the process of application of the discourse of nursing diagnosis to the bodies of nurses and patients are individual differences, deviations, and complaints by patients allowed to emerge? Individual patient differences are acknowledged not in the diagnoses themselves, but in the "due to" or "related to" part of the diagnostic statement (Carpenito, 1993; McFarland and McFarlane, 1993). The first half of the diagnostic statement itself is assumed to be universally applicable to all human beings, under the defining characteristics, which are constructed using empirical analytic science.

The individual clinical case to which the diagnosis is applied is represented in the second half of the diagnostic statement which contains the specific individual etiology. However, the possible etiologies are already spelled out in the handbooks and textbooks (Carpenito, 1984; McFarland and McFarlane, 1993). In other words, the labels or the

subjects or the diagnoses are considered universally applicable. The diagnoses are assigned by application of the universal identifying criteria, and the causal etiology is to be assigned from the list of possible "individual" etiologies.

One problem with this clinical application of empirical analytic research is that probability statements do not describe tendencies of individuals, but of groups. The full nursing diagnosis statement can thus be viewed as an attempt to produce a "morbus" entity as described in chapter three with respect to medicine, by combining a universal entity and an individual clinical situation in a unique classification (Taylor, 1979).

For example, consider Fitzpatrick's (1990) description of the axes that are currently being considered for Taxonomy II that include age and chronicity. She argues that using axes will integrate the "clinical with the scientific for discipline development" (p.106). The obvious difficulty of classifying such a "morbus" entity is not acknowledged. Henderson (1978) defined nursing practice as consisting of "both nursing intervention based on nursing diagnosis and nursing care originating in patient problems or health problems" (p. 79), which assumes that nursing diagnoses and patient problems are separate things.

Presumably, this combination is made in order to capture more of the individual patient's unique circumstances.

Individual clinical variations are also acknowledged in the assessment of the "validity" of diagnoses by individual nurses in clinical practice. Derdiarian (1988) provides three methods for nurses to validate nursing diagnoses in practice situations with individual patients. One method is asking the patient if she or he agrees with the diagnosis. The second is checking with another nurse, and the third is using existing knowledge. Conceivably, these three approaches may yield conflicting answers. This possibility was not addressed by the author.

Lunney (1990) also discussed what she called the "accuracy" of nursing diagnoses. Her study concluded that accuracy is complex and situational. She presents an ordinal scale of minus one to plus five to measure accuracy of a nursing diagnosis, and gives defining characteristics for each level of accuracy. Accuracy in this context is the measure of how well the nursing diagnosis fits the "real" situation, in terms of a number. Like Derdiarian's method of checking "validity", Lunney's method attempts to combine a universally applicable scientific concept with an individual case, in order to determine some degree of truth measured on a scale.

Maas et al (1990) called this idea of accuracy, or validity, the relationship between the nurse's inferred problem and the patient's "true problem" (p. 25). The "true problem" is an entity assumed to exist in an objective manner separate from our understanding of it. In other words, the "object" of the discourse, the human response, is a true problem, and the nurse's inferred problem is the subject of the discourse, the diagnosis.

The way the discourse is structured to handle differences between individual people is viewed as twofold. First, the discourse handles differences between people by the construction of a "morbus" entity. This entity combines a subject in the discourse (a diagnosis) with what is assumed to be an objective observation of patient circumstances, the patient's "true problem". Second, the discourse deals with the individuality of patients by positing "accuracy" or "validity" for a diagnosis that can be measured by assessment (by the nurse, again) of the fit between the inferred problem and the true problem.

The manner in which individual differences among nurses and patients are treated can be described as normalization. Recall from chapter two that the process of normalization involves the statistical average as defined by research becoming the standard to which individual cases are compared in the process of assessment by the nurse

(Carlson, et al, 1981). Interventions by social agents are then applied to the bodies of the patients with the goal of producing more normal outcomes. For example, consider the following quote, "The client's/patient's health status is compared to the norm in order to determine if there is a deviation from the norm and the degree and direction of deviation." (American Nurses' Association, 1973).

Interventions become a normalizing influence on nurses as well as patients, normalizing the nurse's behavior within the clinical encounter towards what has been scientifically determined by the discourse. Indeed, idiosyncratic diagnoses are discouraged. "Conference participants have at least implied that they do not wish to see nurse educators developing 'diagnoses for use in teaching' as a separate or primary task distinct from 'diagnoses for use in research', etc." (Gebbie, 1982, p. 11). The choice for the clinician becomes a choice concerning which of the standardized diagnoses complete with standardized interventions will be used.

For example, at the fifth conference, Roy (1984) argued that a nursing diagnosis taxonomy could and should serve as a guide for practice. That is to say, that the judgement of the nurse takes certain prescribed paths with respect to empirically demonstrated trajectories in order to meet desirable outcome criteria for patients as nurses

have determined them to be. The ANA (Phaneuf, 1985) has identified what they consider to be critical to the future of nursing as "the implementation of standards of practice through the development of criteria related to specific nursing diagnoses". In effect, the practice of nursing, as well as the outcome of nursing, is to be judged by criteria from the normalizing discourse of nursing diagnosis.

To this end, Bulechek et al (1990) presented a guide to measure whether or not nursing diagnosis is being implemented *in a satisfactory manner* at the hospital level. This article concluded that there are certain elements of a model of professional practice that must be in place before nursing diagnosis can be successfully implemented. The list includes the notions of self-governance, accountability and direct access to clients for diagnosis and treatment (p. 20). This view ignores the power relations of the hospital environment in favor of the professional model of social agency as "service to humanity".

Like other discourses which participate in foundational assumptions, nursing diagnosis reveals itself, under analysis, to be a value-laden discourse in its meaning/structure and its application. Normalization is a value assumed through participation in power/knowledge. The power relations inherent within the process of normalization are not changed by having the patient

participate in goal setting or the planning of care because the diagnosis, interventions, and outcomes are already set, thereby severely limiting the available options. Patients and nurses have only the illusion of choices within present power relations supported by the discursive practices of the discourse.

Normalization, of course, has its sphere of useful applications. There may indeed be certain limited things people can justifiably say about the normal physiology of a healing fractured femur. There are, however, more limited numbers of things people can justifiably generalize about *people who have fractured femurs*. The further away the claims move from physiology, the more dependent on the social context are the answers.

What Guides the Discourse

Conflicting goals seem to govern the appearance, disappearance, replacement and coexistence of the theoretical strategies for the generation of a taxonomy. The conflict between theory development and practical application is apparent in this conflict. One goal apparent in the discourse can be termed that of theory development for the purpose of control of clinical phenomena at the population level. Henderson (1978), for example, holds that nursing diagnoses are the first step in theory development "that can be used for prediction and control" (p. 77).

Henderson argues that this first stage of theory development is the same whether you use the model of knowledge generation from Dickoff, James, and Wiedenbach (1968), Chinn and Jacobs (1978) or Jacox (1974).

Fawcett (1986) complained that pragmatic concerns seemed to be more important than theory development of the taxonomy. She stated that the work on nursing diagnosis "appears to have proceeded in a contextual vacuum and has many indications of continuing to be guided by pragmatic, rather than theoretical, interests." (p.397). This position assumes that *theory* provides context and that pragmatics do not. She argues "If nursing diagnosis is to become an integral and meaningful part of nursing science and nursing practice, then theoretical interests must guide future work. I believe that this will occur if further development of nursing diagnosis is clearly based on explicit assumptions that are part of a conceptual model of nursing." (p. 397) "...the work done by the nurse theorist group associated with NANDA appears to be a conceptual model reflecting their particular assumptions about nursing. Although they tried to fit the list of diagnoses to their model, the fit seems forced at best and illogical at worst." (p.397). Meleis (1991) agrees with Fawcett, saying nursing diagnoses "do not emanate from a coherent theoretical perspective" (p. 161).

Logan (1990) also agrees with Fawcett, arguing that nursing diagnoses as they now stand theoretically, are not amenable to independent nurse functions, and that they would have to be rewritten to do so. Logan argues that nursing diagnoses should be limited to only the independent nursing functions. These functions would be derived from theoretical abstractions of nursing phenomena, and be completely unrelated to the functions of other disciplines. Power relations with other disciplines, especially medicine, are completely ignored in this discussion.

Others argue that the diagnoses should be generated from work in practice settings and not from conceptual frameworks. Serious questions have been raised regarding the adaptation of theoretically generated diagnoses to clinical situations (Rasch, 1987). The taxonomy committee's plan to "generate recommendations for making the taxonomy functional in the service setting" has not been brought to fruition (Kritek, 1984, cited by Porter, 1986). Gordon (1990) suggested that each diagnosis should have its own separate conceptual theory base and clinical research.

There are also conflicting approaches evident in the construction of the taxonomy from the perspective of taxonomic science. Porter (1986) pointed out, for example, that it is logically unsound to use nine distinct taxonomic trees for nine overlapping concepts. These overlapping

concepts were used as both an organizing principle and as separate taxons. Porter argues that despite the Taxonomy Committee's insistence that the approach was inductive, the resulting taxonomy was clearly created in a deductive manner (p. 138). Porter also notes the the diagnoses were sorted into four levels of abstraction, but that according to taxonomic science, the entities that are classified by a taxonomy must all exist at the same level of abstraction in order for the organizing principles to sort them by similarities and differences (p. 137).

These discussions concerning the conflicting goals and strategies with respect to taxonomy development underscore the commitment of the participants to the hegemonic dominance of existing power relations. This commitment is unstated and unexamined, so that it functions as a given. The assumptions underlying the effort at taxonomy development have not been clearly established. It is questionable to assume that 1) there are entities that nurses diagnose, 2) that diagnosis is an appropriate model for what it is that nurses do, 3) it is a good thing for nurses to diagnose, 4) that a classification scheme can and should be developed, 5) that discussions of power are not important.

Part Two:

On the axis of authority

In this section, the following questions based on chapter two will be answered with respect to authority in the internal rules of the discourse: What are the rules for who is allowed to speak and who is not? How is the discourse preserved, transmitted, disseminated? What systems are allowed for education, association and advancement of members of the discourse? How is the right to pronounce truth preserved? What positions are available to people within this discourse?

How the Right to Pronounce

Truth Is Preserved

The right to pronounce truth in the realm of the clinical encounter is claimed by NANDA on the basis of its imitation of the discourses of medicine and science within a newly defined professional turf that is uniquely nursing. Other possible claims to the power of pronouncing truth have failed. Levine (1989), for example, observed the failure of the ANA's efforts to convene various groups with an interest in classification schemes for nursing diagnoses as a defeat for what she called true scholarship and says this will serve to legitimize and perpetuate what she called a badly flawed system. Since the ANA has no structural mechanism with regard to NANDA, such calls can

effectively be dismissed without comment, even though there has existed a link between NANDA and the ANA's Congress for Nursing Practice since 1973 (Gordon, 1982b) because one member voluntarily serves on both groups.

In 1989, ANA proposed that it be the "appropriate organization" to assume leadership in the coordination of all classification efforts directed at classifying nursing practice within a national forum (Lang, et al, 1989). In 1987, however, the ANA Board of Directors, on the recommendation of the Cabinet on Nursing Practice, endorsed NANDA as the official association to develop nursing diagnoses (Carpenito, 1989). All ANA cabinet work is now to be forwarded to the Diagnostic Review Committee of NANDA. NANDA has presented programs at the ANA conventions since 1980 (Carroll-Johnson, 1989, p. 471.)

At the eighth conference Lang and Gebbie (1989) reported on the joint venture of the ANA and NANDA toward a submission to ICN. They report on the working relationships between the two organizations by publishing the recommendations of the Collaborative Group on Taxonomies/Classifications of Nursing Diagnoses. The recommendations by this group include the recognition by ANA of the NANDA Taxonomy as the official ANA Taxonomy of Nursing Diagnoses, and that collaboration should continue on a formal level (p. 13). In effect, this move legitimizes

NANDA's Taxonomy and marginalizes any other classification scheme. NANDA's right to pronounce truth is preserved.

Systems for Education,

Advancement, and Association

The entire system of authority for the discourse of nursing diagnosis is NANDA. The association is the source and authority for the entire discourse.

The genealogy has already been discussed. NANDA was formed at the fifth national conference and approved eight committees. At the time of the ninth conference the committees numbered ten: program, publications, public relations/membership, diagnosis review, research, finance, taxonomy, districts affairs, bylaws, and international. NANDA was incorporated in 1985. A refereed journal dedicated to research concerning nursing diagnoses began in 1990.

This structure of the association provides justification, legitimacy, authority, and social presence for the discourse in a manner consistent with other disciplines based on a model of professional power and privilege. According to Foucault, this process confers on the practitioners of the discipline the status of social agents of the modern form of power, bio-power. One unintended consequence of this status is a commitment to

maintaining the current power relations. The oppressive effects of this status will be discussed in chapter five.

Available and Unavailable

Speaking Positions

The first conference acknowledged that the participants were an elite group, and wondered about the acceptance of nursing diagnosis by the "average" nurse (Gebbie and Lavin, 1975, p. 35). This was also reflected in the proceedings of the third and fourth conferences, when Gebbie complained that "Many other nurses, apparently accepting a view of the world that is much more formalized and authoritarian, see 'membership' in the conferences as based on some authority" (p. 11). Gebbie reiterated that all nurses must be encouraged to test, develop, and submit new and revised nursing diagnoses (Gebbie, 1982, p. 11).

Membership in NANDA is open to all nurses from all settings, but participation requires major effort on the part of a full-time practicing nurse. Indirectly, this selects for nurses who have the time and money to travel and work on their own without being paid for it. Speaking positions, therefore, are limited by the criteria of membership and participation in NANDA.

Kritek complained that "the critical component needed is the clear and dominant voice of the nurse in practice, the staff nurse. Currently, that voice is the most often

silenced, the least often heard in nursing dialogue. The challenge to those who have voice is clear: to enable the voice of the staff nurse in this process." (p.11). Meleis concurs: "{nursing diagnoses} do not represent the majority of nurses who have been caring for clients and for communities for years and whose levels of expertise range from the novice to the expert, nor could they do that." (Meleis, 1991, p. 412).

Kim and Moritz (1982) said "Further dialogue between the practitioners and the theorists is essential, and continued input from concerned experts in the area should be made available for a successful finale." (p.xix).

Gordon (1982b) calls for the "involvement of all professional nurses in identifying, further developing, or testing diagnostic categories." (p. 8). The invitation is polite, but the task is weighted by forces of power, class difference, and an attitude that "leaders know best" as the result of academic preparation in the methods of science. They say, in effect, "We've just completed twenty years of work on this. If you don't like it, write us a letter or provide us with counter evidence."

Gebbie writes that practicing nurses are to be encouraged to join NANDA and participate in Taxonomy development, while she realizes that this places a financial and time burden on them. She also suggests that,

"At some point it may be necessary to formalize some method of qualifying for participation to ensure that new people can bring new ideas and energy without causing undue delay." (p. 12.).

Positions from which to speak this discourse are thus limited by the hegemonic dominance of NANDA. At the seventh conference business meeting, a motion was passed which states, "Moved that NANDA go on record as supporting the concept that only registered, professional nurses be responsible and accountable for identifying the nursing diagnoses for their patient population." (McLane, 1987, p. 529). One implication of this motion is that nurses who are not registered, or not professional, have no right to wield this language. This restriction assumes a certain degree of power inherent in the discourse that needs to be limited to a certain speaking position as defined by NANDA. This motion also assumes that people who do not meet the speaking criteria should not enjoy this privilege of acting as a social agent. It is not clear how this is to be enforced, but it is clear that NANDA is the decision making body for approving the use of nursing diagnoses.

Preservation and

Transmission of the Discourse

The discourse is preserved and transmitted in a manner that consolidates the dominance of NANDA as the pronouncer

of truth. This is done by NANDA publications, conference proceedings, newsletters, speakers bureau, workshops developed by NANDA, dissemination to faculty who teach the discourse to students, and by publications in nursing journals. NANDA news and committee reports are included in the journal, Nursing Diagnosis. Guidelines for conducting workshops were presented at the fourth conference (Kim & Moritz, 1982).

The discourse is thus disseminated in many ways. The ANA published the Standards of Clinical Nursing Practice in 1991. The standards include competence as demonstrated by the nursing process which includes diagnosis. Shoemaker (1989) argues that nursing diagnoses should be taught in graduate curricula as well as undergraduate. Lee and Strong (1985) used nursing diagnosis to assess competence in nursing of recent grads, using Likert scale ratings by the grads and their faculty. The AACN (American Association of Critical-Care Nurses) used nursing diagnosis as the framework for conceptualizing nursing practice in their outcome standards. The JCAHO (Joint Commission on Accreditation of Healthcare Organizations) specifies that nursing diagnosis and/or patient care needs be specified in the medical record of the patient (JCAHO, 1992).

These structural mechanisms for the preservation and transmission of the discourse provide necessary

justification for the acceptance and use of the discourse by practitioners within the clinical encounter. Having a history, an incorporated association complete with bylaws, a journal, and a national forum lends legitimacy to the discourse entirely apart from the content. The authority of the discourse is being constructed in imitation of medicine and science because the process efficiently confers power in modern western society (Foucault, 1978).

Handling of Imperfections

Imperfections in the discourse of nursing diagnosis are often classed as major or minor, and approaches to handling either class are based on assumptions concerning the underlying value of the discourse as a whole with respect to professional goals. Many argue that acknowledged imperfections in construction, application and dissemination of nursing diagnosis should be handled with more clinical research (Carpenito, 1993; Kritek, 1985; Fawcett, 1986).

Other authors view the imperfections as indicative of deeper problems that cannot be addressed by more research. Shamansky and Yanni (1983), for example, provided a broad-scoped critical rejection of the discourse, and concluded that nursing diagnosis should be abandoned. It is significant to note that they identified their article as a "minority opinion". The authors cited such difficulties as

frequent disagreement between expert practitioners in their choice of diagnoses, decreased inter-disciplinary communication, and lack of precise language that matches the clinical situation.

Kritek (1985), while refusing to identify herself as a "true believer in nursing diagnosis" (p.3), agreed with some points about the weaknesses in the discourse as identified by Shamansky and Yanni. However, Kritek did not agree with Shamansky and Yanni that the difficulties they describe are indicative of overwhelming inadequacy, saying selected imperfections do not support the case that the effort should be abandoned. Kritek maintains (1989) that a taxonomy is itself a self-correcting device for dealing with inconsistencies because of the *scientific* nature of taxonomies (p.9). This assumption of the value of scientific inquiry (in this case, taxonomic science) ignores the question of the appropriateness of the choice to develop a taxonomy in the first place.

Fredette (1988) argues that imperfections in the nursing diagnosis literature with respect to the notion of causality make it difficult for the practitioner to identify how to direct the plan of care (p. 33). Fredette does not see this imperfection as a major problem, saying that the solution to this imperfection is further dialogue between the practical approach and the scientific approach.

Imperfections in the discourse could certainly be addressed by the official organization. Calls for further dialogue with practitioners might go completely unnoticed by NANDA, or could result in consultation with selected clinicians. The power resides with the association, not the clinicians.

NANDA does not pass official judgement on books about nursing diagnosis, but individuals review books and articles and the reviews are published in the proceedings of the conferences (Kim et al, 1984). Other reviews of books are published in the journal, Nursing Diagnosis. Imperfections can certainly be noted and judged in this manner, since these two sources are official publications that carry much weight. The power to pronounce truth is further consolidated.

Part Three: On the Axis of Value or Justification

In this section on the third axis of a discourse analysis, the value or justification of the discourse for its discursive practices are analyzed. In general, this analysis asks for the justification provided by the discourse for its position as a pronouncer of truth. The following specific questions will be answered: How are the technologies of power justified by the discourse? What justification is provided for the punishment of

participants? How is the suppression of competing discourses justified?

Justification of the
Technologies of Power

The technologies of power used in the discourse of nursing diagnosis are overtly justified within the discourse by reference to nurse empowerment and improved patient outcomes. Carpenito (1993), for example, complained that some authors were against nursing diagnosis because they see it *only* as a way to empower nurses, when in fact it benefits patients at the same time.

On a deeper level, the justification for the application of the technologies of power rests on the assumption consistent with the notion of bio-power, that power/knowledge confers social agency on its practitioners. It is thus the responsibility of social agents to apply power/knowledge for the assumed benefit of those whose have been so constituted by the discourse itself, whether or not the patients believe this is the case. Following the Social Policy Statement (1980) it is believed that nurses are justified in deriving goals and interventions without full participation of patients (Allen, 1987, p.46). In other words, patients are specifically constituted by the discourse to be self-revealing targets of normalization strategies wielded by social agents. As social agents, we

believe that we are advancing civilization by improving the life of those people we have scientifically determined as those needing the application of the power/knowledge that we alone possess.

At the first conference, it was stated that the diagnoses should be validated officially through the ANA or the NLN (Gebbie and Lavin, 1975, p.4). The conference organizers also sought approval from several non-nursing authorities: medicine, medical records librarians, the Joint Commission, and hospital administrators by having representatives participate in a panel presentation to the conference (pp.4-5). NANDA's authority has since grown to the point that external validation by other nursing authorities has become unnecessary.

Creason (1992) proposed patient clinical outcome criteria to answer the question of whether or not specific nursing diagnoses are justified. 1) Do they reflect what is actually happening with the patient? (validity). 2) Are they sufficiently defined so that any nurse observing the same cues would arrive at the same diagnosis? (reliability). 3) Are they useful in designing nursing interventions? 4) Do they clearly communicate the condition of the patient among nurses and the direction for nursing interventions? 5) Is each one sufficiently independent of the other to promote clarity? 6) Will the patient benefit?

- 7) Can they be used in conjunction with medical diagnoses?
- 8) What research base do we presently have to support them and what further research is needed?

These criteria reflect the justification of nurses as social agents within the web of power relations called "normal science" in which nurses identify and protect an overlapping region of experience. Within this region, nurses justify their technologies of power using the language of science for the pronouncement of "truth" with respect to patient outcomes and nurse empowerment. The language of foundational science assumes that description and action in new regions of experience is justified, because knowledge generation provides power over ignorance. Following the repressive hypothesis, knowledge generation is assumed to liberate people from the slavery of ignorance by the provision of knowledge without judgement. Using the language of science, nurses are therefore justified in their research on the "human responses to illness" or the "human responses to the human responses to illness" or any other region we would care to describe, as long as it doesn't encroach too much on the terrain some other discipline has created for itself. Such encroachment would be seen as resistance to current power relations.

Using the language of professionalism, we are justified in applying the knowledge we construct to our own

bodies and the bodies of our patients by educating social agents in foundational science and professional behavior accorded by power/knowledge. In the shifting web of power relations, social status can be embodied by emulating successful models in newly constructed social situations. After overcoming the inertia of the historical stereotype of nursing as relatively powerless, the conceptual momentum of power/knowledge and social agency assumes its own justification.

Justification for the
Punishment of Participants

In order to consolidate the power/knowledge of the discipline embodied in the social agents, control is exercised over the participants in the discourse in the manner of the model of professionalism. Both power/knowledge and professionalism are required for the status of social agency in order to justify patient interventions in our social world.

As an example of such justified punishment, consider that Carpenito (1993) believes that missing a diagnosis should be considered malpractice in the same way for nursing as it does for medicine. This belief is congruent with the the major discourse of nursing diagnosis, which is the discourse of medicine, since most of the diagnoses represent deficits, or altered states, or deficiencies.

This belief seems incongruent with the non-dominant discourses within nursing diagnosis, when a diagnosis of "effective breast feeding" or "functional grieving" is considered.

Since the ANA standards of nursing practice are based partially on the ability to make nursing diagnoses, it is conceivable that nurses could be sued or fired from their jobs for not doing so. The use of nursing diagnoses was meant to be a distinguishing feature of the differing levels of nursing practice at the first conference (Gebbie and Lavin, 1975, p. 26). It would be conceivable, then that an Associate Degree Nurse could be punished for the use of nursing diagnoses, since this would indicate a breach of level of practice.

The systems for punishment of participants could thus be identified as the individual economic unit that hires the nurse, the association and law under which the nurse practices, and the educational institution in the case of the student. Correction, normalization, and punishment thus have systems in place for their application on the body of the nurse.

Justification for the

Suppression of Other Discourses

When a discourse gathers membership, influence, power and momentum, seeking hegemony, creating definitions,

highlighting differences between itself and other competing discourses, it seeks to discredit and suppress other discourses in the interests of solidifying the ideology that constitutes meaning. The arguments in favor of nursing diagnosis gain force because of the general acceptance of the scientific and professionalist approaches highly valued in our culture. A dominant discourse, convinced of the "rightness" of the ideology, seeks to exclude other viewpoints in an effort to accrue power/knowledge by citing benefit to some group or another, who "don't know what is best for them".

The discourse of nursing diagnosis follows this model. For example, in 1987 AORN was asked to edit articles and use the term nursing diagnosis only for official NANDA diagnoses. The editors refused, saying nurses make diagnoses that are not NANDA ones all the time (Puterbaugh et al, 1987).

Harrington (1988) proposed that educators should limit teaching diagnoses to the NANDA list only, saying "random creative efforts in the area of nursing diagnosis threaten the society of nursing and the development of a taxonomy" (Harrington, 1988, p.94). All communication in the discourse, in her view, should be channeled through NANDA. "Educators have the responsibility to control the channels of communication so that responses are productive" (p.94).

"Students should not be confused, and they should not add to the confusion, by using creative, personal, and non-communicable diagnoses. If they all use different languages, students graduating from nursing schools across the country will not be able to communicate with one another about nursing diagnosis." (p.94).

These examples demonstrate the strong influence of NANDA with respect to the suppression of other discourses. The fervor apparent in the quotes above show personal commitment to a "cause" that seems phrased in the same way as a political movement. A similarity between proponents of nursing diagnosis and proponents of a religion has been noted before (Kritek, 1985).

Section Four: The Influence of the Discourses of Medicine, Empirical Analytic Science, and Professionalism on Nursing Diagnosis

The above analyses of the three axes demonstrate the structure of the regularities that order the internal rules of the discourse of nursing diagnosis. This section will present evidence that the major influences on these regularities come from the discourses of medicine, empirical analytic science, and professionalism.

The Discourse of Medicine

As we have seen in the previous chapter, the major discourse in the *development* of nursing diagnosis was

medicine (Dickson, 1993). The major discourse in the development and the present *practice* of nursing is also medicine (Street, 1992). There is abundant evidence that the dominant influence on the internal structure of the discourse of nursing diagnosis as described in Foucaultian terms in this chapter is also medicine.

Whether the intent of the text is to highlight the differences or the similarities between nursing and medicine, the language remains medical. In order to highlight the similarities and the differences at the same time, the medical language remains the basis of comparison. Like medicine, we diagnose, we treat, we measure outcomes. Unlike medicine, we diagnose and treat human response patterns, based on our own body of knowledge. Throughout this process, medicine is the privileged other, the binary partner of nursing in the relation that defines nursing as a discipline.

The following reasons support the claim that the dominant regularity in the discourse of nursing diagnosis is medicine.

1) Word choice. Recall from chapter two that the act of definition is a move of power. The choice of the word "diagnosis" at the first conference maintains both the similarities and differences between nursing and medicine at the same time, without challenging the status quo of

power and influence as it presently stands. As we have seen, this approach is assumed to be justified by the adoption of the models of science, medicine, and professionalism.

Language is a very political and power-oriented activity (Levine, 1989). In the proceedings of the third and fourth conferences, it was speculated that the reason studies making use of nursing diagnosis were not being funded was that there was a "certain uneasiness with the use of the word 'diagnosis'. There are fears of what that evokes in other disciplines" (Kim & Moritz, 1982, p. 13). Myra Levine (1966) had constructed the term "trophicognosis" to be used instead of nursing diagnosis, but this term never caught on. The influence of the discourse of patient needs and problems that was reflected in early definitions of nursing diagnosis has also faded. The word "diagnosis", despite opposition, was adopted.

The derivations of definitions provided for nursing diagnosis are all medical. Derdiarian (1988) derived her definition of nursing diagnosis based on three different definitions of the word "diagnosis" from three different medical sources, which were then "adapted to nursing" (p.138). Carlson et al (1982) based their definition on one of the three different components to the definition of "diagnosis" from Webster's Dictionary.

The words "treatment" and "intervention" are also widely represented. Gebbie (in Carlson, et al, 1982) stated that "more nurses have come to describe their professional responsibility as the process of diagnosing and treating client conditions" (p. vii). Turkoski (1988) notes that the discourse of nursing diagnosis frequently uses medical diagnoses as descriptors (p. 143), medical labels, language, and models within the concept and design of the discourse (p. 144).

The conspicuous absence of the word, "disease" is noteworthy. Emphasis on the word "diagnosis", coupled with strict avoidance of the word "disease" reinforces the definition of ourselves as "not-doctors". This approach uses imitation of the process while scrupulously avoiding turf battles.

The choice of words is justified by how "scientific" they are. Needs and problems do not easily lend themselves to development of empirically demonstrable outcome criteria because the words are already used in other disciplines (i.e. psychology) and in everyday language. Redefinition of words like these would be very difficult and not sufficiently jargon-like to support professional status.

On the other hand, human responses, conditions, and phenomena are concepts that are sufficiently vague and uncommon as to be easily redefined as discipline-specific

jargon. They can lend themselves to scientific measurement, and yet do not tread into territory occupied by another discipline. Any approach or intervention that threatens medical turf would receive immediate comment from medicine (witness the current appeals to public awareness regarding the potential of nurse practitioners to provide primary care under health reform).

The arguments involved in defining what it is that nurses diagnose assume that the applicability of the concept of diagnosis to nursing is already established. This assumption thereby diverts attention from the underlying question of whether or not nurses diagnose to the question of what it is that nurses diagnose.

The choice of classifying nursing diagnoses also reflects the medical discourse. The grid of specification, the taxonomy, of nursing diagnosis was meant to mesh with existing classification schemes. Gebbie (1989) described and summarized the major classification systems in health care as the ICD, the CPT-4 in medicine, the DSM-III in the APA, the SNOP in pathology, and the SNOMED in medicine. She argued that any classification system in nursing must be translatable into currently existing coding schemes. "Anyone wishing to add or to replace a coding system in use will have to demonstrate both the need for and efficacy of the changes." (p.49).

2) The discourse is based on a model of symptomatology and etiology. At the first conference, the diagnoses were referred to as having definitions that would be defined operationally in terms of "signs and symptoms", for example, those signs and symptoms of "incomplete grieving" (Gebbie and Lavin, 1975, p. 25).

Gordon (1976) also explains "defining characteristics" of nursing diagnoses in terms of signs and symptoms. One reason cited for the importance of developing a classification system for nursing diagnosis is that it "Allows application of epidemiological principles and methods to clinical nursing" (Carlson, et al, 1982, p. 25). Carpenito (1984) uses the term "etiological factors". At the seventh conference, Fitzpatrick (1987) advocated using the term "influencing factors" instead of etiology (p. 63).

McFarland and McFarlane (1993) also use the word "symptoms" for the concept of defining characteristics of nursing diagnoses. For example, one diagnosis to be diagnosed and treated by nurses is "Altered Health Maintenance related to inability to secure adequate permanent housing for self and family" (McFarland and McFarlane, 1993, p.23). One defining characteristic, or symptom of this condition is "verbalization of inaccurate information". Viewing "verbalization of inaccurate information" as a *symptom* of "Altered Health Maintenance

related to inability to secure adequate permanent housing for self and family" is a good example of the medicalization of everyday life as described in chapter two.

McFarland and McFarlane (1993) also use the concept of "risk factors" in their presentation of some diagnoses stated as "High Risk for....". Assessment of risk factors as well as signs and symptoms becomes an important component of identifying nursing diagnoses. For example, the risk factors for "High Risk for Activity Intolerance" include sedentary lifestyle, chronic or progressive disease, fatigue or weakness, deconditioned status, weight more than 15% over acceptable standard, pain, and refusal to participate in prescribed activities.

Use of the term "risk factors" also demonstrates an emphasis on epidemiology and population-based statistics. At the fifth national conference, Toth (1984) praised nursing diagnosis for the opportunity to compare patients classed as "acute diabetic patients who are non-compliant with therapy because of a knowledge deficit" from one hospital to another, statistically in terms of their length of stay (p. 100). Population-based diagnoses are thus justified.

This emphasis on epidemiology and population-based diagnoses has serious potential for the creation of

oppressive relations. The application of epidemiological principles to the diagnoses of "incomplete grieving" and "altered family process" has implications for culturally stereotypical interventions. The potential for oppression will be discussed in chapter five, the power analytic.

3) it emphasizes pathology. Fawcett (1990) argued specifically against what she called "the fact" that NANDA's system is based on an externally-driven biomedical perspective with an emphasis on pathology. Fawcett argued that this bio-medical perspective was inappropriate and should be replaced with a nursing perspective derived from a conceptual work by nursing theorists.

Pathology is also emphasized by the choice of the word, "deficit". NANDA diagnoses name states of deficit, impairment and disturbance (Gordon, 1982a) and alterations in functions or in functional patterns (Pridham and Schutz, 1985). Diers (1986) points out that the word "deficit" implies defect. She questions certain uses of the word "deficit" in the discourse of nursing diagnosis, such as "knowledge deficit", and asks how it is that knowledge can be defective.

The overwhelming emphasis on pathology is brought into sharp contrast by the inclusion of "diagnoses" that are health-related, making a clear contradiction between diagnoses. Such a diagnosis is that of "Effective

Breastfeeding" (McFarland and McFarlane, 1993). Popkess-Vawter (1991) recommends adding more wellness-related diagnoses, such as functional grieving, adequate individual coping, improved coping, activity tolerance, and effective airway clearance (p.22). The placement of wellness-related diagnoses in the taxonomy is presently unclear.

4) it emphasizes a disease model (Meleis, 1991). The ICD was one of the classification schemes studied at the first conference. It was suggested at that conference that the the medical classification of diseases (SNOMED, or Systematized Nomenclature of Medicine) was the only one that had room in its numerical classification system for nursing diagnoses to be added (Gebbie and Lavin, 1975, p. 20).

NANDA was denied inclusion in the International Classification of Diseases (Webb, 1992), and Clark and Lang (1992), therefore, recommend a separate international classification for nursing practice whose primary components are patients' needs, nursing actions, and patient outcomes.

5) The discourse of nursing diagnosis has a strong physiological bias (Webb, 1992). At the first conference, working groups were designated and assigned to a physiological system, even though the conference organizers record opposition to such a move as committing the system

"irretrievably" to a pathological and disease based model (Gebbie and Lavin, 1975, p. 5). The resulting diagnoses, predictably, reflect the organization of the working groups.

Approximately half of the diagnoses in Taxonomy I are physiologically-based (Fitzpatrick, et al, 1989). Carpenito (1993) is opposed to calling some of these physiological phenomena nursing diagnoses because she states that doing so takes on an accountability that is not nursing, but medical. Carpenito (1993) also records that critical care nurses complain about the lack of physiological nursing diagnoses. Carpenito calls these diagnoses collaborative problems, and complains that critical care nurses in general emphasize the collaborative problems and avoid dealing with the human response problems. Kritek (1985) argues that the only alternative to nursing diagnoses is "regressive adaptation to a medical paradigm" (p.4), but for critical care nurses, "The so-called medical model of treating anaphylactic shock better describes what we do for a patient than do 20 different nursing diagnoses." (Curry, 1991, p. 124).

At the ninth conference, during the discussion of the work towards Taxonomy II, critical care nurses became quite dismayed at the deletion of physiological diagnoses that they felt were useful in their practice (Carroll-Johnson,

1991, p. 51). The answer given by the committee working on Taxonomy II was that these diagnoses were still approved, but that since they did not represent independent nursing judgements, they did not fit within the new work on Taxonomy II and had been left out. The critical care nurses had been emphasizing the similarities of their practice and that of medicine, but the work on Taxonomy II emphasizes the differences while still using the medical language of diagnosis.

The similar focus of critical care nurses and medicine has been noted before (Gamer, 1979). The discourse of nursing diagnosis emphasizes a medical *approach* to what are assumed to be nursing issues. The result is an incomplete collection of some medical signs and symptoms and not clinical behaviors in themselves (Levine, 1989, p.5).

6) The diagnoses are supposed to be applied in nursing practice, in clinical situations, even though many nursing diagnoses do not seem to fit patient situations (Frank, 1990). The diagnosis is established through the clinical judgement of the nurse, based on scientifically derived categories and recognition of symptoms and risk factors. The knowledge to diagnose and treat the problem that is constructed by the discourse is assumed to exist within the nurse by virtue of education and experience.

The Discourse of
Empirical Analytic Science

The discourse of medicine reflects, reproduces and participates in the social model of the discourse of empirical analytic science with foundational assumptions. Although diseases are historical constructs, they are regarded within the discourse of medical diagnosis as entities, that is to say, things that exist apart from the medical conceptualization of them. Nursing diagnosis emulates medicine's participation in foundational science.

Recall that the assumptions of a foundational view of science include the existence of a foundation of absolutely true facts, and the value-free nature of scientific activity (Hekman, 1986). The adoption of an unexamined medical model into the nursing model of diagnosis perpetuates the assumption that problems are justifiably viewed as reified entities, rather than social judgements.

Most nursing researchers are committed to the dominant empirical analytic paradigm as a model for the profession, and not as a tool to answer certain questions (Dickson, 1993). Carpenito (1993) insisted that one of "nursing's problems" is that we have been content to be described by what we do, not by what we know. Carpenito holds that technicians are defined by what they do, and scientists by what they know (p.92). Curtin (1978) argues, on the other

hand, that nursing should be defined by its philosophy, not its functions. This debate between knowing and doing reflects the social value placed on knowledge over practice. The Cnidus and Cos schools of medical thought are still major influences.

Evidence that the discourse of nursing diagnosis is empirical analytic falls into the following categories:

1) Reductionism. The discourse of nursing diagnosis is based on a reductionist assumption (Tierney, 1987). The assumption is that the conceptualization of people for the purpose of nursing care can be "reduced" to sets of diagnoses for ease of identification, treatment, and measurement of outcomes. Doing so avoids the messy world of social context and value-judgements. The reductionist perspective is valued in nursing diagnosis because of its perceived scientific, value-free nature.

Gordon's (1982a) book on nursing diagnosis reports that some people are of the opinion that the classification scheme for nursing diagnoses, being reductionist, does not adequately reflect the holistic nature of nursing practice (p.40). Kritek (1978) saw nursing diagnosis as "the point where holistic synthesis occurs" (p.40). Kim (1983) adds that nursing diagnoses are created entities that conflict with the concept of the "wholeness" of individual people

(p. 139). Many patient experiences defy classification in NANDA terms (Pridham and Schutz, 1985).

Meleis (1991), for example, calls the diagnoses "esoteric in language and nonrepresentative of the complexity of human beings" (p. 161). "There is a growing number of nurses who view the labelling inherent in the diagnostic process as too restrictive for describing human beings" (Mitchell and Santopinto, 1988, p.25). Eleven years after Gordon's book, McFarland and McFarlane (1993) do not refer to holism at all, and the term "wholeness" refers only to a notion of spirituality.

Various authors have noted the lack of fit between Taxonomy I and the concept of unitary humans derived from the work of Martha Rogers and purported to be the organizing framework for the classification (England, 1989; Gordon, 1987; Roy, 1984; Smith, 1988). Holism as a concept in nursing seems to be fading from the journals and the textbooks.

2) Determinism. The deterministic view of human beings has serious implications for nursing practice, reflecting nursing's commitment to empirical analytic science as the one and only criteria for a professional discipline (Allen, 1987b).

A strictly deterministic, linear view of causality is assumed by the discourse (Turkoski, 1988). Multiple causal

factors are assumed to be discoverable, and specifiable in advance (Gordon, 1982a; Forsyth, 1984; Bircher, 1986; Fitzpatrick, 1987). Nursing care is defined as effective when measurable, expected outcomes result from the planned action (McFarland and McFarlane, 1993) within the clinical encounter.

The emphasis on prediction also reflects the linear view of causality. Carpenito (1993) claims nursing diagnosis provides predictive scientific nursing care, "That is, we know in advance what a patient will probably need." (p. 94). "Once we isolate phenomena, we can describe them, manipulate them, and create preferred outcomes; then we can have the effect we wish to have." (Kritek, 1985, p.6). "Theory supporting nursing diagnosis must account for description, explanation, prediction and control of phenomena that nurses autonomously treat." (Wooldridge, et al, 1993, p. 50).

Determinism is clearly reflected in the presentation to the fifth conference by Forsyth (1984), in which he states that although we cannot demonstrate the empirical existence of causality, we may indeed speak of correlations, associations and relationships among the "entities" being observed (p. 71). These descriptions assume that the phenomena we deal with can be isolated,

identified, studied, and elicited without regard for the social context of the patient.

3) Essentialism (Dickson, 1993; Allman, 1992).

Essentialism refers to the now-discredited assumption that words 1) are names of separate things, and that 2) proper use of a word requires there being some invariant core set of properties that justify application/use of the word. The essentialist perspective has serious implications in nursing, not the least of which exists within the discourse of nursing diagnosis (see Allen, 1986; Thompson, 1992).

At the sixth conference, Kritek (1986) emphasized that taxonomic ordering should reveal the essential properties of phenomena (p. 23). In Webster's (1984) paper, he discussed essentialism, recommending to the participants at the fifth conference that, given a choice between an essentialist view of empirical phenomena and the view that classification schemes reflect only our own conventions and not the nature of the phenomena of concern, that "Wisdom seems to dictate some sort of intermediate position.." (p. 21). Neither the wisdom nor the intermediate position was further justified.

Taxonomies are, by common assumption, viewed as classifications of objective entities using essential properties. Non-essentialist taxonomies would function by stipulative definitions, the measures of which are

pragmatic and functional, rather than essentialist (Allen, 1994) .

Porter (1986) used Fleishman's (1982) definition of taxonomy as "the science of identifying and classifying entities, the study of the bases, principles, procedures and rules that enable classification", and asserts that a taxonomy is necessarily an essentializing discourse.

Some potential pitfalls of essentialist taxonomy development were pointed out at the first conference, including the danger of vague and/or overlapping categories, and the logical possibility, at least, that nursing phenomena may not be amenable to standardization in an essentializing way (Gebbie and Lavin, 1975, p. 14).

Essentialism was reflected in the presentations to several conferences on taxonomic science (Gebbie and Lavin, 1975; Bircher, 1986, p. 76). It was emphasized that a taxonomy will order phenomena in ways which will reveal "essential properties and their relationships" (p. 13). On the other hand, Diers (1986) warns that the scientific assumption that "operational definitions" will name the essential properties of "vague" nursing diagnoses may be unwarranted.

The essential relationships between entities in a taxonomy are understood from an organizing principle. Fleishman (1982) states that the purpose of using a

taxonomic structure to categorize entities is to explain, in a causal way, why they have the properties they do, and why they are similar and different from other entities in the structure, from the basis of the organizing principle. Porter (1986) adds that a process or state cannot be a taxon, according to taxonomic science. "Alterations", for example, has been defined by NANDA as "the process or state of becoming or being made different without changing into something else." (p. 1 in Taxonomy I).

The construction of taxonomies involves the use of organizing principles and/or conceptual frameworks which are themselves value-influenced choices. Foucault therefore argues that the formation of taxonomies:

"...implies a certain continuum of things (a non-discontinuity, a plentitude of being) and a certain power of the imagination that renders apparent what is not, but makes possible, by this very fact, the revelation of that continuity. The possibility of a science of empirical orders requires, therefore, an analysis of knowledge - an analysis that must show how the hidden (and, as it were, confused) continuity of being can be reconstituted by means of the temporal connection provided by discontinuous representation." (Foucault, 1970, p.72-73).

Recognition of the critique of essentialism is reflected in Kerr's (1991) presentation to the ninth national conference in which she states, "The essence of an element is not constant" (p. 7). Kerr goes on to describe methods for validation of taxonomies that includes qualitative analysis along with cluster analysis, discriminant analysis and fuzzy set methods (p. 12).

The influence of essentialism can also be seen in the emphasis on defining the unique characteristics of nursing. Nursing diagnosis has often been cited as *the* unique essential criteria for nursing as a discipline. Kritek (1985) claims that "The generation and classification of nursing diagnoses aims to clarify nursing's separate sphere and articulate those responsibilities that are uniquely nursing's... Equality, even equity, requires a distinct domain to bring to the enterprise...Certainly nursing diagnoses should enhance, not preclude collaboration." (p.4). If nursing were truly autonomous, then the nursing diagnosis would be as informative and useful to the physician as the medical diagnosis is to the nurse (Levine, 1989).

Highlighting boundaries can enhance collaboration only between completely separate disciplines. Since nursing is subordinate to medicine, such highlighting of boundaries tends to be viewed as a bid for complete separation. Logan

(1990) proposes that we take the further step of separation wherein nursing diagnoses would address *only* independent nursing functions, assuming there are such things. In 1989, the ANA stated, "Until nurses can name what they do and assign a computer code to that name, we may be neither reimbursed nor recognized as a profession with unique skills and knowledge." (p.3).

4) The reification of entities. Reification is the transformation of social relations from relations between persons to relations between things. (Hiraki, 1992, p.131). We refer to the individual "having" the diagnosis. The objects of the discourse, the human responses, are not viewed as social constructions. Kritek (1989) refers to this depersonalizing effect as a "challenge" for the language of nursing diagnosis. Lindsay (1990) stated that human responses are real physical things. Hiraki (1992) quotes Watson (1990) as saying the development of nursing knowledge that encourages the view of humans and health caring processes as problems to diagnose gives power to the problems and processes by according them law-like status, separated from the experiences of human beings (Hiraki, 1992, p. 19).

Reification thus assumes value-neutrality. NANDA conferences assume the value-neutrality of nursing diagnoses as scientific concepts. Bircher (1986) told the

sixth national conference that "nursing diagnosis is an abstract concept, an intellectual tool which is neutral. It is as powerful and constructive, or as weak and destructive, as the extent to which it is used appropriately and effectively toward the achievement of an end." (p. 73). This is an example of the technology influencing the product, in the Foucaultian sense. The technology has unintended consequences on the relationship between the people. Hagey and McDonough (1984) state, "Either supporters of nursing diagnosis see the categories as harmless without social context or they take as self-evident and acceptable the political outcomes such categories produce" (p.153). It's not 'just a neutral tool'. The tool structures its own use in discoverable ways.

The power implications of reification are significant. Implications for oppression of patients and nurses will be addressed in chapter five, the power analytic.

5) The discourse of nursing diagnosis is based on instrumental knowledge. This is a "formula approach to people, objectifying, codifying, and reifying human experiences with 'official knowledge' that takes on a life of its own - a life that is separate, decontextualized, rather than connected" (Watson, 1990, quoted in Hiraki, 1992, p.19).

For example, at the seventh conference, Levine (1987) raised what she called a "serious philosophical issue" with respect to the idea that the essence of nursing is treating human responses (p. 51). She argued that this view assumes that humans are simply responding dependent systems, or "targets" for interventions without any conception of human agency (p. 52).

6) It holds natural science as the ideal (Donaldson and Crowley, 1978; Jacobs and Huether, 1978; Kim, 1983; Silva and Rothbart, 1984; Thompson, 1985; Street, 1992; Dickson, 1993). Schilder and Edwards (1993) argue that nursing researchers have been most concerned with whether or not and to what extent their results are generalizable. Maas et al (1990) supports strictly empirical methodological limitations on nursing diagnosis research, "in order to get more funding and exposure in 'the scientific arena'." (p.30).

The ideal of natural science is reflected in the choice of the words and procedures of taxonomic science. For example, Kritek (1985) suggested that it might take nursing 300 years to complete the taxonomic system, if we examine the taxonomic development of the periodic table of elements. Even then, no classification system is ever complete (Harrington, 1988).

The ideal of natural science is also clearly represented in the comparisons made between nursing and other disciplines. Kritek (1985) compares nursing to quantum theory of physics, chemistry, behavioral sciences, and social sciences. Carpenito (1993) compares the diagnosis of decisional conflict to the diagnosis of pancreatitis because she argues that they are both objective entities scientifically describable and amenable to standardized treatments that professionals should be accountable for prescribing.

Natural science as the ideal is reflected in the "naturalism" of nursing diagnosis in the same manner as it is in the discourse of medicine (Allman, 1992). The assumptions of naturalism include the existence of an objective "Nature" separate from human knowledge of it. Nature is assumed to exist prior to culture and social order. Knowledge and truth are therefore assumed to exist separately from power and morality (Allman, 1992). The discourse of nursing diagnosis treats the categories of the human responses (the objects of the discourse) as natural and universal scientific entities.

Natural science is also reflected in the style of statements. Only two examples were found representing the generation of a new nursing diagnosis using a qualitative methodology (Clunn, 1984; Logan & Jenny, 1990). Qualitative

research was, however, suggested at the ninth conference as one promising method for research in nursing diagnosis (Carroll-Johnson, 1991).

Natural science is reflected in the regularity that governs the style of the theoretical *strategies* (Tinkle & Beaton, 1983) used by the discourse to construct knowledge. For example, at the first conference both inductive and deductive scientific strategies for the development of a taxonomy were suggested, but a conclusion was not reached with respect to an organizing framework for the taxonomy (Gebbie and Lavin, 1975, pp 37-56).

Among the deductive approaches to determine a principle of classification suggested at the first conference were Maslow's hierarchy of needs and various nursing theories then current (Gebbie and Lavin, 1975). It was suggested that since both the deductive and inductive strategies contain the possibility of error, one should not be picked over the other (Gebbie and Lavin, 1975, p. 56).

The debate concerning the inductive and deductive approaches has been approached with a considerable amount of theoretical attention. McCloskey (1987) presents the argument that Taxonomy I was created inductively, from concrete to abstract. Kim and Moritz (1982) argue that the products of the first two conferences (inductive) and the nurse theorists' work at the third and fourth conferences

(deductive) might continue to run parallel (p. 7), but the author hopes they will converge (p. 131). In the same volume of the proceedings of the third and fourth conferences, Gebbie (1982) states that a specific decision was made in favor of the inductive approach at the first conference, but that this decision was proving very frustrating to the nurse theorists (p. 9).

Kim (1983) takes the position that NANDA, by adopting the inductive method, completely bypassed the question of a specific theoretical orientation for the classification system, with the adoption of a framework called "unitary man" notwithstanding. She argues that the attempt to remain *atheoretical* by giving operational definitions, etiologies, and defining characteristics resulted in a multi-theoretical framework instead (p. 140).

7) It is a standardized model (Gordon, 1984) based on standards constructed from foundational science. As such, the model can substitute for knowledge and experience in a novice situation, and therefore be a teaching guide, but the model is control-based, not people-based. Things that are hard to measure are left out, causing things like caring and sensitivity to be devalued and/or not evaluated at all (Gordon, 1984). Care based on pre-determined standards contributes to the failure of treating persons as holistic individuals (Bond, 1988; Niziolek and Shaw, 1991).

It is not clear whether a label from a standardized body of knowledge applied to specific human-environment interactions can be the empirical basis of nursing interventions or even if it is the phenomenon that requires taxonomic classification (Porter, 1986, p.138).

Standardized models in clinical situations, however, are barriers to expert practitioners because they limit the creativity and individuality that expert practice entails.

For example, a computerized nursing diagnosis system has been suggested for nursing diagnoses. "The standardized language can be computerized and linkages between diagnoses, interventions, and outcomes can be discovered through documentation and study of actual patient care." (Bulechek and McCloskey, 1990, p. 27). Software would accept the patient data and produce diagnoses and the associated treatments, and become part of the patient's hospital record (Hirsch and Chang, 1990).

Harvey (1993) demonstrated that an ART-2 neural network agrees with expert nurses in the determination of nursing diagnoses. In a 1979 study, however, Matthews and Gaul found no relationship between the ability to make nursing diagnoses and critical thinking ability in both undergraduate students and graduate students. Assigning a diagnosis on the basis of clinical data does not involve critical reasoning. The only danger Booth sees with a

standardized language is that we will lose track of individuals' needs because of "laziness or being pressed for time" (Booth, 1992, p.33).

The Discourse of Professionalism

Nursing, in imitation of the medical model, participates in, reinforces, and reflects the discourse of professionalism in our society. The social discourse of professionalism is reflected in the discourse of nursing diagnosis, as it is described from the power perspective in this chapter. The definition of profession as it is used in this dissertation is:

"an occupation which has assumed a dominant position in a division of labor, so that it gains control over the determination of the substance of its own work...it claims to be the most reliable authority on the nature of the reality it deals with...(it) changes the definition and shape of the problems as experienced by the layman. The layman's problem is re-created as it is managed - a new social reality is created by...the autonomous position of the profession in society." (Friedson, 1970, p.xvii).

Medicine is generally considered the prototype model of a profession. It provides the normative view of reality, discourages and co-opts alternatives, absorbing their

ideology, and has the social power to medicalize aspects of everyday life that haven't been thought of as medical before, such as marital and childhood social role dysfunctions. The status and power of medicine is increased by an alliance with natural sciences because that allows the discourse to deny the ideological nature of its knowledge (Street, 1992) even though medical knowledge is used in a clinical situation that includes many ideological components.

Nursing diagnosis participates in the discourse of professionalism because scientific and professional are believed to be co-extensive (Dickson, 1993). For example, Carlson, et al (1982) stated that the nursing diagnosis movement will result in greater professionalism for nurses (p. x). Gebbie and Lavin (1975) stated that it had become necessary to "state...the reasons that some persons were receiving care from two professionals, the nurse asserting that they were seeing the patients for different problems than the physician." (p.1) and "without such a system nurses will continue to experience difficulty in educating beginning practitioners, designing and performing research, and communicating nursing care within the nursing profession or accross the health system" (p.1).

Gebbie stated at the third conference, "Movement on the classification is linked with movement toward

professional and scientific maturity, and each feeds on the other." (Gebbie, 1982, p. 12) and "The long-term goal is to become a full profession." (Gebbie, 1982, p. 13). Carpenito (1993) specifically equates scientific with professional. Toth (1984) and Roberts (1990) advocate the concept of nursing DRG's for professional power and autonomy. Roberts specifically states that her article "discusses how nursing diagnosis can be used to achieve professional autonomy" (1990, p. 54). At the seventh conference, however, Gebbie (1987) warned that patterning fee schedules based on the medical model of payment (DRG's) reflects superficial imitation without true change, "It is as if we will 'get there' wherever that is, when we are paid just like 'them'." (p. 39). She worried about superficially adopting a jargon that did not reflect any change in actual practice.

Turkoski (1988) analyzed the literature on nursing diagnosis from 1950 to 1985 and concluded that the relationship between professionalism and nursing diagnosis was not clear. Two conflicting positions were represented in these works and analyzed by Turkoski. The first position is that nursing diagnosis was instrumental in developing the concept of nursing as a profession. The second position consists of the belief that the professionalization of nursing has created the necessity for a specific nursing

language. Turkowski concludes that these two positions continue to inform the discourse today, without resolution.

Section Five: Conclusion

This chapter has presented the second part of the analysis of the discourse of nursing diagnosis, the structural discourse analysis. The three axes of the discourse have been analyzed with respect to the questions generated from chapter two. The influence on the described internal structure of the discourse by science, medicine, and professionalism have been identified.

The claim of this chapter is that the internal rules of the discourse, when described in Foucaultian terms, can be seen to be influenced by the dominant discourses of medicine, foundational science, and professionalism. This claim is supported by the evidence in this chapter in the following ways. The words of the discourse and their histories, the discursive strategies of the discourse (the processes) and the assumptions that underlie the discourse have been shown to be influenced by the three dominant discourses. What is included and what is excluded from discussion have also been shown to be influenced.

Evidence has also been given to show that the three dominant discourses are compatible influences in the discourse. In other words, medicine, professionalism, and foundational science are often equated within the discourse

as the one approach to the realization of long-standing goals for nursing. These influences are compatible social models for power and status because, as demonstrated in chapter two, Foucault argues that they represent the dominant technical control strategies of power/knowledge, working together to advance the influence of bio-power.

In Foucaultian terms, the discourse of nursing diagnosis participates in the expansion of our modern conceptualization of power (bio-power) and its expanding control over the details of everyday life. The discourse of nursing diagnosis participates in bio-power by adopting the models of medicine, foundational science, and professionalism and thereby participating in the processes of normalization, confession to social agents, and the medicalization and clinicalization of everyday life as a *necessary consequence* of adopting these models.

The next chapter will provide the final part of the analysis of the discourse, the power analytic.

CHAPTER FIVE: POWER ANALYTIC

Introduction

This chapter presents an analysis of the web of power relations in which the discourse of nursing diagnosis is situated. Section one will address domination effects identified as being perpetuated or extended by the discourse of nursing diagnosis. Section two will identify discourses that have potential to provide alternative speaking positions for constructing subjectivities that might resist dominations perpetuated by nursing diagnosis. Section three presents evidence that nursing diagnosis fosters a belief in the repressive hypothesis. Section four concludes the chapter and demonstrates how the evidence provided supports the following claims.

Three claims are made on the basis of the analysis in this chapter. First, that the discourse of nursing diagnosis perpetuates and extends oppressive power relations within nursing practice and with nursing in the health care system. Second, that there are discourses that provide potential speaking positions from which to articulate specific practices of resistance to power effects of nursing diagnosis in context. Third, that the discourse of nursing diagnosis fosters a belief in the repressive hypothesis in practicing nurses and in nursing

that creates tension within the discipline and within day to day practice.

Section One: Dominations Perpetuated and/or
Extended by the Discourse of Nursing Diagnosis

Domination of Patients

The domination of patients by nurses is extended by the discourse of nursing diagnosis. Through nursing diagnosis, we have incorporated the unacknowledged assumption of elitism within the everyday practice of nursing. The clinical encounter viewed from the discourse of nursing diagnosis is based on a model of social hierarchy and power.

The model of social agency assumed by the discourse of nursing diagnosis constitutes nurses as the authorities to deliver what the social agent decides is needed, not what the patient wants (Porter, 1992). Social agents have the duty of monitoring and upholding the status quo of power relations (Foucault, 1988). This duty is clearly reflected in nursing's goal of facilitating the patients's adaptation to current social circumstances, without consideration of changing those circumstances. Roles are described, defined, and analyzed by the social agent on the basis of prescribed professional assessment procedures. Normalizing interventions facilitate system adaptation to external influences.

Words taken from the marketplace (such as consumer) or words modeled after medicine (such as nursing diagnosis) have unintended consequences that also increase our domination over patients. Hiraki (1992) argues that when the empirical analytic tradition oversteps its bounds and becomes a metaphor for the entirety of nursing care, as it does within the discourse of nursing diagnosis, it reframes (recreates, reconstructs) the reality of the clinical encounter in particular ways we might not have intended. "The nursing process is a problem solving method, and when it is inappropriately applied, has the power to decontextualize the nurse-patient relationship, work as a tool of institutional control, and perpetuate a technocratic ideology that is patriarchal in nature." (Hiraki, 1992, p. 129). The technocratic ideology referred to by Hiraki constitutes patients as systems to be manipulated. This ideology is supported by the words used to speak this perspective.

Domination of patients is perpetuated by the control-based language of science in the ideology of the discourse of nursing diagnosis. Wright and Levac (1992) for example, following Chilean biologist Maturana, hold that discourse based on "descriptions of truth" are an act of violence, and are defined as "holding one's opinion to be true such that another's must change" (Maturana, 1987, quoted in

Wright and Levac, 1992). The authors conclude "nurses are not change agents: they cannot and do not change anyone." (p.915). This realization, the authors claim, would eliminate the language of pathologizing, called the "language of loathing" by Szaz (1973, quoted in Wright and Levac, 1992). The language of nursing diagnosis is extremely pathologizing because the language of diagnosis extends the medicalization of further aspects of everyday life by assuming a situation of domination. The domination effects of pathologizing language sets up dualities or binaries such as compliance and non-compliance. These binaries reinforce the one-down status of the patient.

Nursing diagnosis also perpetuates the domination of nurse over patient by the way the discourse views what it means to be a person. Nursing diagnosis has been purported to describe something about personhood in general, what it means to be a person (Diers, 1986). When this is done from the biomedical approach this becomes diagnosing defects in personhood. Such defects occur with respect to some predefined norm that the patient is not living up to, a defect in coping, self-esteem, adaptation, knowledge, etc., that nurses judge based on a superior position as social agents due to education, professional status, and power (Diers, 1986). Diers points out that deficit means defect. She asks, how can "knowledge" be "defective"?

With respect to the diagnosis of deficits in personhood, this means that the ideology of nursing diagnosis constitutes individuals for themselves and others in a manner that supports domination by social agents through confession and normalization of behavior in accordance with pre-determined norms. The assumption is that the individual is the source of both the problem and the solution. The responsibility for cure rests wholly on the patient in question. That is to say, if the patient does exactly what the nurse prescribes, the cure will be effected. If the patient does not perform correctly, the nurse has no responsibility for the failure to cure. Instead, the patient is given the diagnosis of non-compliance in addition to the original diagnosis. Individuals are thus constituted as targets, victims, and systems to be manipulated by social agents for their own good. Nurses are, at the same time and in the same social space, constituted as change agents who control the power in the lived relations in the clinical encounter.

For example, Carpenito (1993) claimed that there are many people in this country who are grieving but are not being treated because their nurse cannot identify the grief. Presumably, from a diagnosis model, these nurses are unable to recognize grief because they haven't been taught what grief looks like. This talk disregards the

personal/social knowledge of the patient and the nurse. Nurses indeed work with patients experiencing grief, but the discourse that describes "diagnosing" grief brings with it an assumption of a power relation. The notion of "diagnosing and treating" grief is demeaning to the person who is grieving, as well, especially when that person is told that s/he is not progressing "normally".

This mystification of common everyday concepts that already exist in the social/linguistic domain of patients and nurses results in perpetuation of the domination of nurse over patient. Carpenito (1993) argues that asking a student to differentiate between anxiety and powerlessness or grieving is difficult. This argument assumes that nursing students do not already have some idea of what these words mean from their own experience. The students are, in effect, being asked to deny all their previous notions of the social meaning of these terms in favor of the normalized truth from the discourse of nursing diagnosis. Then the students are instructed to apply this discourse to patients without regard to the patient's understanding of these same terms.

Guilt is another example of such a term. In the discourse of nursing diagnosis, the nursing definition, interpretation, and application of concepts like guilt and grief are assumed to be appropriate because of the

education and social status that goes into professional judgement, and not because the nurse understands the situated individual in question. The meanings can become so generalized as to become meaningless, oppressive and trivial. "...when we deal with the experiences of illness or disease, stress or joy, imprecise labeling understates the majesty of the phenomenon and the work in attending to it." (Diers, 1986, p.30). Recall that meaning is not constituted apart from an ideology. The ideology of nursing diagnosis constitutes both nurses and patients in oppressive ways within the clinical encounter.

Grief and guilt can certainly be subjects of informed inquiry, but a method of inquiry that is based on empirical analytic foundational science *necessarily* promotes control strategies from power/knowledge and elitism in the application to human beings. The discourse of nursing diagnosis assumes the value of this form of inquiry for the professional goals of elevated social status and power.

One reason we are taught to value our "elevation" to the status of "professional" is that it gives us *responsibilities* {read "power"} over those who do not share our "expertise". Consequently, the patient is given a diagnosis which defines guilt differently from the patient's own definition, and treatment follows a standardized careplan to remedy this defect, deficit, or

abnormality. When the outcome criteria are met, the diagnosis is "resolved" and the patient's perceived power is reduced while the nurse's power is increased.

Kritek (1985) says "in a service discipline our clients depend on our scientific commitment to discover what is best for them" (p.6). Diagnosing defects in personhood provides the model for the highly paternalistic phrase, "discover what is best for them". "Once we isolate phenomena, we can describe them, manipulate them, and create preferred outcomes; then we can have the effect we wish to have." (Kritek, 1985, p.6). This quote places nurses in a social position of authority over patients viewed as targets of our power/knowledge that creates preferred outcomes.

The Social Policy Statement (1980) says "A nurse's conceptualization or diagnosis of a presenting condition is a way of ascribing meaning to it." (p.11). Whose meaning? Certainly not the patient's. This view assumes that nurses are justified in deriving goals and interventions without full participation of patients (Allen, 1987, p.46). This power strategy produces uncritical, and emotionally and economically dependent clientele (Street, 1992; Mitchell, 1991).

Dickson (1993) suggests that the discourse of nursing diagnosis, informed by professionalism, implies the

acceptance of a standardized, authoritarian, technical role with patients. This emphasis on control-based strategies provides the basis for the diagnosis of non-compliance. This diagnosis will be considered in some detail.

Wuest (1993b) has analyzed the concept of compliance in nursing literature. She argues that the concept of compliance necessarily contains the idea of the powerful nurse and the powerless patient, but it is clothed in scientific language which disallows value critique. It follows that there is a dichotomy of compliance and non-compliance, with one valued over the other (Wright and Levac, 1992). The task of identification and treatment of this condition belongs to the nurse because of the power/knowledge of nursing diagnosis. The task of identifying and treating the condition obscures the conflict over the value of the treatment with which the patient chose not to comply.

The justification for this domination is the professional model of social agency that is consistent with the ideology of bio-power and the repressive hypothesis (Powers, 1991). Diagnosing and treating non-compliance involves the patient confessing their intentions to the social agent, the nurse, who applies coercive treatments to normalize the patient's behavior, producing compliance as the outcome. Both the nurse and the patient assume, in the

manner of the repressive hypothesis, that application of this power/knowledge is liberating instead of controlling. Calling non-compliance a diagnosis is, in effect, naming a patient decision a defect. Treating social defects is the task of social agents.

Domination by Race and Culture

Domination of non-whites by whites and domination of cultures other than dominant white U.S. sub-culture is perpetuated by the discourse of nursing diagnosis. Geissler (1992) has supported this claim by examining the adequacy/inadequacy of three nursing diagnoses with cultural etiologies: 1) impaired verbal communication related to cultural differences. 2) impaired social interaction related to socio-cultural dissonance and 3) non-compliance related to patient value system.

Geissler found that none of the defining characteristics even meet NANDA's own criteria for a major or a minor defining characteristic. By collapsing categories, seven became acceptable as minor defining characteristics. Geissler states "...the inadequacy of the current official nursing diagnoses ...reflects the inability to respond to cultural needs of patients." (p.303). "The existing NANDA defining characteristics address pathophysiological causes of the inability to

speak, which are irrelevant within the context of cultural-language variance." (p.305).

Respondents to Geissler's survey objected to the use of the word "impaired", suggesting instead that social dysfunction is culturally defined, not scientifically defined. "The original NANDA-related factors are so broad that it would be close to impossible to plan care around them." (p. 306). "The suggestions from which the defining characteristic of ineffective communication evolved can be perceived as a problem ethnocentrically located within the nurse, not the patient." (p.306-7).

Coler et al (1991) identified problems with translating nursing diagnoses for use in Brazil, due to cultural differences from the research base of North American culture. "The NANDA diagnostic classificatory system needs to be reevaluated, reconsidered and refocused into transculturally relevant, meaningful, and useful transcultural perspectives." (Leininger, 1990, p. 24).

In 1991, Wake et al performed what they called a "multi-national search for defining characteristics of nursing diagnoses" (p. 57). They included France, Belgium, England, the U.S., Canada, and Columbia. Even with this severely restricted sample, there were no common defining characteristics for hopelessness. The common characteristics for anxiety were panic and nervousness. For

ineffective airway clearance, the common defining characteristic was dyspnea. The authors conclude that one of the limitations of their study was the diagnostic expertise of the nurses chosen to identify the defining characteristics. They also concluded that "Anxiety is a common human response. Manifestations of the response, however, may be influenced by culture." (p. 63).

Domination based on racial markers is also perpetuated by the language of the discourse of nursing diagnosis. Taught within the discourse of nursing diagnosis, nursing students are not exposed to the arguments that led to the general abandonment of the concept of race by anthropology. Instead, we are taught specific stereotypical views of groups of people distinguished by biological markers like skin color. We are taught that stereotyping of the behavior of African-Americans, Asian-Americans, Mexican-Americans and Native Americans for the purposes of individualizing "our" treatment of "them" constitutes culturally sensitive nursing care (Allman, 1992; Powers, 1992b).

The use of stereotypical views serves to perpetuate social domination of some groups by others. Race, like gender, is better conceived of as a verb, not a noun, for it is a thing we do in social situations, and not an "essential" property of reified entities. This view is

nowhere represented in the essentializing discourse of nursing diagnosis.

The use of nursing diagnoses phrased in terms of "potential for (something)" is a good example of an entry point for ethnocentrism. The stereotype of the "violent black male" can result in a diagnosis of potential aggression more often for black male patients than for white male patients. Fernando (1988) reinforces this observation by saying, "... moral characteristics, such as antisocial behavior, may be converted into (pseudo)symptoms as in the diagnostic category of psychopathy used in Western psychiatry" (p.63). Patients of color have had whole constellations of behaviors identified, diagnosed, and equated with the their non-whiteness.

Domination based on culture and race is perpetuated by the discourse of nursing diagnosis through the process of normalization. Nursing diagnosis is a normalizing discourse that functions to bring about power effects (determined, in this case, by empirical markers) based on scientifically based knowledge assumed to be value-neutral. The discourse is applied by social agents who believe in the repressive hypothesis and their role as social agents.

Domination of Women

The oppression of women is perpetuated by the language of the discourse of nursing diagnosis. Given that there are

differential social experiences for men and women, "Enlightened nurses now acknowledge that nursing is a clear paradigm case of women's oppression in society" (Bevis and Watson, 1989, p. 44). Women, for example, are more often diagnosed as manipulative or depressed than men (Allen et al, 1991). Diagnoses of manipulative behavior and depression, when expressed in scientific language, are reflective of the ideal of men's behavior and the devaluing of women's behavior as "feminine" and hence less than normal.

The social context for women contains criteria that devalue their experience and give them minority status with respect to power. This context is not represented in the etiology or nursing interventions for depression. As with racially identified characteristics, the nursing diagnosis is assumed to exist in the non-maleness of the patient, be discovered by the nurse, treated by the nurse, and result in changes in the patient. The changes are judged as acceptable by the nurse, not the patient, through their conformity to outcome measures.

Understanding of the influence of the male-gendered professional ideology on the discourse of nursing diagnosis also explains the reluctance of some female nurses to finding the language of the discourse of nursing diagnosis useful in their practice. The language is variously said to

be obscure (Webb, 1992), or "pompous if not downright silly" (Curry, 1991, p.124).

Socially, nursing is a female-gendered occupation (Street, 1992). Stereotypically, the gaze of the doctor is assumed to be that of the objective scientist (male), and the gaze of the nurse is assumed to be personal and intimate (female) (Street, 1992). The discourse of nursing diagnosis, however, is informed by the male-gendered medical professional model of objective science. The personal and intimate are unacknowledged within the discourse of nursing diagnosis. The personal and intimate are devalued both in the nurse and the patient, in favor of a hierarchy of instrumental domination.

For example, diagnoses not oriented to context-dependent situations (Allen, et al, 1991) are good examples of how behaviors get assigned to be thought of as "naturally male" or "naturally female" and therefore subsequently socially valued or devalued (Tannen, 1990). "The ideology of professionalism incorporates dissimulation, reification, materialism, and patriarchy in such a way as to distort reality so that it appears as 'normal' and 'natural'." (Turkowski, 1992, p.152). In the discourse of nursing diagnosis, behaviors are not discussed as social subject positions that someone can choose to do or choose not to do, but as "the way women are". Diagnoses

categorize the constellations of feminine experience into normalizing notions that are value-laden. Women diagnosed with "ineffective coping, individual" or "impaired role performance" by a nurse would seek treatment, not seek to critique the research that generated the diagnosis.

Further research on these diagnoses from the empirical analytic tradition could result in more criteria for the nursing diagnosis of sexual role dysfunction, when the woman being diagnosed does not fulfill the expectations that are thus identified with being female. Both the female nurse and the female patient are thus caught up in normalized patriarchal descriptions of their own behavior and interaction.

Class Domination

Class domination is perpetuated by the language of the discourse of nursing diagnosis. Following O'Neill, this dissertation defines classism as 1) stereotyping on the basis of economic class with resulting discrimination and 2) as valuing class-based models, goals, and strategies from the dominant culture over those groups peripheralized in the society (O'Neill, 1992, p.140).

Historically, nursing has emulated the classist, restrictive educational requirements of medicine in order to consolidate social status and power. The unintended consequence of educational restrictions creates barriers

for people from other than white, middle-class and owning-class backgrounds (Carnegie, 1991). During their education, nursing students selected in this manner are provided with the value-laden constructs of nursing diagnosis. The process of education within the system of nursing diagnosis results in adherence to a "dogma" that places the culture of the professional nurse in the social position of aid to lower classes (Rodgers, 1991). There is no mention in the discourse of nursing diagnosis that nurses work shifts, or that in some places, nurses still punch time clocks, or the discourse of unions.

The use of nursing diagnoses has classist effects because it reinforces the assumed value of the capitalistic base of American democracy. Nowhere is it mentioned in the literature on nursing diagnosis that the etiology of any of these diagnoses might be an unfair and oppressive economic system. The emphasis in the nursing interventions is on adapting to your position in life (your current role expectations) and not changing that position. Not being able or willing to adapt is grounds for being given another diagnosis, most often some type of "dysfunction", or "noncompliance due to lack of knowledge", or "denial".

As an example of the assumed value of the capitalist base of American democracy, consider the nursing diagnosis of Powerlessness, and its application to people who are

homeless and jobless. Is the situation of powerlessness an alteration of some normal state of affairs to which everyone has a right? Consequently, is the intervention to get them a job or a home? To support a revolution that puts the means of production in the hands of the working class? Acknowledgment of oppressive relations in American democracy is absent.

The definition of powerlessness is "the perception that one's action will not significantly affect an outcome: a perceived lack of control over a certain situation or immediate happening." (McFarland & McFarlane, 1993, p. 505). The interventions include: provide opportunities for the patient to express feelings about self and illness, engage the patient in decision-making whenever possible (e.g., the selection of roommate or wearing apparel), encourage sense of partnership with health care team, reinforce the patient's right to ask questions, teach self-monitoring, provide relevant learning materials, explore reality perceptions and clarify if necessary by providing information or correctign misinformation, help patient communicate effectively with other health team members (McFarland & McFarlane, 1993, p. 508).

Clearly, these strategies are control-based, giving only trivial and illusory choices and feedback to patients. When the powerlessness of the patient is related to

economic circumstances, these interventions further trivialize the concerns of homeless and jobless people, ignoring the economic inequalities and perpetuating the oppression of homeless and jobless people.

The overwhelming emphasis of the nursing interventions in the NANDA literature involves adaptation of the patient to current circumstances, including economic circumstances, no matter how intolerable. If nurses do not always advocate adaptation to extreme circumstances with particular patients, it is reflective not of the flexibility of the taxonomy, or its science, but of the overriding compassion of the nurse.

In the case of the diagnosis of "powerlessness", the nurse is instructed to teach the patient problem-solving skills and assertive communication skills. The outcome criteria for the diagnosis of powerlessness are that 1) patient verbalizes feelings of being in control of situations and outcomes 2) patient demonstrates adequate role functioning and coping skills and 3) patient exhibits appropriate mood (McFarland and Wasli, 1986). Again, in the case of the economically disadvantaged, these outcomes are demeaning and oppressive. The role of social agent thus includes assistance in developing appropriate mood and role functioning within an oppressive economic system as a given, uninterpreted reality.

Domination of Nursing by Medicine

The domination of nursing by medicine is reinforced by the discourse of nursing diagnosis because the discourse is based on the medical model of professional scientific hierarchy that is assumed to be "natural" and "normal" in its present state. Nursing knowledge is subordinate to medical knowledge, and nursing practice is legally subordinate to medical practice. Nurses have been "appropriating both the forms of knowledge (of medicine) and the paradigm in which this knowledge is created" (Street, 1992, p.8). It has been suggested that the choice of the word "diagnosis" might be based on our "paternalistic" power relationship with medicine and that the word diagnosis both separates us from medicine but defines us in medicine's own image (Kobert & Folan, 1990; Mitchel, 1991).

Thus the design of nursing diagnosis reinforces the handmaiden status of nurses (Todd, 1991) by adherence to the model of the dominant group. Roberts (1990) naively asserts that using nursing diagnosis and nursing DRG's would promote more collaboration between nurses and doctors because doctors would go on nursing diagnosis rounds (p. 55). However, it seems there is less collaboration between

doctors and nurses now than there was in the 1800's (Pillitteri & Ackerman, 1993).

The dominance of medicine over nursing is reinforced because it is not challenged, or even acknowledged. The non-confrontational strategy of imitation serves to define nursing emphatically as "not-doctors". By denying the historically complex and intimate nature of the structural and social power/knowledge connections between medicine and nursing, the discourse of nursing diagnosis perpetuates the domination of nursing by medicine.

Domination of Practitioners by Academics

The discourse of nursing diagnosis also perpetuates the domination of academics over practicing nurses. Achieving professional status for nursing has been historically viewed as a more appropriate goal than that of control over the allocation of nursing knowledge and skills (O'Neill, 1992). Therefore, the discourse of nursing diagnosis removes the control of practice from the individual nurses to the academic sphere.

At the fifth conference, practicing nurses were asked to respond to the conceptual framework for the classification of nursing diagnosis developed by the nurse theorists. The responses ranged from acknowledgement of potential to outright rejection (Kim & Moriz, 1982, pp.

264-272). The most common comments from the practitioners were with regard to the time involved in documenting the nursing diagnoses using the conceptual framework, and the ill-defined nature of "unitary man".

Goals common to all nurses have thus been separated into professional goals and working conditions. Working conditions are thereby conceived of as having little relationship to the taxonomy of nursing diagnoses. This creates a split between academics and practicing nurses. An ideology supported by the elite of nursing and not by the rank and file has the potential to split the profession into oppositional groups (Gamer, 1979).

The tension between the ideologies of education and practice can be seen within practicing nurses in the manner in which they approach the discourse of nursing diagnosis. Thompson (1985), for example, notes that practitioners frequently apply empiricist texts paradoxically. This means they may approach the task of diagnosing with the pre-understanding of working class women, but may also apply the taxonomy with the prejudice of aspiring intellectual professionals. The practice ideology structures the time/space of the clinical encounter in terms of the industrial, bureaucratic model. The discourse of nursing diagnosis structures the clinical encounter in terms of the professional medical science model.

Practicing nurses are suspicious of academics who suggest emancipation strategies for nurses, but do not practice nursing themselves (Street, 1992). "So long as nursing practice is explained as originating from, and elaborating upon, formalized theory and technological advances, bedside nurses have not had, or perhaps did not want, any particular share in it." (Maeve, 1993, p. 6). Thomas and Newsom (1992) add that "Nursing diagnosis has been a part of some nursing curricula since the '70's, but a gap still exists between theory and practice" (p.183). Turkoski (1988) notes that "there was scant evidence of nursing research directed at validating specific nursing diagnoses or the effects nursing diagnosis had on actual client care." (p. 144).

Carpenito (1993), who has been involved since 1975, identifies two kinds of opposition to nursing diagnosis: one kind of opponent didn't know anything about it and was not willing to try, and the other type that simply thought it was unnecessary jargon and just more work. Carpenito admits that practicing nurses are still reluctant to use nursing diagnosis, but argues that the answer to the difficulty of using nursing diagnosis is more research.

On the other hand, Schilder and Edwards (1993) argue that it is inappropriate for academics to shift the burden of the application of research findings to the

practitioners and remedy their reluctance by educational courses. It is unlikely that more research, or more inservices, or more educational instillation of ideological perspectives will remedy this reluctance (also see Wiebe, 1991).

One difficulty that practicing nurses have with nursing diagnosis is that the discourse values the general over the specific, the standard over the individual, the Cnidus over the Cos. Dickoff and James, in their 1986 commentary on their 1971 article (1986) reflected on their idea of situation-producing theory as the way to bridge what they saw as the widening gap between academics and practicing nurses. They recognized only two choices. First, practice could be based on a body of knowledge derived from situation-producing theory (such as nursing diagnosis). Second, practice could be left to the whim of the moment.

In this context, situation-producing theory is conceived of as more than a description plus a causal explanation. Theory of this type incorporates the purpose, patient, nurse, outcome, procedure and dynamics of the situation to be produced. This degree of control would be the envy of any logical positivist. Taylor's concept of "morbus" as described in chapter three fits Dickoff and James' description of situation-producing theory.

Dickoff and James also addressed the eighth national conference with respect to academics and practicing nurses (1989). They identified three "recoveries" necessary for the nursing diagnosis "movement", and they asked specifically, "Who has controlling say in the nursing diagnosis movement - practitioners or academicians?" (p. 101). They recommend returning control to the practitioners because, *"It is not clear that the users - in the very role as users - are regarded also as developers and creators of concepts."* (italics theirs). One part of the "recovery" of the movement of nursing diagnosis is thus phrased by these authors in terms of the practicing nurse, not the provision of more research by academics.

Domination of Nursing in The Health Care System

The appropriate goal for nursing within the health care environment according to the discourse of nursing diagnosis is power and status equal to that of medicine, but completely separate in focus. Using the very language of the discourse of nursing diagnosis, Harrington asserts that "The ultimate goal of nursing diagnosis is to achieve adaptation... {of nursing to its environment}..." (Harrington, 1988, p.94). The environment of nursing is not considered, therefore, to be changeable. The task is for

nursing, using nursing diagnosis, to adapt itself to the health care environment as it exists.

Carlson, et al (1981) holds that "Any obstacle placed in the way of the continued development and classification of nursing diagnoses endangers the profession itself." (p. 16). "Politically, nursing diagnosis has done more to advance professional practice than any other previous scientific, professional, or educational movement." (Fitzpatrick, 1990, p. 102). Woolley (1990) insists that nursing diagnosis is the most important development for the advancement of nursing.

According to Thompson (1992) nursing in the 70's and 80's constructed representations of health, nursing, people and environments. These constructions were achieved by privileged white nurses in order to secure their own location in health care dominated by business and medicine without addressing power issues. Value-less imitation of discursive practices of groups that dominate the health care system were believed to promote autonomy, independence and the right to self-governance. However, if this can be done, then "how have respiratory therapists, physical therapists, dieticians, and paramedics, all members of professions younger than nursing, escaped this painful word searching and surged ahead to higher salaries and unquestioned professional status?" (Curry, 1991, p.124).

"Physicians have suffered no identity crises in gradually relinquishing 'medical' tasks to nurses over the years." (p.126). The evidence for the continued oppression of nursing is ignored in the discourse of nursing diagnosis.

The "care vs cure" debate was part of a larger movement that included the nursing diagnosis movement. The emphasis on care sought to totally dissociate nursing from its relationship to medicine, and nursing reference to the concept of disease became a serious mistake. What was called the "regressive medical paradigm" (Kritek, 1980) made treatment of disease an action that nurses disdained, but imitated. Ignoring the power issues and embracing the strategy of an "end run" around the relationship with medicine perpetuates the domination of nursing in the health care system by refusing to acknowledge the issues.

The ANA's Social Policy Statement was intended for an external audience in order to make the case for increasing status for the profession of nursing, using the model of the language of medicine (Allen, 1987). Nurses began treating "clients" with nursing diagnosis instead of patients and blamed the victim if the care did not result in the desired outcomes. Participants were prevented from using anything medical in the language of nursing diagnosis by the prevailing wind of the day, and it was "an intensely political enterprise" (Kritek, 1980, p.5). "...nor is there

evidence that they {nursing diagnoses} have contributed to clarifying the nursing mission or to improving communication among nurses and with the rest of the health care team." (Meleis, 1991).

The medical model of professionalism for nursing diagnosis is the most self-defeating of any possible strategy of autonomy within the health care system because of the unacknowledged assumptions of elitism based on value-less science (Street, 1992). Douglas and Murphy (1990, p 17) state, "to the degree that we emulate the medical model, we are tempted to believe that the development of adequate classification systems unique to the practice of nursing will differentiate us from other health professionals, assure our recognition as scientists in our own right, aid us in achieving a high level of practice, and further other goals important not only to the individual nurse but to the nursing profession as a discipline.". Later in the same article, Douglas and Murphy warn that "the nursing profession is pinning too much hope on nursing diagnosis" and "it has elevated expectations beyond a realistic level." (1990, p.20).

Section Two: Resistance Practices

Resistance to the oppression perpetuated by the discourse of nursing diagnosis arises in different ways. Practices of resistance arise in isolated contexts, in

singular instances of nursing practice involving nurses and patients. The practices that resist the oppressive power relations constituted by the ideology of nursing diagnosis will take different forms depending on the context. The resistance of a nurse in a hospital situation will be different from the resistance of a student, different from the resistance of a patient, and different from the resistance of an academic.

In order to identify practices of resistance to power/knowledge and differentiate them from practices that support power/knowledge and the repressive hypothesis, it is helpful to ask: Who benefits from this discourse? Analysis of practices of resistance has also been called critical scholarship. Critical scholarship as defined by Thompson (1987) is "a pattern of thought and action that challenges institutionalized power relations or relations of domination in the social reality of nursing" (p.28).

The discourses of resistance acknowledged here represent potential constructed subjectivities that could provide ideologies to make meaning that might resist the oppressive power effects of the discourse of nursing diagnosis in specified situations. These discourses are not discourses of resistance in and of themselves.

Co-optation of practices of resistance into the dominant discourse of nursing diagnosis will also be

demonstrated. Co-optation, like oppression, is not a consciously determined strategy of power relations. The process of incorporating minority views into a dominant discourse is viewed, in the scientific ideology, as part of the evolution of truth. To the discourse analyst this process supports the expanding influence of power/knowledge via the repressive hypothesis.

The Resistance of Nursing Practice

Street (1992) identifies practice resistance to power strategies that takes various forms, such as manipulation, passive resistance, and open critique of domination. Because the practice of nursing is an oral culture, there is a biculturalism in the discipline of nursing. Writing things down is too slow for the way a shift proceeds. Verbal report is where the crucial information is obtained and passed on to other nurses, sometimes in the form of gossip (Laing, 1993), a very devalued form of talk identified in a pejorative way with women.

Nursing diagnosis is a part of the written culture of nursing viewed by practitioners as being forced on practicing nurses by academics (Mitchell, 1991). The resistance activities that arise from the ideology of nursing practice, for example, take the passive form of "not doing the paperwork", or at least doing it in a

perfunctory manner, because it is not easy to tell if the nurse is organizing patient care with nursing diagnosis without written notes. The written culture of nursing interprets such passive resistance as nurses not being prepared to be held accountable for their actions and decisions (Carpenito, 1993).

Academics and administrators sometimes hold the assumption that written culture is superior to oral. They see the limitations of the oral culture for the systematic analysis of nursing practice at an abstract level (Street, 1992). "Formal explicit statements fix meaning and do not allow for nuances of interpretation the way tacit understanding does." (Gordon, 1984, p.246). Without institutional "encouragement", it is uncommon for practicing nurses to use nursing diagnoses at all (Thomas and Newsom, 1992).

Management nurses have expressed the opinion that computerized nursing diagnosis provides a rich source of management data (Mehmert, et al., 1989). The practicing nurses, on the other hand, do not value systematic analysis at the abstract level, despite what they are taught in nursing education. Their resistance is passive and unorganized (Street, 1992, p. 269).

The practices of resistance to nursing diagnosis that arise from the oral culture of nursing include an emphasis

and a valuing of the intersubjective meanings of oral communication between people, and the intersubjective effects of communication, sharing, supporting, nurturing, interacting, learning, and teaching. Consciousness raising groups can help nurses value their own oral culture, critique power relations that devalue the process, and develop strategies to compile and learn from the stories of others. Street (1992) argues that this approach has the potential to empower nurses to transformative, resistive action.

The discourse of expert clinical practice, like the Hippocratic approach described in chapter three, is oriented to clinical judgement in a specific context. In the Hippocratic tradition of thought, the clinical perspective is valued over the taxonomic perspective of generalized knowledge development. The discourse of expertise in specific, contextualized clinical situations provides a speaking position and the words for nurses to use to express resistance to the nursing diagnosis movement.

The tension between scientific and clinical judgement remains an on-going point of discussion in medicine, as well. "Medicine cannot be a pure science of particulars when medical laws are statistical probabilities that apply to limited populations and may or may not apply to a

particular clinical case" (Spicker, 1987, p.404). A medical diagnosis does not provide a clinical perspective for either doctors or nurses (Levine, 1989). As in medicine, there is a tension between these two orientations in nursing.

The discourse of nursing diagnosis ignores the tension between the clinical perspective and the taxonomic perspective by trying to categorize an entity similar to Taylor's concept of "morbus" (Taylor, 1979) using the foundational assumptions of the empirical analytic tradition. This attempt results in the same tensions as is found in medicine, but are unacknowledged in the discourse of nursing diagnosis. The discourse of clinical practice is thus being co-opted into the dominant discourse of nursing diagnosis.

Benner's work on expert practice exemplifies the tension between these two perspectives and the co-optation. Benner (1984) lists and describes exemplars and claims that they do not represent an expert *nurse* but are instances of expert *practice* in a specific, individual clinical context. Benner ignores power issues in these descriptions (Street, 1992), but does hold the value of contextualized discourse.

The tension between the clinical approach and the scientific approach is visible in the co-optation of Benner's work into the dominant discourse of generalizable

scientific power/knowledge. The clinical competencies, the specific contextual descriptions in Benner's work, have been translated into abstract, measurable clinical salary ladders. These descriptions are used as standardized criteria for the evaluation of individual *nurses* instead of description of contextual *behaviors*. This use contradicts Benner's original purpose for the work on clinical behaviors, thus reducing the potential of this discourse as a source of words to construct a speaking position from which to articulate practices of resistance to power relations inherent within nursing diagnosis.

Carpenito (1993) supports this co-optation by insisting that we must standardize the language of nursing diagnosis to *incorporate* the intuitive characteristics of expert practice. The traits of expert practice that are eliminated, or selected against, in the discourse of nursing diagnosis are the relational, the contingent, and the nonverbal. The use of these concepts of expert practice forms a kind of talk that does not easily lend itself to incorporation within nursing diagnosis and may be used to phrase opposition to the power implications of nursing diagnosis.

Official co-optation of practice issues that could be developed as a source of resistance strategies is also exemplified by the concept of axes. At the ninth conference

it was suggested that axes be identified to the diagnoses in Taxonomy II (Carroll-Johnson, 1991). The justification for this is provided by Hoskins, et al (1992), who argue that the nursing community has challenged the ability of nursing diagnosis to account for nursing practice. The issues raised have become the axes. The axes "describe the dimensions of the human condition." (p. 117).

The use of axes in the system of nursing diagnosis represents an attempt to co-opt discursive practices of resistance into the dominant model, forming a classifiable "morbus" entity that provides both generalized knowledge and clinical specificity. The result is tension within the discourse and overall support for expanding the controlling strategies of bio-power by co-opting the emphasis on individuality from the oral discourse of nursing practice.

Consider also in this regard, the marginalized discourse of caring as a source of potential subjectivities. Barnum (1990) argued that nursing diagnosis has been a trend that is now being displaced by the emerging focus on caring. Swanson (1991 and 1993) has developed a theory of caring for nursing grounded in phenomenological research.

On the other hand, there is evidence that the discourse of caring is being co-opted by the scientific ideology. The work on caring by Watson (1985) has been

critiqued by Gray (1992), who says that caring has become not a process or state, but an empirically demonstratable clinical concept and called a theory or a science. Gray presents her own tension with Watson's work from a feminist perspective of resistance.

The discourse of caring could be a source of words and perspectives that could be used to construct an ideology that produces practices that resist the power relations inherent in the use of nursing diagnosis. Resistance to the domination effects on patients by the use of nursing diagnosis could be spoken through caring metaphors that incorporate acknowledgement of value statements and situated connectedness.

Feminism as Potential Resistance

Feminist discourse is a strong candidate for provision of alternative speaking positions and words that can be used to form discursive practices of resistance to the domination effects of nursing diagnosis. Nursing devalues feminist discourse in general (Dickson, 1993) and nursing diagnosis in particular avoids feminist discourse.

McFarland and McFarlane (1993), for example, do not mention the word feminist at all. None of the research on nursing diagnosis presented in the national conferences refers to itself as being "feminist".

In following the medical model of profession, white middle-class nursing leaders severed their ties with women's groups and allied themselves with professional groups, instead. The ANA rejected a resolution supporting women's right to vote in 1908, on the grounds that it was unprofessional to have any opinion on such matters. This position was reversed in 1915, just before the passage of the Nineteenth Amendment. O'Neill says the ANA's stand on the ERA is even worse, and the NLN has yet to publically support the ERA (O'Neill, 1992, p.143).

Street (1992) says the discourse of nursing diagnosis reflects a desire to emulate the oppressor, which Street names as medicine. She calls nursing diagnosis an example of liberal feminism where the focus is on equal rights within the same oppressive system, without a focus on changing the system itself, limiting participation to white, middle class, heterosexual females (p.52). Postmodern feminism as described in chapter two could provide the perspective for a more radical critique of nursing diagnosis, such as performed here.

The discourse of nursing diagnosis devalues femaleness (Shamansky and Yanni, 1983) in favor of maleness. Research on nursing diagnoses, coming as it does from the empirical analytic tradition, is an already male-gendered process (Heinrich and Witt, 1993). Feminist critique of nursing

diagnosis would serve to point out the gendered nature and sexist consequences of the discourse (DeMarco, et al., 1993). The use of the language of postmodern feminism would provide the words to deconstruct the power relations inherent in the use of the discourse of nursing diagnosis.

This kind of discourse has already begun to appear. O'Neill (1992) defines nursing as a working class profession affected by its female heritage. She does so in order to create tension and resulting discussion. The female part of O'Neill's definition necessitates a gender analysis. The working class part of the definition reflects the lack of autonomy over skills, and connections to people's concrete conditions such as salaries, hours, benefits, job assignments, rates of pay, etc. The professional part of the definition reflects the personal investment in an occupation, goals of autonomy, control over education, control over scope of practice, pride in practice and accountability, and a code of ethics. This definition avoids the male model of professional including the hidden exclusionary tactics (O'Neill, p.144).

Critical feminist scholarship has also provided critique. Identity politics, for example, has been suggested to have the potential to reclaim marginalized knowledges in nursing. Identity politics is a strategy of resistance to systematic limitations that "problematizes

any attempt to construct identity through essentializing definitions of nursing or through taxonomies, universalizing theories, or essentialist claims regarding the 'object' of nursing practices." (Thompson, 1992, p. 26).

Postmodern feminist discourse that addresses power relations and feminist research practices that include such strategies as consciousness-raising groups have potential for providing both the words and the action strategies to critique the power relations of nursing diagnosis. Furthermore, postmodern feminist discourse is less likely to be co-opted into the discourse of nursing diagnosis than, say, caring or expert practice discourse, because of the assumption of the preferability of the postmodern approach to knowledge generation as opposed to the androcentric scientific professional model.

The Discourse of Ethical

Practical Morality as Resistance

Ethical discussions are devalued in a discourse that assumes a foundational perspective because the entire body of knowledge is assumed to be value-free in both its construction and application. On the other hand, Maeve (1993) cite Bishop and Scudder (1991) that the dominant sense of nursing in general is moral and personal, as opposed to professional and technical (p.10). Levine claims

that all nursing actions have a moral component (1989). The marginalized discourse of ethics and practical morality in nursing literature argues that this approach could give us authority (Dickson, 1993), but in Foucaultian terms, their benefit lies outside of authoritative statements. These discourses could provide ways of talking and acting that could be used by individual practitioners, academics, and administrators to resist the oppressive power relations of nursing diagnosis.

As an example of providing a way of talking that resists oppressive power relations, consider Mitchell's (1991) ethical analysis of nursing diagnosis. Mitchell claims that human suffering is created by the diagnostic process in nursing diagnosis (p.99). She argues that being forced to use nursing diagnoses puts nurses in ethical conflicts (p. 102) which cause unacknowledged stress, suffering, and tension in their practice. Much more effort in the approach of ethical analysis could be supported in order to provide more examples of ethical dilemmas in nursing practice. Such an approach does not ignore the power relations inherent in nursing practice.

The case has been made for nursing as a practical moral way of being in the world (Yarling & McElmurry, 1986) and as a moral art (Curtin, 1978) with practical wisdom (Meleis, 1991). Congdon (1992), for example, advocates a

feminist ethic of caring for nursing that would combine three of these marginalized discourses, (feminism, ethics and caring) that could be used as sources of resistance strategies in situations of oppressive power relations.

Patient Advocacy

as Resistance

Practices of patient advocacy are related to the practical, moral perspective and can also give rise to ideological subjectivities that provide practices of resistance to the oppressive power relations of nursing diagnosis. Porter (1992) says the attempt by nursing to achieve social agency by the attainment of a body of nursing knowledge such as nursing diagnosis contradicts the role of advocacy for nurses. This oppressive situation further devalues the voice of patients and their families because they are considered the targets of the intervention, not as sources of knowledge. To be a patient advocate is to mediate between the patient and a more powerful social system. Nursing diagnosis places nursing more solidly within the powerful social system and further away from patient situations and perspectives. This makes advocacy more difficult. Nurses do advocate for patients, however, but more often they advocate for doctors to patients, because they share the same commitment to the medicalization of increasing portions of life.

As a source of strategies of resistance to oppressive situations, advocacy provides words and actions that can be used to structure alternative nursing actions. Nursing has a moral and practical basis for moving beyond the hospital setting to advocate on a global basis concerning issues such as hunger, violence, homelessness, AIDS, poverty, children's rights, and primary health care (Dickson, 1993, p.81). Nursing could encourage a talent for putting information into terms patients can understand (Curry, 1991) and provide support for decisions that might be unpopular with the health care system in general, or even inconsistent with our own viewpoint, by admitting the voice of patients into the clinical encounter in a stronger fashion.

Union Discourse as Resistance

The discourse of unionism as a source of talk about power is devalued by the discourse of nursing diagnosis because it is not viewed as part of the professional, scientific ideology. Anti-unionism appeals to the classism in nursing and separates nurses from a possible source of resistance strategies and power strategies (Allen, 1987). In following the medical model of a profession, white middle-class nursing leaders removed the links with women's groups and unions, and allied themselves with male

professional groups, isolating themselves from alliances that could provide models of strength that are not male- or science-based (Allen, 1987). There is no union language in the discourse of nursing diagnosis, no discussion that the work of the majority of nurses is "shift work". In fact, the word "shift" is conspicuously absent.

On the other hand, the power component of unionism is attractive to some authors in nursing literature outside of the discourse of nursing diagnosis. Most discussions of power in nursing literature refer to union power. However, "Black female nurses and union nurses have acknowledged far more complexities and sites of coalition and resistance than are addressed by professionalizing strategies alone." (O'Neill, 1992, p.142). The use of union discourse and strategies has potential to form a speaking position to resist oppressive power relations related to nursing diagnosis because union talk already acknowledges class-based oppression. Nurses who acknowledge class-based oppression in general, would be more likely to acknowledge instances of class-based oppression as a result of the application of the discourse of nursing diagnosis.

Co-optation of union talk is likely. Eldridge and Levi (1982), for example, argue that collective bargaining should be moved away from being seen as appropriate to working class goals, and used instead as a power resource

for nursing's professional goals. This quote assumes that "working class goals" are somehow beneath the aspirations of nurses.

There are examples of alliances between trade unions and professional organizations in nursing that serve to expand nursing's base of power, affecting everything from salaries to patient-staff ratios. The discourse of unionism is a promising source of alternative ideologies to the professionalizing influence of nursing diagnosis on the clinical encounter. The vision of nursing as a pink collar occupation can provide for practices that resist the oppressive effects of nursing diagnosis on patients in the clinical encounter.

Empowerment and Social Action as Potential Resistance

Roberts (1983), Hedin (1986), Skillings (1992), and Ricci (1993) all argue that nurses are an oppressed group and describe examples of behavior that demonstrate this, such as horizontal violence and cultures of silence. Because nursing is socially female-gendered, it has a long history of oppression. Ricci (1993), for example, cites Reverby (1987) that the models of hierarchy, responsibility and discipline that were used to shape American nursing were adapted not only from the Victorian family but also the military.

Since nurses function as an oppressed group, the skills used by nurses to resist what they consider to be oppressive both within and without nursing do not reflect open critique of domination. The binary conceptualizations that are constructed include the mental vs. the manual and the written vs. the oral. Nurses feel oppressed by forces outside of nursing such as medicine and by academics and management nurses within the discipline. Nursing diagnosis is considered another oppressive condition within the practice of nursing. The skills of resistance included in the repertoire of an oppressed group are largely passive and indirect. Therefore, nurses resist the discourse of nursing diagnosis with silence, poor compliance with charting requirements, and complaining.

Street (1992), for example, describes these resistance strategies with respect to her own work with nurses in the practice setting. Street noted that nurses participate in premature closure on discourses and practices that would empower them to transform their practice into one of resistance to domination. Instead, Street observed that nurses believe it to be less stressful to keep doing things the way they have always been done even when they know the situation to be oppressive. "Talking back" or moving from silence into speech, is an extremely difficult step. Even when nurses arrive at strategies through collaboration,

they then attempt to impose the plans hierarchically rather than through negotiation. Nurses reactively oppose any change imposed hierarchically, even when it is obviously a better scheme, and even when the plan comes from other nurses (Street, 1992).

Consequently, using the discourse of empowerment as a source of alternative speaking positions would provide nursing with strategies, processes, and words to resist individual practices of domination from nursing diagnosis as they arose. The concept of empowerment means people coming into a recognition of their own power (Lather, 1991). Speaking a language of empowerment, nurses might organize consciousness raising groups in the workplace in order to provide group resistance to nursing diagnosis in that setting. Speaking a language of empowerment, individual nurses might justify their work with patients without using the language of nursing diagnosis.

The discourse of empowered social activism that could arise from this potential source of resistance is easily co-opted by nursing diagnosis, however. Consider the following diagnosis that is supposed to be treated by nursing: "Altered Health Maintenance related to inability to secure adequate permanent housing for self and family" (McFarland and McFarlane, 1993, p.23). One of the symptoms of this condition is "verbalization of inaccurate

information". The political, economic, and power aspects of this patient situation are ignored. Expressing inaccurate information is a "symptom" of altered health maintenance. Any possible discourse concerning social action aimed at provision of adequate housing is diverted into assessment of the ability of the patient to tell the truth.

Talk of empowerment can be co-opted easily to refer instead to a "task" for a social agent, instead of a "process" by which some person or group comes to knowledge of their own power in resistance to social agency. When co-opted, it becomes the task of nursing to "empower" patients or researchers to "empower" research subjects or educators to "empower" students (Mason, et al., 1991; Parker and McFarlane, 1991; Reeder, 1988). In this "empowerment as a treatment" model, patients are considered "empowered" when they are no longer non-compliant with treatments, and make choices that the nurse, as a social agent, considers wise. In the case of nursing diagnosis, "empowerment" of nurses is seen by the proponents of nursing diagnosis as supported when nurses use the discourse in practice (Carpenito, 1993). The definition of empowerment as given above, however, implies that empowered nurses might choose not to use the discourse of nursing diagnosis.

Empowerment is a complex discourse. Public health nurses have been identified as performing both empowering

and coercive strategies within the same case, often being unable to untangle the concepts used in the intervention (Zerwekh, 1992). As a potential source of strategies for resisting oppression, however, empowerment could be widely supported with further writing and discussion. Such writing and discussion would be appropriate subjects for the following approaches to inquiry.

The Discourse of Alternative
Philosophies of Science as
Potential Resistance

Alternative philosophies of science that are not foundational represent another potential source of critique for nursing diagnosis. Changing views in the philosophy of science are discussed infrequently in the nursing literature (Chinn, 1985; Visitainer, 1986; Allen, Benner and Diekelmann, 1986). There is some discussion in the theoretical literature concerning the definition of science and whether or not nursing fits any current definition (Ellis, 1983; Allen, Benner, and Diekelmann, 1986; Thompson, 1990). Nursing diagnosis leaves this debate unacknowledged, claiming that nursing is a science on the model of the natural sciences.

A postmodern feminist discourse analysis such as performed in this dissertation is an appropriate discourse of critique for the ideology of nursing diagnosis. An

important contribution of postmodern feminist discourse analysis is an emphasis on examining the gaze of nursing discourse, the process, instead of what is illuminated by the gaze, the patient or the human responses. The potential for the identification of strategies of resistance to oppressive effects of nursing diagnosis is considerable. Postmodern feminist discourse analysis seeks to identify marginalized ideologies and practices that can create subjectivities from which to articulate situated resistance. Other discourses besides nursing diagnosis within nursing literature could be analyzed using this approach to inquiry, as well.

The Voice of the Patient as Resistance

The voice of the patient is completely absent from the discourse of nursing diagnosis. Patients are constituted according to the discourse as the targets of the interventions, not as participants in the discourse. Individual differences between patients are treated by the discourse as research variables, amenable to standardization, as discussed in chapter four. Patients are not invited to conferences or invited to submit diagnoses for consideration. Panels of patients are not given diagnoses to review. Patients are not acknowledged to have any appropriate place in the discourse at all. They are the

objects of the gaze of the discourse, they do not participate in the gaze.

The voice of the patient could be solicited within the discourse, or viewed as a subjectivity with potential to articulate resistance to the oppressive effects of nursing diagnosis within the clinical encounter. This position might be difficult to solicit since many patients believe the repressive hypothesis and accept their one-down position in the clinical encounter, especially when they have been defined as "not healthy". The grid of power relations in the clinical encounter is much more complicated than simply that of nurse over patient. In other words, the voice of the patient is difficult to find, but necessary to hear.

What questions would we ask of that voice? Maybe we would ask how people feel about being diagnosed by nurses. We could ask opinions about the diagnoses themselves. We could ask their lived experience within the clinical encounter. We could ask patients how they view the organization of patient care. We could ask patients about power relations and how they experience domination. We could even ask patients to tell us what we should ask them. All the feminist process variables that apply to participants in any discourse would be applicable to researching patients' voices, as well. The voice of the

patient is heard the least often in the discourse of nursing diagnosis.

Section Three: Evidence for the
Repressive Hypothesis in Nursing Diagnosis

A belief in the repressive hypothesis includes the belief that becoming a speaking person with power/knowledge reduces your own oppression. Becoming a speaking person from the view of power/knowledge involves confessing your personal truths to social agents constituted by a discourse who apply normalizing interventions based on the scientific knowledge of their discipline, their ideology. The ideology of bio-power, however, constitutes both the social agent and the speaking person as targets of control strategies within hierarchical relations of power and resistance.

Belief in the repressive hypothesis also includes a deluding belief that the revelation of scientific truth has the effect of liberating people from control by powerful authorities. The discourse analyst interprets this same situation by saying that the revelation of truth *increases* the control by powerful authorities over the details of everyday life.

Belief in the repressive hypothesis is perpetuated and extended by the discourse of nursing diagnosis. The lack of a comprehensive and systematic discussion of power relations in nursing supports the operation the repressive

hypothesis in nurses (Powers, 1992b). Consider the answers to the following questions: What interests are served when nurses believe in cooperation between separate but equally powerful disciplines, and who gets to contribute to this debate? What interests are served by the belief that competition between such disciplines would only hurt the welfare of patients? What interests are served by nurses believing they are resisting their own domination in practice situations with the ideology of nursing diagnosis? As long as the power relations remain the same, interests outside of nursing are being served by nursing imitation of medical models of practice.

What interests are served when nurses believe in the ideology of professionalism? The belief that we are professionals keeps us focused on the "advancement" of our profession, arguing over what is included in our meta-paradigm and our body of knowledge. This focus diverts attention from problems in our discipline that are the result of social, political, and economic forces that are not amenable to scientific solutions. This belief diverts attention from individual issues of power and oppression, and keeps the practitioners on the job. Ideological discussions in nursing literature are restricted to terms of patient outcomes, efficiency, and teamwork, successfully avoiding discussions about power and whose interests are

operating in the functioning of the discourse of nursing diagnosis.

Nurses participate in domination as oppressors and oppressed in complex, interwoven grids of power relations involving other disciplines and the general historical social fabric of western civilization. We accept, participate in, and perpetuate the discourse of nursing diagnosis that extends oppression in increasing detail and includes our own functioning as social agents in relations of power. This participation causes vague discomfort and oppressed group behavior in clinical situations that is easily shifted to inappropriate targets in the name of professionalism and science.

Assertiveness is often suggested as an appropriate strategy for professionals. However, any hospital nurse knows that assertiveness from an institutional worker is perceived as a militant display of insubordination (Mauksch, 1990). If nursing diagnoses were dropped from the patient record, would punishment of nurses result? No. The discourse of nursing diagnosis provides no meaningful information for other health providers (Levine, 1989). Assertiveness may be a way of talking that can be used successfully by nurses, but assertive talking needs the words of an ideological subjectivity that recognizes power

relations and how they are upheld, in order to be successful at resisting specific practices of domination.

Medicine and hospital administration both benefit from the labor of nurses and the standardization of nursing practice through the use of nursing diagnosis. Toth phrases this situation as follows: "Hospitals and physicians gain money and prestige on the sweat of nurses, and nurses remain overworked, underpaid, inappropriately used, and told to like it because it is a 'calling'. We perpetuate this lopsided system by refusing to change, disagreeing among ourselves, refusing to trust our peers, downgrading education, objecting to involvement in fiduciary and management principles because 'it isn't nursing, it isn't taking care of patients', and in continuing to believe that we are powerless." (p. 101).

Toth's analysis demonstrates belief in the repressive hypothesis. Toth believes the use of nursing diagnosis will eliminate the oppression identified above by the use of scientifically derived standardized patient classification systems that demonstrate the hard work of nurses. Toth's account does not acknowledge that demonstrating hard work does not address the underlying issues of unequal power relations and how they are perpetuated by the use of nursing diagnosis. Standardization of the work of nursing through the use of nursing diagnosis will instead make it

easier to identify the tasks that can be performed by lesser paid ancillary workers, which would most likely be women of color. Middle class white women would take on supervisory duties, reproducing power relations based on the same professional scientific model of power/knowledge.

In addition to the benefits to medicine, the discourse of nursing diagnosis also benefits the business interests over nursing interests in hospital situations. Nursing diagnosis was openly intended as an aid to determining staffing patterns and budgetary allocations (Gordon, 1982a, p. 287) in addition to benefits with respect to computer based patient records and accreditation documentation (Gebbie and Lavin, 1973). A standardized model such as nursing diagnosis favors the inexperienced nurses and this is to the benefit of hospital administrators because inexperienced nurses cost less. At the fifth national conference, Toth (1984) argued that using nursing DRG's would be helpful to identify individual nurses who are weak in treating a certain diagnosis, or weak in implementation of certain therapies, as measured by the patient's length of stay compared to the length of stay of the "average" patient with the same set of nursing diagnoses. In this case, the weak nurse could receive remedial education, a normalizing intervention.

Nursing diagnosis benefits medicine and hospital administration more than it benefits nurses and nursing. Believing in the overwhelming power benefits to nursing and nurses of the discourse of nursing diagnosis can be seen as participation in the repressive hypothesis.

Section Four: Conclusion

The first claim of this chapter is that the discourse of nursing diagnosis perpetuates and extends oppression within nursing practice and with respect to nurses and nursing within the health care system. Evidence has been presented to support several different sites of this oppression: nurse over patient, dominations based on class, race and culture, and women, academics over practicing nurses, and oppression of nursing as a discipline.

The second claim of the chapter is that there are discourses of resistance that provide potential speaking positions that could be used to articulate practices that resist individual oppressive circumstances of nursing diagnosis. The discourses were identified as expert nursing practice, feminism, unionism, alternative views of science, patient advocacy, ethical practical morality, empowerment and social activism, and patient discourse. The different types of situated resistance strategies to nursing diagnosis provided by these discourses was discussed and the possibilities for co-optation were examined.

The third claim of the chapter is that the discourse of nursing diagnosis fosters a belief in the repressive hypothesis in practicing nurses and in nursing that creates tension within the discipline and within individual nurses. This ideology was described by addressing the interests that benefit from the discourse of nursing diagnosis. The discourse of nursing diagnosis can be interpreted as protecting interests other than nursing that keep the discipline of nursing in a dominated position within health care, and individual nurses oppressed in their practice.

The power relations within which the discourse of nursing diagnosis functions are complex. Turkowski argues that the female emulation of a male professional ideology that includes racism, sexism and classism has the unintended consequences of denigration of our own members as females, causing horizontal violence and hierarchical pressures within the occupation with respect to education, race, class, and gender. Understanding the ideology as male-gendered makes sense of such situations as the ANA's rejection of women's issues outside the occupation in favor of alliances with other (male) professions.

Furthermore, by following the model of medicine, nursing has been isolated from other alliances that could provide resistance to nursing diagnosis. The legally sanctioned medical hegemony in health care is supported by

nursing practices that are class-based, male-gendered, racially-related educationally, legally, politically, economically, socially and culturally (Street, 1992).

Situated practices of resistance to the power relations upheld by nursing diagnosis as described here are viable. Ideological subjectivities can provide words and actions that will take different forms in different circumstances, because nursing diagnosis means different things to practicing nurses, academics, and researchers. Discourse analyses can be performed, published and talked about. Participatory feminist research can engage practitioners and academics alike in the process of addressing power relations in the context of the clinical encounter. The center of the discourse of nursing diagnosis can be displaced by the emphasis from the marginalized discourses on the process instead of the subject matter.

CHAPTER SIX: DISCUSSION, CONCLUSION, AND RECOMMENDATIONS

This chapter will summarize the evidence presented for the claims of the discourse analysis from chapter one. In section one, it will be shown how the evidence and the sub-claims from each chapter support the overall claims of the dissertation. In section two, alternatives for nursing diagnosis will be discussed. In section three criteria will be presented that would have to met by an alternative to nursing diagnosis, in order to avoid the problems identified in this analysis. Section four will present discussion and recommendations.

Section One: Summary of Evidence

This section will summarize the evidence for the claims of the dissertation as they appear in chapter one.

1. Evidence has been presented to suggest that the discourse of nursing diagnosis depends on, reproduces, and extends conditions of social domination by using notions of science, normality, and the role of social agents which constitute individuals for themselves and others in an oppressive manner according to hierarchical categories determined by empirical markers such as race, gender and class, thus limiting their autonomy and responsibility in a systematic manner. This is done through unintended consequences and not by purposeful design.

The postmodern critical feminist perspective openly seeks evidence of oppressive circumstances and limits on autonomy and responsibility. Chapter three showed how the development of the discourse of nursing diagnosis was influenced by the social models of power and social agency from medicine and foundational science, and how the development of the discourse of nursing diagnosis can be viewed as consistent with the description of discourse development from Foucault's power perspective. Chapter three also argued that the models used in the development of nursing diagnosis restricted the options of the present discourse in a systematic manner according to dominations already inherent in those models.

2. Evidence has been presented that the discourse of nursing diagnosis restricts what counts as evidence and limits acceptable input of voices into the structure and functioning of the clinical encounter to those social agents with scientific nursing expertise, thus excluding, for example, the voice of the patient and the patient's family.

Chapter four concluded that the present discursive practices of nursing diagnosis continue to be influenced by the three models: medicine, professionalism, and foundational science identified in the genealogy chapter. The influence of these discourses identified on the

development of the discourse continue to influence the internal structure of the discursive practices in significant ways that restrict the input of voices into the discourse. The voices that have the least input into the discourse of nursing diagnosis are the voices of patients, patient's families, and practicing nurses.

3. Evidence has been presented that the discourse of nursing diagnosis suppresses discussion relating to the operation of power and resistance to power within the discipline of nursing by appeal to the hegemonic dominance of science informed by foundational assumptions and equates this dominance with professional social status. Such suppression results in the perpetuation of oppressed group behavior among practicing nurses by creating tensions between dominant and non-dominant perspectives within the practice of nursing.

Chapter five provided evidence for the claim that the discourse of nursing diagnosis perpetuates and extends oppression within nursing practice and of nursing within the health care system. This chapter also identified potential discourses of resistance that provide speaking positions from which to articulate specific practices that resist oppressive effects of nursing diagnosis. Chapter five also provided evidence for the claim that the discourse of nursing diagnosis fosters in practicing nurses

a belief in the repressive hypothesis that creates tension within nursing practice identifiable in behaviors consistent with oppressed group status.

Section Two: Alternatives

Alternatives to nursing diagnosis have been advanced. Pridham and Schutz (1985) give a language and a classification system, plus criteria for its evaluation. This language is based on human responses to actual or potential health problems (ANA, 1980), although the authors say these are not adequate in prescribing direction for nursing practice. The language is that of patient tasks and competencies. Tasks and competencies are specified for the patient and then reviewed with the patient. It is a scientific model, with foundational assumptions that normalizes patient tasks and competencies and is based on the reified entities of human responses.

Scahill (1991) has outlined what he calls Goal-Oriented Treatment Planning for in-patient child psychiatry that is based on a team approach to goal setting in negotiation with other disciplines such as medicine and social work. The team approach has much to recommend itself, but negotiation with more powerful disciplines is often illusory. The language of this alternative is individualized patient goals, but these goals are

determined by the team, and include minimal input from the patient and/or the patient's family.

Mitchell and Santopinto (1988) proposed an alternative to nursing diagnosis based on Parse's man(sic)-living-health model (1981) that uses a simultaneity paradigm instead of a totality paradigm. The nurse is said to be present to the person's unfolding toward personal hopes and dreams. The patient is the decision maker. The task of the nurse is to express personal meaning, expose paradoxes, create innovative relationships. The authors say that only a nurse can do these things, that anyone can perform the physical skills. The nurse offers a "true presence" grounded in nursing science. This model contains language of patient empowerment, caring, and advocacy. While not adequate, obviously, for a model for all of nursing, there is emphasis on the patient's voice. The philosophy of science on which this model is based is unclear.

Street (1992) recommends that the patient be the focus of the interventions, saying that the power relations might be reduced, because both doctors and the nurses would be giving reasons for their choices that had to do with the patient outcomes, instead of what discipline has the ultimate authority. This perspective, however, underestimates present power relations in the health care system. There is potential, therefore, to simply reframe

the discussion of the power relations based on the illusory criteria of "who does more for patients?"

Section Three: Criteria

An important question that precedes the provision of criteria for an alternative to nursing diagnosis is the question that asks whether or not nurses should continue the effort to construct an organized discourse at all. This dissertation does not take a position with respect to this question. However, this dissertation does support the position that proposed alternatives should be evaluated with respect to the effects identified in this discourse analysis. Does the alternative support any systematic domination, and of whom? Does the alternative restrict the input of voices into the discourse? Does the alternative assume an out-moded philosophy of science by participating in foundational assumptions as a model for the discipline and not as a method to answer certain kinds of questions? The answers to these questions require a discourse analysis similar to the one presented here because the important questions for a service discipline are social questions, value questions, and ethical questions.

DeMarco, et al. (1993) present criteria for evaluation of feminist research in nursing which include assessment of potential oppressive design and analysis that affect research participants and perpetuate bias. These authors

stress that research in nursing should be evaluated by feminist criteria such as examination of the knowledge base, assumptions and conceptual framework for possible oppressive effects (p. 32). "Good science", they argue, includes collegiality, non-hierarchy, mutual dialogue, emancipatory potential, and open discussion of biases (p. 32.) The following areas of research are addressed using feminist criteria: The research purpose, the research question, the theoretical framework, the literature review, the population and sample, the research design, and the results and discussion sections.

Section Four: Recommendations

Discourse analysis can be considered an important approach in nursing inquiry because some of the problematic notions that underlie the various discourses within nursing are not, strictly speaking, empirically based. Instead, the notions are conceptual and discursive, concerned with assumptions and power relations. The marginalized discourses of empowerment and social action, feminism, a wider view of scientific activity and knowledge, advocacy, and unionism can be given more exposure and recognized as valid perspectives for nursing. These perspectives help to emphasize, for example, the process by which the subject matter for inquiry is illuminated, instead of focusing entirely on the subject matter itself. Nursing could also

contribute to the academy by utilizing contemporary developments in the approach to analysis and demonstrating what revised conceptualizations of research and scholarship could mean in a practice discipline.

A feminist postmodernist analysis of the power relations between medicine and nursing, for example, would have important effects on conceptualizing the generation of nursing knowledge (Dzurec, 1989; Doering, 1992). Wuest (1993a), for example, points out that the traditional method of concept analysis in nursing, in seeking the universal critical attributes of a concept, loses the elements that reveal androcentric bias. The nature of the relationship and character of the decision-making process fail to emerge (p.7). "One cannot rehabilitate lives in a social structure that is directed to their dehumanization." (Lichtman, 1982, p.284).

Carpenito (1993) believes that there is no general knowledge in the practical, or that it is inferior knowledge. This view is contradicted by both Schon (1983) and Boyer (1990) who demonstrate the scholarship of the practical, and reflection-in-action. In other words, there is a closer relationship between knowing and doing than Carpenito is willing to admit, and the value of one is not so clearly ahead of the other.

Nurses perpetuate the myths of the value-free nature of science, its universal applicability, and its value-free methods, but the marginalized discourses as described in this analysis have much to offer in changing nursing's view of health from a strictly medical, scientific, and professional one.

The clinical critique of medicine in the tradition of the Cos School of Medicine as described in chapter three is one such discourse that may provide a way of looking at particular instances of clinical practices that resists the approach of nursing diagnosis. For example, Canguilhem (1978) argues that what is statistically frequent is not necessarily normal, and what is statistically infrequent is not necessarily abnormal, and surely not pathological. Canguilhem emphasizes that normal and abnormal are not *descriptive* terms, they are *evaluative* terms. Health and illness are not opposites or even ends of a continuum. "To be in good health means being able to fall sick and recover, it is a biological luxury" (p.7). We must consider it normal for the pathological to occur. A revised notion of normal, combined with an emphasis on an individual clinical situation and consideration of the inherent power relations, is a promising approach to the generation of nursing knowledge. This approach can be considered both scholarly and rigorous.

Given the current power arrangements, nurses work with medical diagnoses all the time, in hospital work, public health, home health, hospice, school nursing, psychiatry, etc. Instead of avoiding the use of medical diagnoses, nurses should clearly name the medical diagnosis whenever our actions address the medical condition of our patients.

Let us not, however, carry the medical model to other patient issues that we also address. The issue of coping cannot be approached in the same way as the patient's CHF. We must not assume we are the instant experts in a patient's life on the basis of a nursing assessment. We do have some expertise with regard to their medical situation. We have evidence, but do not have sufficient expertise to be held professionally accountable for the diagnosis of poor coping, low self-esteem, powerlessness, depression, anxiety, guilt, etc. Patients and patient's families can claim these situations for themselves, provide evidence, reject judgements, and generally have more input into the clinical encounter than the discourse of nursing diagnosis implies.

Nurses are continually called upon to act, and we are asked for help by patients who have identified some problem that they think a nurse could address. Are we negligent in making clear to patients what skills we have available to them? It is a social question that calls for a social

answer. It's not a power question and it's not a science question. It calls for new ways of thinking that challenge our discipline.

Further research is warranted. Other discourses in nursing literature can be analyzed using this methodology, such as the discourse of caring. Patient discourses could be analyzed as potential speaking positions for articulating practices of resistance to nursing diagnosis. Empirical studies could be performed with regard to hospitals that do not use nursing diagnosis. Naturalistic inquiry methods are appropriate to investigate the experience of practicing nurses using nursing diagnosis, and patients' experiences in the clinical encounter. Descriptive studies of expert nursing practice could be extended. Philosophical approaches to knowledge generation such as ethics and aesthetics can be expanded. Nursing as a practice discipline has enormous potential for innovative ways of thinking that may not correspond with the standard, normalized discursive practices of nursing diagnosis.

I am often asked about alternatives. Nursing is only just emerging from the hold of the empirical analytic ideology. Alternative approaches to knowledge generation in a practice discipline are just beginning to be developed. It is too early and/or not appropriate to look for a model for the entire discipline. There may not even be a model

that will fit the work of nursing as a whole, or even the sub-specialities of nursing such as critical care. We can, however, concentrate on several areas right now, such as the education of our future practitioners at the university level with an emphasis on critical thinking skills and a broad scope of classes that includes a perspective on western civilization and the place of nursing within various traditions of inquiry. Nurses must also be persons educated in the traditions of western thought that include historical perspectives on knowledge generation and recent critiques of ideology and science, especially those written by feminist writers.

The intentions of the original proponents of nursing diagnosis were timely and well thought out, but the models available then were limited and inappropriate for a female working class occupation. The unintended consequences are now being played out. On the other hand, we have also seen the beginnings of other possible models for knowledge that have tremendous untapped potential for nursing.

In sum, the discourse of nursing diagnosis constitutes a discourse phrased in modern professional scientific terms and based on an exclusionary model of power. The influence that the discourse seeks in its description of the clinical encounter for the purpose of determining truth within that sphere, does not impinge upon the turf of medicine, because

if it did, nursing would be facing powerful opposition or co-optation. The sphere of influence we are carving out comes instead from patients and their families, and we are using the language of science, professionalism, and patient outcome to justify ignoring these voices.

On the other hand, if we began to address power issues as a discipline and as individuals; if nurses could and would take professional and personal responsibility for the clinical encounter based on models that were not control-based, care might become less oppressive. Emancipation brings autonomy and responsibility and can be quite a frightening prospect. Gordon (1984) says "Nursing, in trying to differentiate nursing expertise, to move beyond obedience to medical orders, and to become more autonomous and accountable can ill afford to reinforce impersonality and mere obedience by adding more rules that tend to restrict judgement." (p. 232). "Nursing, in its bid for professional status, autonomy, greater effectiveness in patient care, and greater legitimacy must be wary of overreliance and idealization of traits that nursing has formerly lacked, excessively relying on formal models as the way to nursing's goals. While nursing must cope with the constraints presented by medicine and bureaucracy, nurses can ill afford to create new chains themselves,

particularly in the name of freedom and growth." (Gordon, 1984, p.243).

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CURRICULUM VITAE

Name: Penny Ann Powers, RN, MS, Ph.C.

- Ph.C. 1992, U. of Washington. Dissertation Title: A Discourse Analysis of Nursing Diagnosis.
- MS in Nursing, 1991, U. of Washington. Thesis Title: A Philosophical Analysis of the Concept of Needs in Nursing.
- Diploma graduate, 1982, Brandon General Hospital School of Nursing, Brandon, Manitoba, Canada.
- Bachelor of Arts, 1970, in Psychology and Philosophy, University of California, Davis.

Papers and Presentations

"A Discourse Analysis of Nursing Diagnosis", dissertation accepted for presentation at the 7th Biannual Conference of European Nurse Researchers, Oslo, Norway, July, 1994.

"The Case for Discourse Analysis in Nursing Inquiry", paper for presentation at the Fifth Annual Feminist and Critical Perspectives in Nursing Conference, Seattle, WA, March, 1994.

"Nursing Diagnosis and the Perpetuation of Racism, Sexism, and Classism", paper presented at the Fourth Annual Feminist and Critical Perspectives in Nursing Conference, Atlanta, GA, March, 1993.

"The Concept of Needs in Nursing" paper presented at the Third Annual Feminist and Critical Perspectives in Nursing Conference in Toledo, Ohio, March, 1992.

"Taken for Grantedness in Nursing" with D. Allen and K. Allman, monograph for Deakin University, Australia, 1991.

"Needs in Nursing: A Foucaultian Analysis" Master's Thesis, University of Washington, 1991.

"Images of Health: From Emic Descriptions to the Wellness Inventory" with N. Woods, et al., who presented the paper at the Western Society for Research in Nursing, Denver, 1990.

"Feminist Research Without Gender" with D. Allen, et al. Advances in Nursing Science, 13(3) 49-58.

"Meaning of Miscarriage Scale" with K. Swanson-Kauffman et al., who presented the paper at the Western Society for Research in Nursing, Denver, 1990.

"Success As Women View It", with K. Swanson-Kauffman et al. who presented the paper at the Western Society for Research in Nursing Annual Conference, Denver, 1990.