The Unethical Conduct Of The Nurse: A Critical Discourse Analysis Of How The Nurse Has Been Constructed By The Nurses Tribunal In New South Wales.

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A thesis submitted for the degree of

Doctor of Philosophy

University of Western Sydney

2010
Acknowledgements

This thesis would not have been possible without the help and support of many people.

My thanks go to my supervisors, Associate Professor Moira Carmody and Dr Jane Cioffi. Moira and Jane not only provided expert advice and gentle guidance but also showed great patience at times when it was most needed. Their constant encouragement to think critically allowed me to move my work from the merely descriptive to new levels of understanding.

My thanks also go to Professor Esther Chang who at the outset encouraged me to undertake this project.

To my colleagues in the School of Nursing and Midwifery who supported me in a myriad of ways, I am endlessly grateful for your interest, generosity and patience.

I am also indebted to the many academics who so willingly provided me with information needed for my research and especially to those who lent me copies of their own theses.

Special thanks go to Mr David McMahon and Mr Ron Lazucki from the Nurses and Midwives Board who generously gave their time to assist me in locating and accessing transcripts of Tribunal inquiries.

Most importantly, my thanks go to my family whose love and belief in my ability enabled me to sustain this journey.
Statement of Authentication

The work presented in this thesis is, to the best of my knowledge and belief, original except as acknowledged in the text. I hereby declare that I have not submitted this material, either in full or in part, for a degree at this or any other institution.

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Signature of Candidate
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Abstract

…the real political task in a society such as ours is to criticize the working of institutions which appear to be both neutral and independent; to criticize them in such a manner that the political violence which has always exercised itself obscurely through them will be unmasked, so that one can fight them (Foucault 1974, p. 171).

The question being asked in this thesis is how and with what effect has the unethical conduct of the nurse been constructed by the Nurses Tribunal in New South Wales?

This question is explored within a poststructural theoretical framework, in which an approach informed by Foucault’s ideas about genealogy, disciplinary power and ethics is used to examine and propose explanations about the emergence, construction and effect of the unethical conduct of the nurse.

The central tenet to my argument is that Tribunal findings of unethical conduct are a new way of speaking about nurses. I propose this new way of speaking has arisen out of the discourse of professionalisation as a means of controlling the practice of nurses, enhancing the power of the profession, and reinforcing the status of nurses as ethical subjects.

In keeping with Foucault’s interest in examining the productive effects of power as opposed to sovereign power and his approach to looking at problems from an alternative angle rather than attempting to solve problems, this thesis provides a critical analysis of the way in which the unethical conduct of the nurse is constructed and examines the effect of this discourse.

The analysis was undertaken on transcripts of five Tribunal inquiries which were held during the period 1998 to 2003. Findings reveal that the construction of the unethical conduct of the nurse in Tribunal inquiries is not based on the Code of
Ethics for Nurses in Australia; rather they arise from normalising judgements drawn from commonly held cultural discourses about ethics. Furthermore, these findings challenge the usefulness and ethics of findings of unethical conduct in disciplinary proceedings. They also raise questions about the use and purpose of the Code of Ethics and as such provide for the possibility of rethinking the way in which the Code is used within the nursing profession.
Chapter One

Introduction to the thesis

This chapter provides an introduction to and overview of the structure of the thesis. The purpose and focus of the thesis clearly identifies the area of interest and intention of the study. My interest and motivation for investigating the topic is explored in the background and context which set the scene for the study. Following this the research aims, research questions, significance and limitations of the study are addressed. The chapter concludes with a brief overview of the content of each of the chapters which make up this thesis.

Purpose and focus of the thesis

This thesis explores the emergence, construction and effect of findings of the unethical conduct of the nurse arising from Nurses and Midwives Tribunal\(^1\) inquiries in New South Wales (NSW). The study adopts both Foucauldian and poststructural methodological approaches to examine how it became possible to speak about the unethical conduct of the nurse. The intention of this thesis is to develop an understanding of the exercise of power on nurses appearing before the Tribunal and its effects through an exploration and examination of findings of unethical conduct, it is not intended to be an investigation into the actions of the nurses.

Foucault’s ideas have been central to this thesis; they provided a space within which it became possible to conceptualise an approach to undertake this project. These ideas enabled a way of examining how power came to be used by certain groups or individuals (such as the discipline of nursing and the Tribunal members) and how this has had effect.

\(^1\) In New South Wales (NSW) the Nurses and Midwives Tribunal (the Tribunal) was previously known as the Nurses Tribunal. This name change took place in August 2004 when significant amendments to the Nurse Act 1991 (NSW) were enacted. These amendments included a change of name to the Act which is now known as the Nurses and Midwives Act 1991.
Within Tribunal inquiries where there is a finding of unethical conduct, the finding is always enmeshed within a finding of unsatisfactory professional conduct or professional misconduct. My interest in this study was not so much in understanding the construction of unsatisfactory professional conduct or professional misconduct rather I wanted to know how it was determined that conduct was unethical. The *Nurses & Midwives Act 1991*, (the Act) sets out what constitutes professional misconduct and unsatisfactory professional conduct, but does not provide any guidance as to what is meant by unethical conduct. This thesis is important because it questions the taken for granted assumptions that unethical conduct has commonly understood meaning and that it is appropriate for Tribunals to make findings of unethical conduct in the practice of nursing. Acceptance by the profession of the concept of unethical conduct as a phenomenon which can be objectively measured and evaluated, has until now been unquestioned. Failure of the profession to subject the construct ‘unethical conduct’ to critical examination highlights the subtle and pervasive effects of disciplinary power which this thesis aims to expose.

**Background to the study**

This project has evolved over a number of years. The impetus for this study arose from my early experience as a member of the Tribunal and the Professional Standards Committee in NSW. I commenced membership of these disciplinary panels in 1996 and since then I have regularly been involved in inquiries as a professional member. From my perspective, one of the striking features arising out of many of these disciplinary inquiries was the gap between nurses understanding of their ethical responsibilities and that of the disciplinary panel. This gap was manifest by a lack of knowledge and understanding displayed by many of the nurses in relation to their ethical responsibilities. However, what to my mind was even more troubling was that some inquiries revealed that the institution in which the nurse was working either did not actively support a culture conducive to ethical conduct or in some cases operated to discourage such conduct.
Further issues of concern were that whilst findings of unethical conduct were made against some nurses appearing before the Tribunal, there was no clear set of principles or examples to guide nurses about unethical conduct. In fact access to a set of principles about ethical conduct specifically for Australian nurses, only became available with the publication of the first *Code of Ethics for Nurses in Australia* (the Code) in 1995 and even then it was not widely circulated to nurses. Furthermore information about the Tribunal processes and the type of sanctions which could be imposed if a finding of unethical conduct was made, were not easy for nurses to access.

These concerns troubled me and based on my experiences with the Tribunal, I formed the opinion that nurses appearing before disciplinary inquiries were in a relatively powerless position and were in effect being let down by their profession. In my view many of these nurses were not well versed in understanding their ethical responsibilities. At an institutional level these nurses were often not supported to act ethically, and yet professionally they were expected to take individual responsibility when things went wrong. Ultimately the process of a nurse having their conduct examined by a Tribunal could lead to a finding of unethical conduct and result in the very serious consequence of deregistration.

Initially these concerns led me to think about investigating nurses’ understanding of ethical conduct. I became interested in investigating registered nurses experiences of ethical dilemmas and their understanding of the Code and as a result undertook a preliminary study in 2001 and 2002\(^2\). The study was a qualitative, exploratory investigation using an interpretive approach. The aim was to develop an understanding of what nurses considered to be ethical dilemmas and how these are managed in their daily practice. It was intended to provide an opportunity to hear what nurses had to say about ethical dilemmas faced by them in their day to day practice. I anticipated that such a project would provide an opportunity for nurses’ participation in the dialogue of nursing ethics, which up to that time had essentially been informed by biomedical ethics.

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\(^2\) Ethics approval was obtained from the University of Western Sydney Human Research Ethics Committee/Panel for the interviews conducted for this initial pilot study. Approval was granted for the period 2001-2003; the initial approval number was HREC 00.53, and a subsequent approval number HREC 01:53 was also granted.
Data was collected from four experienced registered nurses with three or more years post registration experience, using unstructured in depth interviews. The interviews were tape recorded and transcribed. Experienced registered nurses were chosen as opposed to new graduates because a review of the literature demonstrated that experienced nurses were more likely to be able to discuss experiences of ethical practice (Benner, 1984; Tabak & Reches, 1996; Tadd, 2000).

The findings from the study revealed that on a daily basis these nurses had to navigate ethical dilemmas in practice and that whilst they had a clear focus on ethical behaviour, they had no knowledge of the Code or understanding of professional ethics, rather their ethical focus was derived from the moral and ethical values of their families. What this preliminary study highlighted was that these nurses were constantly faced with having to make decisions about ethical dilemmas, for which they had little or no professional guidance or institutional support. Indeed the ethical issues identified by the nurses were not reflective of the dominant medicocentric ethical issues around which much biomedical and nursing literature focused at that time (Dixon, Cioffi & Chang, 2003).

The findings from this early study and my experience as a member of the disciplinary panels left me with the following question. If so little was known in Australia about nurses’ ethical practice, and if the professional understanding of ethical practice in nursing was principally drawn from a biomedical model, how was it that the Tribunal could determine what constituted unethical conduct for nurses? In response to this question I decided to focus on exploring how nurses’ conduct has been constructed as unethical by the Tribunal.
Context of the study

NSW Nurses and Midwives Tribunal

The Tribunal is a relatively recent institution. It is a statutory authority which was established by the Act and commenced inquiries in NSW in 1992. The role of the Tribunal is to consider any matter which may constitute professional misconduct; that is conduct which may lead to the removal of the nurse’s name from the Register or Roll (Nurses Registration Board\(^3\), 2001, p. xi). The Tribunal comprises two accredited\(^4\) nurses and a lay person, and is chaired by the Chairperson or a Deputy Chairperson of the Tribunal who must be a judge or legal practitioner of at least seven years standing (Nurses & Midwives Board, February, 2010).

A complaint made against a nurse is lodged with either the Health Care Complainants Commission (HCCC) or the Board. Once a complaint is made, if considered to be serious, it is investigated by the HCCC. (Health Care Complaints Act 1993, updated on 17\(^{th}\) June 2004). Under the Act and its respective amendments, (such as the New South Wales Nurses Amendment Bill 1996, which was enacted to amend the Act with respect to impairment matters), the failure of a nurse to meet the standards of professional conduct can result in the nurse being required to attend an Impaired Nurses Panel, a Professional Standards Committee, and / or a Nurses and Midwives Tribunal, each of which is constituted by the Board. If the complaint is considered to be serious, the HCCC in consultation with the Board will refer the matter to the Tribunal (Nurses & Midwives Board, February, 2010).

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\(^3\) Under the amendments to the Act in 2004, the Nurses Registration Board became the Nurses and Midwives Board. Both are referred to as the Board in this thesis.

\(^4\) Under the Act an accredited nurse means a registered or enrolled nurse.
The findings of the Tribunal can result in the following outcomes:

- a caution or reprimand
- conditions being placed on the nurse, e.g. that the nurse undertakes medical or psychiatric treatment or counselling or other appropriate conditions relating to practice,
- and/or suspension from practice,
- or removal of the name of the nurse from the register.

(Nurses & Midwives Board, February, 2010).

In essence the Board has the responsibility for promotion and maintenance of professional standards (Nurses & Midwives Act, 1991). Where a nurse fails to meet the standards, the Board has the capacity to suspend or remove the name of the nurse from the register. A nurse who is considered to have engaged in “improper or unethical conduct relating to the practice of nursing” (Nurses Registration Board, 2001, p. 117) can have a finding made against them under Section 4 of the Act of professional misconduct and or unsatisfactory professional conduct. The types of conduct which constitute unsatisfactory professional conduct and or professional misconduct in relation to an accredited nurse are set out in the Act (see Appendix One) which defines professional misconduct as “unsatisfactory professional conduct of a sufficiently serious nature to justify removal of the nurse’s name from the Register or the Roll” (s.4 Nurses and Midwives Act 1991).

The complaints which may be made about a nurse are set out in Section 44 (1) of the Act. They are as follows:

A complaint may be made that an accredited nurse:

(a) has been convicted of an offence (either in or outside New South Wales) and the circumstances of the offence render the applicant unfit in the public interest to practice nursing, or
(b) suffers from an impairment; or
(c) has been guilty of unsatisfactory professional conduct; or
(d) does not have sufficient physical or mental capacity to practice nursing; or
(e) is not of good character.

When a complaint is heard by the Tribunal the facts supporting the particulars of each complaint are thoroughly investigated by the disciplinary inquiry to establish whether the facts are proved and whether the facts support the allegations which formed the complaint (Nurses Registration Board, 2001).

**The need for the study**

The purpose of disciplinary proceedings has been defined by Mr Justice Kirby.

Disciplinary proceedings against members of a profession are intended to maintain proper ethical and professional standards, primarily for the protection of the public, but also for the protection of the profession. (HCCC v Litchfield, 1997, as cited in Nurses Registration Board, 2001, p. 4).

The area of interest for this study lies in Tribunal findings made against registered nurses of unethical conduct relating to the practice of nursing and the effect of such findings. The unethical conduct of nurses appearing before the Tribunal has not been widely discussed in the literature. Two reports relating to nursing Tribunals were uncovered in a literature search. The first completed in 1998, was a report to the Nurses Board of Victoria on *Determining and Responding Effectively to Ethical Professional Misconduct in Nursing* (Johnstone, 1998). The report was “a critical examination of the notion [of] ethical professional misconduct in nursing” (Johnstone, 1998, executive summary). The report identified three generic types of ethical professional misconduct and identified strategies, which may be used by nurse regulating authorities in response to issues of ethical professional misconduct (Johnstone, 1998).

The second report arose from a project to review professional conduct matters in NSW, and to develop case studies for the ongoing education of registered and
enrolled nurses. Subsequently a case book was published to provide information about how complaints against nurses are managed in NSW (Nurses Registration Board, 2001). The case book emphasises that the purpose of the registering authority is protection of public health and safety (Nurses Registration Board, 2001, p. 3).

In 2001 the Board provided the following explanation to illustrate the seriousness of a finding by a Tribunal of “improper or unethical conduct”.

There is no doubt that, in terms of the outcomes of a Tribunal hearing where a nurse is charged with professional misconduct, a finding that the conduct was improper or unethical is a grave finding indeed. It is unusual for the charge of improper or unethical conduct to stand alone, as it is normally linked to another charge i.e. unfit in the public interest to practice nursing due to a criminal conviction, or demonstrating a lack of adequate knowledge, experience, skill, judgment or care in the practice of nursing. Usually the improper or unethical conduct provides a qualitative perspective on the facts i.e., it is not just what was done, but the manner or frame of mind in which the act was done (Nurses Registration Board, 2001, p. 154 [emphasis in original]).

Clearly then from both a legal and professional perspective, nurses are held accountable for their ethical practice (Australian Nursing & Midwifery Council, 2008a). In keeping with this, all nurses are bound by strict standards of professional conduct which include the expectation that nurses will uphold the highest ideals of ethical professional practice (Johnstone, 2009, p. 6). Matters involving nurses, that come before a professional conduct committee may be evaluated against the standards contained in any or all of the professional codes or national competencies (Johnstone, 1998). Indeed the expectation that nurses will meet ethical conduct standards is referred to in all the professional codes and competency frameworks.
The current *Code of Professional Conduct*\(^5\) states that, “A nurse is responsible to ensure that the standard of the nurse’s practice conforms with professional standards with the object of enhancing the safety of the individual, any significant other person and colleagues” (Australian Nursing Council, 2003, p. 2). The professional standards are set out in the Code and encompass:

- the *Code of Professional Conduct*,
- the *Code of Ethics for Nurses in Australia*,
- the *ANC Competency Standards for Registered and Enrolled Nurses*,
- other endorsed standards or guidelines published by the state and territory nurse regulatory authorities, and
- standards developed by professional nursing organizations (Australian Nursing Council, 2003).

According to the Australian Nursing Council (ANC) which is now known as the Australian Nursing and Midwifery Council (ANMC), regulatory authorities when dealing with professional conduct issues “address concerns about an individual practitioner’s professional standards and conduct, and use the outcomes to further develop the profession” (Australian Nursing Council, 2000, p. 1). The professional standards against which the conduct of a nurse can be evaluated are set out in the Codes and these standards are considered to be the agreed standards of the profession (Australian Nursing Council, 2003; Australian Nursing & Midwifery Council, 2008a, p. 2).

To date there has been a lack of literature critiquing the purpose, role and outcomes of Tribunal inquiries, and the purpose, role and effectiveness of the *Code of Ethics* in relationship to Tribunal inquiries where ethical conduct is scrutinised. Such lack of critical analysis reveals a tacit and unquestioning acceptance of the role of the Tribunal and its processes including the role of professional codes, in relation to Complaints made against nurses. Failure to question these roles and the taken for granted assumptions which underpin them, is an unsatisfactory situation

\(^5\) According to the Board website, the 2008 version of the *Code of Professional Conduct for Nurses in Australia* has not yet been approved by the Minister for NSW.
not only for nurses, but also the profession and the public, who rely on nurses to act in their best interests.

The importance of research into this domain is well articulated by Johnstone (2009), in the following comments.

If nurses are serious about ethics and about conducting themselves ethically in the various positions, levels, and contexts in which they work, then they must engage in a critical inquiry about what ethics is and how it can best be applied in the ‘real world’ of professional nursing practice. It cannot be assumed that just because we know of and use certain ethical terms in our conversations that we know what they mean or that we are using them correctly (Johnstone, 2009, p. 11).

According to Jameton & Fowler (1989), ethical inquiry as a form of scholarly research in nursing has been neglected. They define ethics research as exploring “the basic moral norms that undergird nursing research, practice, and education” (Jameton & Fowler, 1989, p. 12). They argue that it is essential in their view, when examining a clinical question that both the philosophical and experiential context be addressed (Jameton & Fowler, 1989, pp. 14-15).

The need for this type of research was highlighted in a recent large study on the use and interpretation of the United Kingdom Central Council (UKCC) Code of Professional Conduct. This study was undertaken in the United Kingdom and involved 1,425 nurses. Whilst those surveyed indicated the importance of the Code in terms of public protection, they nonetheless rated as low those clauses in the Code, which specifically related to reporting situations that put clients at risk. This finding revealed “a tension between the ‘ideal’ of a responsible, autonomous and individual practitioner” and “the reality and demands of institutional working” (Tadd, 2000, p. 74). The author found there was limited use of the Code in practice and on the whole participants demonstrated confusion and lack of clarity about the purpose and role of the Code. Nurses saw the Code as predominantly a defence against allegations of
misconduct, rather than as a tool to enhance professional practice. These findings raise concerns about the nurses’ limited understanding of professional accountability.

The research identified that the concept of advocacy was the most confused by nurses and the author concluded that client and public safety was more rhetoric than reality (Tadd, 2000).

The gap between theory and practice has also been identified by Jones (2001), who contends that what nurses learn in education programs may bear little resemblance to the type of knowledge that is needed to practice safely. She argues that nurse regulatory bodies must involve themselves not only in screening for entry, and in a punitive role, but also “in a role which is able to influence the prevention of poor practice” (Jones, 2001, p. 8). According to Jones, nurses work in institutional settings where “the cultural norm is of the nurse as a doer rather than a thinker” (Jones, 2001, p. 8), and as such nurses’ capacity to maintain practice standards as set out by regulatory boards is impaired. Woods (2003), also identified a theory / practice gap, he argued that nurses who were morally competent and professionally experienced “made ethically effective or ineffective decisions according to circumstances that were heavily influenced by a whole range of contextual factors that were often beyond their control. The net effect was that nurses could respond to ethical issues in a great number of different ways ranging from complete passivity through to ‘desk banging’ or much wider moral protests” (Woods, 2003, p. 7). Of concern was his finding that “Most chose a ‘middle path’ which was predominated by either compromising or subverting” (Woods, 2003, p. 7). More recently Newman and Lawler (2009) identified the effect of the imposition of new management structures on, amongst other things, the oversight of professional standards. They contend that within this new structure, nurse managers have been separated from their role as professionals, thereby marginalizing them from both day to day management of clinical services and from policy development. The impact of this has been to remove these senior nurses from their traditional roles of oversight of all patient care activities and ensuring their congruence with professional standards.

A systematic analysis of five studies of nurses’ ethical conflicts, conducted by Redman and Fry (2000), revealed that ethical conflicts were experienced as either, “ethical dilemmas (two or more clear principles apply but support mutually
inconsistent courses of action) or as moral distress (the nurse knows the right thing to do but institutional constraints make it nearly impossible to pursue the right course of action)” (Redman & Fry, 2000, pp. 363–364). They found that “most specialties experienced ethical conflicts from institutional or health policy constraints” (Redman & Fry, 2000, p. 363).

The literature demonstrates a need for research in this domain which is focused on the relationship between theory and nursing practice. To date, the literature on the whole has focused on these two aspects of nursing as independent entities. In a report to the Nurses Board of Victoria on determining and responding effectively to ethical professional misconduct in nursing, it was recommended that, research be undertaken into nurses understanding of “the nature and potential disciplinary consequences of ethical professional misconduct in nursing” (Johnstone, 1998, p. 109). Holmes also identified a need for research into, “how nurses define or recognise an ethical issue, what choices they make when faced with one and how these influence their actual behaviour” (Holmes, 2002a, p. 19). In Australia this situation remains unchanged as there are still no studies which can demonstrate Australian nurses’ experience, knowledge or understanding of their Code of Ethics (Holmes & Williams, 2007).

Nurses’ experiences are an important means of identifying issues that relate to nursing ethics, which would otherwise be “overlooked or marginalised by mainstream bioethics discourse” (Johnstone, 1999, p. 46). An analysis of how nurses’ unethical conduct has been constructed and how it has had effect, will bring to the fore problems arising for nurses from the taken for granted assumptions which underpin Tribunal findings of unethical conduct.
Research aim

The Nurses Tribunal has not been widely studied, indeed a review of the literature uncovered only two reports on Nurses Tribunals\(^6\), one conducted in Victoria and the other in New South Wales. Broadly my aim in this study is to reveal how the discursive assumptions embedded in the discourse of the unethical conduct of the nurse, and the discursive practices surrounding the discourse, frame understandings about nurses’ unethical conduct.

The study aims are two fold:
1. to explore the emergence and construction of the unethical conduct of the nurse within the discipline of nursing via the disciplinary apparatus of the Tribunal, and;
2. to explore how this construction of the nurse has effect.

Research questions

There are three aspects to this study arising out of the proposition that Tribunal findings of unethical conduct are a new way of speaking about nurses. These are that the emergence and construction of the unethical conduct of the nurse has arisen out of a broader historical, political and social context; that relationships of power arising from this context have been exercised to produce the unethical conduct of the nurse, and that this has had effect through constructing the ethical subjectivity and ethical governance of the nurse. The study therefore addresses the following questions.

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\(^6\) The two reports are:


Nurses Registration Board of New South Wales (2001). *Professional conduct a case book of disciplinary decisions relating to professional conduct matters*. Surry Hills: Nurses Registration Board of New South Wales.
1. What were the conditions of possibility which enabled the unethical conduct of the nurse to come into being?

2. How are relations of power operationalised within and around the Tribunal to construct the nurse as an unethical subject?

3. How do these relations of power have effect?

**Significance of the study**

The significance of this study lies in the fact that Tribunal processes and findings have serious implications for all nurses in practice and yet this topic has not previously been explored. The study examines both the historical context in which the Tribunal is located, and the Tribunal processes and findings in order to understand not only how it became possible to speak about the unethical conduct of the nurse, but also the effect of this discourse particularly with regard to governance of nurses’ ethical conduct.

As with any Foucauldian research, locating the research within its broader context allows for a critical analysis. Nurses in NSW are facing increasing exposure to regulation with the expanding regulatory framework\(^7\) for nurses and thereby greater scrutiny of their ethical and professional practice. The significance of this study therefore is that it provides a way of understanding and highlighting whose interests are being best served by the changing climate. This study provides the opportunity to:

- expose discursive assumptions embedded in the Tribunal which frame understandings of nurses’ unethical conduct,
- expose the relationship between the discourse of the unethical conduct of the nurse with other powerfully located discourses, and
- extend current understanding of the impact of the regulatory framework, in particular the *Code of Ethics* on nurses’ ethical subjectivity.

\(^7\) Changes to the regulatory framework for nurses are discussed in Chapter Ten.
Research process

This qualitative study uses a poststructural framework and incorporates Foucault’s ideas about genealogy, disciplinary power and ethics. The analysis was informed by these ideas and this has allowed me to examine the way in which the Foucauldian concepts of power and knowledge, discourse and discursive strategies, the panopticon, games of truth, subjectivity, resistance and government, take effect in the construction of the unethical conduct of the nurse.

The goal of poststructural activity is to identify “cultural hegemony and the manner in which it is reproduced” (Lupton, 1992, p. 149). I have used a poststructural approach because I am particularly interested in uncovering the meanings underlying the assumptions about nurses’ unethical conduct. Poststructuralism is an appropriate approach to use in this study because it calls into question representations of reality through emphasising the plural, fragmented and multi-vocal nature of such representations (Cheek, 2000, p. 6). The focus of this project as a poststructural activity is to question and expose the hegemonic assumptions which underpin the construction of nurses’ unethical conduct.

Limitations of the study

There are some widely held criticisms of the theoretical and methodological paradigm which informs the research approach taken in this study. These have been discussed in detail in Chapter Three. Aside from these concerns the study is limited by its historical focus which meant that only Tribunal inquiries up until 2004 have been analysed. How the approach by the Tribunal to unethical conduct might have changed since that time is not addressed. Another potential limitation is that the study was limited to Tribunal inquiries conducted in NSW therefore it is not possible to apply these findings to other Australian states or territories.
Organisation of the thesis

The organising framework for this thesis can be traced by the way in which the chapters and their contents are set out. The first three chapters set the scene for the study and provide a discussion of the rationale, theoretical framework and methodology. In the subsequent chapters the analysis, findings and discussion take place.

This first chapter lays the foundation for the unfolding thesis by providing an overview of the thesis; proposing the research question, and setting out the research process. The background and context to this study are fully discussed and enable the reader to identify my position as the researcher in this study.

Chapter Two explores in detail the ideas of Michel Foucault which have been used to inform the research approach and analysis. Foucault’s ideas particularly on genealogy, disciplinary power and ethics have provided the three arms to analysis used in this thesis, and so this chapter presents a thorough discussion of my understanding of these approaches to analysis.

Chapter Three is a discussion of the methodology. It includes a detailed discussion about postmodernism and poststructuralism and draws on the discussion in Chapter Two to identify synergies with the work of Foucault. In this chapter, I also explore and respond in some detail to criticisms which are frequently leveled at these ways of thinking.

The next seven chapters address the three arms of analysis. In Chapter Four, I draw upon Foucault’s ideas of genealogy and use critical discourse analysis to examine the documentary data which provides insight into the historical, political and social conditions within which the discourse was located. Chapter Five constitutes a discussion of the use of narrative and Foucault’s ideas about normalising judgements and surveillance. This is followed by a critical examination of the way in which surveillance is used in the Tribunal inquiries. Within this chapter an overview of the
Tribunal inquiries analysed for this study is provided in both summary and table form.

Chapters Six, Seven and Eight, provide an extensive discourse analysis of the Tribunal inquiry transcripts drawing on Foucault’s ideas of disciplinary power to inform the analysis. This analysis examines discourse through the narrative representations of the nurse which take place in the Tribunal inquiries. These narrative representations of the nurse are constructed by the Complainant, the nurse, and the Chairperson of the Tribunal (who represents the views of the panel).

Chapter Nine comprises the third arm of the analysis in which a discussion of the findings from the analysis of the data from the previous chapters is drawn upon and examined within Foucault’s ideas of ethics, to explore the ethical subjectivity of the nurse and how this is governed. Chapter Ten completes the thesis with a discussion of the implications of the study for the nursing profession.

**Conclusion**

The literature demonstrates that there is concern amongst nurse ethicists about the lack of research into issues of nursing ethics. In particular, there has been no research conducted into the conduct of nurses appearing before a disciplinary panel. It is important to note that the nurses themselves are not the focus of this study and that this is in keeping with a Foucauldian approach to analysis which is centered on the object rather than the subject. In undertaking this study I do not wish to condone or justify the actions of the nurses who are represented in the inquiries. It is my view however, that despite the actions of the nurses, the profession is not absolved from the responsibility of ensuring just and fair processes, and it is in this spirit of inquiry that I have undertaken this thesis.
Chapter Two

Informing the methodology: a discussion of the ideas of Michel Foucault

Introduction

This thesis uses Foucauldian methodological approaches to show how, for political purposes, the discipline of nursing produced the unethical nurse through the discourse of unethical conduct.

The purpose of this chapter is to discuss the ideas of Michel Foucault which influenced the methodology I use to examine and propose ways of understanding how and with what effect the unethical conduct of the nurse was constructed in Tribunal inquiries. Foucault’s ideas provided a methodological framework and his conceptual tools provided the means for analysis. Critical discourse analysis is the methodological approach I have chosen to examine the phenomenon of unethical conduct. My approach to discourse analysis is mainly informed by Foucauldian ideas about genealogy, disciplinary power and ethics. These ideas allowed me to examine the way in which the Foucauldian concepts of power and knowledge, discourse and discursive strategies, the panopticon, games of truth, subjectivity, resistance and government take effect in the construction of the discourse of the unethical conduct of the nurse.

Before tackling Foucauldian ideas in depth and in order to provide a context for understanding these ideas, I will commence this chapter with a brief overview of the ideas and work of Michel Foucault. Following this will be a discussion of Foucauldian ideas and concepts which are relevant to this thesis. This discussion is important because it provides a detailed overview of Foucault’s ideas and methodological concepts as I have understood them. My intention is to provide a context for the reader to understand the approaches taken to analysis in this thesis.
The ideas and concepts are discussed in the following order: discourse, critical discourse analysis, archaeology, genealogy and ethics, power, and disciplinary power.

**Understanding Foucault**

My reason for writing about understanding Foucault relates to contextualising his ideas; without examining the context from which his approaches to analysis of the human experience are derived it is difficult to understand or attribute meaning to many of his conceptual ideas. This approach to understanding how meaning is derived is central to the work of Foucault. He was interested in understanding the history of ideas, in particular rethinking the concepts; power, knowledge and subjectivity (Davidson, 1986; McHoul & Grace, 1993). His work can be divided into three phases, each of which was concerned with a central theme of trying to examine changes in society. He was not interested in trying to identify a root cause for such changes, rather his interest was directed to analysing relations of people with social and historical practices in order to reveal the arbitrary and contemporaneous nature of these practices. Foucault’s analyses were centred on exposing the notion of universality, which he saw as a totalising regime; and to thereby create an opportunity for different understandings (Foucault, 1988, pp. 10–11). He identified the problem of relations and interrelations of truth, power and the self which were the focus of his analyses (Dickens & Fontana, 1994, p. 12; Foucault, 1988, p. 15).

The philosophies and theories of Marxism, phenomenology, structuralism, psychoanalysis and the Enlightenment were influential in developing Foucault’s ideas and approaches to analysis (Danaher, Schirato & Webb, 2000, pp. 11-12). Foucault was influenced by a large number of theorists; amongst who were Heidegger and Canguilhem, who influenced Foucault’s ideas that knowledge is not a rational, inevitable, continuous process over time, and that knowledge is limited by its context. Structuralism and the work of Saussure was influential with regard to understanding meaning as relational. Nietzsche’s influence was significant because he posited that knowledge resulted from relations of power; and the Enlightenment
period with its focus on notions such as justice, equity and progress was also significant (Danaher, Schirato & Webb, 2000).

The central theme to Foucault’s work on human experience is an investigation of how people “constitute themselves as subjects and how they treat one and other as objects.” (Couzens Hoy, 1986, p. 4). His work can be divided into three phases. In each phase he examined human experience using a different approach to his analysis. These approaches to analysis have been defined as archaeology, genealogy and ethics (Couzens Hoy, 1986, p. 3; Davidson, 1986, p. 221).

His early work undertaken in the 1960s is regarded by many as having a quasi-structuralist focus (Couzens Hoy, 1986, p. 4). Often referred to as his structuralist period, it is represented by his works *The Order of Things* and *The Archaeology of Knowledge*, where he regarded discourse as autonomous and arising out of social structures. Archaeology was the method of analysis used in this period to examine knowledge, concepts and disciplines (Couzens Hoy, 1986, p. 3).

It is argued that he moved to a poststructural focus during the 1970s, where publications such as *Discipline and Punish* focus on social practices as modalities of power which produce discourse, as opposed to the view of discourse as constituting social reality. His genealogical analysis was to do with normative rules such as those of the permitted and forbidden. He examined the relations between knowledge and power and the relationships we have to others through relations of power (Couzens Hoy, 1986, pp. 4-5; O’Leary, 2002, p. 9). His move to examining ethical subjectivity was his third level of analysis and focused on the relation of self to oneself and the notion of governmentality. This phase occurred in the late 1970s and early 1980s and was reflected in his publication on *The History of Sexuality* and his work on ethics (Couzens Hoy, 1986, p. 3; O’Leary, 2002, p. 9; Rabinow, 1994).

Foucault was interested in exploring how it was possible to think in a certain way and how language was used to support ways of thinking; central to this was an exploration of truth, power and the self (Dean, 1994, p. 2). For Foucault there is no theory which can explain the entire social reality (Couzens Hoy, 1986, p. 5), rather social reality is partial, discontinuous and historically located and for these reasons
social practices cannot be captured or completely articulated. Foucault rejected the notion of universality, he believed that “there is no external position of certainty” (Rabinow, 1984, p. 4), rather he believed that we are shaped by history and society. His aim was to “understand the plurality of roles that reason, for example, has taken as a social practice in our civilization” (Rabinow, 1984, p. 4). Foucault’s work has been referred to as a critical history rather than a theory. “Such a history is geared toward the critical use of history to make intelligible the possibilities in the present and so can yield to neither universalist concepts of rationality and subjectivity nor metanarratives of progress, reason, or emancipation.” (Dean, 1994, p. 21).

According to Cheek & Porter (1997), Foucault’s work is important because amongst other things it challenges the taken for granted assumptions of health care and medicine. Foucault offers a way of uncovering power and knowledge relations by examining historically specific discourses (Weedon, 1997). From a Foucauldian perspective fixed universal meanings cannot exist, rather historically specific discourses define meaning (Rabinow, 1984; Weedon, 1997). Examining discourse in its’ specific historical context; that is, looking at discourse in practice, provides the opportunity to determine whose interests are being served at a given point in time (Weedon, 1997).

**Discourse**

Examination of discourse as a way of uncovering power and knowledge relations is the central analytic focus of this study of the unethical conduct of the nurse. From a Foucauldian perspective meaning is derived from discourse and it is discourse which produces knowledge (Hall, 2001, p. 73). In order for the concept of the unethical conduct of the nurse to have meaning, there needs to be a discourse or body of knowledge which creates meaning and thus provides a way of understanding the concept.

A definition of discourse provided by Lupton (1992), is that discourse is a group of ideas or ways of thinking which can be found in both text and in social structures.
Bilton, Bonnett, Jones, Skinner, Stanworth & Webster (1996), define discourse as an established world view or accepted knowledge which has arisen from a set of beliefs, concepts or a body of ideas which provide a framework for understanding and action. These definitions capture Foucault’s ideas on discourse except that Foucault locates the existence of discourse within an historical context. From a Foucauldian perspective “in any given historical period we can write, speak or think about a given social object or practice (madness, for example) only in certain specific ways and not others. ‘A discourse’ would then be whatever constrains—but also enables—writing, speaking and thinking within such specific historical limits.” (McHoul & Grace, 1993, p. 31).

Foucault understood discourses as historically located specific bodies of knowledge or social knowledge (Rabinow 1984; Weedon, 1997). He did not see discourse as a single unique body of knowledge, but as a contested domain of knowledge, influenced and intersected with other bodies of knowledge. “Foucault’s idea of discourse shows the historically specific relations between disciplines (defined as bodies of knowledge) and disciplinary practices (forms of social control and social possibility)” (McHoul & Grace, 1993, p. 26). Foucault studied discourse not as a study of language or social interaction rather he studied “discourse as a system of representation” (Hall, 2001, p.72). He understood discourse as a way of representing bodies of knowledge about a particular topic and bodies of knowledge as consisting of statements which are collected into disciplines. According to Foucault, “disciplines are the bearers of knowledge” (Foucault, 1980b, p. 106). The disciplines of interest to Foucault were the disciplines of the human sciences (McHoul & Grace, 1993, p. 42).

Some important concepts for understanding Foucault’s approach to discourse are that discourse is a system of representation and is a function of power (Foucault, 1980b). It is made up of groups of statements and has an archive, it is discontinuous and historically relative, and has an order (Hall 2001; McHoul & Grace, 1993). A group of statements are components of a discursive formation which constitute knowledge about a topic. Statements as part of knowledge are functional units which bring about effects rather than simply representing knowledge. They are understood by rules arising out of specific
historical conditions which govern the function of statements by acting to both constrain and create conditions of possibility (McHoul & Grace, 1993, p. 39). Archive refers to the set of rules by which it is possible to know something, it refers to the form of organisation of the parts – the statements - of the discourse. Investigation of the archive reveals the relations between the discourses (McHoul & Grace, 1993, pp. 30, 40). In relation to discourse, what was of interest to Foucault were the rules and practices which produced statements, and regulated discourse in specific historical periods (Hall, 2001, p. 73). He believed the production of discourse was constituted and controlled by the disciplines as an exercise of relations of power (Foucault, 1971, p. 17).

Discourses were conceived by Foucault to be discontinuous in their development as opposed to rational, “progressive and cumulative” (McHoul & Grace, 1993, p. 4). He believed there is no fixed underlying universal principle guiding the development of discourse (McHoul & Grace, 1993). Rather he believed that knowledge is historically contingent, and so discourse is discontinuous and historically relative. The meaning of discourse is not a fixed, immovable knowledge, because its formation relies on the conditions of possibility arising in history, and those conditions change over time. Foucault firmly rejected the notion of universality, he believed that “there is no external position of certainty” (Rabinow, 1984, p. 4). The way in which discourse is produced; that is, what controls, selects and organises discourse is what Foucault refers to as the order of discourse. How discourse comes together – the historical fragments, and the arrangements of them, speak of the discourse (Foucault, 1971, p. 8).

According to Foucault “each discourse undergoes constant change as new utterances are added to it” (Foucault, 1991a, p. 54) and so there is no single essential historical principle, universal meaning or grand theory attached to discourse (McHoul & Grace, 1993, p. 45). Discourses cannot be fixed as having a fundamental or universal meaning, rather they are constituted by words and their meanings differ according to the contexts in which they are produced and shaped (Jupp & Norris, 1993, p. 47).
In order to show how discourses arise, Foucault identified the following set of criteria for discourse. The criteria of formation; these are the rules or conditions which make possible the objects and concepts of the discourse. The criteria of transformation; the conditions which at a point in time allowed new rules into play, and the criteria of correlation, which is the ensemble of relations which define and situate a discourse among other discourses at a point in time (McHoul & Grace, 1993, p. 44; Foucault, 1991a, p. 54). These criteria make it possible to describe analytically the historical influences on discourse formation and to reveal that discourse does not arise from a universal sovereign form (McHoul & Grace, 1993; Foucault, 1991a). Using these ideas about discourse, this thesis will show how the discourse of the unethical conduct of the nurse has arisen out of political necessity and how this has influenced the way in which the discourse is understood and deployed by the discipline.

Discourses can be seen as social practices (Couzens Hoy, 1986, p. 5) as they shape our perceptions of the world and therefore our reality is shaped by the discourses within which we operate. As social practices, discourses are a means of communication which impart “moral norms” or “imperatives for behaviour” (Jupp & Norris, 1993, p. 49) and as such are a means for the exercise of power and control. “The methods for deciding what is to count as truth are implicit in the discourse which we subscribe to. Thus those who have the power to shape the discourse also have the power to decide not only the methods for arriving at the truth but also to decide which groups of people within the discourse will be the designated holders, generators and disseminators of that knowledge” (Rolfe, 2001, p. 42). Through the establishment of truth, which from a Foucauldian perspective occurs through games of truth, discourses “are assigned the status of objective knowledge, they seem to be beyond dispute and thus serve a powerful legitimating function” (Scott, 1994, p. 360). The appearance of unethical conduct in legislation, such as the Nurses Act 1991 and subsequently in the amended Act, known as the Nurses and Midwives Act 1991, is an example of how the discourse achieves legitimacy through its representation in powerful legal discourse and how it is assigned the status of objective knowledge.
According to Hall (2001, pp. 73–74), the study of discourse has to include the following elements; statements, rules, subjects, authority, and processes and practices. These elements can also be seen as technologies of power or discursive practices which are called upon by the disciplines in the production of discourse. Discourses define and construct the way we are because we are subject to the influence of discourse through discursive practices (disciplinary or regulatory practices) which promote and sustain the power of prevailing discourses. Prevailing discourses exercise power over subjects because who we are and what we do develops within the framework of these discourses (Bilton et al., 1996). The *Code of Ethics for Nurses in Australia* is an example of a prevailing discourse which exercises power over nurses through its capacity to influence nurses and the way they work.

One of the ways in which discourse is able to produce an object such as the unethical conduct of the nurse which has the status of objective knowledge, is by drawing upon other discourses such as legal discourse, professional discourse and ethics discourse, and their normative ideas and commonsense notions to give the discourse legitimacy. Discourses draw upon “existing discourses about an issue whilst utilizing, interacting with, and being mediated by, other dominant discourses” (Carabine, 2001, p. 269).

The discourse of the unethical conduct of the nurse, and the discursive practices which sustain it are derived from bodies of knowledge which produce the object unethical conduct; that is, the discourse defines the unethical conduct of the nurse. Discursive practices, such as the Tribunal and the Codes are disciplinary practices which shape reality through the creation of knowledge. They do this by promoting particular ways of thinking about unethical conduct whilst at the same time excluding other ways. The voices that can be heard and the authority of the voices are established by the discourse. It is important to recognise that not all discourses carry equal authority and that some will be marginalised by those with greater authority or power. “How nurses and nursing are portrayed, both by themselves and by others, is to a large extent the result of powers and practices that operate to position nursing in one way rather than another.” (Cheek, 2000, p. 24).
In this thesis, examination of the discourse of the unethical conduct of the nurse and the powers and practices which shape this discourse will be undertaken using critical discourse analysis as the methodological approach. The following discussion outlines my understanding of critical discourse analysis.

**Critical discourse analysis**

Critical discourse analysis is the approach used in this study to examine the question of how the unethical conduct of the nurse has been constructed in Tribunal inquiries and what relationship this has to the *Code of Ethics for Nurses in Australia*. Examining discourse provides the means for understanding relations of power and how power is used to construct a discourse of the unethical conduct of the nurse. According to McHoul & Grace, “Foucault’s approach to discourse can be called a ‘critical’ approach, since it is geared towards a counter-reading of historical and social conditions and offers possibilities for social critique and renewal.” (McHoul & Grace, 1993, p. 27).

Critical discourse analysis has a focus on uncovering the misuse and abuse of discursive power (Van Dijk, 2008, p. 821). Within this thesis it is proposed that the misuse of discursive power resulted from disciplinary power which was used to create the unethical conduct of the nurse. I argue that this was done in the interests of the discipline at the expense of the interests of the individual nurse. It is not suggested that this was deliberate, rather that it occurred as a consequence of an unquestioned ideological struggle to shore up the professional status of the discipline of nursing.

Discourse analysis aims to uncover the way in which meaning is derived from, or attached to, events and experiences. It is a method of analysis which has arisen out of the social sciences and is frequently influenced by the work of Foucault (Fairclough, 2003, p. 2). Discourse analysis provides a way for seeing social constructs such as the unethical conduct of the nurse, or the *Code of Ethics for Nurses in Australia* in different ways. Discourse analysis can be defined as either
“the study of language in use” or more broadly as “the study of human meaning making” (Fairclough, 2003; Wetherell, Taylor, & Yates, 2001, p. 3). Texts which can be any form of representation of a social construct provide a common source for data analysis (Wetherell, Taylor & Yates, 2001, pp. 1-3). The texts which are analysed in this thesis comprise transcripts from the NSW Nurses Tribunal, documents such as codes and legislation which in part comprise the regulatory framework for nursing in NSW, and literature related to the development of the regulatory framework with a particular emphasis on literature and documents relating to the Code of Ethics.

This type of analysis where the focus is on the whole discursive formation rather than just the language used is more in keeping with Foucault’s ideas of discourse (Hall, 2001, p. 78). Locating texts within their contexts which includes for example contexts such as the political, cultural, institutional and social conditions and analysing this as a whole discursive formation, as opposed to text in isolation, is essential to critical discourse analysis (Van Dijk, 2006, p. 160). The aim is to examine the relationship between the micro events (such as individual Tribunal inquiries) and macro structures (such as the regulatory framework for nursing) and in doing so reveal how texts work within socio-cultural practices (Candlin, 1995; Fairclough, 1995).

According to Van Dijk (2008), critical discourse analysis is aimed at uncovering the “systematic abuse of discursive power” (Van Dijk, 2008, p. 821) and its consequences, which he argues occurs by disguising the role of elite actors in the “discursive reproduction of illegitimate domination” (Van Dijk, 2008, p. 822). In undertaking a critical discourse analysis, this thesis acknowledges that the discourse of the unethical conduct of the nurse occurs within a broader context than any one particular Tribunal inquiry; and so not only examines the processes and practices of the Tribunals but also the broader political, social and historical context of the professionalisation of nursing.

All social practices are discursive, that is they are formed or constructed from human values and understandings – that is, human meaning. Social practices then not only arise out of meaning, they represent, reinforce and construct meaning. “To enter the
study of discourse, therefore is to enter into debates about the foundations on which knowledge is built, subjectivity is constructed and society is managed.” (Wetherell, Taylor & Yates, 2001, p. 5). Critical discourse analysis as an approach for examining the construction of the unethical conduct of the nurse will provide the means to uncover the strategies, processes and practices; that is, the discursive social practices which provided the foundations for the construction of the discourse. One of the ways in which discursive social practices achieve coherence in discourse is through discursive positioning processes such as narration, argumentation, description and explanation for example, which allow for different ways of speaking but which at the same time provide for discourse coherence because they have a shared goal orientation (Rouveyrol, Maury-Rouan, Vion & Noël-Jorand, 2005, p. 293). Within this thesis, discursive positioning processes are described and examined as part of the process of uncovering how they operated in discourse formation and whose interests they served.

Nurses and nursing are defined and constructed by dominant discourses which may or may not be congruent with their experiences. Kermode & Brown (1995) are of the view that nurses need to examine these discourses to uncover “Ideologies which produce discourse which effectively silences or suppresses alternative views” (Kermode & Brown, 1995, p. 15). According to Danaher, Schirato & Webb (2000, p. xii–xiii), ideologies are ideas held within a group which represent the beliefs of the group, and which the group attempts to pass off as universal or common sense. Cheek (2000) defines discourse as consisting of “a set of common assumptions which, although they may be so taken for granted as to be invisible, provide the basis for conscious knowledge.” (Cheek, 2000, p. 23). Exploration of the assumptions in discourse, provide an opportunity to uncover ideologies and thereby create the conditions whereby it is possible to challenge such assumed knowledge.

An example of ideologically based discourse is the discourse of caring which the discipline of nursing and nurses themselves claim is an essential part of what it is to be a nurse. A recent study undertaken by Bourgeois (2006) which examined the discourse of caring found that this belief was based on unquestioned assumptions as to the meaning of caring. When the meaning of caring was examined, the ways in which nurses understood and practised caring were found to be different depending
on how each nurse viewed caring in relation to their own practice. What this study revealed was that a single discourse of caring was not congruent with the different experiences of nurses (Bourgeois, 2006).

From a critical discourse perspective, ideology operates as a “modality of power” (Fairclough, 2003, p. 9) which contributes to maintaining or changing social relations of power. So when examining texts, critical discourse analysis requires the researcher to look at the causal effects of text in relation to issues of power to determine if they are ideologically based. The idea that nurses and caring are synonymous as represented in the discourse of caring is an example of an ideology which serves the political interests of the profession. Similarly this thesis proposes that the unethical conduct of the nurse is an ideologically based discourse of assumed knowledge, operating as a modality of power to subject the nurse to a means of control in the political interests of the profession of nursing.

Critical discourse analysis as the methodological approach to the examination of the unethical conduct of the nurse is informed by Foucault’s analytic ideas. The methods of analysis used by Foucault to examine the notions of truth, power and the self were those of archaeology, genealogy and ethics. This next section of discussion will provide a synopsis of these three levels of analysis. However as the last two are central to the analytic approach taken in this thesis the weight of discussion will centre on genealogy and ethics.

**Three levels of analysis: archaeology, genealogy and ethics**

Foucault was interested in human experiences as they related to truth, power and the self. Over time Foucault developed and used three levels of historical analysis to examine these relationships. These were archaeology, genealogy and ethics.
Archaeology

Archaeology which was the first level of analysis used by Foucault, was essentially a descriptive approach whereby rules underlying social practices could be examined and described (Davidson, 1986; Gutting, 2005). Examining social practices was the vehicle for understanding the structures of the system in which speaking and thinking could take place. Archaeology was considered to be structuralist in approach because the unwritten rules; also thought of as structures, governed and constrained what could be said in a given time. For Foucault, using archaeology as a level of analysis to uncover the rules or structures of what can be said about a particular topic provided an explanation for the constraints on that particular topic (Gutting, 2005).

Genealogy

Genealogy was the next level of analysis whereby Foucault moved beyond structuralism as a method of analysis in which he had attributed meaning to social structures, to examining causality through an analysis of power and its effects. Genealogy “charts the emergence and growth of social institutions as well as the social-scientific techniques and disciplines that reinforce specific social practices.” (Couzens Hoy, 1986, p. 7). In genealogy, Foucault examined authority from the perspective of how authority achieved legitimacy and also from the perspective of exposing abuse of authority. He was interested in analysing the origins (history) of the ways in which we are governed via practices, process, rules and institutions (Gutting, 2005, p. 50). According to Foucault, “The genealogist needs history to dispel the chimeras of the origin” (1984a, p. 80). He believed that the detail of history needed to be probed in depth to reveal the discontinuous nature arising from chance events in history and to thereby dispel the myth that there is an essence underlying history (Foucault, 1984a). In this respect, Foucault questioned the integrity of truth arising from a root cause which can be seamlessly traced through history.
The critical ontology of ourselves has to be considered not, certainly, as a theory, a doctrine, nor even a permanent body of knowledge that is accumulating; it has to be conceived as an attitude, an ethos, a philosophical life in which the critique of what we are is at one and the same time the historical analysis of the limits that are imposed on us and an experiment with the possibility of going beyond them. (Foucault, 1984b, p. 50).

According to Foucault, an historical ontology of ourselves; that is, an “historical investigation into the events that have led us to constitute ourselves and to recognize ourselves as subjects of what we are doing, thinking and saying.” (Foucault, 1984b, p. 46), raises the possibility of “no longer being, doing, or thinking what we are, do, or think.” (Foucault, 1984b, p. 46). An interpretation of what Foucault is saying here is that an examination of the history of what we believe as truth will reveal the partial way in which we have constituted and subjected ourselves to truth. This type of approach where an historical framework is used in the analysis of events, which constitute the subject, Foucault calls genealogy (Foucault, 1980a, p. 117). In genealogy the subject is disregarded, rather it is the events or discursive practices, which constitute knowledge and discourse that are analysed. This approach avoids the trap of historicising the subject and making the subject transcendental, it opposes the search for origins (Foucault, 1980a, p. 117). The task of genealogy “is to expose a body totally imprinted by history and the process of history’s destruction of the body.” (Foucault, 1984a, p. 83). According to Foucault, an historical ontology of ourselves will address the questions “How are we constituted as subjects of our own knowledge? How are we constituted as subjects who exercise or submit to power relations? How are we constituted as moral subjects of our own actions?” (Foucault, 1984b, p. 49). Foucault considered these historical ontologies as the three domains of genealogy (Foucault, 1994b, p. 262).

In this thesis, genealogy provides a methodological framework for examining the historical, social and political conditions in which it became possible to speak of the unethical conduct of the nurse. Examining discursive practices (such as the Code of Ethics, the Code of Professional Conduct and the Nurses Tribunal) which constitute dominant discourses (such as the discourse of professionalisation) arising out of the
conditions of possibility, provided a way of shedding light on the relations of power shaping the construction of the discourse of the unethical conduct of the nurse.

**Ethics**

Ethics was the third level of analysis used by Foucault. In his work on ethics, Foucault studied sexuality in both ancient and modern times to analyse how sexuality operated as a “mode of relation to the self” (Foucault, 1984c, p. 333). He was interested in how through modern techniques arising out of Christianity such as the confessional, and also out of techniques such as psychoanalysis, discovering the truth about ourselves in relation to sexuality is tied to constraint and self-denial. In other words the power of self-control, and through this the search for knowledge of the self or truth about ourselves (Hutton, 1988, p. 131). Foucault also explored how, in more modern times, this process of constructing the self has occurred through modes of subjectification operationalised by the state. He believed it is through these processes and procedures or games of truth that we come to know ourselves in relation to self. Throughout his work Foucault explored the idea of games of truth in relation to knowledge, power and the self (Foucault, 1990a, p. 257; O’Leary, 2002, p. 9).

Foucault used the notion of games of truth, to describe the process by which truth is produced through rules or procedures (Foucault, 1994a, p. 297).

….by truth I do not mean ‘the ensemble of truths which are to be discovered and accepted’, but rather ‘the ensemble of rules according to which the true and the false are separated and specific effects of power attached to the true’, it being understood also that it’s not a matter of a battle ‘on behalf’ of the truth, but of a battle about the status of truth and the economic and political role it plays. It is necessary to think of the political problems of intellectuals not in terms of
‘science’ and ideology’, but in terms of ‘truth’ and ‘power’ (Foucault, 1980a, p. 132).

In his later works Foucault argued these games of truth and forms of subjectification which are imposed upon us should be rejected. Such rejection is a work of self-transformation – an aesthetic, which is the task of freeing oneself from the subjected self to become an ethical subject (O’Leary, 2002, pp. 13-15). Foucault identified ethics as an element of moral conduct, in particular as the way in which an individual transforms oneself or constitutes oneself, through the process of subjectification, as a moral subject.

…the kind of relationship you ought to have with yourself, rapport à soi, which I call ethics, and which determines how the individual is supposed to constitute himself as a moral subject of his own actions (Foucault, 1994b, p. 263 [emphasis in original]).

He identified morality as consisting of three components; a moral code, the behaviour of those subject to the code, and the way in which individuals constitute themselves in relation to the code. It is this last aspect of morality that Foucault identified as ethics (O’Leary, 2002, p. 11), and it is via this aspect of morality that the possibility exists for one to reject the imposition of a universal moral code. Foucault identified four major aspects to ethics, the first he called the ethical substance. This was concerned with ethical judgement, that part of oneself which is concerned with moral conduct such as feelings, desire or intentions. The second aspect is the mode of subjection in relation to one’s moral obligations (Davidson, 1986, p. 228 -229; Foucault, 1984d, pp. 352–354). For example a question that can be posed in relation to this study is; does a nurse adopt the values in the Code of Ethics because she chooses to or because it is enforced through professional obligations? The third aspect is concerned with how one changes oneself to become an ethical subject. For example, what are the ways a nurse might need to conduct herself in order to be ethical in her practice as a nurse? Foucault referred to this aspect as “asceticism” (Foucault, 1984d, p. 355). The fourth aspect Foucault called the “telos” (Foucault, 1984d, p. 355), this referred to the desired outcome from the
self-forming activity. For the nurse this would be about the free and conscious
decision to be the sort of nurse that she aspires to be, and this might well be the sort
of nurse who holds and practices within the values espoused in the *Code of Ethics*,
but the important point here is that these values cannot be imposed, rather the nurse
must have the freedom and the desire for self-transformation.

The problem in relation to ethics as Foucault saw it; is its constitution by the games
of truth arising from social and legal institutions, and it is this which he believed
needs to be rejected. The question then to be asked in relation to ethics is; how is
one to live? Foucault rejected code based morality – that which prescribes the
permitted and the forbidden, in favour of non-normative morality based on an
‘aesthetics of existence’ (O’Leary, 2002, pp. 6). An aesthetics of existence is about
taking care of the self through personal choice. Foucault denies an essential link
between ethics and societal structures (Foucault, 1994b, pp. 260-261).

The idea also that ethics can be a very strong structure of
existence, without any relation with the juridical per se, with
an authoritarian system, with a disciplinary structure.
(Foucault, 1994b, p. 260).

According to Foucault the changes that occurred in morality from ancient to modern
times have not arisen through changes in codes. Codes have remained essentially
unchanged, they function as prescriptive and prohibitive rules or guidelines for
conduct, the changes that have occurred are changes in ethics or the ‘relation to
oneself’ (Foucault, 1984d, p. 355). These changes are a continuous process of self-
transformation. Foucault explained this as:

What is the *mode d’assujettissement*? It is that we have to
build our existence as a beautiful existence; it is an aesthetic
mode. You see, what I tried to show is that nobody is
obliged in classical ethics to behave in such a way as to be
truthful to their wives, to not touch boys, and so on. But if
they want to have a beautiful existence, if they want to have a
good reputation, if they want to be able to rule others, they
have to do that. So they accept those obligations in a conscious way for the beauty or glory of existence. The choice, the aesthetic choice or the political choice, for which they decide to accept this kind of existence—that’s the *mode d’assujettissement*. It’s a choice, it’s a personal choice (Foucault, 1984d, p. 356 [emphasis in original]).

In identifying ethics as a personal choice, Foucault was concerned with rejecting the coercive practices arising from games of truth to which an individual was subjected. This mode of thinking can be applied to this current study, whereby the games of truth exist in forms such as the *Code of Ethics*, the *Code of Conduct* and the Tribunal. The desire for the discipline of nursing to be recognised as a profession was the problem which gave rise to these games of truth. According to Foucault, problematization arises in response to historical phenomena (O’Leary, 2002, p. 116), whereby a phenomenon such as the professionalisation of nursing requires varying responses to provide solutions. For nursing this resulted in the development of a regulatory framework with mandated rules exercised via the codes as a means of government. Considered in the light of Foucault’s thinking these practices can be seen to be coercive games of truth, because they prescribe and prohibit conduct and are exercised arbitrarily.

Government and governmentality; that is the way we think about governing and the knowledge and practices which informs the way we think about governing (Dean, 1999, p. 16), was an area of interest for Foucault in this later period of his work around ethics. Government essentially meant the governing of conduct and could be applied across a broad spectrum of relations from relations in the political sphere; to relations with social institutions, or relations with the self (Gordon, 1991, pp. 2-3). Government entails the shaping of conduct based on a set of norms, this may be a self-reflective activity or it may imply some external attempt to regulate, control and shape the conduct of others (Dean, 1999, pp. 10-11). Foucault was concerned with the way in which Western societies used government to ‘totalize’ and ‘individualize’ (Gordon, 1991, p. 3).
One way in which he illustrated his thoughts on government was through the idea of pastoral power, existing in ancient cultures and later adopted by Christianity and subsequently modern government as “a form of secular political pastorate which couples ‘individualization’ and ‘totalization’ ” (Gordon, 1991, p. 8). According to Gordon (1991, pp. 10-12), Foucault saw the aim of modern government as one which fostered the development of the individual such that the interests of the state were strengthened, through the interconnectedness of relations between political action and personal conduct. According to Dean (1999, p. 11), government is an intensely moral activity because there is an attempt to shape conduct as a rational activity which requires the individual to be accountable for their own conduct, and to self regulate their own conduct.

Foucault identified pastoral power as a technique of power aimed at ruling individuals and he used the analogy of the shepherd and the flock with which to illustrate his ideas of pastoral technology. The shepherd provides for the good of the flock through gathering them together and taking responsibility for them. The flock comprise a collection of dispersed individuals who require the guidance and leadership of the shepherd, without the shepherd the flock would cease to exist. Foucault also drew upon the discourse of the welfare state to illustrate the interrelation of techniques of modern forms of government, which he describes as “the tricky adjustment between political power wielded over legal subjects and pastoral power wielded over live individuals” (Foucault, 1990b, p. 67). This adjustment is able to take place because according to Foucault the links between the microphysics and macrophysics of power are enabled by biopower or biopolitics, where the issues of the individual are interconnected with issues of state (Gordon, 1991, pp. 4-5).

Adopting Foucault’s notion of governmentality, it can be argued that the regulatory codes in nursing represent both centralised and pastoral forms of power. They are the technologies which link the macrophysics and microphysics of power. Viewed within this model and using the analogy of the shepherd, codes can be seen metaphorically as the shepherd which operate to govern the conduct of all nurses in Australia for the good of the profession; but they also operate as a form of pastoral power to provide for the good of the individual nurse by guiding and providing for...
their moral development and acquisition of knowledge. The question arising from the advent of the codes as Foucault would see it; is how are these power interests rationalised?

In this thesis genealogy and ethics provide the framework for analysis, central to which are the concepts of discourse and relations of power. Within this framework a critical approach to the analysis of discourse must look to how power operates within and around the discourse.

**Power**

Foucault saw it as his task to uncover how power operates in society (Rabinow, 1984). He was interested in the effects of power and what constitutes these effects as opposed to what governs power (Foucault, 1980b). Foucault understood power and knowledge as inextricably linked (Henneman, 1995), and that power is exercised over people through discourses. He was interested in how the social and historical construction of the subject occurred through discourses (Petersen, 1994), and the role of power in this process.

From a Foucauldian perspective, the relationship between power and knowledge lies with the object of the discourse, this is where power lies, not with the subject, the subject is simply “the element of its articulation” (Foucault, 1980b, p. 98); the vehicle through which power operates and has its’ effect. “In short, it is not the activity of the subject of knowledge that produces a corpus of knowledge, useful or resistant to power, but power-knowledge, the processes and struggles that traverse it and of which it is made up, that determines the forms and possible domains of knowledge.” (Foucault, 1995, p. 28) The subject therefore is a function of discourse; the subject occupies a place in discourse, but is not an originator of discourse (Foucault, 1984e). For example, within the discourse of the unethical conduct of the nurse, the object is unethical conduct which operates on the nurse to produce the subject the unethical nurse. Thus the discourse is powerfully positioned to construct the subject. This illustrates Foucault’s conceptualisation of the power and
knowledge nexus which is that “changes of public ideas precede changes in private individuals, not visa versa.” (McHoul & Grace, 1993).

An important attribute of power within Foucault’s thinking is its duality. On the one hand power is used to limit knowledge through rules which maintain and reproduce power relations, and on the other to produce knowledge through the production of discourse and through resistance to discourse (Henneman, 1995). Power therefore can be understood to have both repressive and productive effects.

What makes power hold good, what makes it accepted, is simply the fact that it doesn’t only weigh on us as a force that says no, but that it traverses and produces things, it induces pleasure, forms knowledge, produces discourse. It needs to be considered as a productive network which runs through the whole social body, much more than as a negative instance whose function is repression. (Foucault, 1980a, p. 119).

The productivity of power can be evidenced through institutional apparatuses such as the Nurses Tribunal and related technologies (techniques) such as the inquiry processes which “allow the effects of power to circulate in a manner at once continuous, uninterrupted, adapted and ‘individualised’ throughout the entire social body.” (Foucault, 1980a, p. 119). Thus the apparatus, in this case the Nurses Tribunal, is enmeshed in a constant play of power through discursive practices, which arise out of the inquiry and which regulate nurses’ conduct (the social body) in practice.

The existence of the regulatory framework for nursing and the Nurses Tribunal serves to make possible the discourse of the unethical conduct of the nurse. The findings and orders of the Tribunal, which can be seen to be productive effects of power such as protection of the public and the profession, are also linked to repressive techniques such as deregistration. So the effect of power can be both productive and repressive or juridical. Foucault’s interests were less with the negative effects of power and more with the productive effects of power which he proposed occurs at the localised grass roots level and which in
a capillary fashion connects power with more centralised forms of power or sovereignty (Foucault 1980a; Foucault, 1980b, p. 96).

Foucault believed that power needs to be “considered as a productive network which runs through the whole social body” (Foucault, 1980a, p. 119) as opposed to something which is negative and prohibitive as in a juridical conception of power. In this way it can be seen that power does not belong to any one person, rather power exists everywhere and as such it is exercised rather than possessed (Henneman, 1995). Foucault held that an examination of the exercise of power is about analysing the mechanics of power, because how it is operationalised occurs at a grass roots level in “the fine meshes of the web of power” (Foucault, 1980a, p. 116). Power invests and installs itself at the grass roots level where it is in a direct relationship with its object, it is at this point where power produces its effect (Foucault, 1980b, p. 97). Foucault saw this type of power as disciplinary power, based on normalisation, emerging out of bourgeois society, and as different to sovereign power which is based on the rule of law. He believed these two types of power are antithetical in relation to each other and described them in the following way “on the one hand there is the re-organisation of the right that invests sovereignty, and on the other, the mechanics of the coercive forces whose exercise takes a disciplinary form.” (Foucault, 1980b, p. 107).

Foucault proposed rules for the study of power amongst the most significant of which was to study power not simply as a means of repression but as a means of production. Another was to examine power in an ascending fashion, by examining the micro level of power relations and how power at this level is “invested and annexed by more global phenomena” (Foucault, 1980b, p. 99). He summarised his methodological precautions by saying:

We should direct our researches on the nature of power not towards the juridical edifice of sovereignty, the State apparatuses and the ideologies which accompany them, but towards domination and the material operators of power, towards forms of subjection and the inflections and
utilisations of their localised systems, and towards strategic apparatuses. We must eschew the model of Leviathan in the study of power. We must escape from the limited field of juridical sovereignty and State institutions, and instead base our analysis of power on the study of the techniques and tactics of domination. (Foucault, 1980b, p. 102).

According to Foucault truth and power are linked, truth (knowledge) is produced and sustained by power but it also induces and extends the effects of power (Foucault, 1980b, p. 93). It is produced by “multiple forms of constraint” and is “centered on the form of scientific discourse and the institutions which produce it” (Foucault, 1980a, p. 131). Truth exists in the form of discourses which are accepted in society. (Foucault, 1980a). “Truth becomes a function of what can be said, written or thought.” (McHoul & Grace, 1993, p. 33 [emphasis in original]).

The relationship between knowledge and power is inextricably linked “there is no power relation without the correlative constitution of a field of knowledge, nor any knowledge that does not presuppose and constitute at the same time, power relations” (Foucault, 1979, p. 27). According to Hall, “Knowledge, once used to regulate the conduct of others, entails constraint, regulation and the disciplining of practices.” (Hall, 2001, p. 76). In the inquiries which are analysed in this study, it is proposed that power derives from multiple techniques, the cumulative effects of which are the production of the discourse of the unethical conduct of the nurse. The knowledge which constitutes the unethical conduct of the nurse; that is the discourse, is used to regulate the conduct of the nurse and with broader effect to strengthen the power of the discipline of nursing.

**Disciplinary Power**

In Foucault’s work the concept of discipline is understood as an important means of maintaining power which is achieved through discursively constituted norms (Cheek
& Porter, 1997; Henneman, 1995). Foucault describes disciplines such as nursing or medicine as “the bearers of discourse.” (Foucault, 1980b, p. 106). Disciplines exercise disciplinary power as a means of social control and creating social possibility (McHoul & Grace, 1993, p. 26). According to Foucault, power can both subjugate and “make subject to.” (as cited in Rabinow, 1984, p. 21). Institutional disciplinary technologies or disciplinary practices are mechanisms of disciplinary power, their aim is to create a “docile body that may be subjected, used, transformed and improved.” (Foucault, as cited in Rabinow, 1984, p. 17).

Disciplines such as medicine are powerful forms of social discourse which are able to exercise legitimate forms of social and regulatory control over people (Bilton et al., 1996). According to Foucault (1979, p. 184), “The power of the Norm [sic] appears through the disciplines.” The norm is sanctioned disciplinary knowledge which indicates “membership of a homogeneous social body” such as nursing or medicine, and plays a part in the “classification, hierarchization, and the distribution of rank”, within the social body (Foucault, 1979, p. 184). So for example within the social body of nursing, the norms articulate what it is to be a nurse, the nurse is therefore subject to the norms.

As society becomes more complex, disciplines provide a means of exercising control through their regulatory role (Bilton et al., 1996). This regulatory role is exercised through codes which represent homogenisation of features of the discipline. Codes mark the first stage of “the ‘formalization’ of the individual within power relations.” (Foucault, 1979, p. 190). Foucault’s work challenges taken for granted assumptions such as the legitimacy of disciplinary codes by examining what are supposed to be value free concepts and exposing their discursive construction, to reveal how power and knowledge have effect.

For Foucault the discourse of medicine and the discursive practices of the profession are, “one of the most powerful of contemporary discourses which defines, organises and controls human bodies from birth to the grave” (Bilton et al., 1996, p. 424). From a Foucauldian perspective discourses are forms of knowledge which construct and constrain people through regulatory devices such as codes which act to discipline people to conform (Bilton et al., 1996). The disciplinary mechanisms of
examination, normalising judgements and hierarchical observation are used to maintain power (Henneman, 1995).

Foucault likened the architectural structure known as the panopticon as a model of how the disciplinary mechanism operates and takes effect. The panopticon was designed by Jeremy Bentham in 1785, it was a revolutionary design for a prison which allowed all prisoners to be observed without knowing exactly when they were being observed. It was this function of observation, individualising each prisoner and making them visible, whilst the observer remained invisible which guaranteed order (Foucault, 1995, p. 200). As a disciplinary mechanism, its function was to provide a way of making power relations work, not with the aim of increasing power for the sake of power; rather with the aim of strengthening “the social forces – to increase production, to develop the economy, spread education, raise the level of public morality; to increase and multiply” (Foucault, 1995, p. 208). The effectiveness of the panopticon in strengthening relations of power was due to its focus on the relationship of the individual with power, as opposed to the governance of the individual by sovereign power. The panopticon functioned by making each individual visible at all times, a subtle but continuous observation, allowing for abnormal behaviour to be identified, measured and recorded, and at the same time providing a space for normalising individual behaviour through processes of training or correction (Foucault, 1995). The panopticon provided a structure and a system for enhancing the power of the discipline through normalisation as opposed to a system focused on strengthening personal power such as sovereign power (Rabinow, 1984, p. 20). Panopticism “is the general principle of a new ‘political anatomy’ whose object and end are not the relations of sovereignty but the relations of discipline” (Foucault, 1995, p. 208).

According to Foucault;

…the real political task in a society such as ours is to criticize the working of institutions which appear to be both neutral and independent; to criticize them in such a manner that the political violence which has always exercised itself obscurely
through them will be unmasked, so that one can fight them.

(Foucault, 1974, p. 171)

Within the discipline of nursing the Tribunal is an example of the type of institution Foucault was talking about. It is an apparatus of disciplinary power. Disciplinary power is exercised by the Nurses and Midwives Board through the Tribunal by a localised web of activity (administrative, professional and informal), that take place in and around the Tribunal inquiries. From a Foucauldian perspective, it is through this web of activity that power is exercised, not as sovereign power but rather as relations of power. These relations of power exist as a technology of power via the mechanisms of surveillance, normalising judgments and examination (Foucault, 1995, p. 170). Disciplinary power is essentially a means of training, where individuals are both its’ objects and instruments (Foucault, 1995, p. 170).

Disciplinary power as exercised by the Tribunal has effect by singling out and segregating individual nurses, identifying and analysing their behaviour and then putting the means in place to correct the behaviour. Knowledge is derived from this discursive process and ultimately becomes the focus of training. In this way the unethical conduct of the nurse becomes the object of the discourse and the nurse becomes the instrument through which disciplinary power operates and takes effect. Foucault demonstrated how through discursive construction, knowledge can be privileged as expert knowledge on which the authority to exclude or marginalise other knowledge is premised (Cheek & Porter, 1997). For instance the dominant discourses in the health care sector; in particular the discourse of medicine, shape truth and rationality and so determine the issues which are pre-eminent in the health care arena (Cheek & Porter, 1997). Using a Foucauldian analytic approach to expose the discursive construction of the health care sector, enables such construction to be called into question, so that other possibilities can be considered in effect turning otherwise unquestioned assumptions into a contested domain (Cheek & Porter, 1997).

An analysis of the Tribunal inquiries in this study, where nurses were found guilty of unethical conduct, reveals that the individual actions of each nurse are identified, closely examined and positioned to support a finding of unethical conduct. On the basis of the information revealed at Tribunal inquiries, the Tribunal members made
their findings and determined and enacted a level of control on each nurse’s practice. This ranged from removal (segregation) of the nurse from the register or roll, to placing conditions (singling out and identifying) on the nurse’s practice. These outcomes were designed not as punishment of the individual nurse as would occur in a juridical system, rather to protect the interests of the public and the profession and to control the actions of the nurse. Ultimately, through the mechanisms of disciplinary technology, knowledge about unethical conduct is constructed which serves as a discourse for the exercise of disciplinary power.

Foucault argues that one of the ways in which disciplinary power attains legitimacy is through its engagement with sovereign power, because power is able to be exercised through both disciplinary and juridical means (Foucault, 1980b, pp. 106-107). The Tribunal inquiries can be seen as an example of this, where they are both a function of the discipline of nursing and also of legislation.

Disciplinary practices are an exercise of power comprising a set of techniques that operate as a technology to serve the function of the disciplines such as nursing. Disciplines are “techniques for assuring the ordering of human multiplicities.” (Foucault, 1995, p. 218). Within nursing, this technology of the discipline has been appropriated, in the form of the Tribunal, as a means of ensuring continuation and strengthening of the professional enterprise. Disciplinary technology is used to reinforce and reorganise the internal mechanisms of power (Foucault, 1984f, p. 206) so as to ensure the continued and effective function of the profession. In order to have this effect, the discipline functions as a means of government, the aim of which is to ensure cohesion through extending the skills of the social body; in this instance the whole of the profession of nursing, and organising the forces; that is the individual nurses who constitute the social body, so as to foster useful obedience (McHoul & Grace, 1993, p. 68). Within the discipline, government is achieved by identifying and analysing the normal and the abnormal and then using this knowledge to foster obedience through the process of normalisation. One of the means by which the discipline of nursing achieves this form of government is through the operation of the Tribunal.
Foucault’s insights into how a subject is governed through disciplinary power and ethics are particularly relevant for an examination of how the unethical nurse came to be constructed and the implications of such a construction on the profession; but perhaps more importantly, on nurses individually.

**Conclusion**

This chapter has provided an overview of the ideas and methods of analysis employed by Foucault which have informed the approaches to critical analysis applied in this thesis. The next chapter will describe in detail the methodology used in the thesis.
Chapter Three

Methodology

Introduction

This chapter outlines the methodology used in this study. Included is an overview of the conceptual framework of the thesis including a discussion about poststructuralism and postmodernism and criticisms of Foucault and poststructuralism. This is followed by a discussion about the study design, data sources, methods of data analysis and ethical considerations. The background, purpose and significance of the study have been addressed in Chapter One and a detailed discussion of the ideas of Michel Foucault which have been used to inform the methodology can be found in Chapter Two.

Conceptual framework

This is a qualitative study using a poststructural framework, incorporating Foucault’s ideas about genealogy, disciplinary power and ethics and his conceptual tools of power and knowledge, discourse and discursive strategies, the panopticon, games of truth, subjectivity, resistance and government to inform the analysis. The study examines how it became possible to speak of the unethical conduct of the nurse and the likely implications of this discourse for nurses and the profession. My aim is to reveal how discursive assumptions embedded in the discourse of the unethical conduct of the nurse and the discursive practices surrounding the discourse, frame understanding about nurses’ unethical conduct.

There are three parts to this study each of which uses critical discourse analysis along with other forms of analysis appropriate to the data being analysed in each part.
Part 1 draws upon Foucault’s ideas of genealogy and uses critical discourse analysis to uncover and examine the historical, political and social conditions which enabled the emergence of the unethical nurse. This is done by examining the context of the development of professional codes in nursing.

Part 2 draws upon Foucault’s ideas of disciplinary power to analyse the way in which surveillance and normalising judgements have been exercised in and around the Tribunal inquiries to construct the unethical conduct of the nurse through narrative.

Part 3 draws upon Foucault’s ideas of ethics to explore the relationship between the way in which the nurse is positioned in the Code of Ethics and the way in which the nurse is positioned by the Nurses Tribunal.

The central tenet to my argument is that Tribunal findings of unethical conduct are a new way of speaking about nurses. I argue that this new way of speaking has created both the object ‘unethical conduct’ and subject ‘the unethical nurse’, and has arisen out of the discourse of professionalisation as a means of controlling the practice of nurses; enhancing the power of the profession, and reinforcing the status of nurses as ethical subjects. This is achieved through the exercise of disciplinary power, which is operationalised in Tribunal inquiries by singling out and disciplining those nurses who are not acting as ethical subjects. Consistent with Foucault’s interest in examining the productive effects of disciplinary power as opposed to sovereign power and his approach to examining the multiple components which constitute problems rather than attempting to solve problems, my intention is to offer a critical analysis of the way in which the unethical conduct of the nurse has been constructed in five Tribunal inquiries.

In keeping with the theoretical perspective of poststructuralism and Foucault’s ideas about discourse, the data collected for this study are viewed as texts. Texts are any form of representation of a social construct (Wetherell, Taylor, & Yates, 2001, pp. 1-3). The textual material which are analysed for this study are considered to represent social constructs in that they constitute and reflect social values, norms and ideologies. In this respect texts are thought of “as part of a complex and constantly reflexive relationship” (Lupton, 1994a, p. 26). All data used in this study are situated
in a social, historical and political backdrop of shared meanings. My understanding therefore is that the data does not exist independent of, or in isolation to, the often complex and contradictory social worlds which constitute this backdrop, rather the data is constructed from and within this backdrop (Parker, 1999).

In this study, a critical and qualitative approach to data analysis is required in order to understand the complexity and multiplicity of meaning located in the discourse. According to Parker (1999, p. 2), fixed or set methods that exist in forms of quantitative analysis would restrict understandings of discourses and discursive practices. This thinking is also in line with Foucault’s ideas that there is no one causal factor or theory by which social constructs can be explained. The intent in this thesis is to develop an understanding of how meaning is attributed to the construct of the unethical conduct of the nurse. Therefore a qualitative approach to examine the social practices in which the discourse is located will be undertaken to uncover how meaning is represented, reinforced and constructed.

It is acknowledged that Foucault rejected any attempt to explain social constructs as arising from universal foundations (Foucault, 1990c, p. 22; Gutting, 1994, pp. 2-3). In line with this thinking he also rejected any attempt to label his work as theory. There are nevertheless, commonalities and synergies between his ideas and those of postmodernism and poststructuralism which have provided a way of conceptualising a framework for analysis in this study. In the following discussion I will provide an overview of poststructural and postmodern theory and identify the commonalities with Foucault’s work. In order to bring a critical edge to these ideas I will also consider and discuss some of the common criticisms which have been levelled at the work of Foucault and at poststructuralism.

**Poststructuralism and postmodernism**

The theoretical approaches of poststructuralism and postmodernism are often talked about interchangeably and indeed it is difficult to find literature which adequately distinguishes between them (Winch, 2001, p. 14). For this reason before moving on
to a discussion of poststructuralism, a discussion of postmodernism and its relationship to poststructuralism is warranted.

Postmodernism is a theoretical perspective in which the modernist assumptions, in particular the use of grand theories or metanarratives are rejected (Cheek, 2000; Rolfe, 2001). Modernity is considered to be the period between the mid 15\textsuperscript{th} to mid 20\textsuperscript{th} century, and modernism is thought to be a stage of modernity approximating with the mid 19\textsuperscript{th} to mid 20\textsuperscript{th} century. Modernism is founded on philosophical beliefs which arise out of the Enlightenment project, where science and rationality dominated thinking about human progress (Rolfe, 2001). The goal of this period according to Winch, Henderson & Creedy (2010), was to replace the earlier church dominated thinking: which was essentially founded on superstition and tradition, with that based on a scientific rationale. This mode of thinking lead to a belief in knowledge as “value-neutral” and people as free, rational, autonomous agents. (Winch, Henderson & Creedy, 2010, p. 98). Foucault critiqued these modernist assumptions. He argued that the Enlightenment was a period of intense domination and control of humans through the processes of rationalisation and as such rationality was a source of political power (Best, 1994, pp. 26 -29).

Lyotard (1984, p. xxiv) defines postmodernism as “incredulity to metanarratives”. From a modernist perspective metanarratives are a source of rationality, they are stories which are used to describe, explain and justify social constructs. Metanarratives do not require any external legitimation because according to Rolfe “they are true precisely because they claim to be true” (2001, p. 40). In modernist thinking not all metanarratives have equal authority. For instance in the Enlightenment period, some such as science had much more authority than others such as religion (Rolfe, 2001) and thus were more significant sources of power and control.

By contrast, the social world viewed through a postmodern lens is made up of multiple perspectives for example gender, race and class. Therefore it logically follows that from a postmodern perspective there can be no one structural principle or metanarrative, which can be used to explain the disparate array of social phenomena that occurs in the social world (Agger, 1991). In this respect postmodernism is both “antireductionist and pluralist” (Agger, 1991, p. 116). The
way in which people differentially experience the world is based on the multiple perspectives of the discourses which frame them (Agger, 1991). “Thus, like poststructuralism, postmodernism rejects the project of a universal social science, falling back on the particular modes of knowledge defined by the multiplicity of people’s subject positions” (Agger, 1991, p. 117). From this perspective it can be seen that postmodernism is synergistic with Foucault’s ideas. Indeed according to Best (1994, pp. 27-28) postmodernist ideas can be identified in all aspects of Foucault’s work. However, he cautions against describing Foucault as a postmodernist. Rather, he argues that Foucault’s work is informed by postmodern positions.

From a modernist perspective, text has a single meaning; whereas from a postmodern perspective there are many valid interpretations of text (Rolfe, 2001). In light of this it can be understood that in postmodernism, reality is considered to be a plural and partial concept. Reality can be viewed from multiple positions and it is recognised that any representation of reality in the form of explanation, description or exploration can only be partial, in that it represents only one approach to meaning (Cheek, 2000). Postmodern approaches challenge the “view that it is possible to represent reality, speak for others, make truth claims and attain universal understandings” (Cheek, 2000, p. 5). This provides a direct challenge to the modernist perspective, central to which is the notion of a single, unified, rational truth (Cheek, 2000). Rather than just seeking to describe and understand an area of interest, postmodern approaches seek to explore the taken for granted assumptions and understandings which shape the construction of the area of interest, with a focus on whose views are represented and whose are marginalised or excluded and why (Cheek, 2000).

The term poststructuralism and its associated ideas had its genesis in France, where it represented the European avant garde in critical theory (Huyssen, 1990 pp. 258-267). Postmodernism on the other hand arose in America as a critical response to capitalism and its associated technologies (Huyssen, 1990; Kaplan, 1988, p. 4). Poststructuralism and postmodernism are often considered synonymous and thus in theoretical debate the terms are frequently used interchangeably (St. Pierre, 2000). This is because; according to Agger (1991), they have much in common in terms of
valuing “plurality, fragmentation and multi-vocality” (Cheek, 2000, p. 6), however poststructuralism differs from postmodernism in that its emphasis and focus is centered on texts and the way in which reality is represented in texts. Postmodernism tends to more broadly focus on analyses of history, society and culture (Cheek, 2000).

Poststructuralism, like postmodernism, posits that truth is historically and socially constructed and thereby challenges both logical empirical and interpretive representations of science. “What is challenged is the notion that truth, the subject and reality are separate and independent from the social conditions that made them possible.” (Heslop & Oates, 1995, p. 257). Both reject the notion that text as a representation of reality is independent of historical and cultural context (Agger, 1991). According to Agger “poststructuralism …is a theory of knowledge and language, whereas postmodernism…is a theory of society, culture and history” (1991, p. 112). Despite these differences between postmodernism and poststructuralism, both are nevertheless “effective as critiques of positivism…, interrogating taken-for-granted assumptions about the ways in which people write and read science” (Agger, 1991, p. 106 [emphasis in original]).

Poststructuralism arises from a number of theoretical positions, all of which challenge Enlightenment philosophy (Heslop, 1997). There are a wide range of theorists located in the poststructural domain including, Saussure, Benveniste, Marx, Althusser and Freud, and more recently Lacan, Derrida, and Foucault (Heslop, 1997; Weedon, 1997). The range of their theoretical positions is such that there can be no fixed meaning or theory of poststructuralism. Nevertheless, in all its forms there are some fundamental assumptions about language, meaning and subjectivity (Gavey, 1997; Weedon, 1997).

The central concern of poststructural analysis is language; because language is where social organisation and its’ consequences, and individual subjectivity, that is “our sense of ourselves” (Weedon, 1997, p. 21) is constructed. Language “constructs the individual’s subjectivity in ways which are socially specific” (Weedon, 1997, p. 21), it constitutes social reality rather than reflecting social reality as a given. Thus, by contrast to humanism where the subject is viewed as being rational, conscious and
unified, in poststructural theory as in Foucauldian thinking, subjectivity is not a fixed, rational, unified phenomenon; rather it is a site of conflict and disunity, which reflects its social construction by economic, social and political discursive practices (Weedon. 1997).

From a poststructural perspective the constitution of meaning is within language, not within the subject; there is no fixed or given meaning over time. This approach accords with Foucault’s view, that meaning is located with the object not the subject and that discourse operates on the subject through the object. Poststructural assumptions of language arise from the structural linguistics work of Ferdinand de Saussure, in which language was viewed as constituting social reality, as opposed to simply reflecting social reality (Weedon, 1997). However, within poststructuralism there are different schools of thought on the production of meaning which include the Foucauldian, psychoanalytic and deconstructionist schools. From a Foucauldian perspective the focus is on the social and historical construction of meaning, whereas in the psychoanalytic perspective the focus is on a fixed psycho-sexual order. From a deconstructionist perspective the focus is on the relationships between texts and the production of meaning. With regard to this thesis, neither the psychoanalytic nor the deconstructionist perspectives would allow the questions this study poses to be fully addressed because as Weedon (1997) argues they both fail to pay attention to social context or the power and knowledge relations of the discursive field within which texts are located.

According to Weedon (1997), the work of Michel Foucault is a most useful form of poststructural theory because of its focus on history, which is absent in many other poststructural perspectives. From a Foucauldian perspective, meaning arises from language and language arises out of discourses which are socially, politically and historically located. In this approach discourse and power are subjected to detailed historical analysis, which questions basic assumptions and from which political implications become apparent (Weedon, 1997). Poststructuralism viewed through a Foucauldian lens is a useful approach for the study undertaken in this thesis, because it can be used as a framework for understanding power and power relations and thus for identifying and understanding the possibilities for change.
In summary, a poststructural approach allows for examination of different discourses. It recognises plurality of meaning and that there is not a fixed order of things naturally or logically determined, thereby allowing the possibility of choice (Weedon, 1997). Foucault’s ideas can be understood within both postmodern and poststructural theory on the basis of his “criticisms of Enlightenment rationality, totalizing approaches to history and society, and humanistic theories about the subject” (Dickens & Fontana, 1994, p. 12).

This thesis like other analyses drawing on poststructural ideas aims to call into question representations of truth. The focus is on exposing the assumptions which underpin the notion of truth, through questioning why reality is represented the way it is and why this is accepted as normal. This approach questions what alternative ways there are of representing the same reality and why these alternatives are marginalised or suppressed (Cheek, 2000). The data in a poststructural approach to research are the textual representations of reality, be they, spoken, enacted or written, it is the reality they represent which is the focus of the research (Cheek, 2000). “Poststructural perspectives challenge the notion that language is a neutral, objective, value-free conveyer of aspects of reality. Rather, they expose and interrogate language itself as being both constituted by, and constitutive of, the social reality that it seeks to represent” (Cheek, 2000, p. 40).

Having provided a discussion of the way in which Foucault’s ideas and the theoretical concepts of poststructuralism have informed this study, the next section will discuss and answer some of the criticisms levelled at Foucauldian and poststructural ideas.

**Criticisms of Foucault and poststructuralism**

One of the major criticisms across all domains of theory has concerned women and their absence in theory development. Neither the ideas of Foucault nor those of poststructuralism are immune to this criticism. Feminist theory posits that androcentrism is the dominant construct in society (Gavey, 1997; Jagger, 1992;
Little, 1996; Scott, 1994). It is so pervasive that it shapes what is considered as truth and reality in society and tacitly serves to sustain and perpetuate power interests of men, through economic, cultural and social arrangements (Gavey, 1997). Little (1996) refers to androcentrism as a hidden bias that “has a disturbing cumulative effect on our understanding of ‘human’; over time, our substantive conception of what is normal for humans has come to be filled in by what is normal for men.” (Little, 1996, p. 4). Feminist criticisms of Foucault are focused on the androcentric nature of his work, which feminists believe is reflected in his failure to pay attention to gender (Ramazanoglu, 1993; Sawicki, 1994). However, Ramazanoglu (1993) defends Foucault, arguing that he offers an approach to understanding power relations and that he challenges feminism to question assumptions about women’s subordination. “The implications of his argument suggest that feminist political practices are based on a misunderstanding of the power relations that feminism aims to transform” (Ramazanoglu, 1993, p. 3). This position is also supported by Weedon (1997), who argues that theory can be useful to feminist concerns, irrespective of the position or lack thereof, of women in the historical development of theory. She proposes that for theory to be useful to feminists, it needs to be able to address women’s experiences and the power relationships which structure those experiences so as to identify sites for resistance and change. According to Weedon (1997) a feminist poststructural appropriation of Foucauldian thought provides the theoretical tools for understanding power relations, their effect on subjectivity and the possibilities for change.

Further feminist concerns with Foucault arise from the humanist stance adopted by liberal feminists. In liberal feminism, humanism is reflected in the belief of a universal and essential true nature to women that is different to that of men (Weedon, 1997). This belief serves to universalise what it is to be a woman and denies the different ways in which women experience and make meaning of their lives. These humanist assumptions are reproduced in the “privileging of, women’s experience” (Gavey, 1997, p. 51), such that the experiences of women are given the status of truth. “The power of experience in the constitution of the individual as a social agent comes from the dominant assumption in our society that experience gives access to truth. It is assumed that we come to know the world through experience” (Weedon, 1997, p. 76). However, this approach fails to account for the influence of discourse
in constituting the experiences of women. “There is little question of experience being open to contradictory interpretations guaranteed by social interests rather than by objective truth.” (Weedon, 1997, p. 76). These views reflect those of Foucault; who argued for abandoning the subject in favour of looking at the social and historical events which constitute the discourse in which the subject is placed. One of the problems arising for feminist theory which emphasises liberal feminist constructs of women and men as having an essential nature; is that this approach serves to contribute to the status quo of women and men in society (Gavey, 1997). By contrast, a Foucauldian approach challenges the assumptions underpinning the constructs of women and men.

Another criticism which is widely levelled at Foucault and poststructuralism is that of relativism, according to this criticism, poststructuralism - which holds that reality is a partial construct, in effect denies any essential truth or single claim to truth. Indeed in a poststructural approach all truths are relative; that is, all truths are positioned and constructed and therefore poststructuralists view the reality in question from a particular position and as such are only able to capture partial realities and understandings (Cheek, 2000; Cheek & Porter, 1997; Walker, 2010). Accordingly, postructuralism cannot hope to capture the true ‘essence’ or nature of reality and therefore it denies people the capacity to discern between competing truth claims, which in effect can cause people to be disenfranchised (Walker, 2010, p 74). However, from a poststructural perspective all theoretical methodologies provide a partial view of reality because they are constructed and in turn construct understandings about knowledge and truth claims (Cheek, 2000, p. 63). The importance therefore of a poststructural perspective is the recognition that all knowledge is partial, relative and is generated by power based discourses, and it is the effect of these discourses be they productive or repressive that poststructuralism enables us to uncover (Cheek, 1997 as cited in Cheek & Porter, 1997 p 114).

Critics of poststructuralism working within a critical social framework also argue that power as a relational notion lacks emancipatory intent (Heslop, 1997). Francis (2000) argues that the emancipatory concerns of feminism and nursing to empower individuals and to improve their lives are at odds with poststructuralism. According to this point of view, poststructuralism dismisses emancipatory concerns as arising
from “modernist truth narratives” (Francis, 2000, p. 23). Poststructuralism therefore essentially undermines the humanist position of emancipatory intent. Considered from this perspective, the usefulness of poststructuralism is limited to providing a critique of discursive practices; it is unable to construct new discourses and therefore is unable to meet the emancipatory concerns of both feminism and nursing (Francis, 2000). However, Weedon (1997) argues that the agenda of poststructuralism in feminist hands is to critique patriarchal power relations so that sites of resistance and change can be identified which will enable the development of strategies for change.

In critical social theory the subject is considered as an autonomous, rational being, whereas in poststructuralism the individual’s subjectivity is constructed in socially specific ways through language (Heslop, 1997). However, unlike poststructural conceptions of power as relational, in critical social theory power is understood in terms of domination and subordination (Heslop, 1997). Porter (1997, as cited in Cheek & Porter, 1997) points out that challenging the power of experts has long been part of the project of the modernist perspective. Whilst there are differences amongst the theoretical positions which arise from the modernist perspective, one of the important commonalities is a “belief in at least the possibility of a ‘unified subject’ and, on the basis of this, they adhere to social projects that they assert would improve the autonomy and integrity of that subject” (Porter, 1997, as cited in Cheek & Porter, 1997, p. 111). Foucauldian and poststructural perspectives reject the notion of the subjects’ authenticity, because authenticity would require an essence of the subject beyond discourse. According to Porter (1997, as cited in Cheek & Porter, 1997) the consequences of rejecting the authenticity of the subject leads to a denial of external reality. Knowledge is considered to be socially produced, never to be regarded as certain and therefore denial of external reality means there can be no rational criteria with which to judge between forms of knowledge. The problem with this position according to Porter (1997, as cited in Cheek & Porter, 1997) is that while a Foucauldian analysis may be useful for identifying where things have gone wrong, the denial of external reality means there can be no basis for moving forward.

From a Foucauldian perspective deciding what are rational criteria upon which to judge what is truth, ignores the influence of social and historical events and their impact on shaping what is considered to be rational criteria and what is considered to
be knowledge. Contrary to Porter’s position, a Foucauldian perspective holds that a critique of the construction of subjectivity allows for forms of resistance. It is this analysis and the resistance that stems from it, that makes new knowledge possible and thereby provides a basis for moving forward. Fundamentally, from both a Foucauldian and poststructural approach to knowledge, there is no fixed existential knowledge from which rationality can be derived, knowledge is always a constructed and contested domain.

A Foucauldian poststructuralist approach to analysis offers a way of understanding how power operates and the effects of power. As power is everywhere and operates at all levels of society in a capillary network of power relations, overcoming power is not necessarily progress (Cheek, 1997 as cited in Cheek & Porter, 1997). The usefulness of a poststructural approach to nursing is neatly conceptualised by Cheek (1997, as cited in Cheek & Porter, 1997):

The project of possibility for nursing lies in Foucault’s alternate conceptualization of power. Such a conceptualization involves nurses working ‘with’ power rather than ‘against’ it, recognizing that they themselves are part of a present in which the task is not to overcome powerful others but to use understandings of the operations and effects of power to further nursing. (p. 114).

Having identified how Foucauldian and poststructural ideas will inform this study and having considered and responded to criticisms about Foucault and poststructuralism; the subsequent discussion will focus on the study design, data sources, the criteria and selection of Tribunal inquiry transcripts and documentary data, methods of data analysis and ethical considerations.

**Study design**

This is a qualitative study informed by Foucauldian ideas and poststructural theory. The study uses an exploratory and critical discourse analysis research design to
examine the discourse of the unethical conduct of the nurse. An exploratory study approach is required because a review of the literature has revealed that little is known in Australia about nurses’ experiences of unethical conduct and how the Tribunal shapes responses to such issues. Exploratory studies are used when a topic has not been researched before and there is minimal researcher control over the data (Brink & Woods, 1989). In this study there has been no researcher control over the production of the data as all selected data was produced for other purposes.

The study analyses the discourse of the unethical conduct of the nurse, using critical discourse analysis as the primary methodological tool. According to Jackson, Clare & Mannix (2003) a study fits within a critical paradigm if it challenges the status quo. Foucault’s approach to understanding relations of power through questioning the status quo by examining the whole discursive context as opposed to text in isolation fits within the critical paradigm (McHoul & Grace, 1993). In this study the status quo is the unquestioned assumptions existing around and of the discourse of the unethical conduct of the nurse. A major function of a poststructural approach is to expose and question taken for granted assumptions about reality (Cheek, 2000). Critical discourse analysis challenges the status quo because it “seeks to display the reproduction of ideology, and the more subtle forms of control, persuasion, and manipulation in the meanings inherent in the discourse” (Lupton, 1994b, p. 54). This study uses a poststructural framework to analyse the prevailing discourses which are revealed through the various forms of textual representation of reality (Cheek, 2000) and the discursive practices which sustain them, in order to trace how the unethical conduct of the nurse has been constructed and whose interests have been represented by this construction (Carabine, 2001; Weedon, 1997).

**Data sources**

In keeping with the theoretical positions of poststructuralism and the methodology of critical discourse analysis, the selection of data for this study was based on the relevance of the data to the questions posed by the study, which are as follows:
1. What were the conditions of possibility which enabled the unethical nurse to come into being?

2. How are relations of power operationalised within and around the Tribunal to construct the nurse as an unethical subject?

3. How do these relations of power have effect?

In response to these questions the following data was collected for analysis:

- Complete transcripts of five inquiries conducted by the New South Wales Nurses Tribunal were collected from the period 1998 to 2003. In each inquiry, findings were made against the registered nurse of unethical conduct. I was interested in collecting Tribunal inquiry data from the inception and early days of the Tribunal in order to analyse historically how it became possible to speak about the unethical nurse.

- The Code of Ethics and the Code of Professional Conduct for Nurses in Australia and associated reports, legislation, policy documents, and literature relating to the history and development of professional codes and regulatory and disciplinary practices in nursing. (For a complete list of these documents see Appendix Two). These documents were selected because they provided a broad representation of the historical, political and social conditions from which the discourse arose.

This contextual approach to data collection was designed to allow for the whole discursive formation to be analysed through an examination of the relationships of micro events and macro structures and is consistent with critical discourse analysis. An important feature of critical discourse analysis is that sample size is of less significance in a study of textual material than the elements of the text itself (Holloway & Wheeler 1996; Lupton 1994a; Patton, 1998).

Elements such as style, structure and persuasive features and how these reflect the broader social, historical and political context are the critical features of the analysis (Lupton, 1994a). An important feature of a poststructural approach is that reality is regarded as a plural concept which is constituted by multiple voices. Accepting this poststructural theoretical proposition, “it follows that no single representation of
health care or nursing practice can hope to capture the “truth” about that care or practice.” (Cheek, 2000, p. 20). Thus the wide choice of the texts selected as data and which were analysed for this study reflect these theoretical positions.

I had no previous involvement with the data which was collected and analysed for this study. This method of data collection is referred to as “unobtrusive methods of research” (Lupton, 2004, p. 486). According to Lupton, (2004) such methods of data collection have the advantages of reducing any potential for bias, are generally easier to obtain and involve minimal expenditure. In this study the potential for bias was reduced because all the data had been produced for other purposes (Lupton, 2004). The data was readily accessible and the transcripts of Tribunal inquiries were available on the public record as were policy documents relating to the codes in nursing and the regulatory and disciplinary frameworks. Legislation, reports and literature about; disciplinary practices, and the use of codes of ethics and regulation in nursing, were obtained through nurse regulatory authorities, institutional libraries and the internet.

The process and criteria for the selection of Tribunal inquiry transcripts

In 2004, I sought and received the permission of the Deputy Registrar for the New South Wales Nurses Registration Board, Mr Ron Lazucki to access Tribunal transcripts. One of the functions of the Board is to record and transcribe all Tribunal proceedings. In most Tribunal inquiries conducted up to 2004, typed verbatim transcripts of the recording of each day of an inquiry were made. At the completion of an inquiry the Tribunal delivered its findings, which were reported under the title ‘Reasons for Decisions’.

The process and selection of Tribunal inquiry transcripts was influenced by the following factors:
• The extensive nature of each inquiry and the amount of reading and analysis required to undertake a discourse analysis meant that the number of transcripts selected for analysis needed to be less rather than more. Ultimately five Tribunal inquiry transcripts were selected for analysis. The duration of each of the five inquiries varied from one day to three days and resulted in a total of 740 pages of transcript for analysis.

• Data collection took place in 2004. Up to August 2004 the Tribunal had conducted inquiries and delivered findings in a total of 96 inquiries.

• Significant amendments to the Nurses Act 1991 were enacted from August 2004 after a major review of the Act had been conducted. These amendments included a change of name to that of the Nurses and Midwives Act 1991. In view of the likelihood that the amendments would impact upon subsequent Tribunal inquiries, I ceased data collection at this point.

• I travelled into the Board offices on a number of occasions where I was assisted to locate transcripts by the Tribunal Officer Mr David McMahon.

• In order to determine which Tribunal inquiries were relevant to the questions posed by this study, I initially read each of the 96 transcripts of the Reasons for Decisions and then applied the following criteria to sample selection:

  o Inquiries which were conducted and findings handed down between the period from the commencement of the Tribunal in 1992 until 1st August 2004.

  o Registered nurses whose names had been removed from the Register after having been found guilty of professional misconduct and where there was a finding of unethical conduct.

  o All inquiries with a suppression order or non-publication order were excluded.

  o Inquiries were excluded where transcripts of the inquiry and reasons for decision were incomplete or not accessible.

  o Inquiries in which I had been involved as a Tribunal member were excluded.

  o Inquiries conducted solely into complaints against an enrolled nurse, midwife or psychiatric nurse, were excluded.
One of the problems I faced with data collection of Tribunal transcripts was that they were only available in hard copy and as a result many of the transcripts were either missing, or were incomplete, which excluded them from the study. This was because critical discourse analysis requires the whole of the discourse to be analysed and so it was important to have access to complete transcripts.

From 1992 when the Tribunal commenced inquiries into complaints into unsatisfactory professional conduct and or professional misconduct up until 1 August 2004, the Tribunal had delivered findings in a total of 96 cases of complaints against 98 accredited nurses of which 70 involved registered nurses. The remainder involved enrolled nurses (14), psychiatric nurses (7), midwives (3) and accreditation unknown (3). The decision to exclude inquiries solely involving enrolled nurses, midwives or psychiatric nurses was made on the basis that the majority of inquiries involved registered nurses, and it was possible that findings against registered nurses might involve different discursive approaches to that of other groups of accredited nurses. Ultimately, five inquiries met the sampling criteria, the findings of these inquiries were handed down between 1998 and 2003.

In keeping with Foucault’s interest into an historical investigation of the context which shaped discourse and ultimately the subject, I particularly wanted to examine the conditions which allowed the unethical conduct of the nurse to be spoken about. I was therefore interested in examining the historical context in which early Tribunal inquiries took place. Hence, it was opportune to cease my data collection in 2004, not only because it limited the number of inquiry transcripts to be analysed which was important given the size of each transcript and the level of detailed analysis required for each transcript, but also because this period provided a specific historical, political and social context within which to locate the analysis.

**The process and criteria for selection of documents**

Locating and analysing discourse in context is a key feature of Foucault’s genealogical approach to discourse analysis. His methodological ideas of genealogy
guided my approach to documentary data collection. In this respect I selected texts which represented the historical framework in which it became possible to speak about the discourse. I propose therefore, that the documents and events which constitute the regulatory framework for nurses in Australia and which I argue arose from the discursive landscape of the professionalisation of nursing comprise the historical framework.

Essentially the criteria I applied to the selection of documents as data for analysis was deliberately loose in order to maximise the representation of the historical context. I sought documents which were related to nursing and in some way to the regulation of nursing. This included all the codes of ethics and the codes of professional conduct for nurses in Australia and associated reports, legislation, policy documents, and literature relating to the history and development of professional codes and regulatory and disciplinary practices in nursing. The push for the professionalisation of nursing in Australia was in historical terms a relatively recent event, which primarily occurred in the 1980s and 1990s, so much of the documentation was selected from this period, although I also collected more recent documents which were relevant to the study.

Analysis of these documents was essential in this study because they constituted the historical, political and social backdrop which enabled the unethical conduct of the nurse to be spoken about. In keeping with a Foucauldian approach to analysis these documents were analysed as groups of statements which constitute relations of power. It was how these documents took effect which was the principal focus of the analysis.

**Methods of data analysis**

According to Lupton, discourse analysis can be identified as a poststructural activity because the goal is to identify “cultural hegemony and the manner in which it is reproduced” (Lupton, 1992, p. 149). In this study uncovering cultural hegemony i.e., the dominant influences in the discourse of the unethical conduct of the nurse and the
way in which this is reproduced through regulatory and disciplinary practices, will provide new ways of conceptualising and understanding these practices. Adopting a poststructural approach is intended to disrupt and unsettle the status quo by calling into question the assumptions about the unethical conduct of the nurse. Discourse analysis will provide “…a way of understanding how notions and experiences of the social and material worlds are constructed and reproduced in textual form.” (Lupton, 2004). The aim of discourse analysis is to identify “…patterns of talk” (Taylor, 2001, p. 15), within the text. The task according to Cheek, “…is not to look for real and authentic representations of nursing, but rather to look for the speaking and representation that is done about nursing.” (1995), p. 239 [emphasis in original]).

In keeping with critical discourse analysis, texts collected as data for this study are considered to be representations of social constructs which have arisen out of human values and understandings. This type of analysis of textual material provides a means of exploring “…the ways that humans impart meaning to the social and physical world and interact with each other, without directly asking them about these issues.” (Lupton, 2004, p. 486). In this study, the analysis of the various forms of text have revealed how the notions and experiences of unethical conduct in nursing are given meaning through their construction and reproduction in text which in turn constitute the discourse of the unethical conduct of the nurse. According to Van Dijk (2008, p. 821), locating texts within their context and analysing the whole discursive formation is essential to critical discourse analysis and it is this approach to textual analysis which has been adopted in this study.

Central to this study is developing an understanding of the meanings underlying the assumptions, which underpin the way in which the unethical conduct of nurses is constructed. Thus the emphasis in discourse analysis is on the features and the influences rather than the message of the discourse (Lupton, 1992). The steps involved in an analysis of discourse rely on the interpretation the researcher brings to the “underlying sociocultural meanings of the features of the text” (Lupton, 2004, p. 489 [emphasis in original]). This tends to make the steps involved in discourse analysis somewhat more difficult to identify than those more commonly used methods of qualitative data analysis, such as counting the number of times certain features appear in the text or constructing content categories (Lupton, 2004). By
contrast, in discourse analysis the process is an iterative one, where the researcher in looking for patterns must return to and review the data many times. Patterns in language use are identified and then used to refer back to or to build upon the assumptions being made about the “nature of language, interaction and society and the interrelationships between them” (Taylor, 2001, p. 39). In keeping with the iterative process of discourse analysis, the data obtained in this study has been carefully and thoroughly read and reread on multiple occasions.

In developing the approach to a Foucauldian and poststructural analysis used in this thesis, I drew upon the work of Carabine (2001) and Lupton (2004). Carabine (2001) undertook a genealogical discourse analysis in a study about unmarried motherhood in the period 1830 – 1990. Her guide to the steps involved in doing a Foucauldian genealogical discourse analysis is reproduced here in a modified form:

- Know the data by extensive reading and re-reading;
- Identify themes, categories and objects of the discourse;
- Look for evidence of an inter-relationship between discourses;
- Identify the discursive strategies and techniques that are employed;
- Look for absences and silences;
- Look for resistances and counter-discourses;
- Identify the effects of the discourse;
- Contextualise the material in the power/knowledge networks
- Be aware of the limitations of the research (Carabine, 2001, p. 281).

Lupton (2004) adopted a similar approach to that of Carabine (2001). According to Lupton the following questions should be addressed when analysing data using discourse analysis:

- Why are certain words, phrases and images used to describe and portray the events, individuals, issues or social groups involved?;
- What is the deeper or ‘hidden’ sociocultural meaning and assumptions conveyed by these words, phrases and images?;
- Whose interests are served by these representations?;
- What sorts of moral judgements are expressed?
• How are social groups portrayed, and what implication does this have for their role in society? (Lupton, 2004, p. 489).

The analysis of data in this study combined the approaches recommended by Carabine (2001) and Lupton (2004). I am interested in the ideas of discourse as expressed by Carabine and which are consistent with the ideas of Foucault. These are of “discourse as consisting of groups of related statements which cohere in some way to produce both meanings and effects in the real world, i.e. the idea of discourse as having force, as being productive.” (Carabine, 2001, p. 268). In keeping with critical discourse analysis, this analysis aims to go beyond the obvious meanings of the texts to the subtextual meanings. According to Lupton (1994b), subtextual themes are not immediately obvious, as they represent the ideology which underpins the meaning of the text. Analysis of the subtextual themes has been undertaken by examining not only the choice of words used in each text but importantly how the narratives construct images, which elements or events are focused upon in the text and the relationships of the text to the micro and macro events which constitute the context.

Foucauldian methods provide a means of identifying and analysing the contextual nature of relations of power. In this study it is not the experience or conduct of the nurse that is analysed. Rather, the analysis focuses on how that conduct is spoken about in Tribunal inquiry transcripts and the relationship this has to the broader context. This involves considering the historical, political and social backdrop of the development of the Code of Ethics for Nurses in Australia and the regulatory framework for nursing in NSW. What is important in this analysis is not so much who said what, but rather how the speaker is positioned in relation to the context, the meaning conveyed by what they are saying and the meaning conveyed by what is not said (Lupton, 1994a). The process of reading both the documentary data and the transcripts in depth and undertaking multiple re-readings whilst asking the questions appropriated from Carabine (2001) and Lupton (2004) allowed me to identify discourses and discursive practices and to analyse these as an exercise of relations of power through a Foucauldian lens.
As set out in the beginning of this chapter, there are three parts to this study in which analysis of the relations of power was undertaken to uncover how it became possible to speak about the unethical conduct of the nurse. In each part, critical discourse analysis was undertaken, using Foucauldian ideas as the lens through which to view the textual data.

**Ethical considerations**

There are no major ethical considerations arising from this study. All data collected for this study had previously been produced for other purposes. The research is based on a discourse analysis of already produced documents and literature; as such there is no participant involvement. At the time of data collection ethics approval for this stage of the project was not required because the *University of Western Sydney Ethics Protocol Form for Research Projects Involving Human Participants* did not require ethics approval for data available in the public domain. Transcripts of Tribunal inquiries are available on the public record for any member of the public to access.

I sought the assistance of the Board to access and locate hard copies of transcripts. Permission to access the Tribunal inquiry transcripts was sought in July 2004 and subsequently granted by the Deputy Registrar, Mr Ron Luzucki. Transcripts were obtained with the assistance of the Tribunal Officer, Mr David McMahon.

I avoided using any material from the transcripts which might allow for the people or places involved to be identified. Whilst this was not strictly necessary as these transcripts are available on the public record, I nevertheless wanted to focus my analysis on the way the nurse was spoken about; I therefore considered that the names and places of those involved were irrelevant to the study questions. In keeping with the method of unobtrusive data collection, I have chosen not to include proceedings in which I have been involved, because of the possibility that my analysis would be influenced by my previous involvement.
Conclusion

This chapter has provided discussion about the methodology used in this thesis. What is apparent about the conceptual framework and the methodology is that there is no one distinct way of approaching analysis in this study. This is consistent with the ideas of Foucault that there is no one way of viewing reality. Understanding that what constitutes knowledge and truth is subject to different perspectives has provided a way of developing the methodological approach used in this study.

The next chapter addresses the first of the three arms of analysis adopted in this study. In this chapter Foucault’s ideas of genealogy and critical discourse analysis will be used to examine documentary data to provide insight into the historical, political and social conditions within which the discourse of the unethical conduct of the nurse was located.
Chapter Four

“A working framework for nursing practice”: a critical analysis of the historical context which created the conditions of possibility for the discourse of the unethical conduct of the nurse

Introduction

Foucault stated that the task of genealogy “is to expose a body totally imprinted by history” (Foucault, 1984a, p. 83). Genealogy as an analytic method provides a way of exposing the discontinuous and historically relative nature of the discursive context related to this study. In this chapter a genealogic approach to analysis uncovers the professional self-interest which shapes the subject – the unethical nurse. The purpose of this chapter is to examine the historical context so as to reveal the socio-political conditions within which the discourse of the unethical conduct of the nurse evolved and is located. Taking this approach to analysis can be considered a critical approach as it acknowledges that the Tribunal and the discourse of the unethical conduct of the nurse are part of a larger picture and do not exist in isolation. In order then to understand these socio-political practices, an exploration and examination of the discursive context from which they arose and in which they are currently situated is necessary.

This chapter sets out to do this by examining all of the documents which are historically and contemporaneously relevant to enabling the construction of the unethical conduct of the nurse by the processes and practices of the Tribunal. It concludes by examining how the intersection of socio-political discourses link particular documents directly to the operation of the Tribunal and in doing so reveals the imprint of the context on these operations of disciplinary relations of power.
The documents which have been analysed in this chapter are listed in Appendix Two. Initially, because of my interest in examining the relationship of the *Code of Ethics* to Tribunal findings of unethical conduct, the documents were selected on the basis that they related to history of the *Code of Ethics*. Having read these documents it soon became apparent that the *Code of Ethics* had arisen out of a broader political context to do with the professionalisation of nursing. So in order to better understand the context I extended my selection of documents to include those related to the history of the current regulatory framework for nursing in Australia.

I begin by setting the context for discussion in this chapter with a brief Foucauldian analysis of the regulatory framework for nursing. I then undertake to examine the discursive context for the development of the *Code of Ethics* and the *Code of Professional Conduct*. Following this, I trace the development and purpose of the Codes; and then critically examine how they came to be positioned as the standards of the profession, through an analysis of the content of the *Code of Ethics* and through an examination of its relationship to the *Code of Professional Conduct*. I then undertake to critically examine the use of the *Code of Ethics* through an analysis of the literature, and conclude the chapter by exploring the relationship of the Codes to the Tribunal.

### A Foucauldian analysis of the regulatory framework for nursing

The regulatory context from which the discourse of unethical conduct arose consists of professional codes along with a range of standards, policies and legislation, all of which were linked to ensure the professional status of nurses through an enhanced regulation of nurses and nursing practice. From a Foucauldian perspective the context is a disciplinary technology of surveillance exercised in the interests of the discourse of professionalisation which operates at two levels. One is at a panoptic level, where nurses regulate their own practice through self-governance based on new nursing knowledge represented through the *Code of Ethics* and *Code of Professional Conduct*; and the other at a disciplinary level, where legislation in the form of the *Nurses & Midwives Act 1991 (NSW)* and the *Health Care Complaints Act*
1993, enabled the profession to exercise normalising judgements against nurses who had strayed from these new nursing norms.

From a Foucauldian perspective, the development of a regulatory framework for nursing had two main effects. It facilitated a new type of disciplinary mechanism in the form of the Nurses Tribunal in NSW which, through the application of sanctions, provided an avenue for the exercise of power by the Nurses and Midwives Board of NSW\(^8\) to enforce the regulatory framework. Secondly as a means of objectifying the subject; in this case the nurse, through organising, sorting and delineating a role for nurses based on the ideology of professionalism.

I argue that the development of the regulatory framework was driven by the ideology of professionalism, and provided a new and independent body of knowledge, which was widely believed by nurses to be needed for nursing to become self–regulating and achieve professional status. The newly developed regulatory framework operates as a form of surveillance and examination, a technique to promote the visibility of the individual nurse. Such a technique operates as a mechanism of power by subjecting the individual to continual observation such that they become the “desired object of the discipline” (Winch, 2001, p.100). According to Foucault (1995), regular observation (as would be the case for nurses whose practice is embedded within the regulatory framework) is a form of “almost perpetual examination” (Foucault, 1995, p.186).

The development of the regulatory framework with its focus on professionalisation, provided the means for objectification of the conduct of the nurse, in effect placing the nurse in a field of surveillance - of examination of their conduct, where each nurse could be held accountable for their conduct. For Foucault “the examination that places individuals in a field of surveillance also situates them in a network of

\(^8\) The Nurses and Midwives Board (NMB) was formally known as the Nurses Registration Board (NRB) of NSW. The name change was the result of a recommendation made in the Report of the Review of the Nurses Act 1991 undertaken by NSW Department of Health and published in October 2001. This recommendation arose in response to arguments from both midwives and nurses to acknowledge the position of midwifery by including it in the title of the Act (NSW Department of Health, 2001, p. 52). The Act is now the Nurses and Midwives Act 1991.
writing; it engages them in a whole mass of documents that capture and fix them” (Foucault, 1995, p. 189).

In nursing, the Codes provide a means of examination of the conduct of the nurse, as they not only prescribe or set the standards via the individual attributes required of the nurse, they also act as a form of self–examination for the nurse. Where the nurse fails to act within the prescribed norms, the Codes provide the grounds for more formal examination of the nurse’s conduct through such disciplinary mechanisms as the Tribunal. In this way disciplinary power is exercised at two levels, initially at a micro level it is invisible and diffuse, exercised through and by the individual nurse, to bring about homogenisation with the discipline. Where a nurse fails in this form of self–examination, disciplinary power is then exercised at a macro level, through visible and directly targeted means such as the Tribunal, as a way of ensuring disciplinary cohesion and thereby protecting the regulatory interests of the profession. According to Foucault, “the individual is no doubt the fictitious atom of an ‘ideological’ representation of society; but he [sic] is also a reality fabricated by this specific technology of power that I have called ‘discipline’ ” (Foucault, 1995, p. 194).

The particular disciplinary attributes required of a nurse are detailed in the documents which make up the regulatory framework. Part of this construction of the professional nurse focuses on the nurse’s accountability to the public, patients and the profession through an ethics discourse in the form of the Code of Ethics. In this respect it can be seen that the power of the discourse of professionalisation arises out of its intersection with other significant discourses, in particular the discourse of ethics.

The regulatory framework exists as a disciplinary mechanism which has produced a discursive space for the construction of the professional nurse. The framework can be seen as a part of the web of relations of power which act to connect the macro expectations of the profession to the micro level of the individual actions of the nurse. The Codes and values present in the regulatory framework, in particular those related to ethical conduct and the ways and means by which they attempt to govern and shape individual nursing practice will be examined in the ensuing discussion.
In the following section, analysis is focused on the discursive context which enabled the development of the Codes.

**The historical, political and social context of the development of the Codes**

Despite the need for a code of ethics in nursing first being identified in the early twentieth century (Fry & Johnstone, 2002), codes are a fairly recent development in nursing. The earliest codes were developed in Liberia in 1949; the United States in 1950 (Sawyer, 1989), and by the International Council of Nurses (ICN) in 1953 (Fry & Johnstone, 2002). In Australia it was not until 1993 that the first code of ethics was published. Prior to this, Australia by virtue of being a member of the ICN adopted the *ICN Code of Ethics in 1973* (Holmes & Williams, 2007).

In Australia the decision was taken to develop an Australian code of ethics on the basis of findings arising out of a project to develop nursing competencies, undertaken as part of the *1990 Australian Nurse Regulatory Authorities Conference (ANRAC)*[^9]. The project established that Australian nurses did not have a clear focus on ethical behaviour. It recommended that there should be two codes; a code of ethics and a code of professional conduct (ANCI, 2000; Woodruff, 1991).

The discursive context in which the development of the Codes was located was overtly political. The literature clearly reveals that nurses were actively seeking to challenge the relations of power in which nursing was situated and this was manifest by an anxiety amongst nurses about the professional status of nursing. Indeed even as early as the post-war years, professionalisation was the overriding concern of Australian nurses (Holmes & Williams, 2007).

[^9]: ANRAC later became the Australian Nursing Council Incorporated or ANCI and then subsequently the Australian Nursing Council or ANC, and is now known as the Australian Nursing and Midwifery Council or ANMC.
A clear reflection of this level of anxiety is revealed in an ANRAC 1990 workshop discussion paper related to the establishment of the ANC;

claims were made that other organizations and bodies would intervene if the state and territory nurse registering authorities did not take steps at a national level to co-ordinate policy formulation and standards development, and implement certain policies and procedures related to nursing regulation (Percival, 1995, p. 19).

At the international level the challenge to relations of power was evidenced by the ICN revised code for nurses published 1973. According to Woodruff (1991, p. 14), this document revealed a shift in focus from nurses’ traditional obligations to institutions and medical practitioners; to a concentration on nurses’ ethical obligations to patients. Tadd (2004) also identifies this historical shift in the ICN code and notes the increased emphasis on autonomy and responsibility. Edgar (2004) argues that the objective of the code was to “promote the professional status of nursing in the face of overt opposition” (Edgar, 2004, p. 158). The opposition Edgar was referring to was that of the medical profession which expected nurses to be subordinate to doctors in all respects (Edgar, 2004). The ICN code by reference to moral autonomy and by having a distinct moral orientation was the means for nursing to underscore their claim to professionalism (Edgar, 2004, p. 158).

The means of achieving professional status; accountability, standards, education and professional control, were widely discussed in nursing literature. The World Health Organisation’s goal of ‘Health for All by the Year 2000’ and the corresponding publication of Health for all Australians, were identified by nursing organisations and nurse leaders as providing the opportunity and framework for legitimating nursing’s push for professionalisation (see Cheek, Gibson & Gilbertson, 1995, pp. 36-37; Gray, Pratt, Clark, Ryan & Vidovich, 1989; & Pearson, 1990). Analysis of the literature published during the period of the 1980s, revealed that this discourse of professionalisation was underpinned by a widespread fear that the opportunity for nursing to move beyond its status as handmaiden to doctors, to that of autonomous
professional, would be lost if nursing was unable to establish itself as a profession in its own right.

During this period the medical profession were the pre-eminent medical provider. They significantly influenced government policy in all matters to do with health service provision and were also represented on statutory authorities, such as the Board. At this time nurses were well aware that failure of the profession to be self-regulating exposed them to an increased risk of external control by other interested groups (Jenkins, 1989), in particular the medical profession. According to Cheek, Gibson & Gilbertson (1995) writing about the position of nursing in the 1980s; nursing was “highly vulnerable to external control at this time. As an emerging profession it is fragile and struggling to establish a discreet identity” (Cheek, Gibson & Gilbertson, 1995, p. 36).

An analysis of the literature revealed that nurses believed the pathway to achieve professional status was one of tertiary education, accountability, establishing standards, engaging in nursing and health discourse and decision making, and establishing and practicing within a code of ethics (See Gray & Pratt, 1989, p. 149; Marles, 1988; Percival, 1995; Tiffany, 1982, p. 43). According to the Executive Director of the Royal College of Nursing Australia, “any profession must establish standards for itself” (Percival, 1995, p. 11); the importance being that establishing and maintaining standards in nursing would not only raise awareness amongst the public about nurses concern with quality nursing care, but also demonstrate the “professions recognition of its obligation to be accountable to the public” (Percival, 1995, p. 15).

In Australia, the push for a code of ethics in nursing was driven primarily out of this urgency for professionalisation. The nursing literature on the whole, did not reflect a concern with the purpose of the code other than as a necessary prerequisite to achieving professional status. Such a link between a code of ethics and the professions was clearly identified in 1987 by the Royal Australian Nursing Federation (RANF) where they state:
Traditionally, professional groups have formulated sets of guidelines setting out the beliefs, values and principles that underlie the practice of the profession as a whole and of its members as individuals. These guidelines are known as codes of conduct, codes of ethics or professional ethics. Such a code is one of the distinguishing features of a profession. It indicates the behaviours that are characteristic of the profession and which are expected in the professional role (RANF, 1987, p. 1).

The link was also highlighted by Kelly and Woodruff (1995), who stated that the justification for the adoption of a code of ethics in nursing was due to nursing gaining greater acceptance in moving from a ‘semi-profession’ to a profession, and that prominent amongst the attributes of a profession were:

Territoriality over a field of competence, community approval of this specialised domain, and a code of ethics focusing upon service to a particular clientele (Kelly & Woodruff, 1995, p. 95).

Gray and Pratt (1989) identified that accountability required nurses to adhere to “the profession’s code of ethics as a means of self-regulation” (Gray & Pratt, 1989, p. 154) and that ethical decisions should be based on reason not emotion. Exactly what they meant by this is unclear, although it seems to suggest a prescriptive approach to the decision making of an ethical nature. They argued that accountability is “pivotal to any idea of professionalism” (Gray & Pratt, 1989, p. 157) and that nurses “are accountable for exercising power to control their profession’s destiny” (Gray & Pratt, 1989, p. 156). They proposed that rather than trying to prove that nursing is a profession, nurses would be more effective in developing and defining standards and mechanisms for evaluation. This could be done through “formulation of and adherence to a professional code of ethics, and the setting of standards for nursing” (Gray & Pratt, 1989, p. 157). According to White and Chiarella (2000), who in writing about the development of standards and codes for nursing, identified there was “a very real desire amongst many Australian nurses to demonstrate their bona
International nursing literature also reflected a concern with the professional status of nursing, and the need for a code of ethics was recognised as a prerequisite for professional status (see Barazzetti, Radaelli & Sala, 2007; Sasso, Stievano, Jurado & Rocco, 2008; Verpeet, de Casterle, Lemiengre & Gastmans, 2006). Gillon (1986) writing about nursing and medical ethics asserted that one motivation for nurses’ interest in professional ethics was;

that nurses are increasingly resentful of their ancillary role in medical care (ancilla is the latin for a maidservant, handmaid or female slave, and ancillary is defined a subservient, ‘subordinate [to],’ or [literally] ‘of or pertaining to maidservants’). The more firmly nurses can entrench themselves as an acknowledged profession the more the resented ‘ancillary’ label and role can be replaced by the concept of nursing as a profession complementary to medicine (Gillon, 1986, p. 115 [emphasis in original]).

Gillon argued that the concern with ethics was as much about “occupational self-interest” (1986, p. 116), as it was about nurses’ concern for patients best interests and issues of moral conflict which nurses were increasingly confronting. Wilson-Barnett (1986) expressed similar views, that “ethical issues in nursing must therefore be viewed within a context of an emerging professional conscience, within a multi-disciplinary team in which nurses have generally held a somewhat subordinate role” (Wilson-Barnett, 1986, p. 123). He argued that recent changes in nursing required nurses to be more accountable for ethical decision making. “Recent developments in nursing practice reflect increased knowledge of effective care, changing needs of patients and an attempt by the profession to become complementary to doctors not poor substitutes or mere ancillaries” (Wilson-Barnett, 1986, p. 123). Accountability was seen as an important step in demonstrating professional status. According to Dr Margretta Styles, accountability was equated with “being a humane and expert care giver, a curious scientist, and insatiable and perennial learner, an eager teacher, a
supportive colleague, a skilled bureaucrat, an astute political activist and a committed professional” (Styles, 1985, p. 73), and that:

As committed professionals, accountable for our best, we must work together to rationalize and strengthen nursing’s governing processes and policies. Only then can the profession effectively carry out its responsibility to the public and to its members (Styles, 1985, p. 75).

Clearly the need for the development of codes in nursing arose out a general push within the nursing community to ensure control of nursing by nurses through the professionalisation of nursing. The ideology of professionalism adopted by nursing and which discursively shaped the development of the professional codes, arose out of accounts of professionalism which according to Holmes and Williams (2007) were based on essentially masculine viewpoints. They contend that “the ideology of professionalism is thus directed at problems of individual and collective misdemeanour, incompetence, negligence and poor standards, and an assumption that all that is required is stricter, more extensive or more refined professional standards” (Holmes & Williams, 2007, p. 43). Concurrent with this push for the professionalisation of nursing, were a number of key activities occurring in Australia throughout the 1980s and the 1990s, which specifically gave impetus to development of professional codes.

In 1987 a study into professional issues in nursing in Victoria was commissioned by the Hon. D.R. White, Minister for Health in response to the concern of nurses with respect to the status of their profession in Victoria. The terms of reference were broad in nature but were centrally concerned with examining the changing role of nurses and examining professional issues in nursing. The study was believed to be the first such study based on the voice of nurses. Amongst the specific issues to be covered by the study was “the role of the nurse in ethical decision making on issues raised by current medical technology and practice” (Marles, 1988, p.vii). One of the “critical professional” issues to emerge from the study was “the inevitability of nurses moving towards greater professionalism” (Marles, 1988, p. xviii). A major conclusion arising from the Report was that:
Unless nurses achieved the degree of autonomy common to other health professionals, they would be unable to participate fully and effectively in shaping the future of both their own profession and of the health care system. It was considered that this would only be achieved through the confidence, knowledge and understanding that would accrue to nurses who had achieved equal professional standing with those groups and individuals in the community who already played major roles in influencing the future of the health system (Marles, 1988, p. xxi).

The Report recorded that there were approximately fifty submissions which raised ethical questions. Moral dilemmas were identified as one of the priority issues. The types of ethical challenges experienced by nurses were categorised as:

(i) those producing a conflict between the nurse and others involved in the situation: (ii) those causing a personal internal conflict for the nurse in that he or she felt confused or ill-equipped to make the decisions demanded; and (iii) those creating a conflict with the nurse’s need to act within the law (Marles, 1988, p. 164).

The Report further identified that nurses felt a sense of powerlessness to give effect to their ethical viewpoints and that often they experienced ethical conflict in relation to meeting their duty to the institution and doctors, as well as to patients (Marles, 1988, p. 166). In response to the ethical issues raised by nurses, the Report identified a lack of; codification, personal preparation, and systematic support, and saw this as a barrier to resolution of these issues. The need for an ethical framework to assist nurses in the delivery of nursing care was identified, and the following statement was made in regard to the need for a code of ethics.

Codes of ethics were seen as necessary, both to assist the nurse in a difficult area of critical importance, to safeguard the patient from individual variations in nursing care, and to
provide protection for the nurse from outside pressure in ethical situations (Marles, 1988, p. 177).

In the same year, the RANF published a series of articles by nurses intended to stimulate debate and raise awareness amongst nurses of the number and complexity of ethical dilemmas faced by nurses. They identified the need for a framework for action where ethical dilemmas arose. Professional codes were seen as the means of setting out “behaviours that are characteristic of the profession and which are expected in the professional role” (RANF, 1987, p.1).

In 1989, *Nursing in Australia: A National Statement* was published, having been developed and prepared through the collaboration of four nursing organisations, the Australian Nursing Federation; College of Nursing, Australia; New South Wales College of Nursing; and, the Florence Nightingale Committee, Australia. The Statement provides a clear link between professional status and a code of ethics. It claimed to incorporate the ideals and values of nurses and to represent a vision for the future. Within the Statement it was acknowledged that the role of nurses was open to interpretation and that within the community and amongst the health professions there were diverse and conflicting views about nurses and nursing. Hence the intention of the Statement was to explain and promote nursing, and the role of the nurse within the wider community. The Statement claimed that nursing was different to other health professions because nurses provide holistic care. There is a strong emphasis in the Statement about professional accountability and the relationship between nursing and caring. The authors identified that: “In caring for and about individual human beings the Australian nurse practices in accordance with the International Council of Nurses ethical code” (Gray, Pratt, Clark, Ryan & Vidovich, 1989, no page number).

Whether the broad cohort of practising nurses at that time had any knowledge of the *ICN Code of Ethics* is doubtful as there is no evidence in the literature to support this assertion; so it is difficult to imagine that the Code, as claimed in the Statement, influenced the practice of nurses in any way. What is more likely, is that the reference to Australian nurses practising within the ICN code was used to bolster the belief in the professional status of nurses.
In 1988 at ANRAC, a list of competencies for the registration of nurses was tabled; and in 1989 the *Nursing Competencies Assessment Project* commenced with a report tabled to ANRAC in 1990 (Woodruff, 1991, p. 3). This report identified the difficulty that nurses experienced in identifying and assessing ethical issues, both in relation to the proposed competencies and in the workplace (Kelly & Woodruff, 1995, pp. 93-94).

Concurrent with this push for the development of standards and professional codes were significant changes to the education of nurses. In 1984, the Federal Government agreed to the transition of pre-registration hospital based programs to the higher education sector. The transfer was to be complete by 1993. This move saw the abandonment of what had essentially been an apprenticeship style of nurse training based on the Nightingale model which had originally been introduced into Australia by Lucy Osborne in 1868 (Russell, 2000). According to Russell (2000), the impetus for change to nurse education arose from an increased militancy amongst nurses in regard to improved wages and conditions; the changing role of nurses; international developments in nursing and nurse education, and other factors such as the changing role of women in society (Russell, 2000 p. 20).

The discursive context in which the push for the development of professional codes arose, was one in which there was a belief within nursing that in order for the voice of nurses to be heard, nurses needed to attain the same degree of professional status accorded to other health professionals; and in particular, that accorded to the medical profession. There was a strong belief that nurses needed to demonstrate to both the public and other health professions their professional accountability, and that the best way to do this was through the development of a code of ethics and a code of conduct. There was also a sense that in order for nurses to meet the increasing demands on their practice, they needed a framework for ethical guidance.

It is apparent that nurses were of the view that a professional code would represent the ethical standards of nurses (Chiarella, 1995, p. 65); would provide for regulation and control of nurses by nurses; and would demonstrate nurses’ accountability to the general public (Percival, 1995, pp. 15,19). In all these ways, developing professional
codes was a central tenet in the push for nurses to gain control over nursing and to once and for all achieve an unambiguous professional status.

The development and purpose of the Codes

In response to these growing concerns about the professional status of nursing, the 1990 ANRAC commissioned the preparation of draft codes, which commenced the early phase of the development of a code of ethics and a code of professional conduct (see Woodruff, 1991, pp. 18, 34). The members of the profession were invited to submit their views to a specific set of questions, and twenty five responses were listed as having been received. The responses were sent in by individual nurses and others representing nursing organizations; at the same time a review of the literature was also undertaken. In their submissions the respondents were asked to address questions relating to the purpose of a code of professional ethics, the purpose of a code of practice/conduct and specific considerations for an Australian code of ethics for nurses (Woodruff, 1991. p. 4).

The subsequent discussion paper prepared by Woodruff (1991) identified issues for consideration arising from the submissions. These included concern about the potential for the code to be a rigid and inflexible document which prescribed conduct, but which failed to meet the needs of nurses in practice. This issue arose out of concern about what was seen to be nurses’ historically driven unquestioned obedience to doctors and others in authority. Concern was also expressed about the potential for conflict between the moral obligations and views of the professional, and those of the individual.

Discussion within the paper on the purpose and application of a professional code did not reveal consensus, and notions about its purpose were vague. It was generally held that a code of ethics was a public statement about the values of the profession, and as such should not be binding; additionally it should serve as a guide for the resolution of dilemmas in practice, and furthermore that there should not be a combined code of ethics and professional standards. “The code of ethics ought to
state broad ideals, whereas a code of conduct must be binding in particulars” 
(Woodruff, 1991, p. 10). The ideology of nurses as professionals and nursing as a 
profession permeated discussion in the paper.

In summary, Woodruff (1991) proposed that “that a code of ethics is needed by the 
nursing profession of Australia, in order to complement that of other health 
professions” (Woodruff, 1991, p.18). In addition, that it should be seen as a clear 
statement of the “ethical standards accepted and adhered to by professional nurses in 
Australian practice” (Woodruff, 1991, p.18). The general view expressed throughout 
the document was that the reasons for a code, apart from acting as a public 
declaration about ethical values in nursing, was that professionals needed a code of 
ethics for professional ethical guidance. Aside from these two themes, there was no 
other substantive reason given for the purpose of a code. Throughout the paper there 
was limited discussion as to how a code would achieve this end of ethical guidance 
or what exactly was meant by ethical guidance. Indeed Woodruff specially stated 
that the code of ethics should not be a reference for particular ethical dilemmas, 
rather:

The code should be seen clearly to be a statement both to 
society and to practitioners of ethical standards accepted and 
adhered to by professional nurses in Australian practice, it 
cannot and should not attempt to be a reference for 
particular situations of ethical dilemma for individual 
nurses, but should be brief, inclusive, and able to be adhered 
to by nurses from a variety of cultural and religious 
backgrounds (Woodruff, 19991, p.18).

This somewhat nebulous statement highlights the lack of a clearly articulated 
rationale for the purpose of a code of ethics, other than to serve as a public statement 
of evidence of the professional ethical values of nurses. The role of the code with 
regard to the ethical practice of nurses, on the whole received limited attention in the 
literature. It is likely that the difficulties experienced in articulating a rationale for 
the purpose of a code of ethics in relation to the ethical practice of nurses was 
reflective of the discursive context in which its construction was located, where the
dominant discourse of professionalisation, not only provided the impetus but also clearly shaped the subsequent development of the Code of Ethics.

The proposed code of ethics, arising out of the discussion paper put forward by Woodruff (1991); included a statement about the ethic of nursing, collaborative practice, knowledge, autonomy (in regard to consumers of health care, not nurses) confidentiality, discrimination, justice, responsibility to colleagues, responsibility to employers and conscientious objection. There was concern that the code should be written in such a way that it carried no legal implications and yet was authoritative; however how such authoritative status would be achieved by the code was not explored.

The code is written in the form of a statement of beliefs, in order to avoid the possible legal difficulties ..., yet to be more authoritative than “desirable” or “should” (Woodruff, 1991, p. 19).

By contrast to the way in which the proposed code of ethics was being positioned as a statement of professional beliefs or values, the rationale and purpose for a code of conduct was much more definitively positioned as a disciplinary tool for punishment of poor nursing practice.

A code of conduct should be comprised of more specific statements of unacceptable behaviour, and serve as a reference for practitioners, and as a guide for disciplinary boards. It should attempt to combine the salient features of Australian nursing statutes (Woodruff, 1991, p.18).

It was considered that a code of conduct should, in particular, “offer some direction to practitioners and disciplinary boards.” (Woodruff, 1991, p. 14); and it was acknowledged that whilst both codes are closely related, they nevertheless serve separate purposes, although “It is believed desirable that the nurse make the connection between the principles of the code of ethics, and the examples of
unprofessional behaviour of the code of conduct” (Woodruff, 1991, p. 34). Once again, just how nurses were expected to do this was left unexplained.

According to Woodruff (1991), the code of ethics should state the beliefs basic to the profession to which all members;

are able to subscribe, but which allow for application within the chosen moral structure of individual nurses. The code of ethics may be said to comprise the fundamental and overriding beliefs which are essentially held by those who practise nursing (Woodruff, 1991, p. 22).

Whereas the code of conduct;

should set out the behaviour which is not acceptable from a member of the profession, even on the basis of personal ethical belief. Its provisions are not open to individual interpretation. Breaches of the code will be examined in the light of the evidence presented, and the situation in which the misconduct is alleged to have occurred. Its provisions should convey a sense of law and regulation, yet should not be particularized in the statutes (Woodruff, 1991, p. 22).

In summary, at the time of the development of the Codes, the purpose for the proposed Code of Ethics was specifically aimed at developing a public statement which identified the guiding principles which underpin the practice of nurses and which represent the fundamental values of the profession. It was argued that nurses should be able to exercise choice in the way in which they expressed these values and that the values in the Code were not legally binding. Whereas the proposed Code of Conduct was intended to provide clear directional statements to nurses about what is and is not acceptable practice in nursing, it was not negotiable by nurses and was designed to be used by disciplinary committees.
In 1995, when defining the purpose of a code of ethics, Kelly & Woodruff state that it “provides a public statement of the moral values which a given professional group has voluntarily accepted, and which members are bound to uphold when this can be done without sacrificing other important interests” (Kelly & Woodruff, 1995, p. 96). They believe that it should be used to guide moral thinking and in this way serve regulatory requirements through self-regulation, and additionally that it should define the meaning of membership of the nursing profession.

To be self-regulating, each nurse must recognize accountability for her/his practice, accept responsibility for choosing among options for action, and for the consequences of those actions. The code is intended to assist in these choices. Codes state norms, and norms represent an implementation of values (Kelly & Woodruff, 1995, p. 97).

Despite the decision to develop two separate codes - a Code of Ethics (1993) and a Code of Professional Conduct (1995), the Codes were nevertheless intrinsically linked by the underlying discourse of professionalisation. The link is revealed by the statement that the two Codes along with Australian nursing’s published practice standards “provide a working framework for nursing practice” (ANCI, 1993; 1995), and that the Code of Ethics along with other documents comprise the “agreed standards of the profession” (ANCI, 1995).

Nurses were expected to view the Codes as interrelated. The Code of Professional Conduct obliged nurses to adhere to the professions standards and cited the Code of Ethics as part of the professions standards. This linking of the two Codes in effect ameliorated any possibility that the value statements would simply serve as guidelines to ethical practice and that nurses could exercise choice with regard to adopting the values expressed in the Code of Ethics. This interpretation of the Code of Ethics as professionally binding is given impetus by statements such as the following which define a code as “a conventionalized set of rules or expectations devised for a select purpose” (Johnstone, 1999, p. 51). The use of words such as rules and expectations clearly signify a non negotiable status attached to the Code. Thus whilst it was argued that the Code of Ethics should not be legally binding, the
Code was in effect professionally binding through the *Code of Professional Conduct*, despite the discourse of choice represented in the following statement from the *Code of Professional Conduct*.

The set of standards embodied in the Code of Professional Conduct differs from the Code of Ethics for Nurses in Australia which relates to the ideals of the profession and the moral values that nurses voluntarily accept (ANCI, 1995).

Thus linking the *Code of Ethics* to the *Code of Professional Conduct* as the standards of the profession meant that the positioning of nurses as having the choice to voluntarily subscribe to the values of the *Code of Ethics* was misrepresentative of the position faced by nurses. This ambiguity and distinct lack of clarity arising out of the contradictory positioning of nurses capacity to exercise choice in regard to the *Code of Ethics*, has in effect, left the way open for nurses to be positioned as having failed to adhere to the standards of the profession and for professional disciplinary action to be taken.

The positioning of the *Code of Ethics* as on the one hand aspirational in its intent and on the other as punitive through its links to the *Code of Professional Conduct* highlights the dilemma faced by the profession. The push for professionalisation provided the opportunity for the development of the *Code of Ethics* but also had a constraining effect. On the one hand the Code was seen as a means of freeing nurses from the constraints of etiquette which according to Johnstone (1999), had historically governed nursing practice. It was widely believed by the profession, that this would be achieved through a framework for ethical practice in the form of a code of ethics which would require nurses to operate as independent ethical agents and no longer as simply handmaidens to the moral superiority and authority of doctors. On the other hand the profession needed to protect this new found freedom. This was achieved through operationalising mechanisms of punishment for those nurses who did not operate within this new professional framework.

These ambiguous and dual purposes of the *Code of Ethics* resulted in functions which were, and still are in effect oppositional; that is to encourage independent
ethical thinking whilst at the same time mandating ethical conduct. Indeed according to Fry and Johnstone (2008), codes of ethics amongst other things serve the purposes of “cultivating moral character” (Fry & Johnstone, 2008, p. 54), prescribing conduct, and regulating the ethical professional conduct of nurses through acting as a tool to enable the ethical competence of nurses to be evaluated. More recently Johnstone (2009) reinforces this view of the purpose of codes of ethics, identifying their purpose as providing rules or expectations to guide ethical professional conduct. She positions codes of ethics as reflecting the moral values of practitioners, and functioning as “meaningful action guides” (Johnstone, 2009, p. 21). According to Johnstone (2009, p. 21), the nature of codes can be either prescriptive in that they specify the duties of the professional, or aspirational which are “virtue-directed” and state “desirable aims”. Johnstone believes that the main purpose of a code of ethics is directing:

What professional ought or ought not to do, how they ought to comport themselves, what they, or the profession as a whole, ought to aim at (Johnstone, 2009, p. 21, cited Lichtenberg, 1996, p.14).

This view however is not one which has received uncritical support. Scott (1998) raises her concern that the principles of ethics are being inappropriately used by the nursing profession to make punitive judgements about professional behaviour. She argues that there is a strong cultural attachment within nursing to the ideas of “duty, rules and principles” (Scott, 1998, p. 480), and that essentially within nursing we are seeking a “prescriptive framework from which to judge our own actions (if we are honest) and those of our colleagues” (Scott, 1998, p. 480). She goes on to say “there is a real danger within the nursing context that ethical principles will be used as a stick with which to beat the nurse, rather than as providing a potential framework within which to consider the real complexity of the issues that can arise in health care” (Scott, 1998, p. 480).

From a Foucauldian perspective, it can be seen that the development of the Code which was situated in the discursive context of professionalisation, provided a mechanism for strengthening and reconfiguring relations of power within the
profession and within health and medical discourse. These issues of power and control were paramount, and required the profession to maintain control over all aspects of nurses’ practice. One of the means to achieve this was through a proclamation about the ethical values of nurses in the form of the *Code of Ethics*, which provided the public and the profession with tangible evidence about the professional ethics of nurses.

I argue that the push for professionalisation was at a cost to developing the Code as a tool which is useful for nurses in their day to day practice. The Code operates through the panoptic principles of self regulation which are not principles that are likely to encourage ethical development; rather they are principles which encourage unquestioning obedience to a set of rules for practice. Increasingly the Code is being co-opted as a tool by employers and professional disciplinary panels to make judgements about the conduct of nurses. In light of this, discussion in the remainder of the chapter will undertake to provide a critical overview of the *Code of Ethics* and its relationship to other regulatory practices including the *Code of Professional Conduct* and the Tribunal.

**A critical overview of the content and functions of the Codes**

In this section I undertake a critical analysis of the evolution of the content of the *Codes of Ethics*, to reveal how the content has been discursively framed. (For a chronology of the development of the codes see Appendix Three).

In the 1993 and 2002 versions of the *Code of Ethics*, the statements and values expressed strongly reflect the issues identified in the discussion paper by Woodruff (1991). The essence of which is captured in the stated purpose of each Code, which essentially remained unchanged from one Code to the next. The purpose of which was to:

- identify the fundamental moral commitments of the profession,
• provide nurses with a basis for professional and self-reflection on ethical conduct,
• act as a guide to ethical practice, and
• indicate to the community the moral values which nurses can be expected to hold (ANC, 2002).

Clearly the Codes serve as a public declaration about the link between ethics and nursing and thereby set out one of the key attributes required of a profession. The other clearly stated purpose is to provide nurses with a guide to ethical practice. Herein can be seen a point of tension arising from competing discursive demands; to establish nursing as a profession and, to provide an ethical framework for nurses. In this section I argue that of these competing discourses, the discourse of professionalisation is the more powerful of the two, and the problems which are identified with the Code, in particular the continuing ambiguity as to its purpose, arise from these competing discursive demands.

Both iterations of the Code provided six broad value statements intended for the use of nurses. In the 1993 version, nurses were expected to use the value statements to “reflect on the degree to which their practice demonstrates the stated value” (ANCI, 1993). The values were:

• Nurses respect persons’ individual needs, values and culture in the provision of nursing care.
• Nurses respect the rights of persons to make informed choices in relation to their care.
• Nurses promote and uphold the provision of quality nursing care for all people.
• Nurses hold in confidence any information obtained in a professional capacity, and use professional judgement in sharing such information.
• Nurses respect the accountability and responsibility inherent in their roles.
• Nurses value the promotion of an ecological, social and economic environment which supports and sustains health and well being (ANCI, 1993).
The 2002 version of the Code, espouses value statements almost identical to those from the earlier version and these are considered to reflect the “ethics and ideals of the profession” (ANC, 2002, p. 2), which are that:

- Nurses respect individuals’ needs, values, culture and vulnerability in the provision of nursing care.
- Nurses accept the rights of individuals to make informed choices in relation to their care.
- Nurses promote and uphold the provision of quality nursing care for all people.
- Nurses hold in confidence any information obtained in a professional capacity, use professional judgement where there is a need to share information for the therapeutic benefit and safety of a person and ensure that privacy is safeguarded.
- Nurses fulfill the accountability and responsibility inherent in their roles.
- Nurses value environmental ethics and a social, economic and ecologically sustainable environment that promotes health and well being.

There is little obvious difference between these two iterations of the Code. There are however subtle differences which point to the increasing professionalisation of nursing; for instance the background and introduction sections of the 2002 version have a stronger emphasis on nursing as a profession. There is also a reference to the professions’ intentions and responsibility as well as the nurse’s professional responsibility; whereas the introductory sections of the 1993 version speak more of nursing practice and nurses. There is also an attempt in the 2002 version of the Code to link the value statements more specifically with ethics, which is not apparent in the 1993 version. Whilst the value statements are essentially the same between the two versions; in the 2002 Code there is evidence of an orientation towards the greater level of accountability expected of nurses. This is demonstrated in the language used in the value statements and in particular in the supporting explanatory statements, which move from the more passive form in the 1993 version to a more active form in the 2002 version. This shift can be seen to be reflective of the discursive context in which the development of the Codes was situated and demonstrates a growing confidence about nurses’ professional status.
More recently in 2008 the ANMC published a significantly revised version of the *Code of Ethics* and the *Code of Professional Conduct for Nurses in Australia*. At the same time they also published a separate *Code of Ethics* and *Code of Professional Conduct for Midwives in Australia.* The following discussion does not include the midwifery Codes as the data collected for this study did not involve midwives. This version of the *Code of Ethics* specifically states that it is “supported by and should be read in conjunction with, the Code of Conduct for Nurses in Australia.” (ANMC, 2008a, p.1). Both these Codes along with other published practice standards are considered to “provide a framework for legally and professionally accountable and responsible nursing practice in all clinical, management, education and research domains” (ANMC, 2008a, p.1). The Codes apply to all nurses in all areas of practice and according to Johnstone “nurses are bound by the standards of conduct” addressed in the Codes and the *National Competency Standards* (2009, p.1). These recently revised versions of the Codes provide more detailed explanations than was provided in the earlier versions about the standards required of nurses.


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10 In 2001 a review of the *Nurses Act 1991* was published; it recommended that the Act establish two Registers, one for nurses and one for midwives. Those nurses eligible for dual registration would be registered under both Registers. This change arose out of a recognition that not all midwives are registered nurses and that direct entry midwifery courses were now available; in addition under the registration practices governed by the Act prior to the review there was a risk that the public might believe that a midwife was a registered nurse and midwife, and that midwives who were not registered nurses might be required by employers to undertake nursing duties beyond their scope of practice (NSW Department of Health, 2001).
This discursive framework is reflected in the purpose of the Code, by the statement that the Code should “indicate to the community the human rights standards and ethical values it can expect nurses to uphold” (ANMC, 2008b, p.2); by an explanation provided in the introduction about the nursing professions position on human rights (see ANMC, 2008b, p. 3); and also, in the detail of the explanations provided for each of the value statements.

This change in emphasis in the current Code, from ethical statements designed to demonstrate the professions’ accountability to the public and thereby its’ professional status; to statements which take a strong stance with regard to the professions’ position on human rights, reflects a growth in confidence about the professional status of nursing. It also can be seen as a strategic political move designed not only to continue to promote the professional status of nursing, but importantly to do this through positioning the profession and individual nurses within the profession as having committed to a distinct ethical stance on human rights. In this way the profession can be seen to be taking a stand on contemporary, politically charged issues of both national and international significance. This change in approach to the codification of nursing ethics is not isolated to Australia; rather it is reflective of the growth in confidence happening internationally in relation to codes of ethics as the following statement from an ICN publication reveals.

Many early codes of ethics for nursing did, in fact, emphasise the personal conduct of the nurse, and projected the ethical image of the professional nurse to the public at large. Later codes of ethics emphasised the responsibility of the nurse to the patient and the maintenance of nursing practice standards (Fry & Johnstone, 2008, p.54).

The current version of the Code contains eight value statements which whilst expressed in different terms, are nevertheless essentially unchanged in intent from previous iterations of the Code. This Code however, provides much more detailed explanation of the intent of each value statement and therefore goes some way to addressing criticisms of the earlier Codes that insufficient information was provided. However a drawback from this approach; is that as a result of the detail, the Code is
far more prescriptive than the previous Codes, and could be interpreted as placing an onerous responsibility on nurses to act as prescribed within the detail of the value statements.

For instance in Value Statement 3 which requires nurses to value the diversity of people, the explanation states that nurses are required “to develop cultural knowledge and awareness and greater responsiveness to the languages spoken enabling them to better understand and respond effectively to the cultural and communication needs of people in their care, their families and communities during a health care encounter” (ANMC, 2008b, p. 6). Another example can be found in Value Statement 4 which states “Nurses value and accept responsibility for self-care. This involves maintaining their own health, acknowledging their physical and psychological strengths and limitations.” (ANMC, 2008b, p. 7). In Value Statement 7 nurses have responsibility to report “aspects of a colleague’s professional practice giving reasonable cause for concern. Nurses ensure colleagues are given reliable information about the risks posed by people to whom they are providing or planning to provide care.” (ANMC, 2008b, p.10).

Whilst at a superficial level these value statements appear to express laudable sentiments, a closer examination reveals a significant problem with this approach which is likely to impact upon these values being implemented in practice. Essentially this comes down to the fact that there is no guidance as to how a nurse might meet these responsibilities, what the limits are on these responsibilities or how a nurse might recognise a situation requiring ethical action on their part. Nor is there any recognition of the personal, social, political and institutional constraints which nurses may experience in trying to meet the required ethical standard.

Like the earlier Codes, this version also refers to the value statements as guides for reflecting on practice (ANMC, 2008b, p. 3). This approach is supported by Johnstone (2009), who argues that a code of ethics should not be interpreted as a prescriptive set of rules; no code of professional nursing ethics should be regarded as an authoritative statement of universal action guides. Rather,
it should be regarded only as a statement of prima-facie rules which may be helpful in guiding moral-decision making in nursing care contexts, but which can be justly overridden by other, stronger moral considerations (Johnstone, 2009, p. 24).

Despite this view, the way in which the Code of Ethics is written and the way in which it is directly linked with the Code of Professional Conduct increases the likelihood that the Code will be interpreted literally; by nurses, professional and regulatory bodies, and even the courts. Such interpretations are likely to result in unrealistic expectations being placed upon nurses with regard to their ethical conduct, and thereby leaving the way open for nurses who have not met these expectations to be found to have acted unethically.

The Code of Ethics and the Code of Professional Conduct along with nursing competencies make up the regulatory framework, and provide the means by which the professional and regulatory bodies in nursing are able to exercise control over nurses through the strategies of self-monitoring, standardisation, and homogenisation; thereby giving effect to the claim of professional status. The responsibility for understanding and applying the Codes in practice is left up to each nurse. According to Johnstone, a code of ethics provides:

- a stringent moral responsibility to promote and safeguard the wellbeing, welfare and moral interests of people needing and/or receiving nursing care. These codes also variously recognise the responsibility for nurses to balance equally the needs and interests of different people in health care contexts.

What is often not stated, however, is how nurses ought to fulfill their moral responsibilities to deal effectively with the many ethical issues they encounter on a day-to-day basis (Johnstone, 2000, p.108; 2010, p. 146).

The failure of the various iterations of the Code of Ethics to provide sufficient clarity about how the stated values should be applied in everyday practice is replicated in their failure to explore or provide direction to the nurse about the concept of
unethical conduct. There is no reference in the 1993 version of the *Code of Ethics* to unethical practice; the 2002 version refers to nurses “ethical responsibility to report instances of unsafe and unethical practice” (ANC, 2002); and the 2008 version refers to “reporting, to an appropriate authority, cases of unsafe, incompetent, unethical or illegal practice” (ANMC, 2008b, p.4). The Codes however have not provided a definition of what is meant by unethical practice nor have they provided guidance as to how a nurse might recognise such behaviour, this is despite the fact that since 1991 in NSW there has been legislation in the form of the *Nurses & Midwives Act* enabling Tribunals to make finding of unethical conduct.

The *Code of Professional Conduct* (1995) also makes reference to unethical conduct in the following statement “…any circumstances which compromise agreed standards of the profession, or any observation of questionable or unethical practice, should be made known to an appropriate person or authority” (ANCI, 1995). This statement also appears almost verbatim in the 2008 version of the *Code of Professional Conduct*. However like the *Code of Ethics*, these documents fail to elucidate on what is meant by the concept of ‘unethical practice’, nor do they provide any insight as to what type of practice constitutes ‘questionable or unethical practice’.

The failure of the either of the current Codes to provide information or insight into what may be considered unethical conduct, continues to leave nurses in a vulnerable position in relation to understanding how this might be interpreted or used in a disciplinary proceeding. Chiarella (1995) identifies that one of the problems with professional standards, is that lack of clarity about their purpose, has at times led to their inappropriate use as mechanisms to discipline nurses. More recently Fry and Johnstone (2008) have noted that:

> The legitimated authority of professional nursing codes is, however, beginning to change as is evident by their increasing use as a ‘tool of peer review’ by managers and disciplinary boards in instances where a nurse’s conduct is called into question (Fry & Johnstone, 2008, p.57).
Given this increasing authority of professional codes and the potential for nurses to be held accountable for practicing according to the standards set by the Codes; the following warning by Chiarella (1995), about the standards of the profession are even more pertinent today. She states that it is “most important that the profession is clear about the purpose of its standards, and that the language used to describe that purpose is correspondingly clear and unambiguous.” (Chiarella, 1995, p. 73). This concern with the clarity of codes has more recently been highlighted by Tadd et al., (2006), who cautions of the need for codes to be written so as to minimise uncertainty and ambiguity.

In essence, the Code of Ethics states the moral values and commitments underpinning the profession of nursing. The Code is expected to have effect through controlling the ethical conduct of the nurse via the panoptic principle of self-regulation; through the mechanisms of self-appraisal, and, the expectation that nurses make the connection between the Code of Ethics and the Code of Professional Conduct. Where these mechanisms fail to have the desired effect, the Code of Professional Conduct enables disciplinary mechanisms such as the Nurses Tribunal to be put in place. From a Foucauldian perspective, the increasing levels of surveillance and visibility of the nurse made possible through the expanding codification of ethical conduct which is evidenced in the most recent version of the Code of Ethics; serves to capture and objectify the nurse in increasingly specific ways, thereby reinforcing the power of the discipline. In effect, the Codes exist as an exercise of disciplinary power and have arisen out of the professions response to the need to clearly establish its professional status. Whether beyond this they serve the function of actually enhancing the ethical and professional conduct of nurses is unknown. Indeed the following analysis of the literature in regard to this issue demonstrates that there is widespread confusion and lack of knowledge amongst nurses about the use of codes. The current situation where the status of the Code of Ethics in regard to disciplinary matters is unclear should be a significant cause for concern by the profession, given the potentially serious implications for nurses.
A critical examination of the Code of Ethics through an analysis of the literature

In Australia there has been a relatively unquestioned acceptance of the Codes by the nursing profession, which is evidenced by a lack of Australian nursing research into professional codes, and widespread adoption of the Codes by Australian nurse regulatory authorities and professional bodies. This has occurred despite findings of a number of earlier studies undertaken in the United Kingdom, Israel and the USA, which revealed that on the whole nurses either did not know or knew very little about their respective codes, nurses did not use the codes to inform their clinical practice, and nurses derived their knowledge of ethics from sources other than their codes (Davis, 1991; Miller, Beck & Adams, 1991; Nursing Ethics Committee, 1989; Tabak & Reches, 1996; Tadd, 2000; Vousden, 1987; Wagner & Ronen, 1996; Whyte & Gajos, 1996).

These findings were mirrored in the findings of a small pilot study conducted as part of this thesis. In this study qualitative data was collected from four experienced registered nurses working in a variety of health care settings. The data was collected using unstructured in depth interviews in which participants were asked to describe in depth their experiences of ethical dilemmas in practice. The interviews took place from mid 2001 to mid 2002. The findings revealed that none of the nurses interviewed were familiar with the Code of Ethics. Rather they identified families as a significant source for acquiring their moral and ethical values; other sources included religion and other nurses who were thought of as role models (Dixon, Cioffi, & Chang, 2003).

One of the participants who had been nursing for twenty five years when asked if she knew about the Code of Ethics or the Code of Professional Conduct responded:

No, I mean I’ve seen the book for sale in the bookshop and I thought I might buy it to figure out what the expectations are.
Another participant when speaking about dilemmas she faced in practice stated she had her “own moral beliefs and ethics that mean I will act in a certain way”.

Another participant when talking about what influenced her understanding of ethical and professional practice said:

I guess – I don’t know. I guess it’s from things that were – from things that I learnt as a child growing into – things that have been with me my whole life and things that my parents have taught me of what’s right and wrong.

It would appear from more recent literature that this situation remains relatively unchanged with there being limited research on the use of codes in practice and international studies still reflecting a lack of knowledge and use of codes amongst nurses (Nummienen, van der Arend & Leino-Kilpi, 2009; Solum, Slettebø & Hauge, 2008; Tadd et al., 2006). According to Tadd et al., “nursing codes appear to be ‘paper tigers’ with little or no impact” (2006, p. 376). In Australia there are still no studies which can demonstrate nurses’ experience, knowledge or understanding of their Code of Ethics (Holmes & Williams, 2007). Holmes and Williams argue that further research is needed to establish why codes are not effective in shaping practice (2007, p. 175).

A research abstract published on a European Commission project to study the content and use of codes of ethics in nursing concludes that there has not been any systematic investigation into the knowledge nurses have about their codes and the use of their codes. Indeed they indicate that “nurses in general have a poor knowledge of their code and rarely consult a code when they encounter ethical dilemmas in practice, even when it is used for disciplinary purposes by their regulatory body” (van der Arend, 2003, p.98). This was also the case in a Dutch study where it was found that most of the participants were unable to discuss the content or the values and principles of their codes of ethics and were unable to give examples of their use of codes in practice (Heymans, van der Arend, & Gastmans, 2007). A similar criticism has been leveled at the United Kingdom Central Council (UKCC) Code of Professional Conduct, the first edition of which was published in
1983. According to Tadd (1994), “the consensus of nursing opinion seems to have accepted uncritically the proposition that its existence benefits patients and nurses alike. It is difficult to say to what degree, if any, the existence of an ethical code enhances the moral climate of nursing.” (Tadd, 1994, p.16)

In the UKCC study it was found that sixty percent of nurses had either never used the Code or used it five times or less and that nurses in the study did not find the Code helpful in providing guidance on ethical practice. The study demonstrated that a mismatch existed between the expectations of nurses and the expectations of the statutory body in relation to the purpose and use of the Code. On the whole nurses did not value the Code nor did they use it as intended. Tadd (2000), concluded that in order for this to change, “its’[the Code’s], principles should not be fixed or abstract nor should they force themselves from authority onto reality. They require participation, so that they remain relevant to reality and enlighten the moral and professional consciousness of nurses rather than limit it” (Tadd, 2000, p. 162).

An analysis undertaken by Holmes (1992) into the published discourse of nursing ethics, noted “that there has been hardly any substantive critique of codes and codification” (Holmes, 1992, p. 20). Another paper which questioned the effectiveness of the UKCC Code, similarly identified a lack of critique and concluded that there is a need to establish the function of a professional code, to identify whose benefit the code is meant to serve, and most importantly to establish if the code plays “any effective part in raising ethical standards in nursing practice” (Tadd, 1994, p.17).

One of the criticisms leveled at the UKCC Code has to do with its failure to identify degrees of accountability which it is argued, often leaves nurses in the position of believing “they have responsibilities in areas of practice where they have little influence.” (Tadd, 1994, p. 19). Concerns about the Code are summed up in the following statement:

The concern raised here is not just that the Code may not have significantly enhanced the moral climate or the standard of care in the field of nursing practice, but rather that the
obligations it places upon practitioners in the absence of an adequate support network, are unreasonable. They are unreasonable because they proclaim the registered nurse to be an accountable professional, yet fail to acknowledge that in the real world of modern health care very little power is invested in the world of the bedside nurse. (Tadd, 1994, p. 19).

Tadd (1994) contends that in reality, the Code is “little more than an exercise in ethical tokenism.” (Tadd, 1994, p. 23) and concludes that there is an urgent need to increase the effectiveness of the Code, so that it does not come to be regarded as an irrelevancy by nurses. Similar concerns were expressed by Holmes (2002b), in regard to the Code of Ethics for Nurses in Australia. He argued that the Code is a tool which serves to maintain the status quo by articulating that which “the audience wants to hear” (Holmes, 2002b, p. 17). A further concern is that the Code runs the risk of encouraging “moral passivism” where nurses can “subscribe to the highest moral ideals and believe that by doing so they have discharged their moral responsibilities towards others and yet, at the same time, never lift a finger to help another person.” (Johnstone, 2001, as cited in Dakin, 2001: p.25). This concern was also raised by Pattison (2001) with regard to many nursing codes, resulting from what he argues are inherent ethical defects in the codes themselves. A more recent study of nurses’ knowledge and use of their ethical codes found that on the whole nurses did not use their codes; the authors concluded that for most nurses the code was irrelevant to their day to day work (Tadd, et al., 2006). Another recent study conducted in a nursing home in Norway found that nurses tended to focus on patients problems from a biomedical perspective. Nurses when faced with ethical problems transformed these into “technical-rational problems” and their solutions were guided by time and daily routine, despite knowing that this was against patients’ interest. The authors concluded that the nurses did not recognize the moral challenges in the small everyday episodes of their work (Solum, Slettebø & Hauge, 2008).

On the international stage there has been a push by the European Federation of Nurse Regulators in response to nurses increased mobility throughout Europe to enhance patient safety and public protection through establishing a Code of Ethics and a Code
of Conduct for European Nursing. The expectation is that European nurses will comply with the standards set by the Code, the main objective of which is to protect the public. The document is expected to provide a common understanding amongst nurses and the public about the values and codes which govern nursing (Sasso, Stievano, Jurado & Rocco, 2008). Here, clearly the purpose of the Code is protection of the public (as opposed to the development of ethical understanding of practice), which is to be achieved through nurses’ compliance with a set of standards. The question that has to be asked of this prescriptive approach to nurses’ ethical practice is whether ethical practice which must arise from ethical thinking and reflection can be mandated in such a way. One of the problems with this approach is that whilst there may be agreement as to what constitutes the ethical values of the profession, the application of these as standards to specific practice situations cannot be commonly understood. To assume a common understanding is to assume that all nurses think and act in the same way, and have access to the same resources. It presupposes a level of commonly held expertise by all nurses.

A study of Italian nurses revealed they viewed their Code strictly as a set of guidelines which were useful for ethical reflection and examination of their practice in specific situations (Barazzetti, Radaelli & Sala, 2007). Similarly a recent Finnish study revealed that student nurses valued their codes as a means of providing knowledge of ethics and values (Numminen, van der Arend, & Leino-Kilpi, 2009). This finding however needs to be interpreted with caution given that the study participants were student nurses and educators, who were exposed to education about the codes. The student nurses may not have held the same views once they were in practice and no longer exposed to an educational framework with which to support their knowledge and use of the codes in day to day practice, furthermore the study does not address the issue that education alone will not alleviate the practice gap which exists between the ethical principles of the codes and the reality of daily practice.

In a study conducted to review Belgian nurses’ views on the development, dissemination and implementation of a code of ethics, the authors noted the lack of literature investigating the role of codes of ethics in ethical decision making and the factors which comprise an effective code. Their study revealed that nurses believed
that effective implementation was crucial to its success and that this required education as part of their initial training, implementation and support for the use of a code by administrators at the workplace, and ongoing training. They noted there was no consensus in regard to whether the code should have a legal or disciplinary function. Overall the nurses felt that a code well supported at an institutional level, by such means as provision of the Code to all departments within a hospital, ongoing training, and participation as partners in policy-making decisions, would assist them to deal with ethical dilemmas. (Verpeet, de Casterle, Lemierre, & Gastmas, 2006, p. 539). However according to Numminen, van der Arend & Leino-Kilpi (2009) there is a scarcity of research which focuses on education and teaching of codes.

In a critique of the ICN Code of Ethics and a number of other European nursing codes Edgar (2004) argues that these codes are based on general principles or statements which do not provide for the specific nursing situation to which they are supposed to be applied and as such a gap exists between the general principle and the situation faced by the nurse. Furthermore he argues that such general principles assume a level of knowledge and expertise on behalf of the nurse which the nurse is expected to use when applying the principle to practice; in other words they presuppose a standardized level of competence. The problem with many of these codes he argues is that they assume a problem solving approach which he likens as being akin to mathematical modeling, where a particular formula (read standard) can be applied to any set of problems to solve the dilemma. The problem he identifies with this approach is that it ignores the complexities inherent in each ethical situation faced by nurses, which cannot be effectively resolved by application of a standardised principle. He argues that:

Few moral problems are worthy of the name if they can be resolved clearly and precisely to everyone’s satisfaction, with no residual sense of harm or injustice being felt by any of the parties involved (Edgar, 2004, p. 162).

In another study undertaken between Chinese and Swedish nurses to compare their ethical concerns it was found that both groups of nurses experienced similar workplace distress and ethical problems and that the nurses were struggling with the
same types of ethical dilemmas, in particular, conflicting views with physicians on the right course of treatment for patients and limited power to fulfill the nurses duty to provide the best care (Wadensten, Wenneberg, Silen, Tang, & Ahlstrom, 2008). The use of professional codes was not discussed in the study, even though nurses were specifically asked how they coped with ethical dilemmas at work. One can only assume that failure of the nurses to mention codes of ethics means that they either do not use; do not know about, or do not have access to ethical codes.

Similarly an Australian study undertaken in Victoria to explore nurses’ experiences of ethical issues and how effectively they deal with them, reported that of the nurses surveyed the majority would discuss ethical issues with their peers and or nursing leadership (Johnstone, Da Costa, Turale, 2004). Like the previous study, the Code of Ethics did not rate a mention in the published findings, however as a significant percentage of the nurses surveyed revealed that they had a reasonable knowledge of ethics in nursing practice, it is unlikely therefore that they did not know about or have access to the Code of Ethics, which leads to the conclusion that perhaps they simply did not use the Code of Ethics.

In a critique of professional codes, in particular the 1992 UKCC Code of Professional Conduct; based on the question as to whether nursing codes are ethical and whether they are able to promote ethical behaviours and awareness amongst nurses, the author argues that the codes “do little to develop or support the active independent critical judgement and discernment that is associated with good moral judgement and, indeed, good professionalism” (Pattison, 2001, p. 8). He presents a view that the Codes are limited in their ethical focus and that they attempt to serve multiple functions, such as professional self preservation and rules for action and in doing so effectively negate any ethical agenda. He argues that including other such functions within an ethical code implies that these are ethical functions, and that this is at best ambiguous and at worst misleading. He is critical of codes for their failure to “enshrine the principle of honesty and truth telling” (Pattison, 2001, p. 9) and argues for the inclusion of a common universal set of moral principles to promote ethical behaviour. He is critical of the codes use as a tool to find professional misconduct and its failure to define or explain the meaning of such terms, arguing that it “fails to be either good law or regulation, or to be good ethics” (Pattison, 2001, p. 14).
More recently, Pattison & Wainwright (2010) reviewed the latest version of the United Kingdom Nursing and Midwifery Council code of conduct which was published in 2008. They are critical of its claim to act as a code of ethics arguing that it has introduced a specific, narrow understanding of ethics. They argue that it promotes an idealised and unrealistic notion of the ethical nurse which in their view functions to disempower nurses with regard to developing their ethical thinking and ethical practice. (Pattison & Wainwright, 2010, p. 14).

In a review of the literature on codes undertaken by Holmes & Williams (2007) for the ANMC as part of their review of the Australian Codes, they found that much literature called into question the effectiveness of codes. They report that there has been little research on the effectiveness of codes and that studies that have been published demonstrate a lack of knowledge and awareness amongst nurses about their ethical and professional Codes. Nevertheless, Holmes & Williams are optimistic about a change in the status of codes, reporting that over eighty eight percent of nurses and ninety eight percent of midwives who responded to an on-line questionnaire to review the Code of Ethics and the Code of Professional Conduct for Nurses and Midwives in Australia, were aware of the Codes and used the Codes in practice, for personal development and for education (Holmes & Williams, 2007, p. 154). However, these findings need to be interpreted with caution as there is no indication as to the number of nurses who responded to the questionnaire, and there is a likelihood that the sample was skewed because nurses and midwives who had an interest in this area were more likely to respond than those who didn’t.

The relevancy of the Code of Ethics to the day to day practice of nurses is questionable, if as according to Holmes, the Code is nothing more than “a tool for the internal regulation of nursing practice in the pursuit of professionalization” (Holmes, 2002b, p. 17). He goes on to say that even in this respect it has not been successful, having failed to command respect outside of nursing. Indeed Chiarella (2002, p. 138), states that “…the professional role of nurses is consistently diminished by the courts and tribunals when it is examined alongside the professional authority of doctors.”
However in a more recent publication undertaken as part of the final report on codes for the ANMC, Holmes and Williams (2007) state that the proposed *Code of Ethics* reflects the insights gained from the literature about codes by:

Providing general guidance rather than specific instructions, providing an ethical framework within which practice must be located rather than mandating specific commitments and actions, and employing language which is sufficiently non-prescriptive as to stimulate reflection (Holmes & Williams, 2007, p. 152).

What an analysis of the literature has revealed is that amongst nurses internationally there is limited understanding, knowledge and use of professional ethical codes. Amongst some authors there is also a concern that an overriding push for professional status has been at the cost of ensuring a fair and useful set of ethical guidelines for nursing practice. This analysis of the Codes and the literature on the use of the *Code of Ethics* reveals the expectations of the profession do not meet the day to day practice needs of nurses. I argue this places nurses in an invidious position and leaves nurses facing the dilemma that use of the Code may leave them exposed in regard to disciplinary matters. In light of this conclusion the next section will examine the relationship of the Codes to the Tribunal.

**The relationship of the Codes to the Tribunal**

Such a conclusion warrants an analysis of the relationship of the Codes, in particular the *Code of Ethics* to the Tribunal. The purpose of disciplinary proceedings according to Mr Justice Kirby are that: “Disciplinary proceedings against members of a profession are intended to maintain proper ethical and professional standards, primarily for the protection of the public, but also for the protection of the profession.” (HCCC v Litchfield, 1997, as cited in NRB, 2001, p. 4).
According to Johnstone (1998), matters involving nurses, that come before a professional conduct committee may be evaluated against the standards contained in any or all of the professional codes or national competencies. She notes that the standards of ethical conduct expected of nurses is referred to in all the professional codes or competencies.

In NSW the passing of the Act enabled a new disciplinary structure for hearing complaints against nurses in the form of a Committee or Tribunal (Chiarella, 2002; Nurses and Midwives Act, 1991 NSW). In making a decision about professional misconduct a Tribunal has to decide if the allegations which constitute the complaint are proved, they then have to determine if the nurse is guilty of unsatisfactory professional conduct based on whether or not there was a breach of standards and then finally whether the breach of standards is sufficiently serious to justify removal of the nurse’s name from the Register or Roll (NRB, 2001, p. 119). According to the Board:

In order to establish a breach of standard, the Tribunal is expected to apply the normative standards which exist to establish proper practice (NRB, 2001, p. 119).

Indeed the Courts have held that professional misconduct is measured by the extent to which the conduct departs from the proper standards (NRB, 2001, p. 120). The Act provides for the Board to establish codes of professional conduct. The first Code of Professional Conduct for Nurses in Australia was published in 1995. It identified that the working framework for nursing practice consisted of the Code of Ethics, the Code of Professional Conduct and the published practice standards for nursing in Australia. A revised version of the Code of Professional Conduct published in 2003 was more specific with regard to the make up of professional standards identifying these as encompassing:

- the Code of Professional Conduct,
- the Code of Ethics for Nurses in Australia,
- the ANC Competency Standards for Registered and Enrolled Nurses,
other endorsed standards or guidelines published by the state and territory nurse regulatory authorities, and
standards developed by professional nursing organizations.

The latest version of the *Code of Professional Conduct* published in 2008, specifically links with the *Code of Ethics* by the following statement:

These two companion Codes, together with other published practice standards (eg competency standards, decision-making frameworks, guidelines and position statements), provide a framework for legally and professionally accountable and responsible nursing practice in all clinical, management, education and research domains (ANMC, 2008a, p.1).

The *Code of Professional Conduct* requires a nurse to practice in accordance with the agreed standards of the profession and contains a warning to the effect that a breach of the Code may constitute professional misconduct or unprofessional conduct (ANC, 2003). According to the ANC, regulatory authorities when dealing with professional conduct issues “address concerns about an individual practitioner’s professional standards and conduct, and use the outcomes to further develop the profession” (ANC, 2000, p.1).

The 2008 version of the *Code of Professional Conduct* is more specific and indicates that the conduct standards discussed in the Code are mandatory. The document further defines professional misconduct and unprofessional conduct as:

Professional misconduct refers to ‘the wrong, bad or erroneous conduct of a nurse outside of the domain of his or her practice; conduct unbefitting a nurse’ (eg sexual assault, theft, or drunk and disorderly conduct in a public place). Unprofessional conduct refers to ‘conduct that is contrary to the accepted and agreed practice standards of the profession’ (eg breaching the principles of asepsis; violating
The ethical and professional conduct of nurses appearing before the Tribunal has not been widely discussed in the literature. Two reports relating to nursing tribunals were uncovered in a literature search. The first completed in 1998, was a report to the Nurses Board of Victoria on *Determining and Responding Effectively to Ethical Professional Misconduct in Nursing* (Johnston, 1998). The report was “a critical examination of the notion [of] ethical professional misconduct in nursing” (Johnstone, 1998, executive summary). The report identified three types of ethical professional misconduct, which are defined as “unethical conduct (moral turpitude/moral delinquency), moral incompetence, and moral impairment” (Johnstone, 1998, executive summary). In addition the report identified “simple non-compliance, conscientious non-compliance, and coerced non-compliance” (Johnstone, 1998, executive summary), as behaviours which are not considered to constitute ethical professional misconduct, but which do however involve a breach of ethical standards. Finally the report identified three strategies, preventionist, interventionist and postventionist [sic], which may be used by nurse regulating authorities in response to issues of ethical professional misconduct (Johnstone, 1998). The second report arose from a project to review professional conduct matters in New South Wales, and to develop case studies for the ongoing education of registered and enrolled nurses. Subsequently a case book was published to provide information about how complaints against nurses are managed in New South Wales. The case book emphasised that the purpose of the registering authority is protection of public health and safety (NRB, 2001, p. 3).

The literature on the disciplinary use of codes is scant. In a Dutch study it was reported that a specific function of the codes of ethics was to provide a disciplinary mechanism, however the codes had not as yet functioned in that sense as they had not been referred to in verdicts made against nurses. The authors in this study argued against the use of codes for disciplinary functions believing that this would encourage defensive nursing practice, which in their view defeated the purpose of codes of ethics which was to act as a guide for ethical conduct (Heymans, van der Arend, & Gastmans, 2007). Similarly in a study of the *Italian Code of Deontology* it was found
that participants did not see the Code as providing protection for nurses, rather they
saw its role as providing guidelines as opposed to a protocol for practice. They
believed for nurses to act with autonomy and responsibility their actions in a given
situation could not be prescribed (Barazzetti, Radaelli & Sala, 2007). In a study
conducted by Tadd et al., (2006) involving nurses in six European countries (UK,
Finland, Italy, Greece, Poland and the Netherlands), there was a mixed response to
the idea of codes being used as a disciplinary measure, with some believing codes
should fulfill this function and others opposed to such an idea, believing they are too
general to be used in such a way. There was also a level of resentment at the idea that
the codes obliged nurses to report on the conduct of other nurses. In a review of the
NMC Code, Pattison and Wainwright (2010), are critical of the use of ethics in
relation to disciplinary aspects of the Code, arguing that it should not be used as a
quasi-legal instrument because this will encourage conformity as opposed to
professional development and reflection, which they argue are essential to ethical

In a recent publication, Johnstone (2009) warns that practising within a code will not
necessarily protect a nurse against a complaint heard by a disciplinary hearing or a
court. She also warns against the risk that the requirements of a code “may be taken
as absolute, and as ends in themselves, rather than as prima-facie guides to ethical
professional conduct” (2009, p. 22). Yet it is clear from the Code of Professional
Conduct that nurses are obliged to practice according to the standards of the
profession, and in the most recent iteration of the Code of Professional Conduct there
is a clear statement about the legal and professional obligations of each nurse to abide
by these standards, so it is difficult to see how a nurse would not interpret the
standards of the Codes as binding. Given that increasingly the Codes are being used
in NSW by professional standards committees and tribunals to determine if a nurse’s
actions are contrary to the standards of the profession, this raises the question as to
how a disciplinary body will interpret the standards of the Codes when examining
complaints against a nurse; and how they determine findings of unethical conduct.
Conclusion

A lack of literature critiquing the purpose, role and outcomes of the Tribunal, and the lack of research into how the Tribunal constructs its findings in relation to the conduct of nurses appearing before the Tribunal reveals a tacit and unquestioning acceptance of the role of the Tribunal and its processes. Additionally a lack of research into the relationship between Tribunal findings of unethical conduct and the Code of Ethics raises questions about how the unethical nurse is constructed in disciplinary proceedings.

This presents a significant dilemma for nurses who find themselves charged with unethical conduct. There seems to be an unquestioned assumption that nurses know what constitutes unethical conduct; however there is a dearth of research or literature to support this assumption. Indeed the view expressed by Edgar (2004), that it is not possible to quantify moral problems and that “moral competence allows one to do something, and what precisely one does depends on the understanding of what it means to be a professional nurse in that unique situation” (Edgar, 2004, p.172), highlights the difficulty in being able to locate and clearly articulate a definition of unethical conduct. If, as according to Edgar, “ethics lies in the recognition of the problem, not in its solution” (Edgar, 2004, p. 166), it raises questions about how it is possible for a Tribunal to quantify the conduct of nurse as unethical. Finding a nurse guilty of unethical conduct suggests there is some sort of measurable ethical standard such as a Code of Ethics which can be applied to the conduct of the nurse.

This is problematic because the literature reveals that internationally codes of ethics are on the whole not understood or used by nurses. The review of the literature highlights that there is very little research which the points to the effectiveness of codes of ethics as a tool for professional practice, on the contrary the research demonstrates that on the whole the codes are an ineffective tool. This underscores the concern held by some nurses that the codes simply serve the limited purpose of shoring up the professional status of nursing.
Whilst there have been studies critiquing codes of ethics in nursing, there has however been very little research on how nurses are supported in their use of codes of ethics; in particular how nurses are educated about ethics and how they might apply this knowledge to the use of codes in their day to day practice. The position in Australia according to Johnstone, Da Costa & Turale (2004, p. 24) is that there has been no analysis of formal education and how it prepares nurses to deal with ethical issues.

There seems to have been an assumption by nursing regulatory bodies that the mere provision of a code was sufficient for them to meet their responsibility to engender a knowledge, understanding and use of codes amongst nurses. There has been no serious examination or analysis of how best to support nurses in developing and applying their understanding of ethical practice. In this sense the regulatory bodies for nursing can be seen to have failed nurses and as a direct consequence they have also failed in their responsibility to protect the public.

The literature demonstrates that there is concern amongst nurse ethicists about the lack of research into, and education about, issues of nursing ethics in both theory and practice. In particular, a review of the literature highlights a number of gaps which include insufficient research into; the Code of Ethics, its purposes and effectiveness; education for nurses about the use of Codes and how to apply the values expressed in the Codes in clinical nursing practice; the use of the Code in disciplinary proceedings and; how the conduct of nurses appearing before the Tribunal is constructed.

The next four chapters will go someway to addressing the last of these issues, by undertaking a critical discourse analysis of how the unethical nurse has been constructed by the Nurses Tribunal in NSW. Discussion of the findings from the analysis and implications for the profession will be undertaken in Chapters Nine and Ten, in which I will canvass the issues of ethical subjectivity, the use of the Code in disciplinary proceedings, and ethics education for nurses.
Chapter Five

Narrative, normalising judgements and surveillance; their use in Tribunal inquiries

Introduction

In this chapter I discuss of the use of narrative and Foucault’s ideas about normalising judgements and surveillance and their relevance to the analysis of the Tribunal inquiries. Following this is a critical examination of the way in which surveillance is used in and around the Tribunal inquiries. The analysis of the Tribunal inquiry transcripts will be discussed in the next three chapters. To set the context for the discussion of the analysis of the Tribunal inquiry transcripts, a brief summary of each of the Tribunal inquiries analysed in this study is provided at the end of the chapter.

For this study I accessed five Tribunal inquiry transcripts from the NSW Nurses and Midwives Tribunal inquiries, where findings of unethical conduct were made against the nurse. The inquiries were conducted between 1998 and 2003 and were selected on the basis of meeting the study criteria which are set out in Chapter Three. In keeping with Foucault’s ideas on discourse and subjectivity, the focus of the analysis of the Tribunal inquiry transcripts is on the way in which the nurse is spoken about by the participants in the Tribunal inquiries where findings of unethical conduct were made.

Analysis of the discourse of nurses’ unethical conduct has not been undertaken to date. Whilst there has been a research focus on nurses’ ethical conduct, an understanding of the meaning of unethical conduct to nursing has yet to be examined. Analysis and discussion in the remainder of the thesis will explore how meaning is given to nurses’ conduct through an examination of how, in individual
Tribunal inquiries, the participants construct and organise narratives about the nurse’s conduct in order to present a particular image of the nurse as unethical. The processes and practices of the Tribunal inquiries which give meaning and power to what is said about the nurse are structured and hierarchised through the mechanisms of surveillance and normalising judgements. It is via these mechanisms of disciplinary power that the discourse of unethical conduct arises and is made visible.

Foucault’s concepts of surveillance and normalisation will be used in the analysis of the Tribunal transcripts to examine the way in which judgements about the nurses are constructed and take effect in each of the Tribunal inquiries. Discussion in this chapter will focus on how the disciplinary mechanism of surveillance was exercised in the inquiries. Subsequent chapters will focus on a detailed analysis and discussion of how normalising judgements were used to construct a preferred narrative presentation of the nurse. These concepts are examined by exploring how relations of power are exercised through the processes and practices of the Tribunal inquiries and through the narrative presentations of the nurse.

A finding by the Tribunal that a nurse’s conduct is unethical conduct presents the public and the profession with a serious issue with which to contend and in consequence legitimizes the role of the Tribunal in the web of relations which constitute disciplinary power. It is anticipated that uncovering how unethical conduct is constructed in the Tribunal inquiries selected for this study, will contribute to the literature about nursing ethics and regulatory practices. In particular, it is anticipated that uncovering how nurses are constructed as unethical subjects will inform knowledge and create debate about Tribunal processes and practices and the use of the Code of Ethics as a disciplinary tool.

The next section of discussion outlines the relevance and significance of the use of narratives and normalising judgements to the analysis.
Use of narrative

Narrative is defined as “the situated, temporally ordered retelling of past events from a particular point of view” (Rymes, 1995, p. 501), and it is through narrative that the speaker is actively able to construct a particular point of view (Rymes, 1995). In the Tribunal inquiries analysed in this study, cultural discourses were drawn upon and intersected throughout narrative to present a cohesive representation of the nurse from the narrator’s point of view. According to Carabine (2001, p. 269) discourses are fluid and opportunistic. In these Tribunal inquiries the construction of the unethical nurse could be seen to be both fluid and opportunistic because normalising judgements made about the nurse were shaped by both the complaints and how the nurse was discursively positioned by the various players in relation to the complaints. The context of the Tribunal inquiry provided the means whereby normalising judgements were formed and given credibility which in turn contributed to discursively created knowledge about unethical conduct.

Each narrative presentation about the nurse arose from a storyline, which I identified as the storyline of the ethical nurse. According to Andersson (2008, p. 145) storylines are defined as “collective and culturally dependent narratives that make up the pillars upon which individuals build their own personal stories.” They provide an interpretative framework which allows meaning to be given to the actions of people and provide the means for identifying how narrative identities are created in relation to societal discourses (Andersson, 2008, p. 150). In other words how the narrative of the unethical conduct of the nurse has been created in relation to the storyline of the ethical nurse. In the analysis for this study, this concept of storylines will be used to examine how the narrators drew upon collective and culturally dependent discourses or norms of ethical conduct as the framework or storyline for making normalising judgements to give meaning to each nurse’s actions.

Analysis of the individual narratives of the Complainant, the nurse and the Chairperson (Chair) in each of the Tribunal inquiries was undertaken by identifying and examining the discourses embedded in the narrative to reveal the way in which
the conduct of the nurse was positioned to present a preferred presentation of the nurse.

**Use of normalising judgements**

Normalising judgements arise out of the panoptic enterprise. In the Tribunal inquiries they are used as the means of measuring each individual nurse’s level of cohesion with the professional body; or as Foucault would call it “the social body” (1995, p. 184). The importance of normality to the profession is that it is the means by which “membership of an homogenous social body” can be specified, and additionally is a means of “classification, hierarchization and the distribution of rank” (Foucault, 1995, p.184). In effect it acts as a means of control of the individual members of the profession. The Tribunal processes and practices use relations of power to exercise normalising judgements as one of the principal functions of its role as a disciplinary mechanism of power.

Along with surveillance, normalising judgements are a technique of disciplinary power, exercised through the Tribunal with the ultimate aim of developing disciplinary knowledge and enhancing disciplinary power. The Tribunal is in fact a process of normalisation, where sanctioned knowledge is used as an instrument of normalisation (McHoul & Grace, 1993, p. 17). From a Foucauldian perspective, knowledge develops alongside techniques of power and, “knowledge gained on the basis of disciplinary power is formulated according to norms of behaviour” (McHoul & Grace, 1993, pp. 70-71).

In order to maintain professional cohesion the disciplines use a process of normalising judgements to identify and establish deviation from the norm, which can then be punished in such a way so as to reduce the identified gap through organisation and standardisation (Foucault, 1995, p. 184). Normalisation is about “judgements about what is normal and what is not in a given population, rather than adherence to absolute measures of right and wrong” (Rabinow, 1984, p. 21), and is used as a technology of disciplinary power to impose and enforce ideological or
“moral evaluations such as the work ethic. The ultimate effect of discipline is ‘normalization’. “ (Best, 1994, p. 37).

These processes of normalisation are evident in the Tribunal inquiries, where nurses who have strayed from the professional norm are required to appear before the Tribunal to have their actions examined, compared and judged in accordance with the norm. Normalising judgements exercised by each of the participants in the Tribunal inquiries arise from cultural discourses about nurses’ ethical conduct. Cultural discourses in this context refer to how people generally assume the majority of nurses’ act, talk and feel. According to Kiesling (2005), cultural discourses comprise and reflect widely held assumptions, which in this case are about how nurses “are and should be” (Andersson, 2008, p.140). Normalising judgements arising from cultural discourses about nurses’ ethical conduct provide the means for specifying both proscribed and prescribed behaviours which in turn are used by the profession to govern and shape ethical behaviour amongst nurses through such disciplinary technologies as the Nurses Tribunal.

Ultimately, in Tribunal inquiries where the conduct of the nurse sits on the continuum between professional and unprofessional conduct determines the outcomes for the nurse. In order for the ultimate finding against the nurse of professional misconduct to be made and for the name of the nurse to be removed from the register, the Tribunal in each of the inquiries first found that the conduct of the nurse was unethical. To do this they had to establish that the nurse’s conduct was in opposition to the norms of ethical conduct.

Normalising judgements made about the nurses’ conduct will be examined by analysing the transcripts of the Tribunal inquiries with a focus on how each participant uses narrative to construct the way in which the nurse is presented and how meaning is attached to this presentation. The importance of these judgements to the profession are that not only do they provide a mechanism for control and correction of the individual nurse through punishment and training, but more importantly, they have the effect of sending a message to the membership of the
profession, about what is and is not acceptable ethical conduct. In addition, these judgements set a benchmark for standards and punishment which can be drawn upon by the Board and subsequent Tribunals. At a much more fundamental level however, they provide a legitimate means for exercising professional power and serve as evidence of the level of commitment the profession attaches to exercising and maintaining professional control.

How normalising judgements are used to construct understandings about the unethical nurse will be the focus of the analysis of the Tribunal transcripts in the subsequent chapters of the thesis. The remainder of this chapter will focus on an analysis of how surveillance had effect in the Tribunal inquiries. This is significant because the Tribunal is located in a context, so in order to understand the way in which the context shaped the inquiries, the processes and practices of the Tribunal will be critically examined. The purpose is to uncover how surveillance was exercised in and around the inquiries and how as a technology of power, surveillance contributed to constructing the unethical conduct of the nurse.

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11 In November 1997 the Board published its first edition of Boardworks, a newsletter of the Nurses Registration Board. This edition provided the first published information for nurses about the disciplinary process. Subsequent editions which have been published at least biannually provide a brief overview of a selection of cases from the Tribunal, Professional Standards Committee and Impaired Nurses Panel. The Board has also published Professional Conduct a Case Book of Disciplinary Decisions relating to Professional Conduct Matters. A second edition is due to be published later this year.
Use of surveillance

Foucault identified the processes of surveillance as one of the important mechanisms of the disciplinary technology of power which along with normalising judgements enables the construction of knowledge. The next section of discussion will provide an overview of the means of surveillance exercised in the inquiries.

Surveillance or hierarchical observation is a means of exercising an all encompassing gaze over the individual nurse. Power relations are an inherent property of surveillance, they extend as a network to encompass the nurse in the “fine meshes of the web of power” (Foucault, 1980a, p. 116). The means by which surveillance is exercised, that is through power relations, occurs at a number of levels. It is through the processes and practices of the Tribunal that the net like organisation of power forms and takes effect. What is apparent from my analysis is how power circulates amongst the participants and how the hierarchical processes and practices of the Tribunal create disparity in the relations of power between the participants. The object of this circulating power is the conduct of the individual nurse which is under the gaze of all participants, and through the Tribunal inquiry, under the constant gaze of the Tribunal members. The effect is to focus the gaze on the individual nurse as subject of the complaints and their aberrant behaviour as the object.

Surveillance is the means by which information can be collected from a variety of sources about the nurse which not only validate the complaints, but which collectively create a context for giving meaning to the nurse’s conduct. It is this process of constructing understanding of each individual nurse’s conduct which allows knowledge about the unethical nurse to be formulated and fabricated. According to Foucault (1995, p.217) surveillance through a whole range of techniques and strategies supports the ‘accumulation and centralization of knowledge’ which has ‘carefully fabricated’ the individual within the social order. The gaze allows for the unethical nurse to be identified, supervised and altered and is a necessary function of the exercise of power by the Tribunal. Foucault in his theoretical analysis, identified disciplinary surveillance arising because: “As the machinery of production became larger and more complex, as the number of workers
and the division of labour increased, supervision became ever more necessary and more difficult.” (Foucault, 1995, p.174). In discussion to follow the ways in which surveillance is exercised through the inquiries is examined.

**An examination of how surveillance operated in and around the Tribunal inquiries**

From a Foucauldian perspective disciplinary power is aimed at cohesion. Regulation arising from legislation provides a means for coercing a large and diverse workforce such as nursing to act as a cohesive whole by constraining and controlling the practice of the individual nurse. Legislation forms part of the network of power relations, part of what Foucault refers to as “the spatial ‘nesting’ of hierarchized surveillance” (1995, p.171-172). In the discipline of nursing one of the means of surveillance is exercised through legal discourse. This takes the form of the *Nurses and Midwives Act 1991* which regulates nursing, and the *Health Care Complaints Act 1993* which regulates the Health Care Complaints Commission (HCCC). These Acts operate as part of a hierarchised network of gazes to specify and make functional surveillance through the Tribunal. The Acts specify processes and procedures which partition and objectify the nurse as a means of disciplinary supervision and control.

The way in which nursing is regulated is specified in the *Nurses and Midwives Act 1991*. Amongst other things, the Act specifies requirements for registration or enrolment and includes a section on the Board, and a section on complaints and disciplinary proceedings. This latter section constitutes a significant proportion of the Act. The Act provides broad information on what constitutes unsatisfactory professional conduct. Importantly, the Act specifies that if a nurse is considered to have engaged in improper or unethical conduct relating to the practice of nursing, a finding of unsatisfactory professional conduct can be made under Section 4 of the Act by a Tribunal (Nurses Registration Board [NRB], 2001, p.117). However the Act does not provide an explanation as to what is meant by improper or unethical conduct.
The meaning of professional misconduct and unsatisfactory professional conduct is set out in the Act in fairly broad terms. Professional misconduct, in relation to an accredited nurse, means unsatisfactory professional conduct of a sufficiently serious nature to justify removal of the nurse’s name from the Register or the Roll. Unsatisfactory professional conduct, in relation to an accredited nurse, includes any of the following:

(a) any conduct that demonstrates a lack of adequate:
   (i) knowledge;
   (ii) experience;
   (iii) skill;
   (iv) judgment; or
   (v) care,
   by the nurse in the practice of nursing;

(b) the nurse’s contravening (whether by act or omission) a provision of the Act or the regulations;

(c) the nurse’s failure to comply with an order or determination made or a direction given under section 48, 55 or 64 or with a condition of registration;

(d) a nurse’s holding himself or herself out as having qualifications in nursing other than:
   (i) those in respect of which the nurse’s registration or enrolment was granted; or
   (ii) those recorded in the register or the roll in respect of the nurse; and

(e) any other improper or unethical conduct relating to the practice of nursing. (s.4 Nurses and Midwives Act 1991).

From the provision in (e) above, it may be possible (although this is not clear in the Act) to infer that all conduct listed from (a) to (d) can be considered by the Tribunal to be improper or unethical relating to the practice of nursing and is grounds for a finding of unsatisfactory professional conduct. Subsection (e) which begins with

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12 Under the Act an accredited nurse means either a registered nurse or an enrolled nurse.
“any other”, in effect extends the gaze of the Tribunal by making provision for the Tribunal to determine, that conduct which does not fall within that specified in the Act, can be considered to be improper or unethical.

Examination of the relevant legislation illustrates how relations of power are constituted within the legislative framework. As a mechanism of surveillance the legislative framework provides a means for identifying and singling out nurses whose conduct does not meet the standards specified in the Act. A direct effect of the lack of clarity in the Act in relation to what is meant by improper or unethical conduct, gives extensive power to the Tribunal to construct the meaning of improper and unethical conduct.

Legislation clearly sets out the relationship between the Board and the Tribunal. The Act specifies that the Board has the responsibility for promotion and maintenance of professional standards (Nurses and Midwives Act 1991). Where a nurse fails to meet the standards, the Board has the capacity to suspend or remove the name of the nurse from the register. A determination of whether or not a nurse fails to meet the standards which may warrant suspension or removal from the register is made by a disciplinary hearing conducted by the Tribunal.

Analysis of legal discourse operating in and around the Tribunal reveals that the discursive context of the Tribunal is shaped by legislation. Established by the Act, the Tribunal is a statutory authority independent of the Board (NRB, 2004, p.3). Under the Act, the Tribunal has and may exercise the jurisdiction and functions conferred or imposed on it, by or under, this or any other Act (s.59 Nurses and Midwives Act 1991). According to the Act:

The Board must refer a complaint to the Tribunal if the complaint is that the nurse has been guilty of professional misconduct or if the Board is of the opinion that the subject-matter of the complaint (not being, in the Board’s opinion, a frivolous or vexatious complaint), if substantiated, may provide grounds for the suspension or cancellation of the nurse’s accreditation. (s45 [2] of the Act).
The *Health Care Complaints Act 1993* which applies to all health care practitioners in NSW forms part of the legal discourse which operates in and around the Tribunal. Together with the *Nurses and Midwives Act 1991*, these Acts focus the gaze of the Tribunal squarely on the actions of the nurse. One of the specified functions of the *Health Care Complaints Act* is “to provide an independent mechanism for assessing whether the prosecution of disciplinary action should be taken against health practitioners who are registered under the health registration Acts.” (Health Care Complaints Act 1993, Part 1, s.3 [d]). The HCCC is a statutory authority constituted by the *Health Care Complaints Act 1993*. Its specified functions include receiving and dealing with complaints about the professional conduct of health care practitioners including their clinical management or care of individuals.

Legal discourse constituted by the Acts, creates a net like organization where power flows from the relationships constructed within this discursive context. Within these Acts, both the HCCC and the Board can receive a complaint about a nurse or midwife, and are responsible for notifying and consulting with each other with regard to the complaint. The complaint will be investigated if either body decides the complaint warrants such investigation. The HCCC is responsible for assessing and investigating the complaint. After assessing the complaint, if it is found that the complaint raises significant issues of public health and safety, appropriate care or treatment of a client, or provides grounds for disciplinary action, the complaint must be investigated by the HCCC (Health Care Complaints Act 1993, s.26). The HCCC has significant and extensive powers of investigation. After investigating a matter, if the HCCC determines the nurse is guilty of professional misconduct, the matter is referred to the Board for prosecution by the Tribunal. On referring the matter to the Tribunal the HCCC in effect becomes the Complainant and throughout the inquiry is referred to as the Complainant.

These specifying functions of legislation effectively map out the power relations to be operationalised through the Tribunal. This leads to a hierarchical flow of power from the Board and the HCCC, through the Tribunal to its ultimate destination the nurse. In this relationship, surveillance is aimed at collecting information about the nurse, the nurse ‘does not have the reciprocal power to ‘observe’ the observer’; the flow of power is not equal (McHoul & Grace, 1993, p.71).
From this analysis it is can be seen that legal discourse is a powerful discourse which provides for an effective and extensive network of surveillance. The discourse not only specifies the structure and function of the Tribunal, but specifies the types of complaints which can be made, the nature of the relationship between all participants in the Tribunal processes and importantly the extent of surveillance which can be undertaken in the process of establishing and finding proven a complaint of professional misconduct. Ultimately the discourse provides through the mechanism of surveillance, the means for both segregating and coercing the individual nurse to conform to the cohesive whole of the nursing profession.

**Surveillance and the Tribunal**

The Tribunal is a relatively recent institution which commenced hearings in 1992. The Tribunal acts as one of a series of systems of supervision of the vast workforce of nurses registered or enrolled with the Board. Through the Tribunal, the Board is able to exercise its legitimate disciplinary power for the protection of the public and the profession. In order to exercise such power there needs to be a system, a means of surveillance, whereby individual nurses, who represent a threat to the protection of the public and the profession, can be made visible by processes such as identifying, classifying and ultimately controlling their actions and behaviour. The discursive context of the Tribunal provides such a means.

The Tribunal is constructed by legislative discourse, which sets out the rules, processes and practices under which it can operate. Whilst it has no juridical authority, it nevertheless has legislative authority. Reference to legislation was made in all the inquiries analysed for this study. In the following example the Chairperson explains how legislation constructs the hearing.

We have to carry out an inquiry in the procedure that’s set out under the Nurses Act. The starting point really in terms of what we do is set out in section 44, and I’m not going to suggest that you start trying to plough through the Nurses Act
now, but Section 44 sets out a number of grounds on which
the Health Care Complaints Commission can make
Complaints to us. (T1, Day 1, p.16).

The Tribunal “comprises two accredited nurses and a lay person, and is chaired by
the Chairperson or a Deputy Chairperson of the Tribunal who must be a judge or
legal practitioner of at least seven years standing” (NRB, 2001, xi). In this hierarchy
of surveillance, the members of the Tribunal, led by the Chair are responsible for
conducting the inquiry and for making and handing down findings about the nurse.
Surveillance arising out of the discursive context of the Tribunal directs the flow of
information and the relations of power. For these relations of power to be effective,
the Tribunal members rely on information collected about the nurse (who is
sometimes referred to as the respondent in the inquiries) by participants involved in
the inquiry. This information is provided either directly by those who are called to
give evidence at the inquiry or indirectly through evidence gathered by the HCCC
which becomes the Complainant once the matter goes before a Tribunal. Evidence
collected by the Complainant which is presented to the Tribunal, demonstrates the
extent of surveillance undertaken by the Complainant. Evidence usually includes
information about the nurse’s mental health, hospitalisations, court convictions and
issues to do with personal relationships, as illustrated by the following example. In
this example the nurse is the respondent.

The respondent had extensive personal difficulties which
accumulated, culminating in the commission of the offences
for which the respondent was before the Court in X date and
of which the respondent was convicted in X date. Those
difficulties are referred to at page X and X of Dr X report.
The respondent was involved in a car accident in which the
respondent was run off the road in X date, possibly resulting
in post-traumatic stress disorder. At about that time the
respondent’s personal relationship with a partner of a number
of years also ended and the respondent moved from X
address. The respondent was having difficulty as well with
the respondent’s daughter who was undergoing the HSC examinations in that year. Dr X was of the view that those matters were directly linked with the respondent’s fraudulent appropriation of money from bank accounts of the X residents for whom the respondent was caring in X date. The respondent was hospitalised at X hospital between X date with a serious depressive disorder and hospital admission should be seen as the culmination of the difficulties from which the respondent was suffering over that period. (T2, Day3, p.5).

In the Tribunal surveillance is continuous, it is not simply limited to the function of collecting information about the conduct of the nurse for a determination by a Tribunal. It also serves the function of protecting the public and coercing the nurse to conform to the normative standards of the profession. The following example highlights how surveillance continues after the Tribunal findings have been handed down.

The Tribunal is of the view that the respondent will be in a position to practice after a period of some 12 months under certain strict conditions. They involve supervision, the respondent’s participation in effective drug counselling and treatment, as well as monitoring of the respondent’s practice. In that way, both the public interest as well as the respondent’s personal interest will be served. By removing the respondent’s status as a registered nurse while allowing the respondent to practise later when fit as an enrolled nurse, leaves the respondent incentive to help the respondent. (T1, Day 3, p.14)

An analysis of the Tribunal inquiries to be discussed in the following chapters reveals the extensive nature of the gaze. Depending on the particulars of the complaints this involved evidence from the following sources; colleagues, supervisors, police, doctors, psychiatrists, counsellors, medical records and the
Board. Within this technology of surveillance, legal discourse which shaped the Tribunal processes and practices enabled other powerful discourses in particular medical discourse to be drawn upon in constructing both the complaints and the findings about the nurses in this study. The intersection of powerful discourses significantly strengthened the relations of power which operated within and around the Tribunal.

In the hierarchy of power relations constructed by this system of supervision, the Tribunal operates as a seat of power, legitimised under the Act it is able to function as a centralised authority using a network of intersecting gazes to exercise power. The structure of the Tribunal permits an extensive and pervasive surveillance of the nurses who appear before it. Through a series of intersecting gazes the collective focus is entirely on the actions of the nurse. What is taken in by the gaze is any past, present or possible future actions of the nurse which support the complaints made about the nurse. In this regard there are no boundaries the gaze can reach as far back as childhood or project the future. Surveillance not only makes visible the unethical conduct of the nurse but puts in place a means for constraining and controlling the nurse with the intention of making the nurse conform to the desired image of the profession.

**Surveillance and the Complainant**

The role of the Complainant is central to the gaze. Within the discursive context of the Tribunal, the Complainant is a very powerful participant. The Complainant is represented in the inquiries by a legal officer, usually a barrister. The Complainant has power to investigate allegations against the nurse, collect information in regard to the allegations, formalise the complaints and subsequently bring the nurse to the attention of the Tribunal. This process of hierarchical observation operates in the form of an extensive network of relations of power which enables the Complainant to collect and convey information from people connected with the minutiae of the nurse’s actions to the Tribunal. Legal discourse shapes the rules and processes of the inquiry. Within the inquiry the powerful position of the Complainant is reinforced
because of the privileged access they have to legal discourse through their representation in the inquiries by a barrister. The power of the Complainant lies in their authority to not only exercise but also control the extent of the gaze and in doing so set the context to shape the positioning of the nurse. Ultimately, the power to make findings about the conduct of the nurse rests with the Tribunal members whereas the power of the Complainant lies in the capacity to shape the way the nurse is spoken about. Here, we can see at work one of the central tenets of Foucault’s thesis on disciplinary power, which is that power is not located with any one person or body such as the Tribunal or the Complainant, rather it is hierarchised and diversified.

The *Health Care Complaints Act 1993* specifies the means by which the Complainant can investigate a complaint against a nurse and specifies the powers to carry out the investigation. The powers of investigation include a network of activities such as obtaining expert reports, authorisation to enter, search and seize documents, and interview and obtain information from persons in relation to the matter. Through the process of collecting information about the nurse, the Complainant if satisfied that the information can be used as evidence, can formally lodge one or more complaints with the Tribunal. Once a complaint has been lodged, it is the wording of the particulars of the complaints which affords the Complainant the opportunity in the inquiry to probe and reveal the personal and professional history of the nurse.

The Complainant does not have a free hand in constructing the complaints which can be made against a nurse. The Complainant must select the appropriate complaints from those specified and detailed in section 44 of the Act. The complaints are generic in nature and as such provide the opportunity for more specific detail in the form of both personal and professional particulars which single out and identify the individual actions of the nurse. In order for the nurse to be found guilty of the complaints before a Tribunal, the particulars have to be proven by the Complainant to the satisfaction of the Tribunal members, and the Tribunal members have to find the evidence supports a finding of unsatisfactory professional conduct or professional misconduct within the meaning of Act.
In the hierarchy of decision making that exists in the inquiries, the onus is upon the Complainant to convince the Tribunal members about the particulars of the complaints. In the inquiries analysed for this study the Complainant used a number of strategies to achieve this end. By drawing on relations of power made possible by legal discourse, the Complainant was able to collect information that included details about each nurse’s professional practice, health history and social history.

In effect, the complaints arising from surveillance are a technology of disciplinary power which provides the Complainant the means for singling out and objectifying the actions of the nurse. According to Foucault (1995, p. 47) the productive function of the gaze is increased by specifying the type and process of surveillance and making it functional. By focusing on smaller and smaller elements the Complainant was able to gather and relay the minutiae of information about the nurse through the various networks which made up the gaze. From a Foucauldian perspective, it is through processes such as these that the disciplinary gaze is expanded.

**Surveillance and the nurse**

Analysis of each of the Tribunal inquiries revealed the extent and effect of surveillance exercised on the nurse, where the purpose of surveillance was to focus an intense and uninterrupted gaze on the nurse. The response of the nurse however was not simply as a passive recipient of surveillance rather the nurse at times resisted this technology of power, and at other times succumbed to the coercive intent of surveillance. These seemingly contradictory actions of the nurses reveal the play of power as each nurse attempted to negotiate their preferred position within this disciplinary technology.

Foucault believed that disciplinary power (as opposed to force or violence) could only exist where subjects were free and as such had the possibility of resisting (Foucault, 1983, pp. 224 - 226); and that resistance directed at specific techniques or instances of power is the most effective form of resistance (McHoul & Grace, 1993, p. 86). Where there is no possibility of resistance then power is fixed in a state of
domination rather than in a relationship to the subject, and therefore exists as sovereign power (Winch, 2005). It is the extent of domination which constitutes limits to the autonomy of actions of those subject to it. From a Foucauldian perspective, autonomy is understood as ‘a capacity to govern one’s own actions’ (Patton, 1998, p. 73.).

Analysis of each of the Tribunal inquiries revealed there was marked resistance by the nurses to all forms of surveillance. The approaches to resistance adopted by the nurses, reflects how they subjectively positioned themselves in the relations of power which constitute disciplinary power. How autonomous the nurse actually was within these relationships was reflected in the level and type of resistance offered by the nurse. This took the form of targeting all the techniques of disciplinary power through offering passive resistance by; refusing to cooperate, actively challenging the findings of surveillance, offering alternative interpretations of the evidence, and finally by refusing to be coerced by the findings of the Tribunal. In each of these instances of resistance the nurse was engaged as an agent in their subject positioning. According to McHoul and Grace (1993, p.87): “If resistance is to be effective, it requires the active interrogation of the tactics employed in a struggle.” Ultimately however, the disciplinary techniques which operated through powerful discursive frameworks allowed for the unequal exercise of power and limited both the capacity and effectiveness of the tactics of resistance exercised by the nurse.

The following extract from a Tribunal illustrates the resistance offered by one of the nurses to surveillance by the Board. In this instance, the Complainant informed the Tribunal about the failure of the nurse to attend an Impaired Nurses Panel13 which had been set up to investigate complaints about drug taking by the nurse.

13 See Chapter One - under the Act a nurse who is impaired can be required to attend an Impaired Nurse Panel.
Under Tab x the Board on the X date writes to the respondent and in paragraph two indicates its resolve to convene an Impaired Nurses Panel to inquire into the extent of the respondent’s current health problems. And in the second last paragraph in the second sentence advises the respondent the Board’s policy X in other than exceptional circumstances may be regarded in itself as being evidence of impairment. Under Tab x there’s a further letter to the respondent from the Board dated X which refers to the respondent’s failure to attend a meeting with the Impaired Nurses Panel on X date and failure to notify the Board of any inability or decision not to attend.

In the final paragraph indicates that the respondent’s been given one final opportunity to participate in the impairment process. Under Tab xx is another letter from the Board to the respondent on the X date indicating they don’t seem to have appeared any … appeared to have received any response from their letter of the X date and that the matter had been resubmitted to the Board. The committee resolved that the respondent be reminded of the confidential non-disciplinary nature of the impairment process and of the fact that if you choose once again not to respond to the Board’s approach the matter will be treated as a disciplinary issue and ask the respondent to respond within fourteen days of the X date. Then under Tab xx of the documents is a letter from the Board to the complainant dated the X date which outlines the Conduct Committee of the Board on the X date consider advice from the Impaired Nurses Panel in relation to the respondent’s non-compliance with a request that the respondent attend a medical assessment and it was resolved that the matter be referred to the Health care Complaints Commission for investigation and report as a disciplinary issue. (T3 day1, p.24–25).
In response to the evidence of the Complainant, the Chair of the Tribunal set out how the legislative framework is constructed to deal with this type of resistance.

While attendance at an Impaired Nurses Panel is, strictly speaking, not obligatory, s.70L empowers the Board to take failure to attend an Impaired Nurses Panel into account when considering a person’s application for accreditation. Further, s.70J permits the Board under certain circumstances to treat a matter which it had referred to an Impaired Nurses Panel as grounds for a complaint within the disciplinary process of the Act and refer the matter to the Health Care Complaints Commission. (T3, day2, p.7).

The capacity of the nurse in these inquiries to offer resistance was limited by the unequal power relations created by the discursive framework of surveillance. The immense power created by legislation for all parties involved in surveillance, but in particular for the Complainant to investigate, collect and collate information about each nurse, practically speaking left these nurses with little capacity for resistance except through passive means. Significantly, regardless of their relative powerlessness, each of the nurses exercised some form of resistance through the tactics of choosing not to comply with the means of surveillance.

Such resistance was risky for these nurses because legislation (of which the nurse may or may not have been aware) provided a means for interpreting such behaviour as further evidence of their misconduct. Where a nurse refuses to attend for medical examination or before a “confidential non-disciplinary” impairment hearing of the Board, the Act provides that failure to comply is “evidence that the nurse does not have sufficient physical and mental capacity to practise nursing” (s45 [6]), and additionally, may refer the matter of failure to comply to the Tribunal (s55 [4]). Here, we can see how the discursive framework of surveillance provides for the intersection of legal and medical discourses from which knowledge about the nurse can be constructed.
Conclusion

The focus of this discussion has been on exploring how surveillance was used as a technology of disciplinary power in and around the Tribunal inquiries. The discursive context in which these relations of power were operationalised was created by legal discourse and intersected with other discourses, most notably medical discourse, to frame the way the nurse was spoken about. As a result of these powerful discourses, the relations of power operating within the technology of surveillance are not equal and this raises questions about procedural fairness. These questions arise because of the lack of clarity in the Act about what is meant by improper or unethical conduct which leaves this concept open to the Complainant to interpret; and also because the very powerful discourses drawn upon by the profession in exercising surveillance are not readily available to the nurse. These issues and the implications arising from them will be discussed more fully in the last two chapters of this thesis.

Discussion in the next three chapters will now turn to the analysis conducted on the narrative presentations of the nurse in the five Tribunal inquiries which were selected for this study. In order to set the context for the analysis overall, the remainder of discussion in this chapter will provide a brief overview of the Tribunal inquiries analysed in this study. The complaints which could be made against a nurse at the time of these inquiries are set out on the next page, and a summary of the complaints and particulars of each case are provided on pages 135 – 138. For ease of reference, the inquiries are summarised in table form on page 139.

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14 Complaints are set out in the Nurses and Midwives Act 1991 (NSW). The ‘particulars’ refer to the information collected on the nurse by the HCCC which supports each complaint. Chapter One provides an overview of the Tribunal.
Complaints which can be made under the Act

Complaints which may be made about a nurse are set out in Section 44(1) of the *Nurses and Midwives Act 1991 (NSW).*

44(1) A complaint may be made that an accredited nurse:
(a) has been convicted of an offence (either in or outside New South Wales) and the circumstances of the offence render the applicant unfit in the public interest to practise nursing, or
(b) suffers from an impairment; or
(c) has been guilty of unsatisfactory professional conduct; or
(d) has been guilty of professional misconduct; or
(e) does not have sufficient physical or mental capacity to practise nursing; or
(f) is not of good character.

Overview of the inquiries

There were five Tribunal inquiries selected for analysis in this study. The findings for these inquiries were delivered between 1998 and 2003. The respondent in each inquiry was the nurse against whom the complaints had been made by the HCCC. In four of the five inquiries the nurse was male, however as this was a direct result of applying the sampling criteria (outlined in Chapter Three) to selection of transcripts, no significance should be attached to this.

In Tribunal inquiries the HCCC is the Complainant, and is responsible for making the complaints which come before the Tribunal. The HCCC is represented in each inquiry by a legal representative, who is most often a barrister. In the inquiry, the nurse is able to represent themselves or have a private legal representative. They can also choose not to attend the inquiry, although this may carry consequences for the nurse. In each inquiry, the hearing is conducted before the Tribunal which is made up of the Chairperson (Chair) who in these inquiries was a barrister, two registered nurses and one lay person. The members of each Tribunal are appointed by the
Board. At the completion of the hearing it is normal process for the Tribunal members to meet, discuss the evidence and make their decisions\textsuperscript{15}. These discussions are confidential. Once the decisions are made, the Chair delivers the findings on behalf of the Tribunal members.

The following is a brief summary of the inquiries analysed for this study.

**Tribunal inquiry 1 (T1)**

In this inquiry there were three complaints against the nurse who worked in a medical/surgical hospital. These were that the nurse:

- suffered from a physical and mental disorder;
- was guilty of professional misconduct or unsatisfactory professional conduct because he had engaged in improper or unethical conduct and,
- was convicted of offences which rendered the nurse unfit in the public interest to practice nursing.

The particulars in relation to the complaints were the nurse:

- was addicted to X drug;
- falsely informed the Board, that he had begun weekly drug urine screening;
- failed to comply with voluntary undertakings given by him to the Board to supply three monthly reports from his drug and alcohol counsellor regarding his employment;
- failed to undertake random urine analysis and,
- had been convicted of larceny, possession of X drug and possession of another drug.

In this inquiry, there were three narrative presentations of the nurse. The first was given by the Complainant, the second by the nurse, and the third by the Chairperson (Chair) representing the Tribunal members. The nurse represented himself, he did not have legal representation.

\textsuperscript{15} In my experience as a Tribunal member, the views of each Tribunal member are thoroughly canvassed in private and the findings delivered by the Chair are representative of these views.
**Tribunal inquiry 2 (T2)**

In this inquiry, all complaints listed under Section 44. (1) of the Act, were made against the nurse who worked in a disability group home.

The particulars were that:

- the nurse had committed three criminal offences related to fraudulently taking money from intellectually disabled clients in a group home where the nurse was the manager;
- the nurse was alleged to have depression or anxiety which accompanied the dishonest behaviour related to the stealing offences.

In this inquiry, there were two narrative presentations of the nurse. The first was given by the Complainant and the second by the Chair. The nurse did not appear before the inquiry and was not represented.

**Tribunal inquiry 3 (T3)**

There were three complaints made against the nurse who worked in a medical/surgical hospital, mainly in intensive care. They were that the nurse was guilty of:

- unsatisfactory professional conduct; or
- professional misconduct and,
- suffers from an impairment.

Both the first and second complaint relied on the same particulars; the difference was that one alleged professional misconduct and the other alleged unsatisfactory professional conduct. The third complaint was that the nurse suffered from an impairment.

The particulars relating to complaints one and two were that the nurse:

- left the area in which he was working without informing anyone, leaving patients unattended and also that he was sleeping whilst on duty;
- reported sick but then worked as a casual employee at another hospital and,
- failed to attend an interview with an Impaired Nurses Panel.
The particulars relating to Complaint 3 were that the nurse:

- had a drug addiction.

In this inquiry, there were two narrative presentations of the nurse, the first given by the Complainant and the second by the Chair. The nurse did not appear before the inquiry and was not represented.

**Tribunal inquiry 4 (T4)**

In this inquiry the conduct of two nurses was before the Tribunal. One was a registered nurse, the other an enrolled nurse. Both nurses were working at the same mental health institution and were in a de-facto relationship. The conduct complained of was to do with an assault on a patient by the registered nurse in response to the patient assaulting the enrolled nurse.

The complaint was that both the nurses were guilty of professional misconduct and or unsatisfactory professional conduct. For the purposes of this study, only the inquiry into the conduct of the registered nurse will be analysed.

The particulars relating to the complaints against the registered nurse were that:

- the conduct was unethical conduct in that the nurse assaulted a patient;
- the nurse provided false reports to the nurse unit manager and hospital authorities;
- the nurse failed to provide first aid, report the incident and take appropriate care of the patient.

In this Tribunal inquiry, there were three narrative presentations of the nurse, the first given by the Complainant, the second by the nurse’s legal representative, and the third by the Chair representing the Tribunal members. The nurse did not appear before the Tribunal but did have legal representation.

**Tribunal inquiry 5 (T5)**

In this inquiry four complaints had been made about the nurse who worked in a drug and alcohol clinic. The complaints were that:
• the nurse was convicted of offences under the Drug Misuse and Trafficking Act;
• that he was guilty of unsatisfactory professional conduct;
• or in the alternative professional misconduct in that he demonstrated a lack of adequate judgement and care or other improper or unethical conduct and,
• the nurse was not of good character.

The particulars of the complaints were the nurse:
• whilst employed in a drug rehabilitation clinic stole X drug;
• self administered X drug;
• supplied X drug to clients of the clinic in exchange for sex and money and,
• illegally administered X drug to the patients via the incorrect route.

In this inquiry there were three narrative presentations of the nurse. The Complainant’s narrative presentation, which included evidence from the witness. The nurse’s narrative self presentation, which included the narrative presentation by his legal representative, and the narrative presentation of the nurse by the Chair.
## Summary of Tribunal inquiries analysed for this study

<table>
<thead>
<tr>
<th>Tribunal inquiry</th>
<th>T1</th>
<th>T2</th>
<th>T3</th>
<th>T4</th>
<th>T5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sex of respondent</td>
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<td>Female</td>
<td>Male</td>
<td>Male</td>
<td>Male</td>
</tr>
<tr>
<td>Qualification</td>
<td>RN &amp; EN</td>
<td>RN</td>
<td>RN</td>
<td>RN</td>
<td>RN</td>
</tr>
<tr>
<td>Area of work</td>
<td>Medical surgical hospital</td>
<td>Disability group home</td>
<td>Medical surgical hospital</td>
<td>Mental health institution</td>
<td>Drug &amp; alcohol clinic</td>
</tr>
<tr>
<td>Duration of inquiry</td>
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<td>2 days</td>
<td>2 days</td>
<td>3 days</td>
<td>4 days</td>
</tr>
<tr>
<td>Respondent represented at inquiry</td>
<td>Represented self</td>
<td>Unrepresented</td>
<td>Unrepresented</td>
<td>Represented legally</td>
<td>Represented legally</td>
</tr>
<tr>
<td>Complaints (as set out in s.44 (1) of the Act)</td>
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<td>a, b, c &amp; d, e, f</td>
<td>b, c &amp; d</td>
<td>c &amp; d</td>
<td>a, c &amp; d, f</td>
</tr>
<tr>
<td>Findings: complaints proved</td>
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<td>a, c &amp; d</td>
<td>All</td>
<td>All</td>
<td>All</td>
</tr>
<tr>
<td>Orders: removed from register</td>
<td>Time period unspecified</td>
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<td>2 years</td>
<td>2 years</td>
<td>1 year</td>
</tr>
</tbody>
</table>

In the next three chapters a critical discourse analysis of the narratives of the Complainant, the nurse, and the Chairperson is undertaken. The extracts taken from the Tribunal transcripts have been included to illustrate the discursive components of the narratives. Sections of text which are illustrative of the discursive ways of speaking about the nurse were underlined by me to assist with the analysis; the underlining was not part of the original transcript. Discussion of the findings and implications arising from the analysis of the Tribunal inquiries can be found in Chapters Nine and Ten.
Chapter Six

A critical discourse analysis of the narratives constructed by the Complainants

Introduction

In each of the inquiries the Complainants\(^\text{16}\) presented their argument about the nurse through narrative. In these narrative presentations the Complainants drew upon discourses which they used to position the nurse in relation to the storyline of the ethical nurse. Storylines provide the foundation for constructing a preferred narrative. They are based on “collective and culturally dependent narratives” (Andersson, 2008, p. 145) such as the narrative or discourse of the ethical nurse. In the inquiries analysed for this study the preferred narrative presentation by the Complainants was that the conduct of the nurse was unethical.

In order to reveal the ways in which the nurse had been positioned within the discourses to construct a preferred narrative presentation of the nurse as unethical I undertook a critical analysis of these discourses. This approach to analysis allowed me to examine how normalising judgements had been exercised by the Complainants to construct the object, the unethical conduct of the nurse.

In the following analysis I draw extensively on extracts from the Tribunal inquiry transcripts to illustrate how the Complainants constructed the conduct of the nurse as unethical. The findings will be discussed in two parts; the first in relation to the discourse of trust, and the second in relation to the discourse of accountability.

\(^{16}\) The Complainant (the body making the complaint about the nurse), in each of the five inquiries analysed for this study was the HCCC and was represented by a barrister. For the purposes of this analysis the barrister for the HCCC is called the Complainant and the respondent is called the nurse.
Within the discourse of trust, the Complainant drew on three different ways of speaking about the nurse to position the nurse as unable to be trusted. These ways of speaking were identified as; speaking about the nurse as dishonest, speaking about the nurse as intentionally dishonest, and about the nurse as causing damage. Within the discourse of accountability, the Complainant drew on two different ways of speaking about the nurse to position the nurse as failing to be accountable. These ways of speaking were identified as; speaking about the nurse as failing to meet their responsibilities, and as unfit to practice nursing.

**Analysis of the discourse of trust**

Drawing upon the discourse of trust as a core attribute of what it is to be a nurse, the thrust of each of the Complainant’s narrative was aimed at discrediting the nurse in relation to this ethical norm. The narrative framework which the Complainants used to locate the nurses’ conduct in relation to the discourse of trust was to position the nurse as;

- dishonest by using strategies to create doubt about the honesty of the nurse,
- intentionally dishonest by attributing intentionality to the actions of the nurses, and
- causing damage - this was done by attributing effect to the actions of the nurses.

This framework provided the scaffolding for characterising the nurse as someone who was unable to be trusted. The Complainants were able to draw on these normalising judgements to establish that the nurse could not be trusted. The following analysis will reveal how in the inquiries the Complainants devoted much of the narrative development to these normalising judgements.

In the inquiries the narrative content was based on the specific complaints made about the nurse and therefore was different in each inquiry. Despite this, the analysis revealed there was a pattern of characterisation and ultimately classification of the
nurses’ conduct which was constructed within this discursive framework of trust, and this set the scene for the narrative construction of the nurses as unethical subjects.

In the following sections, examples from the Tribunal transcripts will be used to discuss and demonstrate how the nurse was positioned within the narrative framework in relation to the discourse of trust.

**Positioning the nurse as dishonest by creating doubt about the honesty of the nurse**

The construction of the nurse as dishonest and unable to be believed was the most significant component of the Complainants’ narratives. In each of the inquiries discursive strategies were used by the Complainants to position the nurse as dishonest. My analysis revealed the types of discursive strategies used varied with the narrative content and included the following ways of speaking about the nurse; raising allegations about the nurse which did not form part of the complaints, extensive use of value laden words, and challenging other discursive representations of the nurse including self representation by the nurse.

**Raising allegations about the nurse which did not form part of the complaints.**

By using this discursive strategy the Complainants were able to extend their narration of the nurse’s dishonesty. This was achieved by highlighting the extent of the nurse’s acts of dishonesty whilst at the same time making the Tribunal members aware of the likelihood that not all acts of dishonesty were known to the Complainant or the Tribunal. Using this strategy the Complainant was in effect able to create an image of the nurse as having been involved in acts of dishonesty beyond that which could be revealed to the Tribunal. In this way the Complainant was able to create a sense that the Tribunal inquiry was uncovering just ‘the tip of the iceberg’ and that the true extent of dishonesty had not been revealed. The examples that follow are taken from Tribunal inquiry 1 (T1) and Tribunal inquiry 3 (T3).

In the extract from T1, the Complainant alleged that the nurse may have been involved in a matter of stealing. Whilst this was a matter of conjecture, the allegation
nevertheless took on a level of truth through the developing narrative. The Complainant not only developed the suggestion of dishonesty by alluding to a possible conviction for stealing, but also gave weight to it by suggesting this was a matter that the nurse should have disclosed to the Tribunal. He suggested that the nurse had a “choice” to make about disclosure and that his failure to disclose was an “absent admission”. Use of the words “failure to disclose” and “absent admission”, suggest to the Tribunal that the nurse had something to hide and as such was not being honest.

There is one other matter which doesn’t appear in that complaint which is a indication on the Police Service record that on or about X date in the Court of Petty Sessions in X that the nurse may have been convicted of a matter of stealing.

…it’s not a situation where I could prove that allegation.

... I simply raise it because the nurse has a choice to make himself as to what matters he wishes to disclose and what to disclose to the Tribunal and that’s a matter for him. (T1, Day 1, p. 25).

....It’s on that matter that we have no evidence other than what appears on that Police document and an absent admission from the nurse. It’s a matter that we would take no further. (T1, Day 1, p. 45).

In the next example the Complainant raised allegations which did not form part of the complaints made against the nurse, but which related to a possibility that the nurse failed to disclose to his employer restrictions on his practice. Despite having no evidence, the Complainant used these allegations as a means of effectively raising doubts about the nurse’s level of honesty with his employer.

I note that the nurse presented himself for night duty as a nurse from an agency. He's known to X Hospital and was not
permitted to work. The agency was then apprised that the nurse had conditions from the Board that restricted his authority to dispense drugs and that that was still current and makes the observation that the agency did not appear to be aware of this.

The Commission has no further evidence on that issue. (T1, Day 1, p. 36).

This strategy was also adopted by the Complainant in T3. In this inquiry, the Complainant frequently raised allegations which no longer formed part of the particulars of complaints but which portrayed the nurse as dishonest. The inference arising from these allegations was that the nurse was stealing drugs and using these same drugs whilst on duty. The use of the word “inappropriate” to describe the nurse’s behaviour in the same paragraph where it is alleged that the nurse was procuring drugs, strongly infers that the nurse was affected by drugs when working.

That this respondent had played music in the X unit in an inappropriate manner and inappropriately danced whilst in the unit. These particulars have been deleted but I simply mention because they may appear in certain documents and whenever they do appear we would not wish the Tribunal to take any account of them. And in the same vain [sic] prior to the original Complaint being filed there were also allegations in relation to this respondent allegedly using the drug X and/or asking other colleagues to procure that drug for him. Investigations are such that that matter was not pursued. (T3, Day 1, p. 9).

There’s a report that the staff from within the X unit had ordered stocks of X drug and they concluded that a total of X phials could not be accounted for. X number of empty phials were later recovered from the sharps container within the X unit. And, also the orders revealed X drug showed a significant short falling volume against those administered.
Can I reiterate that the reason I’m taking members of the Tribunal to these matters is that they’re essential to then understand the decision of the X Board, not for the purposes of the Complaint before you today. (T3, Day 1, p. 30).

In a further example from T3, where the way in which the nurse was spoken about was intended to create doubt about the honesty of the nurse, the Complainant raised the possibility that the nurse had not been honest with the Board appointed psychiatrist.

He told Dr X that over X period he was quite seriously injured in an accident, airlifted to X hospital and spent some time in the intensive care unit. Can I indicate that this is once again a matter which we cannot completely clarify but there would be some doubt as to the accuracy of what the respondent told Dr X in relation to an accident and his hospitalisation. But at the end of the day it’s probably not a matter firstly that can be resolved and secondly that would assist the Tribunal any further. (T3, Day 1, p. 20)

Use of value laden words

The use of value laden words was a strategy used extensively by each of the Complainants and was crucial to the narrative construction of the nurse as someone who could not be trusted. The following examples are illustrative of how the Complainants used this strategy to variously characterise and classify the conduct of the nurse in relation to the norm of honesty. The words and phrases used are frequently derogatory and create a sense of contempt for the nurse. They have the effect of portraying the nurse not only as dishonest, but more significantly as someone whose evidence simply cannot be believed.

There is an over-riding impression created by the evidence provided by the nurse that he’s too slick by half when it
comes to his response to the issues which have been raised (T1, Day 2, p. 43).

There are in our submission a number of difficulties simply by the way in which this man has played up. (T3, Day 1, p. 46).

We say that not only are the convictions for drug matters serious but the Tribunal would also be concerned about the circumstances under which those offences occurred, that you would have considerable concerns about exactly what the nurse has been up to in recent years and that any decision that you make would have to reflect the view in our submission that to put it bluntly he’s not to be trusted. (T1, Day 2, p. 48).

It will be submitted on behalf of the Complainant that those responses that have been made from time to time by the respondent to various authorities are not characterised by completely candid responses (T3, Day 1, p. 18).

Well this witness had been most evasive in his answers and indeed has given different and inconsistent evidence (T5, Day 2, p. 41).

Well I suggest to you Mr X that you are not telling this Tribunal the truth (T5, Day 2, p. 58).

In Tribunal inquiry 4 (T4), the Complainant initially prefaced his case by stating that the nurse’s account “is not a true one” (T4, Day 1, p. 10), and then proceeded to give credibility to this positioning of the nurse, by repeatedly referring to the evidence from the nurse as “unbelievable”, “implausible”, “inherently implausible”, “doesn’t make sense”, and “totally unbelievable”.
Similarly in Tribunal inquiry 5 (T5), the Complainant used the strategy of highlighting and establishing inconsistencies in the nurse’s evidence as the primary means of discrediting the nurse and creating doubt about his honesty. The Complainant repeatedly referred to the nurse’s account as “remarkably inconsistent”, “entirely implausible” “implausible” “defies belief”.

In my submission the respondent nurse is not a credible witness. His evidence before the Tribunal yesterday was replete with inconsistencies of xxx, implausible accounts and in my submission he was neither frank nor candid with the Tribunal in the evidence he gave. (T5, Day 3, p. 2).

The account he put before this Tribunal was that each of those X women threatened him and it was in direct response to those threats that he supplied X drug. In my submission that’s a remarkably inconsistent account. (T5, Day 3, p. 3).

Now if indeed she made that threat it is my submission entirely implausible that she would then proceed to offer him money and entirely implausible that she would proceed further to offer him sex, and in my submission that evidence should be rejected. Secondly, it is implausible that having offered the money and being told by the nurse that he didn’t want anything for X drug why would she then offer sex as payment for X drug when he had already said to her he didn’t want any payment? It defies belief in my submission and isn’t plausible and should be rejected. (T5, Day 3, p. 3).

…so again in my submission there is a significant inconsistency between his evidence before this Tribunal and the material provided elsewhere. Now Ms X statement was tendered without objection and she was not required for cross-examination. In my submission, her evidence, or her evidence as contained in the statement and to the extent that it
differed from that of the nurse should be preferred to the nurse. The nurse’s credibility, in my submission, is in tatters as a result of the inconsistencies to which I have referred. (T5, Day 3, p. 5).

In the next set of examples, the Complainants used value laden words to attribute qualitative dimensions to the actions of the nurse. This strategy emphasised the level of disjunction between the motives and actions of the nurse, and the extent of need and dependency of the patients.

In Tribunal inquiry 2 (T2), the Complainant described the nurse’s actions as “sophisticated and fraudulent” and the patients as “vulnerable” in order to accentuate the extent of the nurse’s dishonesty. The following is an example of how the Complainant used this strategy. He described the people the nurse was responsible for as “basically intellectually disabled people” and argued:

If she could do that to that sort of client base with complete disregard until she was caught and charged with it, she could continue that same action with respect to anyone she has charge of (T2, Day 2 p. 42).

This strategy was similarly adopted by the Complainant in T4. There was repeated use of emotive value laden language which positioned the nurse in one way and which was juxtaposed against the way in which the patient was spoken about. The following extract highlights the way the Complainant used this strategy to create a preferred image of the nurse. In particular, the Complainant used qualitative descriptions of the patient as well as sarcasm to paraphrase the nurse’s evidence as a means of positioning the nurse within the discourse of trust. This strategy was used to ridicule the nurse’s account of an incident and had the effect of creating a sense of total disbelief in the nurse’s account of the incident with the patient.

In this extract the Complainant described the patient in two ways. In the first instance, by referring to the patient as “violent” and positioning the nurse’s account of his response to a violent patient as “unbelievable”. In the second instance, the
Complainant constructed an impression of the patient as extremely vulnerable by referring to him as “elderly”, “a gentleman”, “a bleeding old man”, “left bleeding by the nurse”, “at risk of a neurological injury”, “elderly mentally ill patient” and so on, to position the nurse’s conduct as dishonest and defying belief.

The other perhaps more telling reason as to why you would disbelieve the nurse’s unsworn account is the very circumstance of firstly his assaulting patient X in the courtyard and the purported need to leave the courtyard (T4, Day 1, p. 59). What possible reason would there be for taking the elderly patient to a private location in which to extract an apology, it just doesn't make plausible sense that that was the purpose of taking him to the TV room. If there is a plausible reason you’re being denied any knowledge of it. If there was a good reason for patient X being taken to the TV room against his will, he a violent patient supposedly, why would you aggravate his aggressive nature by forcing him down the corridor out of the courtyard and into the TV room to try and extract from him an apology for his aggressive violent behaviour, it just doesn't make sense. When you compare what the nurse says in the record of interview about why he left him there bleeding (T4, Day 1, p. 60)

See he's just totally unbelievable, (T4, Day 1, p. 61).

Now the nurse acknowledges that an aggressive patient is aggravated by his presence. It's more self-evident that an aggressive patient will be aggravated by aggressive conduct on the part of nurses. It's trite to say that the way you treat aggressive patients unless somebody else is exposed to immediate danger is to stand back from them, to give them some space and to not inflame their aggressive behaviour. But the nurse says initially I did inflame this aggressive
man. I grabbed him and forced him to go to the TV room with a view he says to having a polite little conversation about an apology and patient X threw a punch at him, missed and fell over and injured himself then the nurse says well I then had the bright idea that if I stayed around and helped him or called somebody else to help him with his injury I might have aggravated the situation. That just sounds and is implausible in the extreme and what’s even more implausible from the nurse’s account is that he left him, he left this bleeding old man lying on the... lying or in the TV room, obviously bleeding, an old man who had apparently fallen on his face according to the nurse, an old man who anybody with a minimum of nursing knowledge might at least suspect that if he falls from a standing position and lands on his face or his head then there’s a possibility of neurological injury that at least would need to be excluded and what possible reason could there be for walking back the 300 metres to X ward and preferring to attend to his partner's supposed psychological distress which you might think would have abated significantly from the time the assault took place some considerable time before the nurse elected to prefer the interests of his own (T4, Day1, p. 62) partner who was still supposedly still in distress and ignored completely the obvious physical injuries suffered by this elderly mentally ill patient. That makes this account even more implausible in my submission. If it was an innocent injury suffered by patient X in the course of trying to be aggressive towards the nurse he would have no possible reluctance to deal with it in an appropriate professional way. (T4, Day1, p. 63).

That would be the only appropriate thing to do but to simply abandon him for as long as it took to get back to X ward to comfort his partner once there, to discuss with her her plans
and conditions if that’s what he did before ringing Mr X to say by the way I left a bleeding patient of yours in the TV room unattended. You might want to go and check him out, he’s had an accident is unbelievable. (T4, Day 1, p. 63).

Challenging the discursive representations of the nurse

Challenging the discursive representations of the nurse was yet another way in which one of the Complainants positioned the nurse as dishonest. In the following example, the Complainant challenged the way in which the nurse had previously been spoken about by doctors in relation to her mental health status. The narrative development of the nurse as dishonest and manipulative was achieved by developing the ideas that contrary to medical evidence, the nurse did not have a serious mental illness and that she lied about her mental health status to manipulate both doctors and the courts to her own advantage.

The Complainant acknowledged the medical opinion of two doctors and one clinical psychologist about the serious mental health problems experienced by the nurse, however despite this evidence, the Complainant drew on the opinion of a magistrate to position the nurse within the narrative as deceptive and manipulative. Faced with these two opposing discursive constructions of the nurse, the Complainant resolved this narrative dilemma, by selecting the discursive construct (that of the magistrate), which best fit his preferred narrative and used this to reshape the opposing construct (that of the doctors), thereby enabling him to maintain a consistent narrative representation of the nurse.

Throughout the inquiry, the Complainant used the nurse’s mental health status to create doubt about the honesty and authenticity of the nurse. The documented medical opinion that the nurse was experiencing a “fully blown biological depressive illness with suicidal tendencies” became “stress and strain” when spoken about by the Complainant and was given credibility in two ways. In the first instance the Complainant developed a line of argumentation that minimised the seriousness of the mental health of the nurse by repeatedly describing her condition as only “stress and
strain”. In the second instance the Complainant argued that such sophisticated fraudulent action by the nurse against vulnerable patients, could not have been carried out or sustained by someone with a serious mental health illness.

Complainant: Depressive disorder yes. A fully blown it looks like biological depressive illness with suicidal and I can’t make out the second word. (T2, Day 2, p. 19)

Tribunal: Ideation.

Complainant: Ideation okay …………………….it states it is my opinion and that it qualifies for disposal under Section 32 of the Mental Health Criminal Procedure Act etc. It is imperative that she receive on-going psychiatric care. (T2, Day 2, p. 20). All these medical reports go for the period after the offences and before the Court case so you can imply two things there, one is that the nurse decided to seek medical treatment to help her in the Court case. Whether or not she actually had these tendencies or whether or not she was actually stressed, using this particular medical personnel to obtain the discharge for the offences or two that she actually did suffer during that time and taking in the medical... there was consultation with the nurse by the various medical practitioners that she was suffering from certain stress related factors or psychological disorders during, before and after these offences and hence at that particular time in the first Court appearance she was duly released under Section 32. Now that is a view the Tribunal would have put in that context. The view I would put is that given the medical examinations there and their expert opinion and they basically all confirm each other that I think it could be reasonable to suspect that the nurse was suffering from some form of medical or stress-related illness. How that impacted on the ability to steal or take money or
whatever you like to call it, one of the doctors goes into the detail about how that is in a sense a common occurrence of people who have stress that they do certain things like shoplift or steal things etc etc so from... we're not going to argue that position in the sense that she was not under any particular stress or strain at that particular time. Obviously there was some. The level... it's hard to ascertain and certainly what made her then take the action she took would be hard to ascertain too except that the doctors basically state it's possible that she did that because of the stress and strain. (T2, Day 2, pp. 20-21).

That's correct but in a sense that is the dilemma that we raise in that the nurse has a history according to the medical records of depression and psychiatric illness and yet on enquiries to the nursing home she was working in they stated basically that her work performance was satisfactory and I think that there could be issues raised there with respect that she was suffering also apparently stress and psychiatric illnesses during her work at the original group home yet she still undertook quite, it could be saying, quite sophisticated fraudulent action against the Department for quite a long time until it was discovered. She was still able to undertake her duties at obviously a reasonable standard but as I said for a particular time she was still forging and uttering and altering financial records etc etc during that particular time (T2, Day 2, p. 24).

**Attributing intentionality to the actions of the nurse**

Positioning the nurses’ actions as intentional was another significant component of the Complainants’ narratives which was used to situate nurses’ conduct in relation to the discourse of trust. Having set the context for narrative development by establishing the nurses’ dishonesty, the scale of the dishonesty was constructed
through speaking about the nurses’ actions as intentional. This way of speaking enabled the Complainant to locate the actions of the nurse on a scale as far from the norm of trust as possible.

In T1, the Complainant constructed the nurse’s actions as intentional in a number of ways, which included that the nurse had deliberately chosen not to comply with undertakings he had given to the Board, that he blamed others for his failure to meet his obligations to the Board, and he had consciously and deliberately misused his professional expertise to achieve urine test results which were misleading. In the following extract, value laden language, such as “obfuscating” “not inconsiderable charm”, “simply skate around those issues” is used by the Complainant to give weight to the suggestion of intentional dishonesty.

…he has developed a facility to not only delude himself as to what the nature and seriousness of the problems he confronts are, but also by a combination of obfuscating in response to questions and on occasions not using inconsiderable charm to simply skate around those issues and when the evidence appears to be contradictory or when the chronology doesn’t serve his interests, he’s happy to resort to a lack of recollection. (T1, Day 2, p. 43).

The whole purpose of the testing was to have some integrity on the basis that it would be random and regular and the effect of the nurse’s conduct was to neatly undercut those characteristics. His approach was I will organise it in such a way that I know what tests I undergo will be clear, presumably in the hope that the authorities at the end of the day would have cut him some slack, in effect saying well he didn’t comply specifically with the undertakings but we do have a history here of clear tests perhaps the danger to the public has been minimised or reduced. We do criticise him for that because we do say that was a conscious decision (T1, Day 2, p. 45).
Yet another strategy used by the Complainant in T1 to discursively construct the nurse’s actions as intentional was to compare and contrast the nurse’s actions with an image of the nurse’s ability. The Complainant framed the nurse as charming, capable, intelligent and able to look after his own interests. He indicated that the nurse had been well supported and given a fair go both professionally and medically to help with his drug addiction, but who despite all this had failed to rehabilitate. The word “failed” was used repeatedly to describe the actions of the nurse. He was spoken about as having failed to meet his responsibilities. There was frequent mention in the inquiry of how he had failed to meet the undertakings he had given, failed to have urinalysis attended, failed to see doctors, failed to submit reports and failed to provide assistance to the investigation. Through a process of positioning the nurse as intelligent and capable and yet failing his responsibilities, the Complainant was able to create an impression that the nurse’s actions were intentional, because as a capable and intelligent person, the nurse had no reason not to meet his responsibilities.

He failed to undertake any random urine analysis or to provide any reports of such testing to the Board and that he failed to arrange for any reports from his counsellor to be sent to the Board. (T1, Day 1, p. 20).

It appears that he failed to undertake any urinalysis or to provide reports …(T1, Day 1, p. 21).

It appears that he failed to provide a fresh urine sample and appeared to be under the influence of drugs (T1, Day 1, p. 22).

Has failed to undertake urine analysis or to provide reports (T1, Day 1, p. 23).

It’s those undertakings that we say have been consistently ignored (T1, Day 1, p. 31).
The genuinely supportive approach taken by the hospital (T1, Day 1, p. 33).

Failed to attend scheduled appointments or to contact Ms X in relation to a session with staff counsellors (T1, Day 1, p. 34).

The nurse does indicate and I say this in a complimentary way an ability to express his views and to protect his interests in a very articulate and forceful manner. He’s obviously highly intelligent (T1, Day 1, p. 51).

In T2, the Complainant repeatedly spoke about the nurse’s actions as “manipulative”, “deliberate”, “sustained”, “pre-meditated” and “sophisticated” in order to present an image of the nurse’s actions as intentional. He described how the nurse was fit enough to practice as a registered nurse and perform her duties satisfactorily whilst at the same time carrying out “prolonged”, “sophisticated fraudulent actions”, and suggested that her illness only became an issue because of a second court case, at which point she attempted to use the defence used in an earlier court case that she was medically unfit. Through using the following strategies of; illustrating that the nurse was fit to work, describing her actions in terms of complexity by repeated description of her actions as “quite sophisticated” and “prolonged”, concluding that “she knew what she was doing”, and suggesting her claims of ill health were deliberately manipulative, the Complainant discursively constructed an image of the nurse as fit and capable and therefore whose actions were intentional.

Similarly in T5, the Complainant initially spoke about the nurse as deliberately putting patients at risk, and then drew upon this to position the nurse as deliberately trying to cover up his use of drugs. The Complainant used the term “perfectly clear” to establish that the statement provided by the nurse was not true and that his claim that his urine samples were random was a deliberate attempt to mislead the Tribunal. Emphasis is given to the suggestion that it was an attempt to mislead through repetition of the statement that the urine screens were “of no assistance”.

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The risk to patients was serious and he knew it. He was either indifferent to that risk or he knew he was putting them at risk. Importantly his job was to dispense X drug and work in accordance with the program which is set up to help those with dependencies. What he did was directly contrary to that program. So it’s not merely a case of diverting drugs for an altruistic purpose. This is a case of stealing and injecting patients who were trying to seek help and change their injecting ways, not continue with it. (T5, Day 3, p. 22).

He has provided this Tribunal with a number of drug screens. Perfectly clear those screens were not random as stated in his statement. He chose generally speaking when he would provide the urine. They are of no assistance whatsoever to this Tribunal in saying that he’s drug free, absolutely no assistance. In fact the Tribunal could find beyond that they are no assistance and could find that there was an attempt to mislead by stating in the statement that they were random when they weren’t (T5, Day 3, p. 23).

In this next extract from T5, the Complainant drew on medical discourse as a means of validating his presentation of the nurse as intentionally dishonest, by framing the nurse as lacking contrition.

But he also has given evidence in such a way as to in my submission minimize his conduct. (T5, Day3, p. 18).

Now the psychiatrist was concerned that he still minimizes what has occurred and is in denial and certainly in my submission his appearance in the witness box before this Tribunal absolutely supports that. He was extremely reluctant to admit wrongdoing. It had to be coaxed from him. This was not the conduct of a man who was truly contrite and
regretful and is fully aware of the errors of his ways and has redeemed himself. It was not at all, in fact it was to the contrary. It was a man who clearly has some difficulty accepting the enormity of what he did. (T5, Day 3, p. 19).

In this next extract from T3, the nurse was portrayed as having a repeated pattern of behaviour whereby he has deliberately avoided having to account for his behaviour. The Complainant linked this pattern of deliberate avoidance, with his failure to appear before the Tribunal to answer the Complaints made against him.

I should indicate to the members of Tribunal that there does appear to be a suggestion of a pattern in relation to this respondent and I put it no higher than that, that when confronted with criticism of his behaviour he seems firstly to try and not respond and ignore the criticism and then when he does come face to face with those raising the concerns seems to have a method of offering his resignation and simply moving on. But in the absence of the respondent giving any evidence it's impossible to explore that further with him.” (T3, Day 1, p. 19).

…it would be open to you to conclude that when you combine all of those circumstances with the lack of any explanation by the respondent as to why he was in the condition he was in as observed by Dr X and others who we take to have some expertise. (T3, Day 1, p. 50).

In T4, the failure of the nurse to report an incident of patient injury was constructed by the Complainant as a deliberate cover up of assault of the patient by the nurse. The Complainant constructed the nurse’s conduct as intentional by arguing that the nurse deliberately assaulted the patient, and subsequently lied to cover up the assault and shifted the blame to the patient. In the following example through use of phrases “you would wonder”, “you would do more than wonder” “you would find” the Complainant
positioned the nurse’s actions in assaulting the patient as deliberate, planned and intentional.

Fortunately this assault by patient X caused no physical injury but the way to deal with it is according to the well established procedures in the manual and they were ignored and you would wonder, you would do more than wonder why the nurse ignored them. In my submission you would find that rationale for the purpose and intention of his going there was not to ask patient X to apologise but to get some retribution for the distress which his partner had suffered and in the state of anger when he was emotionally involved with the enrolled nurse. That is what lead him we submit to go across there. (T4, Day1, p. 59).

What possible rationale could there be for not just taking the patient to the TV room where the apology was supposed to be issued but forcing him to go there, assaulting him to go there, despite his admitted resistance he was truly manhandled, he was assaulted. (T4, Day 1, p. 60).

In the next set of extracts, the Complainant suggests that the nurse’s failure to get help for the patient’s injuries was because he had intentionally caused those injuries and he was deliberately covering up his actions.

If it was an innocent injury suffered by the patient in the course of trying to be aggressive towards the nurse, he would have no possible reluctance to deal with it in an appropriate professional way. (T4, Day 1, p. 63).

The assertion made by the nurse that the patient had an accident is remarkable (T4, Day 1, p. 68)
You would infer that failure to report the incident concerning the injury to the patient immediately tends to suggest he had something to hide and that his explanation which was given some 5 to 10 minutes after the incident has occurred was not a truthful account. (T4, Day 2, p. 76).

The inference you would draw in my submission is that he didn’t make any serious enquiries because he wasn’t interested in alerting people to the patient’s problem, he was more concerned about the distress his partner was said to be in, and he wanted to get out of there. (T4, Day 2, p. 124).

The Complainant suggests through the use of phrases “you might expect” and “you would expect” and the term “appropriate” that the nurse would have acted differently if his actions weren’t intentional, and that his failure to act in what would be an appropriate way as established by the Complainant was therefore a deliberate cover up of the incident.

Those procedures weren’t followed by the nurse in relation to the alleged assault upon him by the patient which you might expect would be appropriate if the patient truly did attempt to assault the nurse in the TV room then you would expect that would be reported promptly and steps taken to deal with the patient’s violent behaviour in an appropriate way but that wasn’t done either. Again pointing to an implausibility in relation to the nurse’s account. (T4, Day 2, p. 77).

Having repeatedly positioned the nurse’s actions as intentional in T4, the Complainant in his summing up used the more forceful and unambiguous word, “concoct” to leave the Tribunal with no doubt about the intentional dishonesty of the nurse.

Plainly there was sometime before the nurse was interviewed to concoct an explanation which we say he has done about the alleged assault upon him by the patient and there was more
than a week or at least a week in which the nurse and the
enrolled nurse could get together and concoct stories. (T4, Day
2, p. 115).

In order to substantiate the seriousness of the nurses’ actions as intentional the
Complainants in T2 and T4, in their summing up, drew on the authority of legal
discourse to give added weight to the scale of seriousness of each nurse’s actions. In
T2, using case law to illustrate a legal definition of misconduct, the Complainant
highlighted the relationship between misconduct and premeditated, intentional
purpose, so there could be no doubt in the minds of the Tribunal as to where to
locate the nurse’s actions in terms of the discourse of trust.

misconduct generally means wrongful, improper,
unlawful conduct motivated by premeditated or intentional
purpose or obstinate indifference to the consequence of
one's act. (T2, Day 2, p. 41).

What's he saying there is that it's something intentional, it's
something premeditated. (T2, Day 2, p. 41).

Legal discourse was also drawn upon by the Complainant in T4 to give weight to the
way in which the nurse was positioned. The Complainant drew upon the standards
set in two legal cases as justification for positioning the nurse’s failure to give
evidence or to call witnesses as intentional.

Mr Chairman I should say formally and alert my friend and
his client to the fact that I will be inviting you to draw
adverse inferences from the nurse’s refusal or failure to give
evidence to expose them to cross-examination about the
version which they gave not under oath to the hospital
authorities. I just want to make it perfectly clear that I will be
asking you to draw an adverse inference from the failure to
do that. (T4, Day 1, pp. 38-39).
This is not a forum where it is compulsory for the respondent to give evidence, it is an unwise course in my submission for respondents to adopt because the adverse inferences can be drawn from their failure are serious ones. (T4, Day 1, p. 50).

Yes the X nurse is an eye-witness to that allegation against the nurse and the nurse’s failure to call the X nurse to give evidence about that primary issue is a matter which I will invite you to draw the Jones and Dunkeld inference directly such that the failure to call the X nurse, the nurse’s failure to call the X nurse as to what actually happened in the TV room would lead you to conclude that the X nurse’s evidence would not assist the nurse in his reported explanation of what truly happened in the TV room. (T4, Day 1, p. 51).

They’re the submissions I would make in relation to the implausibility of the nurse’s account of what occurred. It’s a hypothesis that’s inherently implausible and one which in the absence of any sworn evidence from anyone you simply could not accept and the standard of proof which you’re aware needs to be applied to the civil standard on the balance of probabilities but according to the Briginshaw qualification that you are comfortably satisfied of the allegation would be readily established based upon the evidence before you. (T4, Day 1, p. 68).

**Attributing effect to the actions of the nurse**

Along with creating powerful images of the nurse as deliberately and intentionally dishonest, the Complainants also used the strategy of attributing effect to the conduct of the nurses. In constructing this component of the narrative representation, the actions of the nurse were not a substantive part of the narrative; rather it was the actual and potential impact and effect of the actions of the nurse on patients, the hospital and more broadly the profession which comprised this part of the narrative.
For example in T1, the Complainant linked the action of stealing a Schedule 8 drug from the hospital where the nurse was employed to the effect of undermining the system of trust that staff and hospitals rely upon to function effectively. In the following extract the Complainant identified trust as the core attribute necessary for a functional hospital system, arguing that if nursing staff can’t be trusted then the system can’t function. He illustrated this by suggesting that administrators must be able to rely on professionals such as nurses, and concluded with the statement that “I can’t put it any more highly than that”. This line of argumentation inferred that trust was so important and fundamental to the “core” of the hospital system that a failure of trust would lead to an “untenable” system. In this narrative representation of the nurse’s conduct, the Complainant used forceful and decisive language to convey powerful meaning. Words and phrases such as “very basic trust”, “duty”, “undermine”, “system which cannot function”, “expected”, “relied”, “wrong”, “suffer”, “risk”, were all used to measure the impact and effect of the nurse’s conduct.

We say the seriousness of that of course is that that undermines not only the record keeping of the hospital but the very basic trust which must exist between nursing staff, treating doctors and their duty to a patient and once you undermine that system of trust you end up with a hospital system which cannot function because then you have to put in place a system akin to having one professional person look over the shoulder of another at all times whilst engaged in their ordinary day to day duties. Clearly a system which would be untenable for all sorts of reasons. It goes to the very core of how hospitals must operate that the administrators the ones that bear the ultimate responsibility must be satisfied that systems are in place of an audit nature that when written and signed off by professionals be they medical practitioners or nurses or others should be expected to be relied upon on their face. I can’t put it any more highly than that. (T1, Day 2, p. 54).
And it's our submission that the inference arising even from the nurse’s version of the act. He does concede that it was wrong but in some way one should discount it because the patient didn't suffer. That may well be true but he loses sight of the fact the global system of administration of hospitals is put at risk by that very conduct (T1, Day 2, p. 55).

Similarly in T2, the Complainant repeatedly spoke about the intentional dishonesty of the nurse, characterising this as an abuse of her position of trust not only for the people in her care but also in relation to her employer.

…and at various times lying to or fooling not only the residents but also the other workers at the nursing home. (T2, Day 2, p. 34).

She lied to the representative of the Nurses Registration Board about the fact that she was not working and that was contained in Exhibit J. She was working while she was unfinancial and she would have been well aware of that particular with respect of the previous enquiries that were made. She has not made any compensation payment to the Department or the Court. (T2, Day 2, p. 39).

She undertook this action against a fairly vulnerable section of the community and as a nurse they were people in her charge. They were basically intellectually disabled people and not only that she undertook the action against the Department she worked for which shows complete lack of trust by the employer in that circumstance. (T2, Day 2, p. 41).

Having characterized the nurse’s actions as pre-meditated, the Complainant then speculated about the potential effect of the nurse’s actions by framing her as so
lacking in moral fibre that she would take advantage of “anyone she has charge of”. This way of speaking about the effect of the actions of the nurse, positioned her as someone who had callous disregard for dependent people in her care and who could not be trusted, both at a patient care level and at an organizational level.

If she could do that to that sort of client base with complete disregard until she was caught and charged with it, she could continue that same action with respect to anyone she has charge of (T2, Day 2, p. 42).

It's highly likely and beyond reasonable doubt that she would not have informed those particular establishments of her previous actions because it would be highly unlikely that anyone would employ someone who admitted to their employer that they had previously been charged on two separate occasions over a number of offences and for issues that occurred not that long ago over a long period of time directly in relation to her job that brought in issues of dishonesty and trust and also abuse of her position with respect to the people she was supposed to be in charge of. (T2, Day 2, p. 43).

In T4, the Complainant spoke about the effect on the patient resulting from the nurse’s “failure” to follow procedures and protocol for handling violent patients, suggesting that this led to violent action by the nurse against the patient resulting in “the old gentleman” being “left bleeding” and unattended by the nurse. He then described how the nurse should have responded in this situation, highlighting the potential seriousness of the nurse’s failure to act appropriately by detailing the risk to the patient from the nurse’s actions.

Failure to involve any other staff, failure to comply with the green alert, failure to remove himself from danger in relation to the patient is an expressed requirement, it’s the first thing you do when a person becomes or threatens to become violent.
remove yourself and other people from danger. What the nurse did was himself become violent by grabbing the patient, taking him from one place, putting him in another place and then on the nurse’s account the patient threw a punch. That is simply unbelievable in my submission. (T4, Day 2, p. 80).

Well you would have expected him to contact other personnel and then wait for their arrival particularly when the old gentleman was bleeding. (T4, Day 2, p. 80).

You might think that his reporting of the incident was delayed some 10 to 15 minutes and plainly in that period of time the patient on his own could have suffered neurological damage, could have been a serious emergency and could have had more disastrous consequences than it had, (T4, Day 2, p. 81).

In this next extract from T5, the Complainant described the intention of a drug program as a means of highlighting how the nurse’s actions had the effect of directly undermining the program. He described what a nurse with experience could be expected to know, and then spoke about the complete disregard the nurse displayed for the welfare of his patient because he knowingly exposed the patient to risk. The nurse was characterized as having a callous disregard for the safety of the patients through “reckless indifference”. Here the impact and effect of the actions of the nurse were that patient safety had been jeopardised.

The program was a program that was designed to change the behaviour of those on illicit drugs. It was to remove them from that culture and try and replace it with a stable culture that had nothing to do with injecting. Regular attendance, therapeutic relationships being built up with those who ran the clinic and that’s quite clear from the documents. (T5, Day 3, p. 13)
From his evidence he said that he was aware that injecting X drug could cause damage to veins. He was aware there was a risk of overdose with injections because it’s absorbed at a faster rate. And he was aware that there was a potential for infection. Now he says he wasn’t aware that X drug was a sterile substance and in my submission as a registered nurse for over five years not to know that X drug is a sterile subject says something about his state of knowledge. But nevertheless he knew sufficient in my submission to know that injecting X drug was a hazardous activity and indeed from the pamphlet which he said he read at the time it makes it perfectly clear that there is a serious risk to health from doing so. (T5, Day 3, p. 14).

Now given his knowledge based on his evidence before the Tribunal and indeed the document which he said he read, Exhibit X, he knew what he was doing was putting these women at an enormous risk. He was injecting them. He didn’t even ask whether or not they had X drug earlier that day. The risk of overdose was obviously in existence. He didn’t ask them whether they’d taken any other illicit drugs. He didn’t ask them whether they had alcohol. He had no idea what these women were on and yet he injected them with X drug. (T5, Day 3, p. 15).

His knowledge was that it was dangerous. He did it either knowingly or with reckless indifference in my submission as to the consequences. A risk of overdose could have been fatal and he put these women in a situation where in relation to these aspects of his conduct there could have been an overdose (T5, Day 3, p. 15).
Analysis of the discourse of accountability

The analysis of the discourse of trust revealed how the narrative presentation of the nurse as a professional person who was unable to be trusted was constructed by the Complainant. This was achieved by drawing upon the discursive components of dishonesty, intentionality and effect to make normalising judgements about the conduct of the nurse.

In the next stage of narrative development the Complainants drew upon the discourse of accountability and intersected this with the discourse of trust to construct the nurse’s conduct as unethical. The image of the nurse created in relation to the discourse of accountability was framed around excluding any possibility that the nurse could meet the normative components of responsibility and fitness to practice. These components of the discourse of accountability comprised the narrative framework in which the nurse was situated by the Complainant.

In establishing the norms against which the nurse’s conduct could be measured, the Complainants relied extensively on both legal and professional standards discourse. Professional standards discourse was underpinned by assumptions about the role of nurses in protecting the integrity of the profession through enhancing, promoting and protecting both professional and public confidence. Intersection of this discourse with legal discourse served the functions of illustrating the importance of standards to the profession and enabling judgements to be made about how the nurse’s conduct jeopardised these normative functions. This discursive strategy strengthened the Complainants narrative presentation of the image of the nurse by giving credibility and legitimacy to the constructed image of the nurse.

Positioning the nurse: failing to act responsibly

The notion of responsibility was repeatedly used by the Complainants when speaking about what expectations the public and the profession could reasonably have of the nurse. In each of the inquiries the obligation of the nurse to meet their professional responsibilities was examined and found wanting. Depending on the context of the
individual narrative, the nurse’s professional responsibilities were examined in relation to patients, other health professionals including employers, the Board and the Tribunal.

In T1 for instance, the failure of the nurse to meet his professional responsibilities were outlined in the particulars of the complaint which had been made against him. In the complaint it was alleged that the nurse had been guilty of professional misconduct or in the alternative unsatisfactory professional conduct, in that the nurse had engaged in improper or unethical conduct in the practice of nursing. The particulars of the complaint were to do with professional regulatory requirements and were significant in framing the nurse as not meeting his professional responsibilities. The particulars detailed the following actions of the nurse which included failure to fulfil the voluntary undertakings given to the Drug Counselling Committee of the Board to have random urine drug screens taken, failing to see doctors as agreed to with the Board and to submit reports to the Board, and failing to provide assistance to the investigation. The nurse’s responses to these issues were deemed unacceptable by the Complainant because in his view the responses were not honest or believable and as such did not meet the standard that the Tribunal had the right to expect from a professional. In this way the Complainant established that honesty by a nurse appearing before the Tribunal was part of the nurse’s professional responsibility. Failure to meet professional standards was unethical and therefore amounted to professional misconduct.

We submit they’ve simply been conveniently raised to explain his conduct before this Tribunal. Perhaps some of them are true but from a professional person facing serious allegations, the Tribunal has a right to expect much better. It's our submission that the Tribunal will be satisfied that the particulars as outlined in Complaint Two have been established and that as a consequence of that finding that you will be satisfied that that amounts to professional misconduct. (T1, Day 2, pp. 45-46)
In the following extract from T4, the nurse’s actions were constructed as unsatisfactory professional conduct because the nurse operated outside his professional responsibilities.

with no responsibility for the patient at all and he if you like decided to take the admission of the patient into his own hands without anybody’s authority and with anybody's permission or knowledge, that conduct is inappropriate, we say sufficient to amount on its own to unsatisfactory professional conduct. (T4, Day 1, p. 55-56).

The Complainant in T1 framed the nurse as irresponsible by illustrating the significant ramifications arising from failure of the nurse to act responsibly. He argued that the whole hospital system was put at risk by professionals who were unreliable. Speaking about the nurse’s conduct in this way served the dual purpose of not only constructing the nurse as irresponsible, but by linking this to the effect on the whole hospital system, the Complainant was able to illustrate the magnitude of the nurse’s conduct.

It goes to the very core of how hospitals must operate that the administrators the ones that bear the ultimate responsibility must be satisfied that systems are in place of an audit nature than when written and signed off by professionals be they medical practitioners or nurses or others should be expected to be relied upon on their face. (T1, Day 2, p. 54).

In T2, the Complainant also spoke about the nurse not having met her professional responsibilities. He identified that the nurse “lied to the representative of the Nurses Registration Board”, was “working while she was unfinancial” and had failed to make “any compensation payment to the Department or the Court” in relation to the fraud she had committed against residents. Furthermore she had shown “blatant disregard” for the Tribunal by failing to attend. On the basis of these and other issues arising out of the discourse of trust the Complainant
concluded “if one looks at the expression of misconduct she has certainly complied with that expression” (T2, Day 2, p. 41). The Complainant also raised the issue that the nurse’s actions against “people in her charge” were also actions committed against her employer and that this meant she could not be trusted by her employer (T2, Day 2, p. 41). The Complainant characterized the nurse’s actions as a failure to meet her professional responsibilities not only in terms of her actions against her patients but also against her peers and the profession and concluded that on the basis of her criminal activities but also her clear disregard for the Board, the public and any authority with respect to nursing that the public required protection from the nurse.

…we believe that her name should be removed from the Roll in relation to that. Not only because of the offences and she has been convicted of these charges but also she’s shown a blatant disregard since that time for the Registration Board itself, the Tribunal itself and also undertaking other actions that certainly show that she has no regard for the public or any authority with respect to the practice of nursing. And considering the seriousness of the original complaint there is... this being a protective jurisdiction raises doubts about the protection of the public. (T2, Day 2, p. 42)

In T3, the Complainant drew upon professional discourse in the form of expert evidence from the peer reviewer who was of the professional opinion that the nurse’s actions were “a severe breach of professional conduct”, to characterize the nurse’s actions as professionally irresponsible.

….leaving the X ward without informing colleagues. And she concludes that in her opinion that is a matter of being a severe breach of professional conduct for the reasons outlined. Secondly she deals with the allegation that the respondent was absent from his duties and left his patients unattended. She concludes that in her view that was a severe breach of professional conduct of a registered nurse working in the X
setting. Briefly in relation to sleeping whilst on duty, she regards that is a severe breach of professional conduct (T3, Day 1, p. 42).

Failing to respond to the request to attend an interview with the Nurses Board, it says in my opinion the vast majority of nurses would not disregard such a request it would indicate poor judgement, and little regard for the Nurses Board or both. This lack of judgement was apparent in other instances for example, calling in sick at one hospital and then going to work at another hospital, I would consider this to be a severe breach of professional conduct of a registered nurse. (T3, Day 1, p. 42).

In this next extract, the Complainant drew upon previous medical and nursing Tribunal inquiries to give weight to the position that the nurse had a professional obligation to reply to complaints and to “assist the Tribunal” (T4, Day 2, p. 75). He also drew upon professional discourse to position the nurse within his professional responsibilities by speaking about the “power and privileges”, “duty”, “obligation” of a “professional person”.

However in relation to complaints against a medical practitioner there are matters other than his interest or the public interest in the right of silence to be considered. Those include the interest of the public in the proper performance by medical practitioners of the undoubted privileges and powers which they have in relation to their patients in the protection of member of the public who are patients from any abuse of those power or privileges (T4, Day 2, p. 74).

Mr Chairman in a Nurses Tribunal decision concerning X of X date you have applied the decision of Bowen Jones in this jurisdiction and in my submission appropriately so. There is no distinction of substance between the obligations of
medical practitioners and those of nursing practitioners in so far as this issue is concerned. (T4, Day 2, p. 75).

This would mean that a respondent has some form of duty to assist the Tribunal in those proceedings. And you go on to say there’s a need for this respondent and other respondents to realise to whatever degree they do have a duty to assist this Tribunal. It’s clear in our view that a respondent is a professional person and as an accredited nurse does have a duty to take part in these proceedings (T4, Day 2, p. 75).

In T5, the Complainant spoke about the expectation of the profession that nurses act responsibly. He then spoke about this nurse’s actions by drawing on professional discourse to make the normalising judgement that the nurse was not of good character.

And nursing is a profession that requires of its members that they responsibly use drugs. They always have access to them. Even without a schedule 8 authority nurses generally speaking work where they have access to drugs and there is no evidence to suggest that this man would not succumb in the same way he succumbed before. He certainly hasn’t given evidence that would permit the Tribunal to form that view in my submission. So the passage of time is not sufficient, there is no evidence whatsoever before this Tribunal of any solid and substantial nature as to a reformation. (T5, Day 3, p. 20)

…it is self-evident that his conduct in X date was not that of a person with good character. He was convicted of a range of offences, he not only stole X drug from his employer, he administered it to himself, he injected himself, he supplied it to patients of that clinic indirectly contrary to the tenants of the program that he was working with. He injected them,
that’s on his evidence alone, and then if you look at the materials which I submit have been proved he did so in exchange for money and sex and on one occasion he had sexual contact with the patient. I don’t think I need to say anything more in relation to whether or not that conduct was of a person without good character. (T5, Day 3, pp. 16-17).

Positioning the nurse: unfit to practice

In addition to the characterisation of the nurses as not meeting their professional responsibilities they were also positioned as unfit to practice nursing because their actions (which had been discursively shaped by the narrative construction of the Complainant) were contrary to the public interest and the interests of the profession. In developing this normative component of the narrative framework, the Complainants drew upon legal, medical and professional standards discourses in various forms to give credibility to the positioning of the nurse as unfit to practice nursing.

This is demonstrated in the following extract from T1. Here the Complainant drew upon the legal definition of professional misconduct and linked it with the role of the profession in setting the standards of professional conduct.

Professional misconduct as a nurse is defined to mean unsatisfactory professional conduct of a sufficiently serious nature to justify removal from the Register or the Roll under Section 4(1) and it's important to keep in mind that it's the profession that sets the relevant standards in relation to professional conduct. The peers of the nurse complained about in effect establish the benchmarks. In this matter the issue of there being any respectable minority view as to the conduct of the nurse simply doesn't arise. His conduct is self-evidently unacceptable to his peers in our submission.(T1, Day 2, pp. 46-47).
In the next extract, the Complainant used a finding from the Supreme Court to set a benchmark for the Tribunal to make decisions about the nurse’s fitness to practice. The Complainant highlighted the emphasis the courts had given to “examining all the relevant circumstances” of a conviction and not just the conviction itself to decide the issue of fitness to practice. He then spoke about there being “a series of decisions in the last 40 years that have reiterated in one form or another that view” (T1, Day 2, p. 48) to give substantial credibility to the benchmark.

In relation to the convictions of criminal offences, it’s clear that the law doesn’t conclude that a conviction automatically is conclusive of the ultimate issue or whether or not someone is fit to carry out their profession. Once again the High Court in X case in the X of the Supreme Court of New South Wales in X date, a case involving whether a barrister was fit to practise made it crystal clear that it’s always necessary to look behind the conviction and examine all the relevant circumstances (T1, Day 2, p. 48).

We say that not only are the convictions for drug matters serious but the Tribunal would also be concerned about the circumstances under which those offences occurred (T1, day 2, p. 48).

This was also the case in T2, where the Complainant relied on a decision of the High Court to establish that fitness to practice was not decided on a conviction alone, rather it was to do with the circumstances of the conviction.

…with reference to 44(1)(a), a complaint has been made against her that she’s been convicted of an offence in the sense in New South Wales and the circumstances of the offence render the applicant unfit in the public interest to practise nursing (T2, Day 2, p. 28-30).
These next extracts are illustrative of how Complainants have drawn more broadly on the circumstances of the offences committed by the nurses to establish lack of fitness to practice, and the need for de-registration.

What he’s [the judge] saying there is that it's something intentional, it’s something premeditated, it’s something that is more than an error in judgement and certainly the nurse’s actions in relation to the fraud, the uttering, the forgery were certainly something more than a mere mistake or error or a lack of competence in that sense and they go to the whole aspect of fitness to practise. (T2, Day 2, p. 41).

If the assault allegation is sustained then in my submission the Tribunal would consider the ultimate sanction of de-registration appropriate in the circumstances for a variety of reasons (T4, Day 2, p. 125).

The allegations concerning the assault goes way beyond a lack of judgement if you find it occurred it’s plainly and improper and unethical conduct and not merely a lack of judgement …could be described so amongst other things but it’s the unethical nature of the violent conduct which we say makes the misconduct so serious. (T4, Day 2, p. 122).

…in my submission the gravity of this man’s conduct and it bears repeating. He stole X drug, he used himself, he injected it, he supplied it to patients of the clinic who were there for help, he injected them and he did so in exchange for money and sex and had sexual contact with them. And he administered it in their company. Its very serious misconduct there’s no question that its very serious misconduct. The nurse has admitted professional misconduct. His conduct was sustained over a period of six months. (T5, Day 3, p. 22).
The following extracts reveal how having framed the nurse as unfit to practice nursing, the Complainants linked this with the need for the nurse to be removed from practice. For instance, it was argued removal would have a “deterrent effect”, would be “sending a message” to the profession and would protect the “integrity and public confidence in the profession”. In this way the Complainants emphasised the role of the Tribunal in maintaining the integrity of the profession and the public confidence in the profession.

There also is an issue which arises which might in broad terms be put as the deterrent effect. What message is being sent to members of the nursing profession if they were aware of the broad parameters of the conduct which has been examined in this case and would they feel that the integrity and public confidence in the profession has been maintained. You have a history of undertakings being given and breached. You have a history of unethical conduct in one form or another. (T1, Day 2, pp. 52-53).

So our position would be that her name would be removed from the Roll for the issues of the protection of the public (T2, Day 2, p. 43).

Well I wouldn't like to put a time limit on it [in reference to removal of the nurse from the roll]. I would just say that... well I probably would in a sense because she could apply straight away if it came to her notice but it would have to be a time that a) gave some seriousness to the offence not only for the protection of the public but also the nursing professional themselves. I mean if they were aware of this and I think that would be something I think the profession themselves would be concerned about. (T2, Day 2, p. 47).

In my submission there is no other order which can be made short of removing this man’s name from the register. The principles that are to be applied in determining the
appropriate course are well known to the Tribunal. It’s a protective jurisdiction. The purpose is not to punish. The purpose is to protect the public and to uphold the reputation of nursing. Another principle to be applied is to send a message to the community that this Tribunal will properly protect it and uphold appropriate standards in relation to nursing. And there’s the principle of deterrence to send a message to the profession that conduct unbecoming to a nurse is not tolerated and will be dealt with appropriately. (T5, Day 3, p. 21).

So in my submission given the clear gravity of the misconduct that it was sustained over a period of time, there has been no evidence, let alone solid and substantial evidence that this man has learnt from what he’s done. The community deserves to be protected and protected from nurses who will in my submission exploit them (T5, Day 3, p. 23).

Discussion

This critical analysis of the Complainants’ narratives revealed that there were two main discourses (or norms) used to construct the narrative presentation of the nurse. These were the discourses of trust and accountability. These discourses, which arise from the storyline of the ethical nurse constitute the textual framework for the narratives, in other words they shaped the narrative. In constructing the narratives the Complainants drew upon these cultural discourses to position the nurse via normalising judgements as unethical.

My analysis of the narratives revealed that each was organised by the Complainant to present a consistent and coherent image of the nurse. The purpose of which was to convince the Tribunal members that the nurse was so lacking in the ethical norms of
trust and accountability, that the Tribunal could comfortably find the nurse guilty of unethical conduct in support of a finding of professional misconduct. The Complainants achieved this by drawing extensively on the discourse of trust and repeatedly positioning the nurse within this discourse as unable to be trusted. Once this had been established the Complainants linked the narrative representation of the nurse as unable to be trusted to the discourse of accountability, where the nurse was positioned as someone who failed to act responsibly and was not fit to practice nursing. These discursive positionings of the nurse were intersected with other discourses and woven throughout the narrative, the effect of which was to produce a robust image of the conduct of the nurse as unethical. In effect, these discursive mechanisms gave the Complainant extraordinary power to shape the narrative presentation of the nurse.

Of importance, were the particular ways the Complainant spoke about the nurse within the discourses of trust and accountability as this was the means by which the Complainant characterised, specified and classified the nurse’s conduct as unethical. The effect of these strategies was to convey how far from the normative components of the discourses of trust and accountability the nurse had strayed.

The position of the Complainant in the discourse activity that is the Tribunal inquiry, is a powerful one which enables the Complainant to co-elaborate the position of the nurse as the subject of the inquiry. According to Rouveyrol, Maury-Rouan, Voin & Noël-Jorand (2005, p. 290) the roles and positions adopted by various actors are co-elaborated through discourse and discourse activity. The effect of this relationship is that the nurse is constrained to work within the narrative presentation constructed by the Complainant and so is forced to negotiate or co-elaborate a position within this already established narrative presentation. This discursive interaction is linked to relations of power where the position of the Complainant as the more powerful actor in each of the inquiries is already established through the technology of surveillance.

This discourse analysis has revealed the role of the Complainant in the discursive construction of the unethical conduct of the nurse. The implications arising from this analysis, along with those arising from the analysis of the narratives of the nurse and the Chair will be discussed in Chapters Nine and Ten. The next chapter will examine
the discursive production of the nurse through an analysis of the narrative self-presentation of the nurse.
Chapter Seven

A critical discourse analysis of the narratives constructed by the nurses

Introduction

Each nurse’s narrative arising from the Tribunal inquiries is analysed using a critical discourse analytic approach to explore how the nurse located their story within particular discourses to construct a preferred self-presentation.

Out of the five Tribunal inquiry transcripts analysed for this study, the nurse was either legally or self-represented in only three inquiries. In one inquiry the nurse represented himself, in another the nurse appeared as a witness and had legal representation and in the third the nurse did not appear but was legally represented. For the purposes of this study, where the nurse was legally represented, I have assumed the narrative constructed by the legal representative is the preferred narrative of the nurse and have analysed it from this perspective.

In the following section I provide a brief overview of the discursive approaches used by each nurse to construct their preferred self presentation through narrative. Following this I draw upon extracts from the Tribunal transcripts to illustrate how the nurses positioned themselves as subjects within the discourses used by the Complainants to construct their conduct as unethical.
Narrative overview

Tribunal inquiry 1 (T1) narrative overview

In contrast to the discursive construction of the nurse by the Complainant in T1, the nurse in this inquiry constructed two distinct and apparently contradictory images of himself. He spoke of himself as a professional who cared about the profession and who was professionally responsible. This construction of the professional self was however juxtaposed against a construction of the personal self, where he positioned himself as a victim in terms of his drug addiction and in terms of the system. These ways of speaking about himself can be seen as an attempt to minimise any impression that his actions were deliberate and within his control. Through the narrative he constructed himself as having insight into his behaviour, about which he was prepared to be honest.

The dichotomous construction of himself on the one hand as an addict, and on the other hand as an honest professional person, was a strategic attempt to resist the way in which he was discursively constructed by the Complainant. The strategies used by the nurse were; to blame the doctors and the system for his failure to meet the conditions required by the Board, to admit to his addiction but to claim that despite this he would be able to get his life in control over the next twelve months so that he would be fit to practise as a registered nurse and, to vehemently protest at any suggestion that he would act other than with integrity with regard to being a nurse. He strongly protested that he was ethical in his practice and that he would do no harm to his profession. The overall approach taken by the nurse was to take the high moral ground when speaking about his actions, so that even when speaking about doing something wrong, he drew on and intersected the discourses of accountability and trust with being a victim, to explain and minimise his actions.

Tribunal inquiry 4 (T4) narrative overview

In this inquiry the nurse did not appear before the Tribunal to give evidence, he did however have legal representation. As in T1, the way the legal representative framed
the nurse’s conduct within this narrative presentation can be seen as a direct attempt to resist the way in which he was constructed in the Complainant’s narrative presentation. My analysis revealed this was achieved by reframing the way in which the nurse was presented within the discourses of trust and accountability. To achieve this, the legal representative focused on constructing the nurse’s account as true and normalising his actions through the implicit suggestion that, given the circumstances, his actions towards the patient were understandable.

The dilemma faced by the legal representative was how to justify the nurse’s actions in light of the evidence. The actions of the nurse were that the nurse did not attend the Tribunal inquiry, and that the nurse had confronted the patient which led to an altercation resulting in injury to the patient. Despite the fact that the patient’s account of his injuries was contested by the nurse, it was nevertheless necessary to have the nurse’s actions with regard to his own account of the altercation normalised as much as possible. This was done by minimising the extent of the patient’s injuries through the suggestion that there was no risk to the patient from the injuries received; by acknowledging that the nurse’s practice in this situation could have been better, but nevertheless justifying his actions as necessary because no-one else would take action.

Tribunal inquiry 5 (T5) narrative overview

In this inquiry, more than one patient had made complaints about the nurse supplying drugs, however only one patient appeared before the Tribunal as a witness. The narrative presentation of the nurse was jointly constructed by the nurse and the nurse’s legal representative. Using similar strategies to those used in the other inquiries, the narrative presentation of the nurse relied on speaking about the patients concerned in such a way as to cast doubt about the reliability of their evidence and speaking about the nurse’s actions in a way which minimized the effect of the nurse’s actions in order to normalise his conduct.

In this next section of analysis, how the nurses constructed a preferred self image within the narratives is illustrated by drawing upon extracts from the Tribunal transcripts. This analysis demonstrates how the nurse took up particular subject
positions as a means of exercising resistance within the discourses of trust, accountability and as a victim.

**Analysis of the discourse of trust**

There were a number of strategies used by the nurses or their legal representatives to reframe the way the nurse had been positioned by the Complainant within the discourse of trust. The strategies were aimed at constructing each nurse as trustworthy. This included locating the conduct of the nurse within an ethical framework, where the nurse was positioned as responsible and wanting to do the right thing and also using strategies to minimize any intent or effect from the nurses’ conduct. This was attempted; by highlighting how, within context the nurses’ actions were justified, by questioning the credibility of witnesses and, in the case of one nurse, using the nurse’s non-English speaking background to resist the construction of the nurse by the Complainant.

In the following example from T1, the narrative description of bag snatching committed by the nurse, was an attempt to reposition himself in relation to the way he was constructed by the Complainant. He positioned himself as an honest person who knew right from wrong, and as someone who was responsible because he was prepared to confront and be accountable for his actions.

In explaining his involvement in the bag snatching incident the nurse attempted to rationalise his actions on the basis of his responsibility to his mother who was being forced to move because he owed her money, which he was unable to pay back. “I’ve put her in this position – I’ve got to get her out of it” (T1, Day 2, p. 22). In this way his actions can be construed as selfless, driven by his sense of doing the right thing by his mother. However, within this narrative presentation, the nurse was faced with the dilemma that his actions with regard to the “lady” from whom he snatched the bag could not be justified. He attempted to resolve this by acknowledging that his actions were wrong, but at the same time minimizing the seriousness of his conduct by talking about immediately giving himself up to the police and returning the bag. “I got back to
my car and thought what am I doing? This is not what I want to do and I gave up” “I just surrendered. I just felt I really don’t want to do this.” (T1, Day 2, p. 23). This was an attempt by the nurse to normalize his actions and position himself as taking responsibility for his actions. He also attempted to normalize the impact of the crime by stating “so the lady got all her valuables back, no one was hurt, nothing happened” (T1, Day 2, p. 23). Furthermore, by minimizing the effect of his actions on the “lady” he was constructing the incident as a relatively minor one which had no adverse outcomes.

In another example from T1, the nurse used the strategy of constructing the narrative around honesty and morality to challenge evidence given by the Complainant that he had stolen and used X drug which had been intended for patient use, and which had resulted in patients being denied pain relief. He admitted that he “kept” X drug, but strenuously denied that in doing so he had deprived patients of adequate pain relief. In an attempt to normalize this conduct the nurse positioned himself within an ethical framework, repeatedly protesting that he knew the difference between right and wrong, and that he would never let his drug taking affect his patients.

I have never done this and I would never do it. What I have said to Dr X and what I’ve said to other doctors and counsellors, is that on three occasions when patients were ordered X milligrams of X drug and the ampoule was X milligrams, I kept the X milligrams that they didn't get. That is what I've done. I have done that. I admit it but I have not denied any patients any analgesia because it's simply unfair beyond me and my drug of choice throughout my life has been X drug anyway. It's just not worth it. It's not fair. It's scary. It's wrong. I haven't done it. If I leave here that's the one thing I would like everyone to know is that I didn't do that (T1, Day 2, p. 26).

In an extract from T4, the nurse’s legal representative constructed the nurse’s evidence as honest by highlighting that his story was consistent every time, was
given immediately following the events, and remained unchanged from the initial evidence.

I might just address the issue about failing to give evidence. It is a problem in the sense my clients are aware of the inference that can be drawn but on the day that this occurred the nurse phoned the Nursing Unit Manager and gave a version of the events at a very short period afterwards. He then wanted to make a statement and was told he couldn’t, he had to give it to Nurse X and on the same day he participated in an interview where in effect he was cross examined by Dr X and the Director of Nursing, Mr X. He doesn’t change his story. He said that’s all I have to give. He doesn’t want to add anything. There is the inference that can be drawn but on the very day here’s three sets of circumstances and his story hasn’t changed from some 10 minutes after the event until today. (T4, Day 2, p. 92).

But I just draw to your attention particularly to the nurse giving his events 10 minutes after his version and even through the interview sticking to that version. (T4, Day 2, p. 93).

In other examples from T4, the nurse’s legal representative positioned the nurse as honest and showing insight by stating that the nurse was prepared to acknowledge that his actions “were not the best course of action”. At the same time he also attempted to normalise the actions of the nurse by characterising them as justifiable in the context of the patient being aggressive, and also because of the nurse’s long standing familiarity with the patient who was known to have a history of aggression. In this way, the nurse’s legal representative attempted to position the actions of the nurse as understandable.

That’s the inconsistency in the evidence but what is consistent is there was a punch thrown by the patient and action taken by the nurse to avoid that which had the patient
on the floor….with the benefit of hindsight as we have, the nurse would concede that it was not the best course of action for him to approach the patient as he did. He does say that he knows the patient. He spent…and known him for a long time and known him to be aggressive and saw him in a courtyard just after he’s assaulted a nurse and took some action. …Certainly he concedes that that is not best practice by a long way. (T4, Day 2, pp. 106-107).

Another strategy used in T5 was to normalise the nurse’s conduct in relation to inconsistencies in the nurse’s evidence, which the Complainant had characterised as evasiveness and a lack of honesty on the part of the nurse. The nurse’s legal representative drew on the nurse’s non-English speaking background as a means of reframing the manner in which the nurse’s evidence was given and also to justify the nurse’s failure to follow the Board protocol.

What I say right up front is that this is a person from a non-English speaking background. It’s a person who the Tribunal has heard doesn’t have the same turn of phrase as those of us who do come from an English speaking background. ........ 

....much of the evidence which my friend says is reluctant or given reticently in fact could just as easily be put into the circumstances of someone who doesn’t have that same term of phrase who is being appropriately cautious about thinking about what they’re being asked and thinking about how to appropriately answer it and much of the evidence in relation to drug screening the Tribunal may well find simply arises from some confusion about how the questions were put and how the answers were given. (T5, Day 3, pp. 24-25).
Analysis of the discourse of accountability

Within each nurse’s preferred narrative presentation, the nurse’s conduct was located in the discourse of professional accountability. Drawing upon this discourse the nurse was constructed as someone who not only valued their professional status, but who used their professional judgment in making decisions. An analysis of T1 revealed that being professionally accountable was woven throughout the nurse’s narrative and was constructed by statements such as:

I haven’t been nursing for a period of ….since mid last year anyway …8 months because I didn’t think my standards were high enough (T1, Day 2, p. 34).

I do understand the seriousness of being a registered nurse a person with responsibility whilst using drugs. I put forward that I did resign from nursing at the first opportunity once I was informed that my standards were slipping”(T1, Day 2, p. 56).

In this way the nurse is also portrayed as being responsible and as someone who values his profession.

I would like to nurse again. I do miss it…I do feel that I can put a lot back into the community and that I did a good job originally as a nurse. (T1, Day 2, p. 34)

In T4 the narrative positioning of the nurse by his legal representative is underpinned by the discourse of accountability. His aim is to present the nurse as a professional person. Who despite having complaints “hanging over” his head for three and a half years, and despite no longer working as a nurse, still takes his responsibilities to the Tribunal seriously. He speaks about the nurse as wanting to do the right thing and be present in person before the Tribunal. He explains that this was not possible because of circumstances beyond the nurse’s control, but nevertheless the nurse was prepared to bear the cost of having a lawyer represent him.
And of course the nurse is aware of the inferences that can be drawn and so forth and so on. It’s a practical decision that he has to make. He wants to be here, he wants submissions to be made on his behalf but he’s not in a position to spend two or three days. (T4, Day 1, p. 5).

The nurse now no longer practises as a nurse. He’s self-employed. Not only does he have the cost of a reasonable legal representative, he has a business loss every day that he’s not there and he’s in the middle of a project… he’s done everything to avoid … to rearrange but he’s not in a position now to continue so they’re practical problems that in the best of circumstances I wouldn’t have to trouble the Tribunal with but that’s the position that we’re in. (T4, Day 1, p. 6).

This matter has been hanging over the heads of nurses X and X for three and a half years, they do not want it delayed any longer. (T4, Day 1, p. 40).

It’s an issue that’s been going for three and a half years. It’s not in any way suggestive that either of the nurses don’t take the proceedings seriously but it’s something they want dealt with and finished and the result determined, whichever way it goes, but they need it done now. Three and a half years is a long time. (T4, Day 2, p. 99).

In an attempt to resist the way the nurse in T4 was positioned by the Complainant as callous and uncaring for leaving an injured patient unattended, the nurse’s legal representative drew on the nurse’s extensive nursing experience to construct his actions within a framework of accountability. He did this by suggesting that the nurse used his professional judgement in assessing the situation with the patient and appropriately determined the patient wasn’t at risk. To give credibility to this suggestion he noted that the injuries were not sufficiently noticeable to come to the attention of other staff.
He made a judgement about the injuries to the patient and that judgement as he says in his record of interview it wasn’t a serious medical emergency. (T4, Day 2, pp. 109-110).

It is interesting to note also that the Nursing Unit Manager did not become aware of the injuries to the patient until the nurse made that phone call, I say that is interesting because sometime had passed and the patient’s injuries hadn’t come to anybody’s attention that was, any nurses attention. (T4, Day 2, p. 110).

In T5, early in submissions, the nurse’s legal representative asked the Tribunal to “suspend the nurse for a period of no more than twelve months” (T5, Day 3, p. 26) and during that time to require the nurse to undergo random urine analysis, have his S8 authority removed, be clinically supervised, and at the completion of that time provided he met these conditions, be allowed to resume practice as a registered nurse. (T5, Day 3, p. 26). In this way, the nurse was positioned as professionally accountable. This was done by clearly establishing for the Tribunal members that the nurse was willing to not only acknowledge his wrongdoing, but was also willing to act responsibly to remedy and remediate his past conduct by proposing a suspension from practice, and offering to participate in a program of random urinalysis and clinical supervision. These strategies were clearly designed to show the reformed character of the nurse and to satisfy the Tribunal members of his fitness to practice as a registered nurse.

Another attempt by the nurse’s legal representative to present the nurse as accountable was in relation to the nurse undertaking further education since the events. Here, the nurse’s legal representative acknowledged that in relation to the complaint the nurse had not provided adequate urine samples, “random samples which as the Tribunal noted really aren’t the best and perhaps don’t properly meet the nurses Tribunal protocols”. Against this backdrop, the nurse was positioned as not having the same level of training then as he has now, “he has two bachelor degrees since then……He had his basic standard nursing training at that point in time and its four years ago.” (T5, Day 3, p. 27). This suggested the nurse was now much more educated and therefore would not be likely to make the same mistakes.
Furthermore, in an attempt to explain the nurse’s conduct in a way which minimized any intent on the part of the nurse, he was characterised as having been under stress at the time, but despite this had the strength of character to pull through and achieve his qualifications.

He was being treated for anxiety and depression, he was on a range of medications for anxiety and depression and he was on medication for pain relief. And at the same time he was struggling to study, ....but to his credit sticks it out and ultimately completes both of those qualifications. (T5, Day 3, p. 28).

Analysis of the discourse of the victim

Positioning the nurse as a victim was a discursive strategy adopted by each nurse or their legal representative. This strategy was particularly important to the nurses as a means of resisting the construction of their actions as intentional. The dilemma created by constructing a self presentation based on the discourses of trust and accountability was that the nurses’ actions belied these narrative accounts of themselves. Thus, by locating their conduct within a victim discourse, the nurses attempted to position themselves as powerless and as the victim, and as a consequence bearing no moral responsibility for their actions. Being a victim provided the nurse with the means for explaining, justifying and normalising their conduct.

Drawing upon a victim discourse in T1, the nurse constructed his actions as blameless and the outcomes as beyond his control. In responding to the complaint that he failed to have random urinalysis attended, he reframed this by presenting himself as actively trying to get urine screens organised and blaming the doctor for the failure. The nurse justified his actions by speaking about how he had initially approached a doctor to have the screens organised, and how he had pursued this with the doctor when it hadn’t been organised. In this way the nurse shifted the blame to the doctor. The next extract
illustrates how the nurse had positioned himself as someone who has tried to do the right thing, but had been powerless in the face of the doctor’s inaction. In speaking about the doctor, the nurse stated:

He didn’t do it for about 3 or 4 weeks so I contacted them and they said well he has to contact us, you can’t do it and so it went on. It took about 5 weeks for him to get the protocol… probably 6 weeks and then he didn’t ring. So I rang him on 3 or 4 occasions and said are you going to ring me… but he didn’t ring and that period probably took about … I don’t know 2 or 3 months and by then… I was moved by then (T1, Day 2, p. 18).

The nurse also positioned himself as a victim in relation to drug taking to minimize the scale of intent on his part. He needed to portray himself in this way so that his subject positioning in regard to drug taking fitted with the self presentation he constructed through the narrative. Positioning himself as anything other than a victim with regard to drug taking would have been incompatible with being a responsible person, accountable for his actions, who is honest, and knows right from wrong and is able to act accordingly. Being a victim allowed him to make sense of his continued drug taking within his presentation of himself as an honest and responsible person.

What nursing has taken away from me... a lot of my identity, a lot of my self-esteem, all of my social life, most of my friends... all of my friends... well sorry taking drugs has done that not nursing... not nursing but taking drugs has done that. It's left me feeling a totally non-valuable member of any community. In short I've lost everything through taking drugs. I don't wish to loose any more particularly at the moment. I haven't got much to loose but I don't wish to loose anything else. In conclusion I ask that the Board give me another chance to prove my ability to control my situation (T1, Day 2, p. 57).
In T4, the strategy used by the nurse’s legal representative was one of blaming the patient. This was useful because it created doubt about the reliability of the patient’s evidence. Also in situating the nurse’s actions against this backdrop, the nurse could in effect be positioned as a victim of the circumstances in which they found themselves. For instance in T4 the patient was framed as violent and unmanageable, “who nobody seems to be able to control”. Speaking about the patient in this way allowed the nurse to be repositioned as a victim of circumstance, this strategy can be seen as an attempt to minimise, explain and justify the nurse’s action.

That in this sheltered workshop was a belligerent, and that’s how he’s described post accident, known to be aggressive verbally and physically to patients and staff, person that nobody seems to be able to control and when he does become aggressive we just sit him down and tell him that’s enough. (T4, Day 2, p. 93).

In trying to cast the nurse’s account of the incident as the preferred account, the nurse’s legal representative set out to discredit the patient’s account of events by casting doubt on his recall.

One wonders how much reliance can be placed on the patient’s evidence given in his record of interview he doesn’t recall the X nurse being there. He doesn’t recall being punched. He makes no admission as to any assault on the X nurse except to say that he called her a bitch I think is what he said because she was sitting in my chair. But then the Tribunal is asked to accept that his version of the events in that X room is correct and I would say that that would be unsafe. (T4, Day 2, p. 101).

In this next extract, the nurse’s legal representative again stressed the aggressive nature of the patient and the nurse’s familiarity with that. This suggested that the nurse used his extensive knowledge of the patient in making a decision about how to react to the patient. In this way the nurse’s conduct is framed as not a spur of the
moment, angry response, but rather a response based on and informed by extensive knowledge and experience with this particular patient.

It’s again …we’re dealing with a patient with a long history of physical aggression that the nurse was well aware of. He made a decision using that judgement which turned out to be not the best one but the most serious allegation of assault in that X room is in my respectful submission the Tribunal could not be comfortable took place. (T4, Day 2, pp. 107-108).

Similarly in T5, the nurse’s legal representative drew upon the conduct of the witness to reframe the conduct of the nurse. By shifting the focus to the conduct of the witness, not only was attention drawn away from the conduct of the nurse but in addition the credibility of the witness was brought into question. In using these strategies the nurse’s legal representative positioned the witness’s evidence as dishonest, and this allowed the nurse to be positioned as a victim of the dishonesty of the witness.

We would say that it is relevant because it clearly would raise some issues in relation to the level of addiction to other drugs if this woman was pregnant and knew that she was pregnant but still was so addicted to other drugs such as X and X that she continued to use. She would have us believe from the evidence that she has given that although she was using she never suffered withdrawals, X drug kept her drug use under total control but now she has just really let slip in evidence that in fact she was a pregnant woman probably well aware of the dangers of using other drugs but nevertheless still using. We would say that it is pretty important to the addiction which she denies existed at the time. (T5, Day 1, p. 69).

The nurse’s legal representative systematically created doubt about the reliability of the witness’s evidence by casting aspersions on her character, in particular by
referring to her pregnancy as a means of highlighting the extent of her addiction. He compared the nurse’s conduct against that of the witness as a means of characterising the conduct of the witness as worse than that of the nurse. He suggested that in effect the nurse was deliberately set up by the witness. Speaking about the witness in this way drew attention away from the conduct of the nurse and focused on characterising the conduct of the witness. In this next extract, the witness is characterised as a liar and as having set the nurse up to serve her own ends. In this way the nurse was effectively positioned as a victim.

“But the person we are meant to believe is basically cheating on the drug program. She’s not just using one other drug she’s using a whole lot of other drugs at a time when she’s pregnant. And we’re told that she says I was there to be helped. Well that’s about as far from the truth as you can get because in fact she was there making the most of X drug in my submission while she was still using X drug, X drug and other drugs.” (T5, Day 3, pp. 29-30).

Well that’s not true. She signed a statement, she told the police it was true. She was ready to go to court and say it was true because that’s what it says in paragraph one but in fact that’s not the truth at all. She asked him to come, she wanted to do a deal with him, she was expecting him, she was sitting there waiting for him. She forgets to tell us that (T5, Day 3, p. 30).

They’re users at the time, both of them. And she in fact is a person in a far worse situation of using. He’s stealing X drug and using it. She’s poly abusing while she is on the drug program and carrying a child (T5, Day 3, pp. 30-31).

Her statements have inconsistencies in them too and we say are in themselves unreliable. Its’ put that the nurse put the
patient in danger. Well he doesn’t deny that but it has to be put in the context of course of the patient putting herself in considerable danger. She’s poly abusing drugs, using X drug as well as being on the drug program and she was in danger generally. What of course is put is that the nurse is never to be trusted again but the patient clean now and she’s an honest reliable and trustworthy witness and always was I just don’t know that that correlation necessarily neatly sits. (T5, Day 3, pp. 31-32).

The following exchange between the Complainant and the nurse in T5 illustrates how the nurse attempted to resist the way he was being positioned by the Complainant through using language designed to minimise the extent of wrongdoing on his part and, by suggesting that the patient was principally responsible for seeking the drug.

(Comp). I suggest to you that you offered to supply her with X drug on that occasion?

(Nurse) I agreed to supply X drug

(Comp) You offered the X drug to her?

(Nurse) I agreed to share the X drug that I had.

(Comp) Well when you say you agreed Mx X you raised the subject with Ms X and you offered to supply her with X drug, didn’t you?

(Nurse) No (T5, Day 2, p. 40).

(Comp) So you inserted the X drug through the syringe through her arm after that, did you not? (T5, Day 2, p. 41)

(Nurse) I pulled down on the plunger (T5 Day 2, p. 42).
(Comp) Then there was some X drug left wasn’t there after the injection?

(Nurse) Yes

(Comp) And you offered to leave it for her, did you not

(Nurse) She requested that I leave it there and I left it. (T5, Day 2, p. 42).

Throughout his evidence the nurse clearly positions himself as a victim both in relation to being a victim of the patients he supplied with drugs, but also in relation to his own drug addiction. He positions himself as powerless because the patients threatened him, they were manipulative and he was vulnerable.

In X month I was repeatedly asked and threatened by Ms X to supply her with X drug. (T5, Day 2, p. 45).

At that particular time I thought that I was feeling very vulnerable and they were very manipulative in trying to get me to continue to supply them with the X drug. The greatest threat to me was that I didn’t want my supervisors then I would go through withdrawals and everything else. (T5, Day 2, p. 68)

**Positioning the nurse as having insight into their conduct**

One of the significant discursive strategies used by the nurses or their legal representatives was to position the nurse as having insight into their conduct. Being able to demonstrate insight through being prepared to admit and take the consequences for their actions, was a strategy designed to give credibility to the way the nurses had been positioned in regard to their honesty and their professional accountability.
In T1 the nurse recognised that admitting to his drug taking was the major impediment to his being able to continue to practice as a nurse, so it was important that he show insight by demonstrating his willingness to do something about his drug taking. The next extract illustrates how he intersected three strategies to challenge the way he had been positioned by the Complainant in relation to his drug habit. He acknowledged his drug habit as a means of demonstrating insight, whilst at the same time attempting to minimize the extent of his habit by speaking about long periods of abstinence. He then suggested how the problem could be fixed.

if you were to try and **clinically categorise me** and my drug use you would say that I was a **chronic relapser** because I’ve had **long periods of abstinence** and **continued periods of abstinence** but I do relapse. It has been **going on for a long time**. If I was to be on **Naltroxone** that would really fix a **chronic relapse problem**, or it would help it a lot (T1, Day 2, p. 34).

In T4, the nurse is spoken about recognising in hindsight that his actions “weren’t the best”. In using this language to describe how the nurse now viewed his conduct, the nurse’s legal representative strategically minimised his actions but nevertheless acknowledged they were wrong.

**with the benefit of hindsight** as we have, the nurse would concede that is was **not the best course of action** for him to approach the patient as he did (T4, Day 2, pp. 106-107).

In the following extracts from T5, the nurse’s legal representative spoke about the nurse being prepared to acknowledge his wrongdoing and take the consequences of his actions. Not only did he position the nurse as honest and of reformed, good character, but also with insight into his past conduct. This strategy can be seen as an attempt to influence the findings and orders of the Tribunal.

**The nurse is prepared to accept those orders** the nurse **concedes** that in X year when this occurred they were guilty
of both unsatisfactory professional and professional misconduct and on my instructions they concede that in X year probably weren’t of good character because of what they did. What they say is that that doesn’t mean they’re [the nurse] not still of good character. (T5, Day 3, p. 33).

This nurse, whilst the matters to which the nurse admits are serious, is a person who we say is entitled to a second chance. (T5, Day 3, p. 33).

In the following extracts, this nurse positions himself once again within the victim discourse but intersects this with the discourse of honesty and insight. He speaks about his relief at getting help and positions himself as willing to have his problem of addiction dealt with.

… I got arrested by the police I informed the police and I was glad that is all came to an end. I wanted the whole thing to end but I couldn’t bring myself to I was dependent on X drug. I needed to have the access to X drug and I couldn’t bring myself that way. I was very glad very relieved that yes the police actually did apprehend me and they put a stop to that yes. (T5, Day 2, p. 50).

There was a period of time when I first started I the first time I put a few drops of X drug in my cup of tea at work that was because I was in a considerable amount of pain and I didn’t have my other drugs with me so I accessed the X drug. Once it was, very effective and then gradually I started taking more and more X drug and then I started diverting X drug to cover those days which I wasn’t at work. (T5, Day 2, pp. 59-60).
Discussion

The Tribunal inquiry was the context in which the nurse’s story was told, and it was this context which set the conditions which structured what the nurse had to say.

The context never exerts a unique and objective influence on discourse as an empirical reality, but is, rather, a subjective mental construct. This construct is defined as a social situation that consists of certain relevant aspects that also shape communication. (Schuck & Ward, 2008, p. 48)

The mental constructs occurring within the context of the Tribunal inquiries can be defined as consisting of the normalising judgements which are made by the Complainant to create an image of the nurse as unethical. The content of the nurse’s narrative was a response to these particular characteristics of the context and was deployed using ‘argumentative strategies that establish coherence, in order to construct a preferred image’ (Andersson, 2008, p. 144). Narrative according to Peterson and Langellier (2006, p. 174) does not simply serve the purpose of a communicative device, rather it is productive in that ‘performing narrative reproduces, recaptures, and re-inscribes power relations: and, performing narrative makes it possible to resist, thwart, and alter these relations’ (Peterson & Langellier, 2006, p. 178).

In this analysis it is evident that the nurses used narrative as an active attempt to resist and re-inscribe the way they had been constructed. They did this by drawing on the discourses in which they were positioned within the Complainant’s narrative and reframing themselves within these discourses to construct a preferred self image. Doing so however created a dilemma for the nurses because they had to not only acknowledge the evidence presented by the Complainants, but re-cast it in a way that normalised their conduct. They had to make their conduct appear understandable or justified whilst at the same time minimizing the effect or damage caused by their conduct. In constructing this preferred narrative account of their conduct, the nurses drew upon and intersected the discourse of the victim with the discourses of trust and accountability.
The analysis of the narrative self presentation of the nurses revealed that the response of the nurses to the way they were constructed in the Tribunal Inquiries was principally one of resistance. Resistance was exercised in a variety of ways, for example by offering passive resistance through refusal to cooperate with the inquiry processes, by actively challenging the findings of surveillance, and by constructing alternative narrative presentations to that of the Complainant.

The two main forms of resistance exercised by the nurses were either non attendance before the Tribunal, or presentation of an alternative narrative to that constructed by the Complainant. The strategy of non attendance can be seen as an outright refusal by the nurse to be subject to the coercive processes and practices of the Tribunal, whereas the strategy of constructing a preferred a narrative self-presentation can be seen as an attempt by the nurse to resist coercive practices by challenging the Complainant’s narrative construction. The approaches to resistance adopted by the nurses reflected their subject positioning in the relations of power exercised through the inquiry process. This included redirecting the focus of the narrative towards blaming others and away from their own actions in an attempt to reposition and reframe their actions as understandable or more normal. Other strategies used by the nurses were to position themselves within a victim discourse and to reframe the way they had been positioned by the Complainant within the discourses of trust and accountability.

From a Foucauldian perspective, resistance can be seen as a form of power which is exercised against the “mechanics of coercive forces” (Foucault, 1980a, p. 107) of disciplinary power. According to Foucault there must be the possibility of resistance for power relations to exist (Foucault, 1983). If there is no possibility of resistance then power is fixed in a state of domination rather than in a relationship to the subject, and therefore exists as sovereign power. In these Tribunal inquiries, resistance by the nurses demonstrates the ways in which the nurse refused to identify with the discursive positions to which they were made subject. Nevertheless their position of resistance was substantially weakened by their relationship to the Complainant and Chair who were the more powerfully located participants in the web of relations of disciplinary power exercised through the Tribunal.
What appears in each nurse’s narrative is their preferred self-presentation. The way in which the nurses approached construction of their conduct, was somewhat different from the approach taken by the Complainant. The self-presentation constructed by the nurse relied on directing the focus away from their actions. They did this by casting light on the actions of others in an attempt to make their own actions less blameworthy, more understandable, or more normal.

The way in which the nurses represented themselves through narrative can be interpreted as a counter-discourse; that is a discourse against power. According to Foucault “it is this form of discourse which ultimately matters, a discourse against power, the counter-discourse of prisoners and those we call delinquents – and not a theory about delinquency” (Foucault, 1977: 209, [emphasis in original]). Foucault saw resistance as a form of counter discourse which made possible the productive effects of power by creating the possibility for change.

Through the use of discursive strategies, the nurses attempted to challenge the relations of power exercised through the Tribunal inquiry and the way in which these had been used to position them through narrative. Whilst it must be acknowledged that the discursive strategies used by the nurses were in direct response to the context and as such were shaped by what it was perceived was best to say and do in the circumstances, nevertheless the main aim of the nurses was to resist the coercive intent of the practices and processes of the Tribunal. The way in which the nurses constructed themselves through narrative reflected their attempts to negotiate a preferred position within the constraints of the context. Through narrative, the nurses can be seen to be using subject positioning as an attempt to establish a coherent self-presentation capable of exercising resistance.

In the next chapter a critical discourse analysis of the way in which the nurse was constructed through narrative by the Chairperson of the Tribunal will be undertaken.
Chapter Eight

A critical discourse analysis of the narratives constructed by the Chairperson

Introduction

In each of the Tribunal inquiries, the Chairperson’s (Chair’s) narrative presentation of the nurse conveys the collective and contextually derived views of the Tribunal members, which were shaped by the preceding narratives constructed by the Complainant and in some cases the nurse. At the outset, the Chair and the Tribunal members heard evidence about the nurse through narrative presentation by the Complainant. Subsequent to that, in three out of the five inquiries they also heard directly from the nurse or from the nurse’s legal representative. In T2 and T3 the nurse was not represented, so in these inquiries the narrative construction of the nurse by the Tribunal was derived solely from the way the nurse was positioned by the Complainant.

The discourses of trust and accountability provided the narrative framework in which the nurse was positioned by the Chair. Through this process of subject positioning, meaning was attached to the conduct of the nurse ultimately serving as justification for the findings of unethical conduct. The findings which arose from the discursive positioning of the nurse in effect reproduced, recaptured and reinscribed relations of power (Andersson, 2008) exercised throughout the inquiry. The discursive construction of the nurse’s conduct as unethical in each of these inquiries enabled the Chair to apply the ultimate sanction of removal of the nurse from practice through a finding of professional misconduct.

In T1, T4 and T5, the Chair was faced with the dilemma of having to determine on the basis of conflicting narratives (i.e. the narrative presented by the Complainant...
and the narrative presented by the nurse) if the conduct complained of was supported by the evidence as presented throughout the inquiry. Ultimately, the Tribunal had to decide if they accepted the nurse’s preferred self presentation where the nurse attempted to normalise their conduct, or that of the Complainant where the nurse’s conduct was presented as significantly deviating from the norm. This dilemma was not a feature of T2 and T3, where the absence of narrative self-presentation by the nurse allowed the discursively constituted narrative of the Complainant to remain essentially unchallenged.

Analysis of the Chairs’ narrative presentations of the nurse, revealed the powerful influence of the Complainants’ narrative constructions of the nurse within the discourses of trust and accountability. The victim discourse used by the nurse as the means of resisting their construction by the Complainant was rejected by the Chair. The narrative construction of the nurse by the Complainant was on the whole adopted by the Chair as the preferred narrative presentation of the nurse. In the following sections of this chapter the discursive construction of the nurse by the Chair will be analysed by drawing upon extracts from the transcripts.

**Analysis of the discourse of the victim**

The discourse of the victim used by the nurse in T1, T4 & T5 was rejected in each case by the Chair. This was significant because the victim discourse was the only means available to the nurse to normalise their conduct. Once this had been rejected by the Chair, the position of the nurse within the relations of power between the players was significantly and strategically weakened.

In T1 the Chair rejected the nurse’s discursive construction of himself as a victim; rather the nurse’s conduct was spoken about in such a way that it was incongruent with being a victim. On the contrary, the nurse was found to have displayed characteristics opposite to those of a victim. In rejecting the victim discourse which characterised the nurse’s self presentation in T1, the nurse was acknowledged by the Chair as having achieved despite his addiction. This was evidenced by the nurse
undertaking study to become a registered nurse. It was noted that the nurse was “sufficiently organised to attend these proceedings as well as the previous directions hearing. His appearance is neat and, in the vernacular, he looks reasonably well preserved” (T1, Day 3, p. 7). Speaking about the nurse in this way, the Chair effectively rejected the victim discourse which was a strong theme throughout the nurse’s narrative, rather he positioned the nurse as a person who was able to make decisions and exercise judgement and who was capable of functioning well despite his addiction.

In T2, the Chair constructed the narrative about the nurse in relation to the residents for whom she had provided care. The Chair positioned the residents as victims of the nurse. In this way both the nurse and the residents were discursively positioned, the nurse as a perpetrator of crime and the residents as defenceless and dependent people who relied upon the nurse for their care. Her actions were thus positioned as callous, heartless and deliberate and signified the extent her actions departed from the normative expectations of a nurse. In presenting the nurse in this way, the Chair effectively ignored the medical evidence and chose to take up the way the Complainant had framed the medical evidence in relation to the nurse’s mental health problems.

The residents who were her victims were people in the severe to profound range of developmental disability, were unable to fend for themselves and were dependent upon her and her co-workers in many aspects of life but especially in financial matters. (T2, Day 3, p. 7).

When talking about the circumstances which prevailed in the institution at the time the nurse committed the offences, the Chair spoke about the nurse as taking advantage of her position. “It was a situation ripe for someone such as the nurse to take advantage of the developmentally disabled and dependent residents.” (T2, Day 3, p. 7). In this way, the Chair was able to further characterise the nature of the nurse as suspect and dishonest in relation to the vulnerable residents.
In T3, the Chair similarly drew upon the victim discourse as a strategy for identifying the potential risk to patients arising out of the nurse’s actions in leaving the patients unattended. In differentiating between the needs of patients in a general ward as opposed to those in an intensive care setting, the Chair characterised the risks to the patients as dire and in this way effectively highlighted how far from the required norm the nurse’s actions were.

The state of health of a patient in an ICU is far more fragile and requiring greater attention. By definition, an intensive care patient requires care which is more complex and requires meeting of special needs. The unauthorised absence of a nurse, especially without informing either workmates or a supervisor, usually, if not invariably, gives rise to risks to the life and/or safety of the patient or patients for whom that nurse is responsible. Usually there are specific tasks to be carried out for a patient which are necessary to keep that patient alive or to ensure a patient does not suffer serious damage. (T3, Day 2, p. 4).

In the following examples from T5, the Chair identified the power imbalance which existed between the nurse and his patients to reject the nurse’s position as victim. This was achieved by reframing the patients as victims of the nurse.

What concerns us in these proceedings, however, is the manner in which he gave evidence in these proceedings. Much of his evidence was marked by a concerted attempt to blame the three patients for his own misbehaviour and misconduct. There seemed to be little, if any, appreciation on the part of the nurse that different standards did apply to him as a nurse, as opposed to the three patients. Those standards applied because he was in a position of privilege and power over them as a registered nurse. (T5, Day 4, p. 18).
That behaviour was characterised by a pattern of expressly exploitative behaviour which causes us special concern. Had he been able to acknowledge the seriousness of that behaviour, this Tribunal may well have concluded otherwise in relation to his character. (T5, Day 4, p. 19).

In each of these narratives the patients are positioned either as victims or potential victims of the nurse. The subject positioning taken by the nurse in T1, T4, and T5, where they positioned themselves as victims was rejected. On the contrary, their actions were framed as deliberate and they were positioned as putting patients at risk. In this way the patients were reframed as the victims. This strategy was effective in strategically positioning the nurses’ conduct in relation to the norms of trust and accountability. Furthermore, it provided a benchmark for the Chair to make normalising judgements about aspects of each nurse’s conduct.

**Analysis of the discourse of trust**

In each of the narrative presentations the discourse of trust was used to make normative judgements about the actions of the nurse. In determining that the nurse was unable to be trusted, the Chair in each inquiry focused on constructing the nurse’s conduct as intentionally dishonest. Analysis of the transcripts revealed that the strategies used by the Chair in each narrative construction of the nurse, concentrated on the degree to which the nurse’s dishonesty deviated from the norms of honest conduct. This was achieved through the use of emotive language to focus attention on the intentionality and effect of the nurse’s dishonesty. In this way the Chair was able to reject the discursive subject positioning adopted by the nurse with regard to their honesty.

In T1, the Chair challenged the nurse’s discursive representation of himself as an honest person. He spoke about the nurse as having good intentions with regard to dealing with his addiction which had not translated into the anticipated outcomes, “after initial good progress and good intentions he left the program” (T1, Day 3, p. 207).
6), and “it is clear from the evidence before the tribunal that despite the nurse’s good intentions he nevertheless resumed or continued using X drug” (T1, Day 3, p. 6). In the following extracts it can be seen how the Chair characterised this pattern of behaviour as typical of someone who was addicted and in this way was able to frame the nurse as someone who could not be trusted because of his addiction.

He failed to comply with the undertakings (T1, Day 3, p. 6).

His failure to provide random urine samples in X date, his brushes with the Police, his arrests on various offences in X date and X date, and his incapacity to work properly in X date, indicate that he was not drug-free but still addicted to X drug during that period. (T1, Day 3, p. 8).

The Tribunal also observes that having seen the nurse give evidence and attend the Inquiry over a two-day period, the nurse’s present condition is not straightforward although this is not unusual among those addicted to X drug. (T1, Day 3, p. 13)

Speaking about the nurse this way served a dual purpose. In the first instance, it served to normalise the nurse’s behaviour in terms of addiction, allowing the Chair to identify the behaviour as the type of behaviour that is common to people who have an addiction. In the second instance, it signified the extent of the problem of the nurse’s addiction and positioned the nurse as unable to break free of his addiction. Characterising the nurse in this way effectively challenged the nurse’s portrayal of himself as an honest person who had a level of control over his addiction and discursively positioned the nurse as unable to be trusted because of his addiction.

The Chair also represented the nurse as having failed to act in a professionally accountable way by speaking about the nurse’s actions as intentionally dishonest with regard to the Board. Here, the Chair adopted the way the nurse had been discursively positioned by the Complainant, characterising the nurse as having “knowingly failed” to do what the Board had required, and of being deceptive and dishonest in an effort to conceal drug usage.
such urine analysis that he did undertake was done more in an attempt to reflect his brief drug-free periods rather than to give an accurate picture of his X drug consumption. (T1, Day 3, p. 11).

information provided by him to the Board was untrue (T1, Day 3, p. 11).

In T2, the Chair adopted the Complainant’s discursive representation of the nurse’s actions as dishonest by speaking about the “large sums of money” (T2, Day 3, p. 7) she had “misappropriated” (T2, Day 3, p. 8), and her failure to cooperate with the police (T2, Day 3, p. 8). He also spoke about her conduct as intentional, signifying the level of seriousness and callousness by speaking about her actions as “systematic”, “premeditated” (T2, Day 3, pp. 8-12) and “carefully organised” (T2, Day 3, p. 8) over a long period of time. Here, there is no doubt in the minds of the Tribunal that the nurse’s actions were motivated by her own interests at the expense of the residents.

The positioning of the nurse as having acted intentionally and dishonestly was also located in discussion about her mental health; “either the nurse’s mental state and condition fluctuated markedly in that period or that the nurse adopted a manipulative approach to achieve the desired result.” (T2, Day 3, p. 11). On the basis of the nurse’s absence from the inquiry the Chair found that the Tribunal could not be “comfortably satisfied” (T2, Day 3, p. 11) about her mental health problems. Here, the strategy which had been used by the Complainant to create doubt about the honesty and intentionality of the nurse was adopted by the Tribunal.

Positioning the nurse’s conduct within the discourse of trust as intentionally dishonest enabled the Chair to find that the nurse’s conduct was unethical and justified finding misconduct. She was described within the narrative as having “breached trust” in relation to the residents and her employer. The extent of the breach was established by speaking about the effect of the nurse’s conduct. This was described in terms of the negative effect on the “quality of life” of “disabled” and “dependent” residents, and that her acts of misconduct were serious because they
were of “such moment and so marked in relation to the dependent disabled persons involved” (T2, Day 3, p. 12). Here, the use of the words “such” and “so”, have the effect of emphasising how far from the norm of honesty the nurse’s conduct actually was.

In T3, the nurse was also positioned by the Chair as unable to be trusted. His actions, when working in an intensive care unit, were characterised as intentional.

On both occasions the respondent was absent from his duties in the X ward and sleeping. Further, he did not at any stage tell or otherwise alert his colleagues, including the supervisor, that he was going to leave his patients. No permission was given for him to do so and no steps were taken by him or by any member of the nursing staff to ensure that adequate nursing care was provided for the patients involved. This was the direct result of the respondent’s unilateral decision to leave the unit and sleep without notifying anybody. (T3, Day 2, p. 5).

The Chair positioned the nurse as deliberately avoiding having to account for or explain his actions by describing the response of the nurse as evasive.

In our view, the response from the respondent is simply an attempt to evade the relevant issues. (T3, Day 2, p. 5).

The overall tone of his response is evasive (T3, Day 2, p. 8).

He also positioned the nurse as a liar. This was done by speaking about the nurse as having asserted that he apologised for taking sick leave whilst working in another hospital, but noting that there was no documentation to support this assertion. (T3, Day 2, p. 6). As the narrative progressed the Chair simply stated that he did not accept the nurse’s claim that his failure to attend an Impaired Nurse’s Panel was as a result of not receiving correspondence. (T3, Day 2, p.8).
In T4, the Chair’s narrative presentation of the nurse was focused on constructing the nurse’s version of events as inherently unbelievable and as a deliberate attempt to misrepresent the events complained of. The nurse was also positioned within the narrative as callous in his actions with regard to the patient. The use of emotive language by the Chair to describe the actions of the nurse left no doubt as to how the Tribunal characterised the actions of the nurse. For instance, the Chair variously described the nurse as giving a “false explanation”, as offering no “apology for or expressed any remorse” for his actions which were “callous and calculating” and of leaving “the scene of the crime”, “lying” and so on. Speaking about the nurse’s actions in this way clearly positioned the nurse as acting with intentional dishonesty.

However having struck the patient he then in a callous and calculating manner decided that the best course of action was to leave the scene of the crime and return to his ward with the X nurse to gain some extra time to try and think of an explanation which may excuse his actions. (T4, Day 3, p. 18).

It is clear from the time of events that the nurse only proceeded to alert nursing staff at X of the patient’s injury after he had a chance to think of a way of explaining away his behaviour. He decided to do this by lying. Again, this further compounds the initial breaches. (T4, Day 3, p. 18).

In the following extracts the nurse’s failure to admit wrongdoing and his attempt to position himself as a victim by “blaming the hospital” along with his failure to appear for cross examination was constructed by the Chair as evidence of the nurse’s dishonesty.

Neither in that letter or in anything put to this Tribunal on their behalf was there any serious acknowledgment that they had done anything wrong. Indeed there was a continued denial that the nurse had punched the patient. Similarly, there has never been any acknowledgment by them that they abandoned the patient without providing any assistance.
Indeed the letter of X date appears to have taken the "blame the hospital" approach. In addition before this Tribunal both respondents declined to enter the witness box and give evidence under oath to explain their actions, let alone subject themselves to cross-examination. This was despite the fact that the nurse himself attended on one day and both were represented both by a solicitor. (T4, Day 3, p.17).

Up to and including the time of the Inquiry the respondents have made no acknowledgment of, or any apology for or expressed any remorse for their actions that day. (T4, Day 3, p. 17).

In this next extract the Chair rejected the nurse’s preferred self presentation that he used his nursing knowledge and experience in making a decision to confront the patient. The Chair explicitly stated that the nurse’s explanation was false and suggested that the nurse’s mental status and nursing knowledge were suspect.

As we noted earlier, it is ironic that the false explanation is no less serious than the facts as we have found them to be. This is an indication of the nurse’s state of mind at the time and possibly his nursing knowledge. The initial assault was therefore compounded by the later actions of the respondents. (T4, Day 3, p. 18).

In T5, the analysis revealed that the Chair dismissed the nurse’s account of his conduct as honest, preferring the narrative account of the Complainant and the evidence of the Complainant’s witness. In response to the issue of the nurse’s non-English speaking background the Chair observed that contrary to the position put by the nurse’s legal representative that the nurse’s non English speaking background hampered his meaning, and noted that:

The Tribunal take into account the fact that the nurse is not a native English speaker. While he is fluent in English, he
frequently used inelegant or clumsy expressions. Even taking that into account, his answers make little sense. (T5, Day 4, p. 11).

The Chair also rejected the nurse’s claim that his behaviour was for the purpose of helping patients with their withdrawal symptoms.

On the basis of the information in our possession, this Tribunal is comfortably satisfied that while his behaviour was the result of and did arise directly out of the nurse’s addiction to X drug, he did not do so for the primary purpose of helping the three patients concerned with their withdrawal symptoms. (T5, Day 4, p. 11).

In characterising the effect of the nurse’s dishonest actions, the Chair drew on the evidence of the peer expert to find that the nurse had “committed a severe breach of professional standards” and that “in relation to other broader ethical considerations the peer expert pointed out that the issues were manifold” (T5, Day 4, p. 14). The Chair proceeded to describe these issues as; a breach of duties to patients, as having “fundamentally undermined the drug rehabilitation program”, and undermining the “attempt to have the patients break out of the illegal drug-taking culture.” (T5, Day 4, p. 15).

He directly undermined the efficacy of the drug rehabilitation clinic where he was employed and directly undermined the attempts of the three patients to cease taking drugs…..His action merely undermined the intention and effect of the rehabilitation program (T5, Day 4, p.15).

In the following extract the Chair drew on professional standards discourse to illustrate the seriousness of the nurse’s intentional dishonesty. He spoke about the nurse’s actions as having crossed professional boundaries, resulting in both patients and staff being exposed to risk of harm.
However the breach of duty went further in that the nurse crossed professional boundaries by consistently engaging in social contact with three clients of the clinic over a period of some six weeks. He did that by offering them lifts, by driving them to their homes and by the sale to them of X drug. On the account of each of the three patients, which we accept, he also attempted to obtain sex in exchange for the drug. Whether or not the patients were in his care as case manager, the nurse acknowledged that he was personally familiar with their clinical details as well as other details of their personal life through his employment as a nurse at the clinic. He abused the relationship of trust with patients of the clinic and abused confidential information in his possession (T5, Day 4, p.15).

The nurse also breached the relationship of trust between himself and his colleagues (T5, Day 4, p. 15). Nurses must be able to rely implicitly on the honesty and reliability of their colleagues, especially in dealing with clients. The nurse exposed the patients to risk and also exposed his colleagues to associated risks (T5, Day 4, p.16).

**Analysis of the discourse of accountability**

In the narrative representations of the nurse by the Chair, the discourse of professional accountability provided a framework for examining and judging the impact and effect of each nurse’s conduct on the profession. Within this discourse the nurses were spoken about as having failed their professional obligations and as presenting a threat to the public. Framing the nurse’s conduct in this way enabled the Chair to position the nurse as unfit to practice in the public interest and as such their actions were found to be unethical.
Underpinning the construction of the nurse as having failed to be professionally accountable was the discourse of professional standards. Within this discourse the nurses’ conduct was found wanting on the basis that the nurses had failed to appropriately respond to their professional obligations which included; responding to the Board and its’ directives as required, responding to employers, and appearing before the Tribunal to answer questions about their conduct.

In T1, the Chair adopted the narrative position constructed by the Complainant that the nurse failed to act with professional accountability. In doing so the Chair rejected the discursive position constructed by the nurse that he was professionally responsible. The Chair drew upon professional standards discourse as a means of identifying the ways in which the nurse had deviated from the professional norm. He spoke about the nurse as a “health professional” who had “an obligation to comply with undertakings given to a Counselling Committee of the Board as a matter of professional duty”. He also spoke about the nurse as having an “obligation” “to respond and deal frankly and promptly with the Health Care Complaints Commission” (T1, Day 3, p. 11) and that he “did not comply with that properly exercised power” (T1, Day 3, p. 12).

The Chair in T1 strongly rejected the narrative self presentation of the nurse. Rather he positioned the nurse within the discourse of accountability and intersected this with the discourse of trust to emphasise the degree with which the nurse had failed to be professionally accountable. He spoke about the nurse as having been intentionally dishonest with the Board and with the subsequent investigation into his conduct. “His failure to comply with the Board’s request is similar in nature to his failure to comply with his undertakings and his refusal to co-operate with the investigation” and that his conduct “constitutes unsatisfactory professional conduct in that it was behaviour that was improper or unethical conduct relating to the practice of nursing” (T1, Day 3, p. 12). Having adopted this discursive construction of the nurse, the Chair qualified the extent of wrongdoing by making normative judgements that the nurse’s unethical conduct was “serious”, “wilful” and “calculated to conceal” and therefore constituted professional misconduct (T1, Day 3, p. 12).
Similarly in T2 and T3, the Chair drew on professional standards discourse to find that the conduct of the nurse was a breach of professional standards. In T2 the Chair spoke about the nurse’s actions as “a breach of standards of the nursing profession” (T2, Day 3, p. 11). In T3, the nurse’s failure to be professionally accountable was found to constitute unsatisfactory professional conduct because he failed to attend an Impaired Nurses Panel, and repeatedly failed to respond to written requests by the Board. The Chair concurred with the evidence of the expert witness that the nurse’s actions constituted “breaches of nursing standards” (T3, Day 2, p. 11). Furthermore in T3, the Chair characterised the nurse’s failure to appear before the inquiry as evidence of a lack of contrition which raised “fundamental questions of his fitness to practice.” (T3, Day 2, p.12).

In speaking about the nurse’s capacity to be professionally accountable the Chair also spoke about the need to protect the public interest and in each case positioned the conduct of the nurse as presenting a threat to the public interest.

In T1, the Chair rejected the nurse’s construction of the events related to stealing as selfless and designed to assist his mother’s financial situation. Instead the Chair found that the nurse’s actions were “serious” because they reflected “the long standing nature of his drug addiction” and “his incapacity to practise as a nurse”, and for these reasons his actions “render him unfit in the public interest to practise nursing.” (T1, Day 3, p. 13). Having rejected the nurse’s narrative positioning of himself, the Chair found that because of his addiction the nurse was not a fit person, mentally or physically to be “an independent practitioner, which he would be as a registered nurse.” (T1, Day 3, p. 14). The Chair also conveyed the view that the public interest in maintaining professional standards required that he not practice for a period of twelve months, but with conditions, could return to work after that time as an enrolled nurse. “In that way, both the public interest as well as the nurse’s interest will be served. By removing his status as a registered nurse while allowing him to practise later when fit as an enrolled nurse, leaves him an incentive to help himself.” (T1, Day 3, p. 14). In the process of exercising normalising judgements about the nurse’s conduct, the Chair found that the nurse’s drug addiction was not acceptable conduct for a registered nurse and that the public interest could not be served whilst the nurse remained addicted to drugs.
In T3, the Chair found that nurse’s behaviour was “consistent with a drug abuse problem” which was “behaviour which was particularly risky to his patients.” (T3, Day 2, p. 13). The Chair positioned the nurse’s drug taking as serious because of the risk his behaviour presented to both his patients and to his professional obligations.

His behaviour exposed patients in his care to risk. It placed him in a situation in which he failed to fulfil a major role obligation at work in circumstances where he should have been performing professional duties. (T3, Day 2, p. 14).

This Tribunal would be neglecting its duty by allowing the nurse to practice as a nurse until it is clearly established in an open and public process that any substance abuse difficulties or disorder have been resolved. … In our view the only means of achieving this goal is to remove the nurse from the register of Nurses of New South Wales. The appropriate period before which he may not apply is two years. (T3, Day 2, p. 15).

In T2, the Chair spoke about there being a lack of clarity around the issues of the nurse’s mental health which the nurse had attempted to exploit in order to position herself in a more positive light. He drew upon the nurse’s positioning of herself as having mental health problems and framed this within the discourse of trust to find that it was not in the public interest for the nurse to remain in practice. “She has relied on her psychiatric illness on a number of occasions, variously alleging that it had been cured, while at other times claiming that she was still suffering from it. Before she is accredited it is in the public interest that those matters be fully canvassed.” (T2, Day 3, p. 16). In handing down the orders to remove the name of the nurse from the register for a three year period the Chair gave as one of the reasons that “there were serious psychological factors involved in the nurse’s acts of dishonesty and those matters may not, as yet be resolved.” (T2, Day 3, p. 16). On this basis the Chair made the finding that the nurse must provide evidence of her mental health if she applied to be put back on the register.
The public interest requires nursing practitioners in this State to be persons who are honest and who can be relied upon in performing nursing duties. In particular the public interest requires persons who will not take advantage of or exploit persons who are in their care. This applies even more so when the persons in their care are already dependent persons, who have an ongoing mental and possible physical disability and who are open to a high degree of exploitation. For all the reasons for which the Tribunal found the nurse guilty of professional misconduct we find that in view of the circumstances surrounding her conviction, she was unfit in the public interest to practise nursing. (T2, Day 3, p. 13).

In T4, the nurse’s conduct was constructed by the Chair to constitute breaches of nursing standards. He repeatedly spoke about the nurse “failing” his responsibilities to the patient and to the hospital authorities, and in this way constructed the nurse as unfit to practice. On the basis of this conduct the Tribunal exercised its normalising judgement that the conduct of the nurse constituted unethical conduct.

We find that by grabbing the patient forcing him into the X room at X and by striking the patient in the face he is guilty of unethical conduct in the practice of nursing. We further find that he is guilty of unethical conduct in the practice of nursing in providing a false report of the events to the X nursing unit manager and subsequently in his interview with hospital authorities on X date. Similarly he is guilty of unethical behaviour in failing to provide immediate first aid, failing to report the matter and failing to adequately take appropriate care for the patient after the events in the X room. In relation to his going to X on the request of the X nurse we find him guilty of demonstrating lack of adequate judgement in the practice of nursing. In all these respects we find that he is guilty of unsatisfactory professional conduct. (T4, Day 3, pp. 15-16).
In particular, because of the striking of a patient, compounded by leaving him without first aid or having reported the injury, we find that the nurse’s fitness to practice as a registered nurse is in issue. We consequently find him guilty of professional misconduct. (T4, Day 3, p. 16).

The fundamental breaches however, consist of the assault followed by the abandonment of the patient without providing assistance. Those factors alone could be sufficient to render him unfit to practice as a nurse. That he has failed to take the opportunity before this Tribunal of explaining his actions by giving sworn evidence merely indicates to us that the unfitness demonstrated by his actions on X date remains current today. (T4, Day 3, p. 18).

In the event we find that there was a breach of nursing standards by the nurse in punching the patient to the face. This was subsequently compounded by the failure of both the nurse and the X nurse to provide any first aid or other assistance to the patient. There was a further compounding of the breach by virtue of their failure to report the matter immediately to other nursing staff who were nearby and who both respondents either knew or ought to have known were nearby. There was a further compounding of this by their providing a false report of the manner in which the patient suffered his injury in the X room, on the part of the nurse in his interview on X date and by the X nurse in her interview on X date. (T4, Day 3, p. 15).

In T5, the Complainant’s narrative presentation of the nurse was adopted by the Chair over that of the nurse. At the outset the Chair set the tone by speaking about the relationship of power between the nurse and the patients. The Chair positioned the nurse as the more powerful participant. He spoke about the nurse’s access to patient information, [he] “was a registered nurse employed at the clinic who had
access to and knowledge of the personal and confidential particulars of their health and other aspects of their personal lives”. (T5, Day 4, p. 4). Positioning the nurse as failing to meet professional standards, the Chair concluded the public interest was put at risk.

In view of the multiple breaches of professional standards which involve the convictions for supply and one of possession of X drug, there can be little if any doubt that the circumstances of the offences as at X date would render the nurse unfit at that time in the public interest to practise nursing.

**Positioning the conduct of the nurse as unethical**

Prior to making the Tribunal orders, which included orders that the name of the nurse be removed from the Register; the Chair in each inquiry, in the process of summing up the Tribunal findings spoke about the unethical conduct of the nurse. It can be seen from the analysis of the Chair’s narrative positioning of the nurse how normalising judgements exercised by the Chair were used to construct the conduct of the nurse unethical. Having constructed the nurse in this way, the Chair was then able to draw upon the discourse of unethical conduct to establish findings of professional misconduct. The following extracts taken from the transcripts of the inquiries powerfully illustrate how the Chair drew upon the discursive representations of the nurse to make a finding of unethical conduct.

**T1**

His failure to comply with the board's request is similar in nature to his failure to comply with his undertakings and his refusal to co-operate with the investigation. Accordingly the tribunal finds that the nurse’s conduct as particularised in Complaint Two constitutes unsatisfactory professional conduct in that it was behaviour that was improper or
unethical conduct relating to the practice of nursing. In our view these breaches are serious in that they were willful actions on the part of the nurse and were calculated to conceal from both the nurses registration board and health care complaints commission the fact that he was using X drug. Accordingly the Tribunal is of the view that his fitness to practice must come into question and that this unsatisfactory professional conduct is sufficiently serious in nature to justify removal of Mr X. name from the Register or the Roll. Accordingly the Tribunal finds Complaints Two established and the nurse guilty of professional misconduct (T1 Day 3 p. 12).

T2

Each breach of trust with a disabled person dependent upon the nurse at a time when she was employed to care for them is an unethical act related to the practice of nursing. (T2, Day 2, p. 12)

There was a systematic and premeditated flavour to the acts of misappropriation. We conclude therefore that in terms of Section 4 of the Act the nurse is guilty of unsatisfactory professional conduct in that she is guilty of unethical or other improper conduct in the practice of nursing. The acts of theft and hence the acts of unsatisfactory professional conduct are of such moment and so marked in relation to the dependent disabled persons involved that questions of her continued registration raised. Consequently the Tribunal finds her guilty of professional misconduct. (T2, Day 2, p. 12).

T3

His working at the hospital while calling in sick at another hospital amounts to unethical conduct because he defrauded his employer by collecting wages from one hospital by way of sick leave while being paid work at the other hospital.
Failure to attend an interview with the Impaired Nurses panel constitutes unsatisfactory professional conduct.

The Tribunal is comfortably satisfied that the nurse is guilty of unsatisfactory professional conduct in his behaviour and demonstrated a lack of adequate judgement, skill and care in the practice of nursing. The events where he defrauded the hospital constitute improper or unethical conduct relating to the practice of nursing. The issue then arises as to whether this conduct constituted professional misconduct. In our view it does in that it raises fundamental questions of his fitness to practice. In particular his actions in leaving his patients, exposing them to risk because of his unauthorised absence and without advising colleagues makes this conduct is sufficiently serious to constitute professional misconduct. (T3, Day 2, p. 12)

T4

We find the complaints proved as regards the nurse. We find that by grabbing the patient forcing him into X-room and by striking the patient in the face he is guilty of unethical conduct in the practice of nursing. We further find that he is guilty of an unethical conduct in the practice of nursing in providing a false report of the events to the nursing unit manager and subsequently in his interview with hospital authorities on X. date. Similarly he is guilty of unethical behaviour in failing to provide immediate first aid, failing to report the matter and failing to adequately take appropriate care for the patient after the events in X room. We find him guilty of demonstrating lack of adequate judgement in the practice of nursing. In all these respects we find that he is guilty of unsatisfactory professional conduct. In particular, because of the striking of a patient, compounded by leaving him without first aid or having reported the injury, we find
that the nurse’s fitness to practice as a registered nurse is in issue. We consequently find him guilty of professional misconduct. (T4, Day 3, pp. 15-16).

T5

In view of the multiple breaches of professional standards which involve six convictions for supply and one of possession of X drug, there can be little if any doubt that the circumstances of the offences as at X date would render the nurse unfit at that time in the public interest to practise nursing. That is because the number of criminal acts involved, the breaches of ethical duty to patients as well as the inherent risks in injecting X drug and his breaches in ethical terms to his colleagues and his employer. The tribunal finds complaint one proved. (T5, Day 4, p. 16).

The Tribunal is comfortably satisfied that the nurse’s actions were unethical even in the context of his own personal addiction. In order to establish professional misconduct, the Tribunal must be comfortably satisfied that the unsatisfactory professional conduct is of a sufficiently serious nature to justify removal of the nurse’s name from the register. In view of the multiple breaches of standards, and as rightfully considered by the respondent himself, the Tribunal is comfortably satisfied that a question of his fitness to practice is raised by his actions in relation to the patients A, B and C as well as by his addictive behaviour in stealing X drug for a period of some months in X date. Accordingly, the Tribunal is comfortably satisfied that the respondent is further guilty of professional misconduct. (T5, Day 3, p. 18).
Discussion

Each narrative presentation of the nurse given by the Chair comprised the collective views of the Tribunal members. In each of the inquiries, the Chair clearly aligned the position of the nurse with the way they had been discursively constructed by the Complainant and dismissed the alternative self presentation of the nurses. The focus of the Chair’s narrative account in each inquiry was to emphasise the extent of the nurse’s unethical conduct within the discourses of trust and accountability. The effect of the construction of the nurse’s conduct as unethical was that it provided the basis for finding professional misconduct which carried the very significant penalty of removal of the name of the nurse from the register.

The combination of the disciplinary technologies of surveillance and normalising judgements used by the Complainant, were powerful strategies which set the context for the subsequent narrative construction by the Chair. In these inquiries the Chair allocated to the nurse the position of unethical subject by drawing upon the discursively constructed norms used by the Complainant. The major focus of the Chair’s narrative representation was on the extent of the nurse’s wrongdoing.

The way in which the Chair discursively constructed the nurse arose not only out of the wholesale adoption of the narrative framework and normalising judgements exercised by the Complainant, but also from rejection of the means of resistance exercised by the nurse. Where the nurse had positioned themselves as the victim, the Chair not only rejected this subject positioning, but repositioned the nurse within this discourse as the offender.

The nurses’ attempts at resistance were on the whole, rendered relatively powerless in relation to the dominant discourses in which their subject positioning was located. In effect all forms of resistance were ultimately marginalised by the findings of the Tribunal. The findings acted as a means of controlling the effects of resistance and rendering them impotent. This was achieved through the orders of the Tribunal which were designed to prevent each nurse from being able to continue to practice
until they were able to demonstrate through a change in their behaviour that they had adopted the norms of ethical conduct.

A significant focus of the Chairs’ narrative construction of the nurse was located within the discourse of accountability. This discourse provided a framework for examining and judging the impact and effect of each nurse’s conduct on the profession. Within this discourse the Chair spoke about the nurses’ failure to meet their professional obligations and linked this to a failure to act in the public interest. Underpinning the findings that the nurse had failed to meet their professional obligations was the discourse of professional standards. Within this discourse the nurses’ conduct was found wanting on the basis that the nurse had failed their obligations to their patients, the Board, employers, and the Tribunal. Within the discourse of trust, the Chair focused on the intentionality and effect of the dishonest conduct of the nurse. The Chair drew extensively on the use of emotive, value-laden language to quantify and qualify the extent to which the conduct of the nurse had deviated from the norms of trust.

Ultimately, in each of the inquiries the conduct of the nurse was found to be unethical. In summing up the findings the Chair drew on the discourses of trust and accountability to position the conduct as unethical. This enabled the Chair to make a finding of professional misconduct and apply the disciplinary sanction of removing the name of the nurse from the Register.

The next chapter will provide a discussion of the findings arising from the analysis of how the unethical conduct of the nurse has been constructed in the Tribunal inquiries.
Chapter Nine

Discussion of findings arising from an analysis of the disciplinary exercise of relations of power in Tribunal inquiries

Introduction

In an overview of professional regulation Montgomery (1998) observed that, “The claim for continued self-regulation now needs to be sustained by a clear commitment to rooting out incompetence.” (p. 51). This study does not question the need for the profession to guard against and root out incompetent nurses. Rather, the critical issue raised by this study is the mode by which incompetent nurses are rooted out, and thus leads to the question, are the means by which nurses are found guilty of unethical conduct in themselves ethical?

The analysis undertaken in this study has revealed that in the Tribunal inquiries, the power to shape the discourse of unethical conduct lay with the Complainant and Chair (on behalf of the Tribunal members); and as such these findings raise fundamental questions about whether in fact this disciplinary process is itself an ethical process. According to the Board, a finding that conduct is improper or unethical conduct is considered to be a “grave finding” (NRB, 2001, p. 154), which adds a qualitative dimension to the conduct of the nurse. The Board state:

Usually the improper or unethical conduct provides a qualitative perspective on the facts i.e., it is not just what was done, but the manner or frame of mind in which the act was done (NRB, 2001, p. 154 [emphasis in original]).
However, an important issue raised by this study is the question of how the Tribunal processes can transparently and fairly determine, ‘the manner or frame of mind’ of the nurse? From a Foucauldian perspective this is not possible, because the manner or frame of mind of the nurse is an issue of ethical subjectivity, which only the nurse can determine. Ethical subjectivity cannot be determined through the imposition of normalising judgements such as those imposed in the inquiries analysed for this study. The findings from this study in relation to the Tribunal inquiries and the implications for the development of ethical subjectivity and the Code of Ethics comprise the discussion in this chapter.

The Tribunal: an exercise in disciplinary power

At the heart of a discipline such as nursing is a cohesive social body which is rigorously maintained by the exercise of disciplinary power. The Tribunal is the final and most authoritative means of exercising coercion to achieve this end. Ultimately, the effect of this exercise of power by the Tribunal is to increase “the forces of the body in terms of economic utility and yet diminish them in political terms through obedience” (McHoul & Grace, 1993, p. 71); or in other words, to exercise control of the nurse in order to maximise productivity. This is achieved by having a cohesive professional body and through maintenance of public confidence in the profession. In this way, the power of the discipline of nursing is productive through the exercise of constraint; it therefore can be viewed as a constraining structure which controls professional conduct through its actions on the individual nurse.

Maintenance of a cohesive social body occurs through a system of gratification and punishment. By punishment, Foucault does not mean sovereign punishment as would be the case in law; rather punishment exists within the disciplines more as an art, aimed at reshaping behaviour through reward and correction (Foucault, 1995, p. 182). Within the discipline of nursing, the Tribunal operates principally as a system of punishment.
Maintenance of the discipline through social cohesion requires homogeneity. Within nursing, the Tribunal is one of the mechanisms of power used to invest individual nurses with the degree of homogeneity required by the profession. It does this through an essentially corrective function; a function which arises out of identifying the level of deviance from the established ‘norm’ and putting in place procedures of correction and training. This form of punishment is according to Foucault at the heart of all disciplinary systems, where any departure of any magnitude from disciplinary determined correct behaviour is subject to punishment. “What is specific to the disciplinary penalty is non-observance, that which does not measure up to the rule, that departs from it. The whole indefinite domain of the non-conforming is punishable” (Foucault, 1995, pp. 178-179).

Within the discipline, punishment is designed to reduce gaps between the individual and the body of the profession. In instituting punishment, the focus is on identifying individual behaviour which differs or deviates from prescribed professional behaviour and putting the means in place to correct the behaviour. According to Foucault “the disciplines characterize, classify, specialize; they distribute along a scale, around a norm, hierarchize individuals in relation to one another and, if necessary, disqualify and invalidate” (Foucault, 1995, p. 223).

My analysis of the Tribunal inquiries used in this study, has uncovered how disciplinary power was exercised in the Tribunal inquiries to construct the discourse of the unethical conduct of the nurse. Within these inquiries, this technology of power enabled the disciplinary sanction of removal of the name of the nurse from the register as the ultimate means of maintaining disciplinary homogeneity.

Through the analysis of both text and context, this study has provided insight into how the “elite actors” (Van Dijk, 2008, p.821), that is; the Complainant and the Chair representing the Tribunal members, use discursive power and its components to construct the nurse as unethical. According to (Rolfe, 2001, p. 42):

The methods for deciding what is to count as truth are implicit in the discourse which we subscribe to. Thus those who have the power to shape the discourse also have the
power to decide not only the methods for arriving at the truth but also to decide which groups of people within the discourse will be the designated holders, generators and disseminators of that knowledge (Rolfe, 2001, p. 42).

This analysis has revealed that the positioning of the nurse in the relations of power exercised in the Tribunal inquiries are productive effects of power which serve the interests of the discipline. Examining the exercise of micro relations of power amongst the inquiry participants, demonstrates how these are connected in a web like manner to the macro structures of disciplinary power, acting as a totalising regime by taking effect through the nurse to construct and constrain their conduct. The aim being - to create a “docile body”; which according to Foucault can be “subjected, used, transformed and improved” (Foucault, as cited in Rabinow, 1984, p. 17). This study reveals that whilst this approach to disciplinary power might serve the interests of the profession, it does not serve the interests of the individual nurse in the Tribunal inquiries analysed for this study.

**Discussion of findings arising from the analysis of the Tribunal inquiries**

Critical discourse analysis was used in this study to examine the context and uncover “thematic elements and continuities” (Winiecki, 2008, p. 773) underpinning the construction of the unethical conduct of the nurse in the Tribunal inquiries. Of significance to this analysis was that the inquiries were not an examination of unethical conduct per se, rather the focus of the inquiries was on attributing meaning to each nurse’s conduct to position it as unethical conduct. Thus the analysis focused on examining the way the nurse was spoken about by the participants in each inquiry. The attribution of the term “unethical” to describe the unsatisfactory professional conduct of the nurse in effect added a crucial qualitative dimension and was used to provide a measure of how serious the conduct was, leading to findings of professional misconduct and orders for removal of the name of the nurse from the register.
The analysis of the five Tribunal inquiry transcripts revealed that the dominant discourses used to shape the conduct of the nurse were the discourses of trust and accountability. The discursive normative components of honesty, intentionality, effect, responsibility and fitness to practice provided the textual framework for the narratives and were used to position the nurses, via the technology of normalising judgements, within the discourses of trust and accountability. Through the disciplinary technology of surveillance the Complainant set the context for the narrative framework, which subsequently directed the way in which all of the participants in the inquiries constructed their narrative responses.

My analysis revealed there were two main strategies used by the Complainant and the Chair to discursively position the nurse within the narratives. These were the use of emotive, value laden language to discredit the nurse and positioning the nurse’s actions in such a way so as to emphasise the scale of the disjunction between the nurse’s conduct and the ethical norm. The effectiveness of these strategies was enhanced by the deployment of powerful interconnected discourses which included ethics, professional, legal, medical and victim discourses.

In response, the nurse appropriated and adapted these strategies in an effort to reframe the way in which they were constructed by the Complainant’s narrative. This was an attempt to present a credible, alternative, narrative self-presentation to the Tribunal members. Operating at the micro level of relations of power, this strategy can be interpreted as an exercise of resistance by the nurse and was the only means available to challenge the status-quo of the Tribunal processes and practices. Within the inquiries, narrative construction occurred at the grass roots level where the micro relations of power operated. It was at this level that the nurse exercised resistance either by not attending the inquiry or through appropriating the strategies made available to them by the Complainant and the Chair. In effect the nurse as the least powerful player was constrained to operate at this level of relations of power. By contrast, both the Complainant and the Chair, positioned as “elite actors” (Van Dijk, 2008, p.821), were able to draw on strategies based on their access to both the macro and micro levels of relations of power.
Ultimately however, the way in which the Complainant discursively constructed the nurse prevailed with the Tribunal members. This resulted because the disciplinary web of relations of power operated at both macro and micro levels of the disciplinary technologies of surveillance and normalising judgements to establish the context of these inquiries. The inquiry processes were a means of exercising an all encompassing gaze over the nurse and were facilitated through the disciplinary technologies. According to Foucault, disciplinary technologies “allow the effects of power to circulate in a manner at once continuous, uninterrupted, adapted and ‘individualised’ throughout the entire social body.” (Foucault, 1980a, p. 119).

One of the most disturbing findings to arise from my analysis was the lack of procedural fairness operating in the Tribunal inquiries, which I contend resulted from the focus on constructing the conduct of the nurse as unethical. The lack of procedural fairness manifested in a number of ways. Of particular significance were the ways the nurse was spoken about by the Complainant and the Chair. This was a strategy used by these ‘elite actors’ to shape the conduct of the nurse to fit a narrative description of being unethical. This included the way language was used to describe the nurse, reframing evidence to present the nurse in a particular way and by raising issues which were not relevant to the proceedings. There was also evidence of disparity in access to legal discourse and notably, there was no demonstrable relationship between the normalising judgements used to construct the conduct of the nurse as unethical and the value statements which make up the Code of Ethics.

Procedural fairness is defined as “the duty to act fairly” (Council of Australasian Tribunals, 2006, p. 3-1). In Australia it is used in preference to the term natural justice. According to the Council of Australasian Tribunals (COAT), issues which may affect procedural fairness such as bias - either actual or apprehended bias, can involve “hostility, sarcasm or aggression” shown by the Tribunal towards a party (Council of Australasian Tribunals, 2006, p. 3-12). Other issues of potential bias include an imbalance in legal representation, and problematic forms of cross examination. Amongst other things this includes behaviour such as “harassing, intimidating or bullying witnesses” and questioning directed toward “collaterally indirect issues of credit” (Council of Australasian Tribunals, 2006, pp. 5-14; 5-15).
Despite the fact that this information about procedural fairness was published well after the Tribunal inquiries analysed for this study, it is nonetheless informative to reflect on the processes and practices of the Tribunal inquiries in light of these standards. The following strategies which were varyingly used by both the Complainant and the Chair can be seen to give rise to questions of procedural fairness. For instance, both the Complainant and the Tribunal in the inquiries were represented by a barrister. In three of the five inquiries analysed for this study the nurses had no legal representation, and whilst there was evidence of the Chair attempting to assist each nurse to varying degrees where they had no legal representation, the nurses were nonetheless, disadvantaged by their unequal access to legal discourse. This is particularly significant because my analysis reveals legal discourse was a very powerful discourse in shaping the context of the inquiries.

The way in which the nurses were spoken about also gave rise to particular concerns about procedural fairness. These ways of speaking involved such strategies as raising allegations which did not form part of the complaints so as to extend the narrative construction of the unethical nature of the nurse; extensive and repeated use of value laden words to characterise the nurse as dishonest and unable to be trusted; and the use of sarcasm to ridicule the nurse. Other strategies such as reframing medical evidence and introducing material which was damaging to the nurse but which was not part of the evidence were also used by the Complainants to support their narrative positioning of the conduct of the nurse as unethical. It is the use of practices such as these which call into question the credibility of the Tribunal in relation to findings of unethical conduct.

Another significant and surprising finding which goes to the issue of procedural fairness is that despite the existence of the Code of Ethics at the time of the inquiries, the Code was not used in shaping the findings of unethical conduct. Its absence from these inquiries raises questions about its use and purpose for nurses. The Code of Ethics is considered to be part of the standards of the profession, yet in the inquiries these were not the standards against which the conduct of the nurse was judged. The nurses appearing before the Tribunals had no means of knowing how they would be judged. They had access to the complaints, but they did not know or have access to
the way in which they would be assessed and judged, because this was left for the Complainant and Chair to construct.

A possible explanation for the absence of the *Code of Ethics* from the Tribunal inquiries is that both these disciplinary technologies operate as a binary system within the regulatory framework for the governance of conduct. The governing function of the *Code of Ethics* is that of the ethical conduct of nurses, whereas the governing function of the Tribunal is that of determining and punishing unethical conduct. The effect of this ethical/unethical binary was that there was no clearly articulated relationship between the Code and the Tribunal. My analysis revealed the norms against which the conduct of the nurse was judged unethical in the inquiries bore little resemblance to the norms or value statements constructing ethical subjectivity in the Code. In particular, in contrast to the Tribunal inquiries where the norms of trust and honesty were the most significant discourses used to shape the conduct of the nurse, these norms did not appear in any of the Code’s value statements. In the explanatory statements accompanying the value statements which are found in the 1993 and 2002 versions of the *Code of Ethics*, trust is mentioned once only. Honesty or the need for the nurse to do no harm through being honest does not appear at all in either of these versions of the Code. Normative statements about accountability and responsibility can be found in value statements in both versions of the Code however, an analysis of the explanatory statements which accompany the value statements revealed limited explanation as to how this should be interpreted in practice.

What this highlights is the existence of a gap between the ways in which the ethical subjectivity of the nurse is constructed by the disciplinary technologies which make up the regulatory framework for nurses. This raises the following questions; how is the nurse to function as an ethical being in relation to these different regimes of truth; and what purpose does the Code serve if the way in which the Code articulates what it is to be ethical is not relevant to the question of what it is to be unethical? In other words if the value statements in the Code are considered to be the norms against which ethical conduct is measured, then any conduct which falls below these norms must in a binary system be unethical. That this is not the way the regulatory framework operated in these inquiries can be seen to be an effect of power which
operated to serve the interests of the profession over and above the interests of the individual nurse.

My analysis of the inquiries demonstrated that there was a lack of transparency in the proceedings about what constituted unethical conduct in the practice of nursing. There was no reference to any professional codes, such as codes of ethics or codes of professional conduct in any of the inquiry transcripts analysed for this study. Rather the inquiries relied upon normative values arising out of cultural discourses to construct conduct as unethical. The problem with this approach is that norms are a form of commonsense judgement; and commonsense judgement is frequently underpinned by assumption and unexplained prejudice. In effect, what the analysis has revealed is that the findings of unethical conduct by the Tribunal have been substantially determined on the basis of the opinions and persuasive argument of the Complainant. Indeed the phrase “unethical conduct” was infrequently mentioned in the inquiries. Yet, unethical conduct was found to have occurred, and was used by each Chair – speaking on behalf of the Tribunal, to attribute the necessary level of gravity to the nurse’s conduct, thus enabling a finding of professional misconduct and the subsequent disciplinary sanction of removal of the name of the nurse from the register.

A review of the relevant legislation revealed there was no guidance or explanation as to what was meant by unethical conduct and it was some ten years after the passing of the Act, before the Board offered some insight into the meaning of unethical conduct in relation to Tribunal inquiries. They describe unethical conduct as:

> Usually the improper or unethical conduct provides a qualitative perspective on the facts *i.e.*, it is not just what was done, but the manner or frame of mind in which the act was done. (NRB, 2001, p. 154 [emphasis in original]).

Furthermore the Board considered such a finding to be a “grave finding” (NRB, 2001, p. 154). Of the five inquiries in this study, only one occurred after 2001, and one occurred during 2001; yet despite the Board’s published position on unethical conduct, there was no reference to this in either of the transcripts for these inquiries.
Unethical conduct as a concept embedded in the Act is accepted and uncontested knowledge arising from assumptions that unethical conduct has universal and commonly understood meaning. In these inquiries, lack of transparency and knowledge about how unethical conduct was to be constructed in relation to the actions of the nurse, left the nurse disadvantaged in relation to the disciplinary power exercised by the Complainant and the Chair - who together, were able to draw upon these unspoken assumptions and use their discretionary judgement to interpret their meaning and application.

I propose that these Tribunal processes and practices had implications for the development of the nurses’ ethical subjectivity. The following discussion will explore the notion of the ethical development of the self using Foucault’s ideas about ethics.

**Ethical subjectivity and the nurse**

One of the important tenants of Foucault’s argument is that ethics is an exercise of personal choice, meaning that it can’t be mandated. Furthermore, he argues that ethics is about the relationship one has with oneself and this process of engaging with oneself can’t be directed, controlled or judged by others.

Foucault identified ethics as an element of moral conduct, in particular as the way in which an individual transforms oneself or constitutes oneself in relation to others, through the process of subjectification, as a moral subject. He speaks of ethics as;

…the kind of relationship you ought to have with yourself, *rapport á soi*, which I call ethics, and which determines how the individual is supposed to constitute himself as a moral subject of his own actions (Foucault, 1994b, p. 263 [emphasis in original]).
He identified morality as consisting of three components; a moral code, the behaviour of those subject to the code, and the way in which individuals constitute themselves in relation to the code. It is this last aspect of morality that Foucault identified as ethics (O’Leary, 2002, p.11), and it is via this aspect of morality that the possibility exists for one to reject the imposition of a universal moral code.

By subjecting the findings of the analysis of the Tribunal inquiries to these ideas of Foucault, it can be seen that the inquiries despite their findings are not able to determine the ethical subjectivity of the nurse. From this perspective it can be argued that bringing moral force to bear on the nurse through complaints and findings of unethical conduct is in itself not ethical and should not be part of the Tribunal process.

The findings from the Tribunal inquiries revealed that the capacity of the nurse to exercise personal choice in regard to their ethical subjectivity was constrained by the way in which they were positioned within the discourse of unethical conduct by the Complainant and Chair. In effect the processes and practices of the Tribunal inquiries were an attempt to impose ethical subjectivity on the nurse. This process of constructing the ethical subjectivity of the nurse as unethical was a fluid process, contingent on the way the Complainant spoke about the nurse. It was also a powerful process because the ways of speaking about the nurse set the framework for the narrative development of the nurse as unethical.

The level of control the nurse was able to exercise in terms of proclaiming their ethical subjectivity was determined by these processes and was in the main exercised through resistance. The nurse’s choice in terms of the way they positioned their ethical subjectivity was limited to either not attending the inquiry; or attempting to try and normalise their conduct, re-establish their integrity and influence the outcome in their favour. One of the main strategies adopted by the nurse to exercise resistance in an effort to reposition their ethical subjectivity was to draw on the victim discourse as a means of shifting the blame to others. The effect of this however was to make the nurse appear self-serving and had the paradoxical effect of reinforcing the way the Complainant had positioned the nurse.
One of the problems with the Tribunal approach to constructing the ethical subjectivity of the nurse was that it did not enable the nurse to reflect on their actions in a way which would encompass the type of ethical subjectivity argued for by Foucault, rather it set the nurse up to exercise resistance. The nurses constituted themselves as subjects by drawing upon the way they were constructed in narrative by the Complainant to exercise resistance; that is, they resisted their construction as unethical. In this way it can be argued the inquiry processes did not engender in the nurse the capacity to engage in ethical reflection. Rather, as is argued by Foucault “the subject constitutes itself in an active fashion through practices of the self” (1994a, p. 291), and it is the practices of the self which he argues are fashioned and imposed upon the subject. Thus the constitution of the unethical subject in the Tribunal inquiries and its rejection by the nurse may be considered, as Foucault would argue, to be a “consequence of a system of coercion” (1994a, p. 291).

It can be assumed that the nurses exercised personal choice when they undertook the actions which led to the complaints and therefore had a professional and moral responsibility to explain these actions and to accept disciplinary sanctions where their actions were clearly contrary to the standards of the profession. However, the Tribunal processes in these inquiries did not lend themselves to fairly and effectively making judgements about the ethical subjectivity underpinning those personal choices. In other words; I argue professional misconduct as a Tribunal finding should not rest on a finding of unethical conduct.

The effect of the Tribunal processes was to construct the ethical subjectivity of the nurse through finding the nurse’s conduct unethical. These processes because of their coercive nature, did not allow for the nurse to constitute themselves as a moral subject of their own actions, or as Foucault would describe it to “take care of the self” (1994a, p. 287) and as such were not likely to assist the nurse to achieve a process of transformation in ethical development or understanding. For Foucault, care of the self is always in relation to caring for others, and so for a nurse to be ethical they must first accept and understand the impact of their actions on others (Foucault, 1994a, p. 298). My analysis revealed that the Tribunal inquiries mediate against the nurse constituting themselves as moral subjects and that this arises
because the Tribunal is principally a means of governance which Foucault describes as ‘games of truth’.

**Games of truth as an exercise of government by the profession**

Throughout his work Foucault explored the idea of games of truth in relation to knowledge, power and the self (O’Leary, 2002, p.9).

> What I am trying to do is to write the history of the relations between thought and truth; the history of thought as such is thought about truth. All those who say that, for me, truth doesn’t exist are being simplistic (Foucault, 1990a, p. 257).

Foucault used the notion of games of truth, to describe the process by which truth is produced through rules or procedures (Foucault, 1994a, p. 297).

> ….by truth I do not mean ‘the ensemble of truths which are to be discovered and accepted’, but rather ‘the ensemble of rules according to which the true and the false are separated and specific effects of power attached to the true’, it being understood also that it’s not a matter of a battle ‘on behalf” of the truth, but of a battle about the status of truth and the economic and political role it plays. It is necessary to think of the political problems of intellectuals not in terms of ‘science’ and ideology’, but in terms of ‘truth’ and ‘power’ (Foucault, 1980a, p. 132).

According to Foucault, attempts by the state, to govern and control the self through what he called ‘games of truth’, serve the economic and political interests of the disciplines. Foucault was concerned with the way in which Western societies used government to “totalize” and “individualize’ (Gordon, 1991, p. 3). He saw the aim of modern government as one which fostered the development of the individual such
that the interests of the state were strengthened, through the interconnectedness of relations between political action and personal conduct (Gordon, 1991, pp. 10-12). These interests override the interests of the individual and in this respect it can be argued that games of truth do not allow for personal choice and growth of the individual in relation to their own ethical values. From a Foucauldian perspective both the Tribunal inquiries and the Code of Ethics (mandated as standards of practice), can be seen as games of truth used by the profession in an attempt to govern and control the conduct and ethical subjectivity of nurses in the interests of the profession.

Politically, this exercise in control of the ethical subjectivity of nurses was an attempt by the profession to remove any risk to securing the professional status of nursing. As has been argued earlier in Chapter Four, the need to control for risk arose out of the political context in which the development of the regulatory framework for nursing took place. Protecting the newly emerging professional status of nursing which clearly served the profession’s political interests was the overriding concern at this time. In order to control for risk, rules and processes such as the Code of Ethics and the Nurses Tribunal, were developed. They were used to identify, define and prescribe risk, the end point of which was the unethical conduct of the nurse. This process of controlling risk was an exercise in power. According to Foucault, power can only operate in relation to the subject. Having a means with which to exercise that power on and through the subject in relation to constructing their ethical subjectivity enhances and strengthens the disciplinary web of power relations. Seen in this light these processes can be understood as overtly political which operated as a means of power and control to serve the interests of the discipline.

Foucault saw the constitution of ethics by the games of truth which arose from social and legal institutions as problematic. He believed the question that should be asked in relation to ethics is; how is one to live? He rejected code based morality – that which prescribes the permitted and the forbidden, in favour of non-normative morality based on an “aesthetics of existence” (O’Leary, 2002, pp.6). For Foucault, an aesthetics of existence is about taking care of the self through personal choice. He denies an essential link between ethics and societal structures (Foucault, 1994b, pp. 260-261).
The idea also that ethics can be a very strong structure of existence, without any relation with the juridical per se, with an authoritarian system, with a disciplinary structure. (Foucault, 1994b, p.260).

According to Foucault the changes that occurred in morality from ancient to modern times have not arisen through changes in codes. Codes have remained essentially unchanged, they function as prescriptive and prohibitive rules or guidelines for conduct, the changes that have occurred are changes in ethics or the “relation to oneself” (Foucault, 1991b, p.355). These changes are a continuous process of self-transformation. Foucault explained this as:

What is the mode d’assujettissement? It is that we have to build our existence as a beautiful existence; it is an aesthetic mode. You see, what I tried to show is that nobody is obliged in classical ethics to behave in such a way as to be truthful to their wives, to not touch boys, and so on. But if they want to have a beautiful existence, if they want to have a good reputation, if they want to be able to rule others, they have to do that. So they accept those obligations in a conscious way for the beauty or glory of existence. The choice, the aesthetic choice or the political choice, for which they decide to accept this kind of existence—that’s the mode d’assujettissement. It’s a choice, it’s a personal choice (Foucault, 1991b, p.356 [emphasis in original]).

The relationship between the nurse, the Code of Ethics and the Tribunal inquiries

What the findings from my analysis highlight is that knowledge of unethical conduct is assumed knowledge; that is, that it is presupposed and taken for granted. According to Van Dijk (2006) knowledge is only expressed when “there is
ambiguity, a risk of misunderstanding, or when an element of context needs to be specifically focused upon” (Van Dijk, 2006, p.164). What the lack of discussion or explanation about unethical conduct amongst the profession suggests, is the idea that; nurses, the profession, the complainant and the members of the Tribunal have a common understanding of what it is to be unethical, that they know unethical conduct when they see it, that they can clearly articulate how and why it is unethical, and that they can judge the extent to which the conduct is unethical. These are all assumptions which the findings from this study challenge.

Within nursing literature there has been some debate as to whether the Code of Ethics should be used for disciplinary purposes. Internationally nurses have indicated their preference for codes of ethics to serve as guidelines for practice. In Australia, the original discussion paper in preparation for the draft Code reveals that there was a preference for the Code to serve as a guide to practice and not to be binding (Woodruff, 1991, p. 10). However at that time in Australia, the Code of Ethics was being developed as part of the regulatory framework for nursing, which included the Code of Professional Conduct and the Nurses Act 1991; subsequently through this discourse of professionalism, the Code was linked with the Code of Professional Conduct as part of the “agreed standards of the profession” (ANCI, 1995), and in effect made binding.

This unquestioned shift in emphasis from a Code designed as a set of reflective guidelines to a Code which constructs and constrains practice in an arbitrary way, based on a universally applied normalising set of standards is what Foucault referred to as ‘games of truth’. This shift reveals the disciplinary play of power being exercised in a panoptic way through standardisation of the Code of Ethics. Linking the Code to the standards of the profession had the effect of extending the disciplinary web of relations of power by providing the means for the self-regulation of nursing practice. What was important at this time was not the relationship between the nurse, the Code of Ethics and the Tribunal; rather it was the power of the profession to govern the ethical subjectivity of the nurse in the interests of the professionalisation of nursing.

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Foucault was essentially concerned with rejecting the coercive practices arising from games of truth to which an individual was subjected. This study reveals the Codes, legislation and the Tribunal, as games of truth which have been imposed upon nurses to shore up the professional status of nursing and which made possible the discourse of unethical conduct. Considered in the light of Foucault’s thinking these practices can be seen to be coercive games of truth, because they prescribe and prohibit conduct and are exercised arbitrarily. From a Foucauldian perspective what it is to be ethical cannot arise from subjection to mandatory codes and disciplinary inquiries because the effect of these processes is to constrain the nurse as an ethical being.

The findings revealed by the analysis conducted in this study show how powerful discourses are linked with disciplinary specific practices and how through these practices the Tribunal inquiries have determined unethical conduct. The findings also demonstrate that there was no clearly articulated relationship between the Code of Ethics and the Tribunal despite the fact that together they make up part of the regulatory framework for nursing. What is revealed in the analysis of these Tribunal inquiries is how the unwritten cultural norms which underpin the discourse of unethical conduct were inculcated into the Tribunal processes and practices; and furthermore how specific effects of power attached to these processes and practices enabled the ethical subjectivity of each nurse to be defined and classified. According to Winiecki, cultural norms “have substantial weight in determining how one can be defined, classified or categorized” (2008, p. 774). Without interrogation of the taken for granted assumptions which underpin this elusive notion of unethical conduct, nurses will always be rendered the least powerful participant in a Tribunal inquiry.

According to Foucault (1980a), power is exercised over people through discourse. Therefore uncovering the power/knowledge nexus which operates through the discourse of unethical conduct will allow transparency and offer the potential for a fairer process for nurses. Within these Tribunal inquiries, the effect of the exercise of power through the discourse of unethical conduct is constraining of the nurse. It can be seen as repressive for individual nurses who are rendered powerless by lack of access to knowledge about this concept, and yet who are subject to punishment as an outcome of the application of this assumed knowledge. By contrast, the discourse of unethical conduct is productive for the profession in that it enhances the professional
status of nursing. It can be seen as part of the web of relations of power providing the profession with another strategy for exercising power and control over each and every nurse and at the same time demonstrating professional accountability to the public.

Conclusion

A review of the literature on nursing ethics revealed there has been little to no attention paid to the concept of unethical conduct. The question asked in this study was aimed at addressing this shortfall in knowledge. Making visible the ways in which the nurse was found to be unethical can provide information about the types of strategies and resources which can be drawn upon by nurses when confronting an ethical dilemma. More importantly however, the value of revealing how unethical conduct has come to be known by the discipline is that it raises questions about the ethics of the processes and outcomes of a finding of unethical conduct.

The next chapter explores these questions through a discussion of the implications arising from this study for the nursing profession.
Chapter Ten

Conclusion and implications for the nursing profession

The findings from this study provide for the possibility of rethinking the usefulness and ethics of the finding of unethical conduct in disciplinary proceedings. They also raise questions about the use and purpose of the *Code of Ethics* and as such provide for the possibility of rethinking the way in which the Code is used. That is, rather than as a standardised set of rules within which ethical subjectivity is fixed, the Code could be refashioned as originally intended; as a guide for nurses in support of the continuous process of developing their ethical being.

Conclusion and implications

This study has revealed that the discourse of the unethical conduct of the nurse arose in response to disciplinary specific needs and was constructed on the basis of assumed knowledge derived from cultural discourses. This finding is consistent with Foucault’s view that discourses are discontinuous and historically relative. The analysis reveals the discourse to be contemporaneous and arbitrary and it is for these reasons that the discourse should be subject to intense scrutiny by the profession.

At July 1st 2010, a national registration and accreditation scheme for the health professions will commence. Nursing and midwifery along with eight other health professions currently registered in all jurisdictions will be covered by the scheme. Under this scheme the responsibility for investigating and hearing serious disciplinary matters will occur in each State or Territory. The profession specific National Boards will establish local and national committees whose function will be (amongst other functions) to investigate conduct, competence or impairment matters and conduct disciplinary hearings. The processes, findings and determinations that can be made will be specified in legislation to ensure national consistency (National
Health Workforce Taskforce, 2008). Amongst the objectives to be set out in legislation for the national scheme is objective 5.3(a) which is to:

Provide for the protection of the public by ensuring that only practitioners who are suitably trained and qualified to practise in a competent and ethical manner are registered (National Health Workforce Taskforce, 2008, p. 3).

It is likely therefore, that the status quo in relation to complaints and findings of unethical conduct in disciplinary hearings, and the Code of Ethics operating as professional standards, will be strengthened under a national scheme. This link between the Code and the Tribunal in effect provides a professionally legitimate process for the conduct of the nurse to be evaluated against the Code. If this becomes the practice of the Tribunal, it raises questions for the profession as to the intention and purpose of the Code.

Whilst the applicability of the findings of this study are limited because the analysis was undertaken on early Tribunal inquiries occurring between 1998 and 2003, it nevertheless has shed light on the importance of a critical examination of the way in which unethical conduct is determined; and highlights the lack of a clearly articulated relationship between the profession’s Code of Ethics and the findings of unethical conduct in Tribunal inquiries. Whilst ethical conduct continues to be mandated as part of the standards of nursing, and legislation exists which specifies complaints and findings of unethical conduct, the issues raised by this study will continue to be of significance to nurses. Whether the value statements in the latest version of the Code more clearly align with investigations and findings into unethical conduct in current Tribunal inquiries is unknown. Nevertheless, given the findings from this study and in light of the move in 2010 to a national scheme and a new structure for the investigation and hearing of disciplinary matters, it is timely for the profession to consider and question both the purpose of the Code and whether there is a place for complaints and findings of unethical conduct by Tribunals.

The findings from this analysis demonstrate a lack of transparency about how unethical conduct was constructed in the Tribunal inquiries. The analysis of the
transcripts of each Tribunal inquiry revealed that findings of unethical conduct were determined on the basis of the narrative presentations given about the nurse. It was also found that the construction of the nurse within the narrative presentations did not draw upon professional benchmarks such as professional codes, professional standards or guidelines against which unethical conduct could be measured and evaluated. In essence, the findings revealed that unethical conduct was constructed through a complex interplay of powerful discourses and discursive strategies which framed the way in which the nurse was spoken about at a given point in time and in a particular context.

The narrative presentation of the nurse can be understood as part of a process whereby discursively constructed knowledge about unethical conduct occurred through normalising judgements which were used as a means of judging nurses’ conduct in relation to what is taken for granted culturally, as acceptable and appropriate ethical conduct for nurses. The effects of these discursively constructed narrative representations of the nurse go beyond the normalisation processes and punishment outcomes that the nurses were subject to as a result of the inquiries. Rather, they can influence how subsequent nurses’ conduct will be judged and also contribute to setting the professional standard for ethical conduct expected of nurses. Thus the discourse of the unethical conduct of the nurse can be understood as an exercise of disciplinary power aimed at regulating nursing.

Knowledge of what it is to be unethical, as determined by the Complainant and Chair is captured and codified in the Tribunal transcripts. Through this process of codification, the Tribunal findings acquire a quasi legal status which powerfully positions them to shape findings in future Tribunal inquiries. Within this study, the finding that the phenomenon of unethical conduct by the nurse is based on culturally derived assumptions; highlights that an attempt to codify what is meant by unethical conduct is subject to interpretation and unexamined prejudice. Furthermore, locating the discourse of unethical conduct within a context powerfully framed by legal discourse gives authority to these assumptions and leaves them uncontested. This has implications for all nurses, as legislation such as the Act, which directly impacts upon nurses’ practice, has been constructed without a critical examination of the assumptions embedded within it, resulting in unintended outcomes. These findings
have implications for other nursing jurisdictions and health professions which are also subject to Tribunal inquiries, this is particularly so in light of the move to national registration, where legislation will specify the processes, findings and determinations that can be made. (National Health Workforce Taskforce, 2008).

This thesis does not question the need for a transparent process which holds nurses accountable for their professional conduct and which provides a mechanism for removal of nurses from practice who have been found to place the public at risk. However, the findings from this study which reveal how unethical conduct has been constructed in support of a finding of professional misconduct, demonstrate that the basis for findings of unethical conduct are in themselves unethical.

The ways in which the nurse is constructed as unethical are through fragmented and arbitrary processes and practices. These processes and practices draw upon commonly held cultural discourses to make normalising judgements which shore up the way in which the nurse is positioned and which lend a false sense of legitimacy to the construct of unethical conduct. This approach does not draw upon the Code of Ethics or any other transparent standards. In fact the discourses used to make normalising judgements about the ethical nature of the nurses’ conduct bear little resemblance to the discourses or norms in the Codes.

Whilst at one level some might argue “so what, the nurses have clearly done the wrong thing” – it is nevertheless ethically imperative that the profession makes its judgements in a fair and just way. Given the findings of this study, it is possible that the interests of the profession and that of individual nurses would be better served with the removal of the concept of unethical conduct from legislation and the Tribunal. This would remove the current and ongoing confusion about the purpose of the Code and would allow the focus on the Code to shift from standards and rules which require conformity and obedience based on inadequately explained imperatives in the form of value statements, to one of guidelines for ethical practice. It would also remove the very real risk of the Code acquiring an increasing disciplinary function. This could provide a fairer process for establishing misconduct; one which is unambiguously based on the professional standards articulated in the Code of Professional Conduct, which from its inception was
explicitly aimed at setting the standards of professional conduct and which was always intended for use in disciplinary matters.

What is demonstrated by the analysis in this study; is that the disciplinary process which results in finding a nurse guilty of unethical conduct does not enhance the capacity of nurses to engage with their ethical subjectivity in a manner which encourages sophisticated ethical reflection about ethical identity. Furthermore, there is a real risk that if the *Code of Ethics* is aligned with disciplinary matters an opportunity to engage nurses with ethical thinking which informs their practice will be lost.

What is missing in this debate, is an analysis of whether a more informed approach to ethics education would better support the ethical development of nurses and their confidence in the use of the *Code of Ethics*. The idea that provision of a Code alone is sufficient to support ethical practice is naïve. Indeed the literature reveals; that codes as a prescriptive document do not work, that nurses are confused about how they are supposed to work with the codes, that they don’t use them and nor do they see them as relevant. This is reinforced by my experience serving as a member on Tribunal inquiries, which time and again highlighted the lack of understanding nurses have about their actions as ethical actions. Given that the Board, aside from making the Code available to the profession has not provided an educational framework to support nurses in their use of the Code; and given that it is clear from the literature that nurses are confused about the Code and do not on the whole use the Code - the challenge is for the profession’s regulatory body to take the lead in providing an ethics framework to support ongoing ethics education for nurses. Such a framework could engage nurses in an explorative, rigorous and critical approach to examining nursing ethics.

Foucault’s ideas about ethical subjectivity could be one way of shaping such a framework in which nurses are challenged to explore how they position themselves in relation to all people with whom they work on a day to day basis. In such an approach, nurses could be encouraged to explore relations of power and how this impacts upon their ethical subjectivity. Such an approach, where the focus is on developing an ethical subjectivity - a mindfulness of the impact of the self on others,
might more readily prepare nurses for the moral ambiguities presented in clinical practice. This process of complex reasoning, is something that a Code alone cannot capture in its value statements nor can it engender in practice. However, the Code encompassed within an ethics educational framework might be a way of engaging nurses in an ongoing reflective process that becomes part of their professional persona. An educational framework such as this, explicitly represented in both nursing curricular and as part of ongoing professional development, could provide a means for the Code to become a vehicle for a dialogue amongst nurses about their ethical identity and provide an opportunity for the focus on ethical conduct to move beyond the value statements expressed in the Code to one of ethical subjectivity.
References


Nurses Registration Board of New South Wales (2001). Professional conduct a case book of disciplinary decisions relating to professional conduct matters. Surry Hills: Nurses Registration Board of New South Wales.


Appendix One

Nurses and Midwives Act 1991

Part 1 Section 4

“Professional misconduct” and “unsatisfactory professional conduct”

4. (1) For the purposes of this Act, “professional misconduct”, in relation to an accredited nurse, means unsatisfactory professional conduct of a sufficiently serious nature to justify the removal of the nurse’s name from the Register or the Roll.

(2) For the purposes of this Act, “unsatisfactory professional conduct”, in relation to an accredited nurse, includes any of the following:

(a) any conduct that demonstrates a lack of adequate:

(i) knowledge;
(ii) experience;
(iii) skill;
(iv) judgment; or
(v) care,

by the nurse in the practice of nursing;

(b) the nurse’s contravening (whether by act or omission) a provision of the Act or the regulations;

(c) the nurse’s failure to comply with an order or determination made or a direction given under section 48, 55 or 64 or with a condition of registration;

(d) a nurse’s holding himself of herself out as having qualifications in nursing other than:

(i) those in respect of which the nurse’s registration or enrolment was granted; or
(ii) those recorded in the Register or the Roll in respect of the nurse; and

(e) any other improper or unethical conduct relating to the practice of nursing.
Appendix Two

Documentary data analysed in Chapter Four


Nurses Registration Board of New South Wales (2001). *Professional conduct a case book of disciplinary decisions relating to professional conduct matters.* Surry Hills: Nurses Registration Board of New South Wales.


Appendix Three

The chronology of the development of the Codes

- July 1993- the ANCI published the first *Code of Ethics for Nurses in Australia*. The Code was developed through the joint co-operation of three key nursing bodies, the ANCI; Royal College of Nursing Australia (RCNA); and, the Australian Nursing Federation (ANF) (ANCI, 2000).

- September 1995- the *Code of Professional Conduct for Nurses in Australia* was formally adopted by the Nurses Registration Board of NSW (NRB) (NRB, 2000, p.13). Work had commenced on the *Code of Professional Conduct* at the same time as the *Code of Ethics* was being developed (ANMC, 2006).

- June 2002- a revised *Code of Ethics* was published and was endorsed by the key nursing bodies. This was the first review of the *Code of Ethics* and commenced in 2001 (ANMC, 2006). According to the key nursing bodies, the code was different but complementary to the *ICN Code of Ethics for Nurses* published in 2000 and together with the *Code of Professional Conduct* the *Code of Ethics* provided a framework for nursing in Australia (ANC, 2002).

- 2003- a review of the *Code of Professional Conduct* was published (ANMC, 2008c).

- 2008- the *Code of Ethics* and the *Code of Professional Conduct for Nurses in Australia* and the *Code of Ethics for Midwives* and the *Code of Professional Conduct for Midwives in Australia* were published. The review of the previous iterations of the Codes had commenced in 2006 (ANMC, 2008c).