DISCOURSES OF DEFICIENCY: AN ANALYSIS
OF THE CRITICAL CARE OUTREACH LITERATURE

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Abstract Discourses of deficiency: an analysis of the critical care outreach literature.

Background Critical care outreach is part of a new approach to manage all critically ill patients, regardless of where they are located in the hospital. It is the complete process of care that focuses on individual patients needs rather than on beds and buildings. There has been a proliferation of research literature since critical care outreach teams were introduced and subsequently required to provide robust evidence in the form of research to prove the effectiveness of their service. The research conducted by nurses has largely focused on phenomenological inquiry and has utilised methodologies such as questionnaires and interviews.

Aim To identify the dominant discourses that have emerged from the critical care outreach literature

Method Discourse analysis is a methodology that has received little or no attention in the critical care outreach literature. This study is a critical analysis that draws on theoretical techniques from discourse analysis to explore the emerging discourses from the critical care outreach literature written specifically by nurses from the year 2000 to 2006. It draws on the work of Powers and Cheek, nurses who have used Foucault's theoretical tools.

Conclusion A discourse analysis of the critical care outreach literature has illustrated how nurses have inadvertently adopted discourses that exist within a medical model that operates with a medical gaze.

Keywords Critical care outreach, intensive care liaison nurse, suboptimal care, deficiencies, Foucault, postmodern, discourse analysis.

Section One

Section Two

Section Three

Section Four

SECTION ONE:

Section one begins with an introduction to the study providing the reader with some historical background information about the introduction of the concept of critical care outreach and finally my own positioning within the study.

Introduction

The purpose of this study is to explore the discourses I believe have emerged from the critical care outreach research literature, specifically in the literature written by nurses. The discourses I have chosen to focus on are the discourses of deficit and risk. I am interested in exploring how these discourses are constructed in the literature of critical care outreach and how they construct nurses. Critical care outreach is a new approach to manage all critically ill patients, regardless of where they are located in the hospital. The theoretical framework I have chosen to underpin this study is a postmodern approach. The discourses apparent in the critical care outreach literature have drawn me to the work of Powers (2001) and Cheek (2000), nurses who have used Foucault's theoretical tools.

Section one provides the reader with an introduction to the historical background of critical care outreach, an initiative introduced recently as a concept of care to manage all critically ill patients regardless of where they are located within the hospital. This section also includes a review of the literature to illustrate how nurses have positioned themselves within the critical care outreach services. To conclude I will discuss my own interest and positioning as an intensive care nurse within this study.

Section two begins with an acknowledgment of the ethical and cultural considerations inherent within the study and how these are addressed. Next the theoretical framework and methodological considerations that underpin the study will be discussed. This section will also introduce the reader to postmodern thought, the theories of discourse analysis, and Michael Foucault.

Section three identifies some of the reoccurring themes and phrases used by nurses in the process of evaluating critical care outreach services. To follow, a discussion is presented linking the dominant discourses that have emerged from the critical care outreach literature to some of Foucault's theories of gaze and surveillance. I am conscious of the depth and breadth of Foucault's work so I have drawn selectively on his ideas through the work of other nurses such as Powers (2001) and Cheek (2000). And finally section four offers a conclusion and recommendations for future research.

Background of Critical Care Outreach

The concept of the critically ill patient requiring skilled critical care nursing independent of where they are located in the hospital has introduced the concept of 'critical care without walls'. It has long been regarded that only those patients who are critically ill existed behind the closed doors of an intensive care unit. However the literature shows it is becoming increasingly evident that there are now more at-risk, deteriorating patients in general wards who would benefit from the input of a critical care outreach team or an intensive care liaison nurse (McGloin, Adam and Singer 1999).

Critical care outreach is part of a new approach to manage all critically ill patients, regardless of where they are located in the hospital. It is the complete process of care that focuses on individual patients needs rather than on beds and buildings. The United Kingdom (UK) Intensive Care Society (2002, cited in Critical Care Outreach p.6) has defined critical care outreach as:

> ….. 'a multidisciplinary approach to the identification of patients, at risk of developing critical illness, and those patients recovering from a period of critical illness, to enable early intervention or transfer (if appropriate) to an area suitable to care for that patient's individual needs. Outreach should be a collaboration and partnership between the critical care departments and other departments to ensure a continuum of care for patients regardless of location, and should enhance the skills and understanding of all staff in the delivery of critical care'.

Service modernisation by the UK Department of Health (DOH) demanded improved performance management and capacity planning. In response, health care practitioners have had to devise innovative methods of delivering effective and efficient services (Valentine and Skirton 2006). The DOH (2000) established a review of adult critical care services and invited an expert group to develop a framework for the future organization and delivery of critical care. The report Comprehensive Critical Care (2003), was due in part from various findings that identified the suboptimal management of patients recently discharged from intensive care, and patients at risk of deterioration on the general wards (Ball, Kirkby, & Williams, 2003).

The study by McQuillan, Pilkington, Allan, Taylor, Short, Morgan, Nielsen, Barrett & Smith (1998), looked at the quality of care patients received before admission to intensive care. The study specified that simple interventions such as the accurate monitoring and recording of a patient's fluid balance, cardiovascular and respiratory status could help reduce the incidence of postoperative complications. McQuillan, *et.al* (1998) identified that suboptimal care and management of airway, breathing, circulation and fluid balance can ultimately lead to an increase in patient mortality and morbidity. The findings of this study were particularly influential in prompting the Comprehensive Critical Care (2003) report. The term 'suboptimal care' according to the authors applies to a lack of knowledge regarding the significance of findings related to patient deterioration causing indicators to be missed, misinterpreted or mismanaged. Ryan, Cadman and Hann (2004) states the term suboptimal care is discussed predominately by the medical profession, although I believe the phrase 'suboptimal' has also appealed to nurses and has been used by them in the critical care outreach literature.

The study by McQuillan *et,al*. (1998) also highlighted other indicators of suboptimal care, including a lack of knowledge, failure to appreciate the clinical urgency, and a failure to seek advice. The results of this particular enquiry highlighted the importance of an adequately staffed nursing work

force. McQuillan *et,al*. (1998) believe a lack of confidence in nurses and their ability to articulate effectively often results in a failure to appreciate the urgency of clinical indicators and to seek advice. Therefore, those at risk - the deteriorating patients are often transferred belatedly or inappropriately to intensive care units.

Buerhaus, et al (2007), believe that nurses are crucial and influential to the timely identification of complications that, if acted upon quickly, might prevent the deterioration of a patients' condition and avoid preventable deaths. The subtle signs of patient deterioration are often not recognised, or can be overlooked by busy ward nurses; the reasons for this are many and varied. Some of these include staff shortages, casualisation of the workforce, lack of skills and knowledge, lack of leadership, lack of clinical supervision, lack of visibility of senior nurses on the wards and a lack of education or time for it (Clark, Leddy, Drain, & Kaldenberg 2006).

Prior to the UK review of adult critical care services another influential study was conducted by McGloin, Adam and Singer (1999). They conducted a six-month audit of medical notes in the University College London Hospitals NHS Trust, to assess the quality of ward care prior to an unexpected ward death or an intensive care unit admission. During the six month audit period, 317 of the 477 deaths occurred in the general wards. Thirteen of those unexpected deaths were considered potentially unavoidable. The abnormal physiological and biochemical markers associated with these deaths included uncorrected hypokalaemia, hypoglycaemia, hypoxemia and hypotension. In the same period, 31 of 86 patients required an inappropriate and potentially avoidable intensive care admission; McGloin, Adam and Singer (1999) believed this was as a result of the suboptimal care delivered on the general wards. Earlier in 1993, a national UK confidential enquiry looking at peri-operative deaths showed that, two thirds of patient death occurred on the general ward three or more days following surgery. The majority of these

deaths were considered preventable by earlier identification and treatment (Gamil and Fanning, 1991 cited in Bright, Walker & Bion, 2004, p.34).

The UK DOH Comprehensive Critical Care Report (2003 p. 14) identified three main aims for outreach services. To avert admissions to critical care by identifying patients who are deteriorating and either helping to prevent admission, or ensuring admission to a critical care bed happens in a timely manner, to enable discharges from intensive care by supporting the continual recovery of discharged patients on the wards, and to share critical care skills between intensive care nurses and ward nurses. The report also provided standards and guidelines and it was explicit in recommending that critical care outreach be introduced as an integral part of adult critical care services in the UK. Funding was therefore made available to those National Health Service (NHS) trusts wishing to establish an outreach service. The composition of the service was not formalised but open for interpretation. Coombes and Dillion (2000), state that no one model for outreach was being adopted nationally in Britain and it seemed that each trust had developed a model in line with its available resources and local needs.

The concept of sharing critical care skills beyond the physical boundaries of an intensive care unit is not exclusive to the UK. The concept of critical care outreach has followed a similar path in Australia with the introduction of medical emergency teams (MET) in the early 1990s. The MET team primarily consists of a doctor and a senior nurse from intensive care responding to ward call outs. Buist, Moore, Bernard, Waxman, Anderson, & Nguyen (2002) conducted a study in an Australian general metropolitan teaching hospital with 300 beds, to determine whether earlier clinical intervention by a MET would reduce unexpected mortality rates. The results of this study showed there was a significant reduction in the incidence of unexpected deaths following the introduction of a MET.

The MET approach is similar to critical care outreach in that its primary aim is to reduce the incidence of cardiac arrest and unanticipated admissions to intensive care by using an early warning scoring system to trigger a callout to the MET team (McArthur-Rouse, 2001). The role of intensive care liaison nurse has also developed in Australia; it was introduced as a way of improving the continuity of care on the ward for recently transferred intensive care patients. The liaison role facilitates care during the crucial transition period; it also helps identify those patients at risk of deterioration, and provides education and support for ward staff.

The introduction of critical care outreach is very much in its infancy in New Zealand (NZ). The concept has been taken up by some District Health Boards (DHB) who recognise its potential and have developed similar services to those established overseas. The surface of emergence of outreach in NZ is predominately as a result of an interest in the UK research. Unlike the UK initiative, there has been no political imperative to introduce critical care outreach into NZ hospitals. The need for a critical care outreach model of care in NZ is developing for the same reasons as it did in the UK, a growing population with an increase in critically ill patients requiring complex care regardless of where they are located in the hospital.

The NZ Intensive Care Clinical Advisory Group (2005) made some future recommendations for intensive care services in New Zealand. The advisory group has identified areas where further work needs to be carried out and have made certain recommendations that include, formulating national standards, national data collection, quality improvement, recruitment and retention of staff, and service organization. The latter recommendation would perhaps indicate there were future provisions for critical care outreach but instead it reflects the capacity and configuration of services and network relations between units throughout the country. The advisory group believes a network of links is needed between intensive care units throughout NZ, which encompasses referral protocols, and clinical support between units. They added that good relationships and clear responsibilities are important for the

network to function effectively and ensure the best care for patients. I believe this latter recommendation would also transfer well into an outreach service in NZ hospitals where the same configuration is maintained throughout the medical and surgical services.

One issue the advisory group were most concerned about was the predicted future burden on intensive care beds. They reported that as at 2001, there were approximately 6.0 available intensive care beds, including 4.4 ventilated beds, per 100,000 people in NZ. The predicted future demand on NZ healthcare resources is also reflected in current morbidity and mortality trends. According to the NZ Ministry of Heath (MOH) document, 'Impact of Population Aging' (2004), the NZ mortality rates for older people have been slowly decreasing over time, with the biggest reduction in the 65-74 years age range. Between 1980 and 1998 mortality rates in this group decreased by 37% and for the 75-84 and over age groups by 35% (p.13).

As previously highlighted, the aging population is placing a greater demand on health care services and as a consequence, based on the current morbidity patterns and predicted population this will lead to an increase in their intensive care occupancy. The advisory group estimated that an extra 70 ventilated intensive care beds will be required to bring the NZ ratio up to six ventilated beds per 100,000 people. To further highlight today's changing health care environment Johnson and Preston, 2001 (cited in Levett-Jones, 2005) state, that fifteen years ago the majority of patients who are now cared for in the general wards would have been in intensive care, many patients who were once cared for in the hospital setting are now managed and cared for in the community, and the patients who are routinely treated in intensive care units today would most likely have died fifteen years ago due to the limitation of treatment options.

In accepting the funding to establish critical care outreach services in the UK, teams were then challenged to provide robust research evidence to prove the effectiveness of their service, thereby justifying the substantial investment made by the government (Ball, Kirkby & Williams, 2003). The process of

having to prove one's worth by way of audit and evaluation has resulted in a proliferation of research about critical care outreach. The research and evaluation carried out by nurses has been mostly qualitative in design utilising methodologies such as literature reviews, evaluations, case studies, retrospective audits, questionnaires, and interviews.

Positioning

As an intensive care nurse with twelve years experience and more recently an intensive care nurse educator for the past twelve months, I have followed the recent innovation of critical care outreach and its clinical application in the UK with particular interest. The historical development of my interest in this new concept of care has not focused exclusively on a practice perspective but also on a theoretical perspective. The themes of critical care outreach and the role of an intensive care liaison nurse have primarily formed the academic focus of my Master of Nursing degree pathway.

During my study pathway I had previously written about the predicted obesity epidemic and its affect on NZ health care resources. I was interested in exploring how we may need to prepare the nursing workforce to manage this predicted population of obese patients. I soon realised that the same question could be asked of the nursing workforce in almost any circumstance when referring to a future prediction. Therefore my initial research interest was to explore the current preparedness of ward nurses caring for deteriorating at-risk patients. I realised it was evident that medicine was now able to offer these increasingly complex procedures to the medically compromised, including the obese. But had the medical profession considered fully the significance of this increasing pressure on the nursing workforce? So the purpose of my research was to investigate nurses working on the general wards and to establish if they have been able to withstand and manage the same demands of this complex patient population. Through my own personal observations and experience in my practice area I had begun to witness an increase in the admission of ward patients to the intensive care unit. This hunch could be further supported by drawing inferences from data collected by the department regarding patient admission and discharge details. Recent data had shown a significant increase

in the number of high dependency admissions (HDU) compared with intensive care admissions (ICU). In 2006 there were 263 ICU admissions compared with the 238 HDU admissions. In 2007 there were 168 ICU admissions compared with 276 HDU admissions.

This local data is collected routinely for the purposes of adding to the Australia and New Zealand Intensive Care Society (ANZICS) database. The ANZICS patient database aims to promote the understanding of the care of critically ill patients throughout Australia and New Zealand. The database's focus is on providing appropriate measures of outcomes of care. Each month our data is collated by nurses working in the department and sent to the ANZICS database. The data is accessible to staff working in the department and its use is permitted and encouraged for purposes of personal interest, research, and presentations.

As an intensive care nurse educator I have explored ways in which I might assist ward nurses and fellow nurse educator colleagues in caring for this increasing group of complex patients. In order for me to assist and perhaps develop a service I was interested firstly in exploring the experiences of a ward nurse whilst caring for a complex patient on the ward. I had observed a gap in the research literature and adapted my original enquiry regarding the obesity epidemic. So my exploration was to begin with a research project using a phenomenological approach entitled: *'Caring for a critically ill deteriorating patient on the ward: a ward nurses perspective'*.

However, as I immersed myself further in the critical care outreach literature I also became aware of the type of language I had begun to read. I was then suddenly made aware of the dominant discourses that were emerging from the literature. I was able to identify the use of common re-occurring themes and phrases that used language such as, "avoidable deaths", "inadequate skills", "deficiencies in quality care", "compromised patients", "competence", and "the need to intervene". Some of this language use I believed may have had the potential to marginalise ward nurses and their sense of worth, and I believed that these emerging discourses were worth exploring further.

Therefore my research focus has changed somewhat and the purpose of this study is to undertake an analysis of the dominant discourses that have emerged from the critical care outreach literature, but more specifically the discourses that have emerged from the literature that has been written by nurses.

Literature Review

The literature reviewed in this section was performed using the following databases and keyword strategies.

Databases included: 'Google', Google Scholar', 'CINHAL', 'Proquest', 'Ebscohost', 'Science Direct', 'MEDLINE', 'Pubmed'.

Keywords included: Critical care, intensive care, critical care outreach, intensive care liaison nurse, early warning systems, medical emergency team, suboptimal care, deficiencies.

The literature review will provide the reader with some examples of how critical care outreach teams have evaluated their services through various research studies. This study focuses specifically on the literature written by nurses involved with critical care outreach. The inclusion criteria chosen for the literature review draws on the writing of nurses from the year 2000 to 2006. This particular time frame was chosen because the research was at its most prolific during this particular period. The aim of this review is to illustrate how the literature has the ability to speak to us in different ways.

The same but different

The global interest surrounding critical care outreach has been at its most significant this decade; predominantly due to the advent of the UK recommendations established to improve its adult critical care delivery. As stated previously, there has been a proliferation of research literature since critical care outreach teams were introduced and required to provide robust evidence to prove the effectiveness of their service. Research conducted by nurses has largely focused on phenomenological inquiry and has utilised

methodologies such as questionnaires and interviews (Richardson *et,al*. 2004, Endacott & Chaboyer, 2006; Chellel *et.al* 2006; Chaboyer, *et. al* 2005).

The findings of some research studies have exposed various gaps that exist within healthcare and these gaps resonate through the critical care outreach literature. The Critical Care Outreach document (2003) states "many of the problems that critical care outreach seeks to address are symptomatic of a historic failure to recognise the increasing numbers of at-risk and acutely ill patients distributed throughout the hospital" (p. 8). Critical Care Outreach (2003) believes this has been compounded by a failure to adequately equip the workforce. This was also highlighted earlier in the study by Buerhaus *et.al* (2007) who believe there is a crucial need to have an adequately staffed nursing work force. Conversely, the introduction of critical care outreach services has also enabled closer collaboration and the sharing of skills and knowledge amongst doctors, nurses, and the wider multidisciplinary team. Evidence of this resonates through the literature; none more so than the relationships built between nurses. The study by Chaboyer, *et.al* (2005), is one such example of how an outreach service has enabled and empowered ward nurses in their practice.

There are various studies conducted from the perspective of an outreach team or liaison nurse based on the outcomes of individual outreach models. For example Ball, Kirkby and Williams (2003) undertook a comparative study to determine the effect a critical care outreach team had on patient survival to their discharge from hospital. Leary and Ridley (2003) did a similar study to examine whether there was a change in the number, causes and sequence of re-admissions to critical care altered as a result of the introduction of an outreach team. Another comparative study by Buist, *et.al* (2002) was carried out to determine if earlier clinical intervention by a medical emergency team prompted by change in a patient's clinical condition reduced the incidence of and mortality from an unexpected cardiac arrest in hospital.

Relationship Building

Chaboyer, *et. al* (2005) identified however, there was little evidence to support the innovation of critical care outreach from the perspective of a ward nurse. To explore this phenomenon further Chaboyer, *et. al* conducted a study using a purposeful sample of 10 nurses by way of in-depth, semi-structured interviews, aimed at eliciting rich descriptions on the benefits and challenges of the role as perceived by ward nurses. The role of the intensive care liaison nurse was seen to be that of an educator, positive change agent, a conduit and role model. Ward nurses also commented that the role encompassed attributes such as advocate, diplomat, advisor, negotiator and promoter of good will. All of which were seen to enable and empower ward nurses in their daily clinical practice.

Relationship Battles

A study by Chellel, *et.al* (2006) evaluated the contribution of critical care outreach to the clinical management of the critically ill ward patient in two acute UK NHS trusts which included five general hospitals. Semi-structured interviews were carried out with the health care professionals who had been involved in the patient's care. The purpose of this was to capture the real-world experience of working with the critical care outreach team. However, the interviews revealed a 'battleweary workforce' overwhelmed by the complex and increasing demands of the critically ill ward patient. The study concluded that the medical and nursing teams at the bedside were inexperienced and often unsupported by the senior clinical decision makers. Workload pressures experienced by both medical and nursing staff meant they were unable to take on any more responsibilities. This was often dealt with 'by passing the buck' as a form of defence which led to gaps and delays in care' (Chellel, *et. al* 2006).

Deficient Processes

Highlighted in the latter study by Chellel, *et. al* (2006) are familiar themes that are reminiscent in other studies including that of Chaboyer, *et. al*, (2005) which tend to illuminate the critical care outreach team in an esteemed light. The language use in the study by Chellel, *et. al* includes statements from the battle weary workforce such as, 'knowing how to get decisions made', 'being listened to', 'someone who knows what they are doing', 'persisting', 'not giving up', 'not missing things', 'having more clout', ' the expert having more time and energy than ward nurses', and 'a willingness to take charge and play a pivotal role'. It is interesting to note that the authors also believe 'that the need for critical care outreach is grounded in complex issues of deficiencies in the processes of ward care' (Chellel, *et. al* 2006). These processes could possibly include the ill equipped work force as highlighted in the Critical Care Outreach (2003) document.

This literature review has presented as a small sample of research studies representing the critical care outreach literature, more specifically studies that have been conducted by nurses. Chaboyer, *et.al* (2005) and Chellel, *et. al* (2006) illustrate how unique each nurse liaison role or outreach team has been in the evaluation of their service. It is important for me to clarify that I am mindful and respectful of nurses' voices and their intentions in carrying out research therefore I have not singled out these two research studies to make a particular example of them. Rather it is my intention to use theses studies to illustrate how the literature can speak to us in different ways, this will also be discussed further in section three. The following section introduces the reader to current conceptualisations and theories of discourse analysis. Firstly, considerations based on ethical and cultural aspects of the study will be addressed.

SECTION TWO:

This section begins by highlighting the ethical and cultural considerations within the study followed by a describing the theoretical framework and methodology used.

Ethical Considerations

The intent of this research project is to explore the emerging discourses from an already published body of research. Therefore using discourse analysis as the research method in this context does not require the participation of research subjects, or the need for ethical approval from an ethics committee. However undertaking this study is in itself an ethical project as I am critiquing knowledge that has been developed in other settings. This is important to address because knowledge that exists in this form is inherently culturally bound within its own location.

I am mindful nevertheless of the effects this study may have in the opening up of ideas and the offering of critique. My intention is to critique the existing body of knowledge while being mindful of the need to respect others nurses' ideas and writing and valuing the effort that was required of them in doing research. Therefore, the utility of this project is to contribute to an already existing professional body of knowledge developed by nurses and to ultimately improve health outcomes for specific client populations. The improvement of health within a specific population is of particular relevance in NZ. This is reflected by a recent commitment in initiatives undertaken by the Ministry of Health (MOH) to improve the health outcomes of our indigenous population, the Maori, an example of these include the MOH toolkits on obesity and diabetes.

Cultural Considerations

As a Pakeha (New Zealander of European descent) nurse I will be mindful and respectful of The Treaty of Waitangi, the founding document of NZ. Maori are the tangata whenua (indigenous people of an area or country) of NZ and a priority population who require appropriate health care interventions. Maori present disproportionately negatively in the majority of health and well-being statistics that are gathered nationally. In 2001 Maori life expectancy at birth was more than eight years less than non-Maori for both genders. The prevalence of cardiovascular disease among Maori was one and a half times more than non-Maori, diabetes two and a half times more prevalent and Maori men aged 45 years or more had a chronic respiratory hospitalistion rate four times that of non Maori (NZ MOH 2004).

The need to improve Maori health is reflected throughout the principles, goals and objectives of the *New Zealand Health Strategy*. The overall objective of the strategy is to ensure accessible and appropriate health services for Maori (Health Research Council 2008). The DHB in which I am employed has an obligation to honour the Treaty of Waitangi by delivering health care that is culturally safe and specific to Maori needs. Upholding the three guiding principals of the Treaty of Waitangi, partnership, participation, and protection ensures this commitment.

The focus of this particular research project does not impact directly on Maori but they often present in poor health with complex comorbidities. It could therefore be argued that any critical care outreach service developed in NZ will impact directly on Maori patients and their whanau (family). Maori will therefore require equal and culturally appropriate access to any critical care outreach service that is developed in the future. In order for any such service to be of benefit, it must take place in consultation with Maori, which deliberately places Maori at the centre of the experience to develop a service for the benefit of Maori (Tolich, 2002). Mason Durie (1996, cited in Tolich 2001 p. 49) sums this up beautifully by saying, what is empowering for the community must be decided by the community.

Theoretical Frame: Am I Postmodern or Poststructural?

I am encouraged to learn that I am not alone in the complexities of choosing the most appropriate paradigm to underpin this project. Cheek (2000) comments that 'postmodern and poststructural approaches are not research methods in themselves; rather they are ways of thinking about the world that shapes the type of research that is done and type of analysis that are utilised' (p. 4). She sees poststructural and postmodern perspectives as having much in common, valuing plurality, fragmentation and multi-vocality, but differing in their focus and emphasis.

Poststructural studies tend to concentrate on the analysis of literary and cultural texts, where the text refers to a representation of any aspect of reality. Initially I was drawn to this approach as I believed the critical care outreach literature had developed its own cultural text. Cheek (2000) explains that researchers who draw on poststructural analysis ask questions of themselves about the representation of an aspect of health care. The significant question I asked was, how is the nurse represented in the critical care outreach literature?

Postmodern analysis on the other hand tends to be wider in scope and its focus is on aspects of culture, society and history. Cheek (2000) refers to postmodernism as an approach that 'allows for the possibility of exploring how the practice setting came to be constructed in the way that it is. What are the assumptions and understandings of health care practice that are taken for granted? Whose assumptions and understandings are they, and why are other views excluded or marginalised?' (p. 41). These assumptions draw people to participate in discourses without being mindful of other possibilities. For example, the assumptions made surrounding the phrase 'suboptimal' care.
Cheek adds an unsettling effect of postmodern thought on what we may have come to take for granted in health practice realms is one of its greatest contributions; it offers possibilities for bringing about change and allowing other voices and perspectives to surface.

The theorist whose work is most consistently associated with postmodern thought is the work of Michael Foucault. Traynor (2006) states Foucault developed an influential approach to discourse analysis in his investigations of institutions and practices of modern European government, in particular medical and penal institutions. O'Connor and Payne (2006) believe Foucault was not merely interested in discourse simply as language but rather to be used as a tool of thought within a culture that reveals truths and power. Henderson (1994) adds the work of Foucault provides us with an insightful analysis of unacknowledged assumptions and metaphors in health care practice.

Manias and Street (2000) state in the Foucauldian sense, knowledge formed in discourses is governed by particular limits, rules, exclusions and decisions. For Foucault, discourses are tactical elements or blocks operating the field of force relations. According to this view, discourses are not merely effects or end products of power; rather relations are seen to be immersed in discourses (p.52). Foucault also challenges the widely believed notions that hold the viewpoint that knowledge is objective and value-free, inevitably progressive, and universal. He argues instead that knowledge is inextricably bound to power (Cheek 2000). 'According to Foucauldian analysis, the examination of individuals by the gaze of experts such as those in the health care field is a disciplinary technique of power that invents a new kind of individuality' (Cheek 2000, p.30).

Methodology: Discourse Analysis

A discourse has been defined as 'a group of ideas or patterned ways of thinking which can be identified in textual and verbal communications' (Lupton, 1992, cited in Powers, 2001, p. 1). Crowe (2005) states that particular discourses determine what happens in nursing practice, and practices that occur in nursing can determine nursing discourses. Some practices are attributed with more importance that others and therefore the person able to carry out the practice is attributed with more value than others, for example, the ability to prescribe (p.56). This importance could also be attributed to the critical care outreach nurse.

Crowe states 'that discourses provide the contextual meaning of language and shape the meaning by which practices and relationships are understood' (p. 56). She provides an example of how some words and actions are understood differently by the context in which they occur. The word 'observation' takes on different meanings in nursing depending on the context in which it occurs. In a surgical context it might mean the regular assessment of vital signs, while in a psychiatric setting it might mean regular assessment of mood state (p. 56). Discourses create discursive frameworks, which order reality in a certain way. They both enable and constrain the production of knowledge in that they allow for certain ways of thinking about reality whilst excluding others. In this way they determine who can speak, when, and with what authority, and conversely, who cannot (Ball 1990, cited in Cheek 2000 p. 23).

I have chosen a postmodern approach as the theoretical framework to underpin this study, drawing on the influences of Foucault. The discourses I see emerging from the critical care outreach literature draws me to the work of Michael Foucault and his notion of power, knowledge and surveillance. Discourse analysis is a methodology that has received little or no attention in the critical care outreach research literature. By using discourse analysis it is my intention to provide an opportunity to enable critical and creative thinking.

This study is a discourse analysis to explore the critical care outreach literature written specifically by nurses from the year 2000 to 2006. Crowe (2005), states that discourse analysis is concerned with how an experience is socially and historically constructed by language. It places the social and historical context, rather than the researchers' hypothesis or the individuals' experience, as central to the enquiry process. For that reason I will explore the discourses constructed in the critical care outreach literature, and not the specific findings or outcomes of the research. As explained earlier it is my intention to critique an existing body of knowledge that was generated in the process of nurses evaluating a service. The utility of this project is to contribute to the existing professional body of knowledge to help improve health outcomes particularly within NZ by encouraging collaboration between nurses to help achieve this.

O'Connor and Payne (2006) believe an 'important consideration of discourse analysis is the relationship between a particular knowledge of a group and the inherent power that creates in relation to those who do not have the power' (p.830). In doing a discourse analysis I am interested in exploring how the relationship of power and knowledge is constructed in the critical care outreach literature and how it constructs both the critical care nurse and the ward nurse.

The purpose of this section was to present an overview of the theoretical framework and methodology while providing a rationale for its use. Included were influences from Foucault, which are revisited next in the discussion section. The following section introduces the reader to reoccurring themes and phrases from the critical care outreach literature that have emerged as dominant discourses.

SECTION THREE:

The following section presents a discussion about the dominant discourses to have emerged from the critical care outreach literature.

My interpretation of the emergent discourses

Critical care outreach is a well intentioned initiative implemented to save lives, an "organisational approach to ensure equity of care for all critically ill patients irrespective of their location" (Critical Care Outreach, 2003 p. 3). It was acknowledged that the audit and evaluation of critical care outreach services was imperative for its ongoing success. Therefore, future funding for newly established outreach teams was dependent on their ability to 'measure activity, costs, benefits and efficiency' (Critical Care Outreach, p. 23). The critical care outreach document adds, that while such data is essential for the funding bodies, 'audit and research will guide the effectiveness and quality of the service and it's benefits to patients and other stakeholders' (Critical Care Outreach, p. 23).

I become curious and anxious to learn about critical care outreach and how I might develop a similar service within the organization I work. As I immersed myself further into the audit and evaluation of critical care outreach I became aware of two distinct groups of writing and language adopted by nurse researchers during the process of evaluating their service. This newfound awareness changed the focus of my research interest as I identified language used in the literature lending itself to draw on particular discourses.

The more dominant discourses represented in the literature I identified as being associated with themes of deficit and risk and called upon the use of a particular language. This included phrases such as "avoidable deaths", "inadequate skills", "suboptimal care", "inadequately treated", "a failure to appreciate the clinical urgency", "a lack of experience", "inadequate articulation", and "deficiencies in quality care". It is important to note that this is my interpretation of the dominant discourses and therefore it is purely subjective.

Discussed previously were the studies by Chellel, *et.al* (2006) and Chaboyer, *et.al* (2005) both examples of how the critical care outreach literature can speak to us in different ways. One particular group of writing speaks of discourses that have the potential to enable and empower ward nurses with language use such as expert, assessment and knowledge. These discourses are concerned with issues such as relationships and team building. However the discourses I have chosen to focus on for this particular study are those that could potentially afford blame, such as, deficit and risk. These discourses are generally associated with issues that surround processes and outcomes.

Knock knock! Who's there?

Let us first consider this notion of 'outreach' and how the once discrete speciality of critical care has recently become part of this visible movement. The Oxford (2001) dictionary defines outreach as 'an organisation's involvement with the community, especially in providing a service or advice outside its usual centres of operation' (p. 528). This definition encapsulates the essence of critical care outreach services and their purpose. The UK Intensive Care Society (2002, cited in Critical Care Outreach 2000 p.3) defines critical care outreach as a collaboration and partnership between departments to enhance skills and understanding of all, in the delivery of critical care.

Critical care outreach was developed in the UK following a DOH review of adult critical care services (Comprehensive Critical Care 2003) which held the view that acute hospitals should give high priority in developing an outreach service to support ward staff in managing at risk patients. They stated 'this should be carried out by personnel trained not only in clinical aspects of care, but also effective in the ways of sharing their skills so that the ward staff feel supported and not diminished' (Comprehensive Critical Care 2000 p.15.).

As previously identified, Ryan *et.al.* (2004) described the term 'suboptimal' care as being discussed from a predominately medical perspective; and its appearance in the literature was influential in prompting the UK audit commission report (1999). Of particular interest to me is the composition of

the expert group that was established by the DOH to propose the framework for the organization and delivery of critical care services. Out of the forty-six experts represented on the group, only five of those have the word 'nurse' or 'nursing' as part of their professional title (Comprehensive Critical Care 2003 p.27). With only five nurses represented in the expert group, does this make the framework one that potentially exists within a medical model with a medical gaze? And yet it seems the profession that has been represented the least is in fact the most prevalent when it comes to developing and evaluating critical care outreach.

Powers (2001) discusses this phenomenon of nursing existing within a medical model in the work of the discourse analysis of nursing diagnosis. She describes that the dominant influences on the internal structure of the discourse of nursing diagnosis is medicine. Whether the intent of the text is to highlight the differences or the similarities between nursing and medicine, the language remains medical. Powers states like medicine, nurses diagnose, treat, and measure outcomes, but throughout this process, medicine is the privileged other, the invisible binary partner of nursing in the relation that defines nursing as a discipline (p 93). It has been suggested that the choice of the word diagnosis, both separates nursing from medicine while at the same time it defines nursing in the image of medicine (Kobert & Folan, 1990; Mitchell, 1991. cited in Powers 2001 p. 111).

That is not to say the medical gaze does not have its place or purpose in critical care outreach but do we as nurses need to be more mindful when adopting frameworks from a predominately medical perspective and how does that affect how we might position other nurses in the critical care outreach literature or otherwise? As Powers (2001) explains, the discourse of medicine is based on empirical analytic science compete with foundational assumptions.

An example of one such assumption seen in the critical care outreach literature, is that care is considered as suboptimal on the general wards as in the study by McQuillan *et,al.* 1998 that identified suboptimal care and

management of airway, breathing, circulation and fluid balance can ultimately lead to an increase in patient mortality and morbidity.

Deficit

'Failure to appreciate the clinical urgency', and 'inadequate skills', are statements from the critical care outreach literature that reflect the discourse of deficit. In the past, nurses have been accustomed to hearing the use of the word 'deficit' in a much different context. Nurses are more familiar with this word when it's referring to a number of something, or the unavailability of something, like a deficit in the nursing workforce, or a deficit in health care resources. The discourse of 'deficient', as it appears in the critical care literature is used in a context that talks about the care that patients are receiving. This was often referred to in the literature as a lack in knowledge or expertise. This reference therefore has an ability to construct the critical care nurse as the one who holds the expertise, knowledge and the capacity.

The critical care nurse is positioned as the one who appears to save the day, as highlighted in the study by Chellel *et,al.* (2006). Ward nurses described how the outreach nurse was able to facilitate and expedite decision making, for the outreach nurse it was often because they felt there was a need for them intervene (cited in Chellel *et,al.* 2006 p. 47).

> 'Sometimes it seems that no one sees the patient as I do. For example, the patient was very ill, his respiratory function was severely compromised and yet the lack of urgency from the medical and nursing teams was astonishing. I was able to liaise with the critical care team and receive support regarding the patient's future management… in doing this I was able to avoid him having a respiratory arrest' (Outreach Nurse).

Traynor (1997) explains in nursing there is no room in the discourse of caring for critique. You are either a caring nurse or you are not and if you are not, then you are clearly a failure as a nurse (cited in Powers 2001 p. 41). Therefore when using the discourses to describe the care given by a nurse one needs to be mindful of the ramifications that might have on nurses' esteem and sense of worth. Also acknowledged in the study by Chellel *et al.* (2006) was a

comment made by a consultant anaesthetist who believed a critical care nurse is able to appropriately facilitate a level of care on the wards that would otherwise be difficult due to the lack of staff and an adequate skill mix. Used in this context the use of the word deficit is more familiar to nurses as it refers to a lack in something or of someone.

The expert gaze

Ellefsen*,* Hesook and Kyung (2007) explained 'gaze' and other related concepts such as 'mode', and 'clinical eye', have all been used to describe health and medical practices, but their use has been infrequent in the examination or description of nursing practice. The authors explain Foucault's use of 'clinical gaze' and Atkinson's' 'clinical eye' describe modes of engagement in clinical situations. The metaphor of gaze indicates ways of knowing and perceiving, a particular stance towards the world (Ellefsen *et,al.* 2007 p.100). Cheek (2000) adds that Foucault refers to gaze as the act of seeing, or the way in which disease, illness and healthcare are viewed. Johnson (2005) believes Foucault describes the notion of the gaze most eloquently by arguing that professional power is derived from the intimate knowledge of subjects, expressed through a clinical gaze.

Ellefsen *et al*. (2007) state there has been very few studies that examine the nature of nursing gaze. It is important to explain the gaze of a critical care nurse is different to that of a ward nurse but I believe neither one is more superior to the other. Lave and Wagner, (1991) believe as cultural agents, nurses are socialised into ways of confronting clinical situations, and they assume, through experiences and interactions with other professionals, specific ways of seeing, knowing and describing in practice (cited in Ellefsen *et.al*., 2007, pg. 100). By exploring Lave and Wagners (1991) belief further, they can illustrate the gaze of a nurse quite distinctly in relation to their practice setting. The following interpretation is anecdotal and describes my own professional observations and experiences of how the gaze of a nurse can be quite distinct. Critical care nurses are exposed to different clinical situations and professionals which will position their 'seeing' and 'knowing' in a different way to ward nurses, therefore the concept of normality for both is quite

different. Normality for a critical care nurse is caring for one patient whose condition is often referred to as acutely ill or unstable. Focus is centred predominately on the physical cues of deterioration. Detection of these cues is rigorously sought after and assisted by way of technology and equipment. For a critical care nurse the physiological markers of deterioration are often more predictable. A practice reality for a critical care nurse is caring for a patient in order for them to survive an acute phase of illness, where improvement is monitored and measured hour by hour and is quite singular and linear in its progress.

The gaze of a ward nurse is one of multiplicity, focused on the varying needs of many, in various disease states and stages, a skill not often possessed by a critical care nurse. I can offer my own anecdotal experiences of redeployment anxieties when faced with the prospect of caring for up to eight patients with out the familiar technology and support at my disposal. Predicting a deterioration in patients who are seemingly well can be challenging, more so with limited resources. A practice reality for a ward nurse is caring for a patient in order for them to leave hospital. They may view a patient's progress in terms of a trajectory where progress is measured by moving towards a goal, for example being discharged home. According to Foucauldian analysis (Powers 2001) the gaze of an expert is a disciplinary technique of power and surveillance that invents a new kind of individuality, in the case of critical care outreach the individual in possession of the power and surveillance is the critical care nurse.

Risk

When reflecting on Foucault's notion of surveillance I am drawn to the discourse of risk. Phrases such as 'avoidable deaths, and 'deficiencies in quality care' are an example of how risk is represented in the critical care outreach literature. This recent need for surveillance and governance as it relates to critical care outreach may be due in part to an increased vigilance surrounding the adverse and sentinel events that occur within hospitals. Avoidable deaths and deficiencies in care would certainly prompt such investigation. A sentinel event refers to the need of significant additional

treatment. It can be life threatening or it has led to an unanticipated death or major loss of function not related to the course of the patient's illness or underlying condition (Quality Improvement Committee 2008 p. 4). This definition certainly encapsulates some of the reasons why critical care outreach was introduced into UK hospitals. As a result the critical care nurse has been placed in the position of surveyor with a much wider gaze of surveillance in operation over them.

Powers (2001) states, that Foucault was particularly interested in the operation of power and its existence at various levels in society. He rejects the notion of power as emanating from the top. He conceived power as being capillary, operating at all levels and directions of society in an extensive network of power relations. Foucault was most concerned with power and the effect it has at the very ends of the capillary network. That is, at the site of its action rather than at some conjectured sovereign point such as the state or law (Powers 2001 p. 27), this same concern is one in which I share with Foucault.

What support is emanating from the top for the critical care outreach nurse, the one who now holds the power? How does this effect the ward nurse, the one at the very ends of the capillary network? Namely the critical care outreach nurse. Holmes and Gastaldo (2002), state that throughout history, nurses have always been situated and involved in the governance of individuals using an array of power techniques. Disciplining and caring are some of the techniques used by nurses to govern individual bodies (p 561). Critical care outreach may have become yet another technique used to help govern nurses by preventing the discourses of risk leading to sentinel events.

Hindess (1996 cited in Holmes & Gastaldo p 561) describes disciplinary power as a form of power exercised over an individual or many persons to produce effects on their conduct, habits and attitudes in order to help them achieve particular skills and new ways of thinking of to render them ready for instruction. NZ may not have fully adopted the concept of critical care outreach as a form of surveillance, but it does embrace a form of disciplinary power to produce its own effect of conduct over individuals, the Health

Practitioners Competence Assurance (HPCA) Act 2003. The HPCA act provides a framework for the regulation of NZ health care practitioners in order to protect the public.

Holmes and Gastaldo (2002), add that Foucault describes disciplinary power as having the capability to train and enhance individuals and utilize people's productive potential while making optimal use of their capabilities. The authors believe disciplinary power operates through an impressive set of tools such as hierarchical observation (surveillance); normalising judgement (creation of norms) and examination (clinical gaze). I believe this description of disciplinary power is more in keeping with the role a critical care outreach nurse plays. The critical care outreach nurse uses an impressive set of tools to help other nurses care for the complex patients in the general wards.

SECTION FOUR:

The final section offers concluding comments and recommendations for future research.

Conclusion

Critical care was once a bounded term within a space, now its being defined as a physiological concept. Critical care outreach was introduced to extend the knowledge and skills that previously took place behind closed doors to beyond the physical boundaries of an intensive care unit. As a result of this extended care the critical care nurse and their capabilities have become more exposed and vulnerable.

If I were to become involved in developing an outreach service how would I like that service to look, what model and whose literature would I now draw on since embarking on this study? What discourses would I draw on to influence me? NZ is unique in that it is situated on the margins of the world, because of this we are able to observe and adapt models of care from elsewhere. What creativity can we bring to our health care system by drawing on the creativity of others?

The discourses of deficit and risk have illustrated how language and text can influence how nurses and nursing practice. It also illustrates how discourses from another model, namely medical can also influence nurses and how they construct themselves and other in the literature.

Recommendations

The introduction of critical care outreach has enabled the development of many things in both a clinical and an academic sense. The critical care outreach research has been diverse and unique, each identifying further recommendations to consider for future research. My questions and recommendations are directed primarily towards how can we develop a critical care outreach framework within a NZ context?

Currently the UK and Australian critical care outreach literature does not appear to demonstrate how the development of their services has accommodated their populations of differing cultures. The Treaty of Waitangi is an integral part in how health care is delivered in NZ, therefore the NZ model of critical care outreach must be developed to incorporate the founding principals of the Treaty by ensuring any new innovation is accessible to all.

It is also important to address gaps that may exist within the primary health care sector. Can this same concept of care translate into the community setting? How can we develop a collaborative network between nurses working in primary and secondary health care settings? Can acute care nurses liase in an outreach capacity with palliative care nurses to meet the needs of patients in their homes and prevent an admission to hospital that is often disruptive to the patient and their families?

Another other aspect of critical care outreach I believe requires further investigation is that critical care nurses have suddenly become professionally exposed. What collegial networks and preparation needs to be developed and in operation to support the nurse in this advanced practice role? And finally, are we adequately preparing the future workforce of doctors and nurses by introducing them to more acute care settings and experiences as part of their undergraduate education?

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