Critical thinking in nursing:
A critical discourse analysis of a perpetual paradox

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Abstract

The term 'critical thinking' has conflicting definitions in nursing. Controversy stems from debates about what is involved in the thinking process that makes it 'critical'. For some, it is an analytical linear problem solving approach within defined parameters while for others it demands an engagement with underpinning theoretical and philosophical influences. Critical thinking is, however, considered crucial and is a compulsory requirement for all NZ nurses. It is believed to be essential for nurses to determine what knowledge to use, what care to provide, and how to decide the best way to deliver this care. Yet, exactly what is required when nurses critically think is not clearly articulated within nursing theory and practice.

A critical discourse analysis (CDA) methodology was used to examine five influential documents that impact critical thinking in nursing. Three professional documents that influence nursing in a prescriptive and pervasive way and two academic nursing texts were analysed. These documents guide the way in which critical thinking is defined and how its use is sanctioned in nursing theory and practice. Informed by the work of Fairclough (1995, 2003) and Huckin (1997), this CDA research adopted a thematic approach in which documents were analysed at a textual and discourse practice level. Following this, critical and social constructionist theory was utilised to provide a contextualised interpretation of the powerful discursive forces impacting on critical thinking.

By focusing attention on the dominant professional, organisational and political discourses which impact critical thinking, this doctoral study identifies assumptions about critical thinking within nursing theory and clinical practice, and the way in which a number of discourses position and influence nurses' professional identities.

The findings reveal how the documents construct the meaning of critical thinking in two significant ways. Critical thinking is predominantly defined within the documents as a cognitive problem solving approach and nurses are discursively positioned to comply with rules and regulations to guide their thinking and practice. However, there is also a requirement for the engagement with the philosophical aspects of critical thinking in order for nurses to provide safe and responsive care in highly complex and challenging health care environments. These two components of critical thinking are not always complementary. The findings highlight the perpetual paradoxes faced by a critically thinking nurse.

This study argues that critical thinking, as used in nursing practice, is a social practice and more of a pseudo-critical thinking approach than a philosophical endeavour. A philosophical approach to critical thinking is shown to be required and yet challenging and indeed potentially compromising for nurses. Recommendations regarding potential support for nurse educators, nurses in practice, and students of nursing are made. The principle recommendation is that professional supervision is used to support critical thinking in nursing, alongside formal education about critical thinking at undergraduate and postgraduate levels.

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Attestation of Authorship

I hereby declare that this submission is my own work and that, to the best

of my knowledge and belief, it contains no material previously published

or written by another person (except where explicitly defined in the

acknowledgements), nor material which to a substantial extent has been

submitted for the award of any other degree or diploma of a university or

other institution of higher learning.

aStewart

4 September 2017

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Signed: Angela Stewart   Date:

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I would also like to thank Jenny Snowdon for the support afforded me during our professional supervision conversations. These conversations reflect those I am advocating within this research.

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Chapter 1:   A critical thinking paradox

"Paradox refers to the interplay of different and seemingly contradictory positions … (and) … acknowledges the existence and interpenetration of opposites, not as dichotomies, but as variances, checks and juxtapositions that recognise the contribution and relevance of more than one understanding" (Spence, 1999, p. 12 & 163)

Topic overview

During nursing education and upon registration, nurses are presented with the compulsory requirement from their formal registration authority that they think critically (NCNZ, 2010). However, within literature there is no single, clear and universally accepted definition of the term 'critical thinking'. Employers of nurses generally discourage or prohibit public or internal 'critical thinking' expressed through the articulation of ideas or opinions that question or challenge the status quo of approved, standardised nursing practice. Yet the contexts within which nurses practice are universally characterised by complexity, competing priorities, and multiple constraints that render critical thinking essential if safe and ethical care is to be rightly delivered to health care consumers. What emerges from this focused overview of the territory addressed by this thesis is the clear and indisputable fact that nurses are caught in a powerful, perpetual paradox.

To explain what a paradox is, Hoffman (2001) differentiates three concepts that contribute to its meaning and possible resolution. Firstly, the elements of some paradoxes can be understood by considered analysis and following this the conflict can be resolved. Secondly, that the paradox occurs as the result of "contradictions between two equally valid principles or between inferences correctly drawn from such principles" as "Antinomy" (p. 370). This form of paradox is considered more complex and more difficult to resolve. Finally, paradox can be impossible to solve. "A contradiction between fundamental principles where there appears to be no solution will be denoted "aporia", which signifies "no way out" (p. 371). The paradox presented within this work would suggest, at times, there is no way to resolve the critical thinking paradox.

This thesis examines how the concept of critical thinking impacts nursing practice by addressing the following four aims:

- To reveal and clarify the notion of critical thinking and the wider dimensions believed to be involved in the application of critical thinking for nursing practice
- To uncover dominant professional, organisational and political discourses which influence the process of critical thinking
- To identify the ways in which these discourses position and influence nurses' professional identities and practice
- To offer practical recommendations to assist nurses in the application of critical thinking in their roles and as part of their professional identities

Positioned within the context of a Doctor of Health Science degree, this work seeks to make a positive contribution to the profession and practice of nursing. In keeping with the objectives of doctoral study, the intention is to both inform and enhance healthcare practice and positively support nursing and thus to benefit recipients of healthcare in New Zealand.

Introducing the concept of critical thinking in nursing

As will be discussed further in Chapter 2, the term "critical thinking" has been used since the time of the ancient Greeks, and the processes the term encapsulates have been debated since then. The term has been used to describe an analytical type of thinking that is much more than simply careful or logical thinking. Researchers maintain that critical thinking also includes wider dimensions such as "critical reflection" and "complex judgement" (Benner, Hughes & Sutphen, 2008), as well as consideration of aspects such as a person's values and beliefs and the way in which biases and taken-for-granted assumptions may influence thinking and action (Brookfield, 2011).

Furthermore, to effectively exercise the skills of critical thinking, domain specific knowledge may be required, "some of which may concern specific methods and techniques used to make reasonable judgements in those specific contexts" (Facione, 1990, p. 2).

The nursing profession is argued to have a discrete body of knowledge underpinned by a variety of theoretical and philosophical perspectives (Fawcett & Desanto-Madeya, 2013). In order to provide safe and responsive care, a nurse is required to consider a range of perspectives and decide what nursing knowledge should be drawn on. Critical thinking is purported by researchers and teachers to be an essential component in determining the knowledge required to enable the selection and delivery of safe, appropriate and effective nursing care (Alfaro-LeFevre, 2009; Benner, Hughes & Sutphen, 2008; Brunt, 2005; Distler, 2007; Fesler-Birch, 2005; Martin, 2002; Profetto-McGrath, 2005; Scheffer,& Rubenfeld 2006; Simpson & Courtney, 2002).

However, despite attempts to define critical thinking for nursing practice, a lack of consensus in defining critical thinking persists within the discipline (Chan, 2013). This raises questions about how nurses are supposed to think critically when definitions are variable and/or unclear.

Another aspect of critical thinking that requires closer examination is the way many professional, organisational and political discourses influence the process of critical thinking. These include the pervading influence of evidence-based practice, the role that critical thinking plays in assessing nursing competence, and the increasing use of institutional standard-operating-procedure protocols and health care policies that may hinder or suppress capacity for critical thinking. Such influences are likely to create tension and conflict as the nurse vacillates between these 'rules' and a considered decision which has emerged from critical thinking. Thus the 'thinking' nurse may be caught in a perpetual paradox, being required and encouraged to

use critical thinking on one hand and, on the other, being constrained by the powerful influences identified above.

This doctoral study is important because examination of the notion of critical thinking and the wider dimensions purported to be involved will add to, and perhaps clarify, the body of knowledge regarding critical thinking. The textual focus provided by the use of critical discourse analysis as a research approach will draw attention to the language used in constructing the meaning of critical thinking for nursing practice.

Research questions

In order to meet the aims of this research, the following research questions were asked:

- How is language used to construct the meaning of critical thinking within nursing theory and clinical practice?
- How do professional organisational and political discourses influence critical thinking within nursing theory and clinical practice?
- How do these discourses position and influence nurses professional identities and practice?

Research approach

In order to answer the above questions, this doctoral research study utilised a critical discourse analysis (CDA) methodology to uncover assumptions about critical thinking within nursing theory and clinical practice. As identified in the previous section, critical thinking is considered an essential requirement for safe and effective nursing practice and is considered essential for a nurse to practice in an autonomous, competent and professional manner. A pivotal driver for enabling critical thinking is the influence of the contexts in which nursing practice is performed. Within these contexts there are potential professional, organisational and political discourses that influence critical thinking and consequently influence nursing practice. For this reason CDA was considered an appropriate methodology for studying the impact of discourse on critical thinking for nursing.

Central to CDA is the intent to draw attention to the way meaning is mediated and controlled by the use of language within our social lives. CDA offers a research approach that provides a structure for critically identifying, through the analysis of discourse, the impact of language on social experiences and meanings (Fairclough, 1995; 2001; Huckin, 1997). Of particular importance for this study was not only the analysis of the way language is used to offer discursive meanings about critical thinking within the texts, but also the way in which these discourses then operate within the social world to shape and influence nursing practice.

Reflective position

As a nurse and as an educator, engagement with critical thinking has been a part of my practice for many years. In the early years as a nursing student, this interest (albeit unrecognised by me at the time) was shaped by nursing tutors who encouraged me to question practice decisions; in particular, requiring me to think about what was informing a particular nursing practice. I am sure there were many tutors who encouraged this, but my most vivid recollections were during my mental health placements. I remember an intense debate about the 'myth' of mental illness, when we were introduced to the writings of Thomas Szasz (1961). I think this is the first time I really understood how a 'worldview' affected health outcomes in such a significant way and how it influenced those in care. I recognised that the way in which I understood the world also influenced the way I judged those in my care. Of course, I was taught to work in humanistic ways, having learnt communication skills and the Rogerian concepts that informed these. Therefore, I learned the art of positive regard, non-judgemental and empathetic approaches. These ways of working supported me to manage my judgements, but they did not address my deeply held values and beliefs and how these influenced my ability to connect in meaningful and useful ways.

In order to work with others in a way that valued and supported their experience, I became aware that I needed to recognise and manage my own experience and emotions. Learning therapeutic relationships was only part of the story; to truly do this necessitated some understanding of myself, my values and beliefs, and insights into the effects of these on my actions. This involved working with people's stories that were at times difficult and challenging. In order to deliver excellent care, I needed to understand what I was doing when delivering care and how this would impact the person I was caring for, and also their family.

I recognised that I wanted to be seen to be a 'good nurse' by those in my care, and also that other professionals would respect my professional knowledge. Being credible was very important to me. I have never accepted something at face value and I needed to know the 'big picture' behind patient encounters. I think this was motivated by an overwhelming need to do the 'right' thing and to be 'seen' to be doing so. This sense of responsibility meant I needed to fully understand what I was doing, so that I could justify it.

As an example, I remember being a new graduate from a comprehensive nursing programme and starting work at a hospital that was taking in the first group of comprehensive graduates from their local Technical Institute. I felt the scrutiny of my experienced colleagues and at times felt out of my depth. The gap between my theoretical understanding and clinical skills compared with the clinical aptitude of graduates from a hospital programme was identified as a deficit and at times a liability. I had a discussion with the Head of the Nursing School where I trained, after my first six months of employment. I was commenting on the stress of being in practice situations and at times on my own (night duty for one) and feeling inadequate and at 'risk'. My memory of her wise words is; "you have your comprehensive knowledge to support you". While

not minimising my feelings or the lack of support I experienced by some, she reminded me of how significant and essential knowledge was for supporting any practice decision. Critical thinking wasn't articulated as such, but the identification of the link of theory to practice and the need to be informed in any nursing action has all the hallmarks of critical thinking.

Understanding the theoretical underpinning of my practice has been important for me throughout my entire nursing career to date. Reflecting on my practice and developing my knowledge is a strong theme in my professional career. Following three years of clinical experience, I began studying towards a Bachelor of Social Science degree, majoring in Psychology. I was encouraged at this time to consider nursing education as a career and the following year took up a teaching position at the local Technical Institute. To support my teaching practice, I completed an Advanced Diploma in Nursing (Mental Health) and undertook psychodrama training to strengthen my mental health nursing practice.

On the completion of my degree I returned to work in an acute mental health ward as I wanted to update my clinical practice. During this time I worked with a young Māori woman who had been admitted for treatment for 'self-harming behaviours'. I had been working with her, (although my feeling was more that I was looking after her), looking at strategies for problem-solving and self-care alongside other team members with what I experienced as little success. This young woman persisted in leaving the 'safe' (in my view) environment of the ward to walk the streets and was frequently picked up by 'gang members', abused, and then returned to the ward. My conversations with her revolved around options she could make around managing her personal safety. I was endeavouring to assist her gain 'insight' and as a consequence change her behaviour to match this new self-understanding. It seemed obvious to me that the best way to remain safe was to not leave the ward. Coincidentally at this time I saw the movie 'Once were Warriors' and this had a powerful effect on my confidence about my ability to work with this woman in a therapeutic way. I felt devastated as I came to see that our life experience was so far apart that the way in which I was working with her was likely to be more harmful than therapeutic. I was imposing a reality that was mine, and not hers. This is a memory that resonates for me in noticing the need for critical reflection to support my practice and the clients in my care. The story of this woman has remained with me and continues to speak to, and inform my belief in the need for nurses to engage in critically reflective practice.

This attention to the emotional aspects of my role resulted in a realisation of its importance in educating nursing students. Carrying out the everyday 'tasks and psychomotor skills' of nursing that were learned through watching, reading and doing were often the focus of a nurse's world and in the main not problematic. Learning emotional management and the facilitation of relationships was more challenging. How could I make a difference?

Reflecting on what was occurring, what I was doing, and how I was going to facilitate change was not going to improve my education practice without a more critical view. Reflecting in this way could enable a justification of practice and problem-solving, rather than a 'knowing' of what

practice is doing (or does). What I was beginning to question was the theoretical basis of my work, - more specifically a comparison of a positivist versus a post-modern paradigm. I was becoming uncomfortable with the notion of an essential self and certainty, and was becoming more critically reflexive. I was aware of the risk of continuing to always look through a particular 'lens' and seeing only what makes sense from that lens. As Denzin and Lincoln (2003) describe, "There is no clear window into the life of an individual…any gaze is always filtered through the lenses of language, gender, social class, race and ethnicity" (p. 31). If I continue to reflect without being reflexive I may not recognise important aspects or consequences of my practice.

Within the nursing degree modules I teach, there is a stated requirement for the students to develop critical thinking and reflective practice, in order to practice as safe and effective practitioners. To develop my teaching and learning practice using a reflective method requires noticing of what is informing my practice and how experiences are visible or invisible to me. "Reflexivity involves critically questioning the meanings, concerns and values that are shaping ones experience' (Hartrick Doane & Varcoe, 2005). This needs to be translated into my teaching and learning practice so, as I facilitate student learning, I notice what informs me, as I help them notice what informs their own practice and its impact on those in their care.

To teach students to think critically is difficult. Students must be willing and able to develop the ability to challenge their taken-for-granted assumptions that inform the way they think. They need to suspend their notions of reality, to consider other ways of knowing, and to look at what may be informing their thinking. This is usually very challenging. It requires careful, respectful and emotionally supportive conversations. In some cases students find critical thinking and reflective practice very threatening. One student told me that she thought I was "dangerous" as she perceived that I was challenging her religious beliefs. The intention was not to challenge her belief in any way, but to help her to be aware of the way her beliefs may affect the way she interacts with others. Critical thinking is also not a thinking process that is valued within all cultures. Critical thinking is predominantly informed by Western thought and teaching students from cultures outside a Euro-centric paradigm can be problematic. It can be challenging for students as learners to suspend their taken-for-granted notions of reality and their assumptions and beliefs in order to foster critical analysis and reflexivity. Assisting students to understand its significance for nursing practice can be challenging. The challenge begins in providing students with an explanation of the defining characteristics of critical thinking. I became aware of the definitional difficulties with critical thinking during this time. Students struggled to understand how, when critical thinking was defined in highly regarded sources as a logical, problem solving approach, the need to suspend 'knowing' was appropriate. This perspective was a significant block for student thinking.

To think critically meant that students must weigh up the presenting information with a logical, bias free approach in order to arrive at a validated conclusion and deliver safe and effective care. Coming to understand how the presenting information would not be value-free and needed to be unpacked to identify the assumptions within it, and challenge the premises

presented, often meant challenging powerful positions and people that held them. Carrying out such questioning in clinical practice was very difficult, often not encouraged and at times prohibited. Critical thinking in practice was most often presented as understanding the facts, predicting appropriate outcomes and demonstrating an understanding of the correct procedures to follow.

The paradox presented by the compulsory requirement to critically think and the definitional uncertainty surrounding the concept requires attention. Alongside this, it is essential that nurses are aware of the powerful influences that impact their ability to employ the outcomes of critical thinking. It is my hope that this study will help illuminate what is meant by critical thinking. In addition, the aim is to uncover discursive practices that surround critical thinking, in an attempt to identify and address social, personal, cultural and structural constraints to our professional identities.

The development of critical thinking in Nursing Education within NZ

According to Kinross (1984), nursing education began in NZ in 1883 with the introduction of nurses who had "trained under the Nightingale system", based on the teaching of the famed nurse Florence Nightingale (p. 193). Rodgers (1987) stated that "a heavy emphasis on obedience as the first law of service to others was both an inspiration for, and the aim of, early nurse training" (cited by, Lusk , Russell, Rodgers & Wilson-Barnett, 2001, p. 199). The educational process that was implemented in NZ utilised an apprenticeship style of training, informed by the Nightingale model as utilised within English hospitals (Kinross, 1984).

The Nightingale model consisted of a curriculum and the application of knowledge and skills to patient care (Kinross, 1984). Indeed, Wood (2002) attests to this and claims that within Nightingale's teachings was "…a beginning scholarly enquiry" (p. 43). Woods provides examples from Nightingale's speeches that indicate an expectation that nursing training involved "…accurate observation … And moreover, observation needed to be coupled with reflection" (p.43). The expectation that nurses underpin their care with nursing knowledge and reflection are early indicators of the incorporation of critical thinking in nursing education.

Papps and Kilpatrick (2002) claim that the "…controls for the direction of nursing education" were enhanced by the "enactment of the Nurses Registration Act 1901" (p. 3). Wood (2002) maintains that nursing developed as a profession during the 1900s with the development of specialty fields, practice development and an increasing demand for "advanced professional education" (p. 45). While a university program for nursing education was initially offered in the 1920s by the University of Otago, it was not sustained. Hospital-based apprentice models of education prevailed and were seen as the best option for the preparation of a professional

nurse. The addition of a postgraduate year was developed in 1928 for those nurses in leadership and education positions and for public health nurses (Kinross, 1984).

According to Woods (2002) the 1930s and 1940s saw the development of nursing research. Nurses assisted in the generation of research, and carried out research in their own right. However, despite this engagement with research, Woods observed that there was a continuing expectation that nurses would be "obedient observers" (p. 46). She quoted from two nursing texts of the day: Pugh (1938) "a good nurse should develop the habits of punctuality, obedience, cleanliness, a sense of proportion and a capacity for and habit of correct statement" (p. 46). Also from the nursing text by Pearce (1939) "While loyalty was needed to physicians' orders, obedience meant primarily obedience to rules established to guard life" (p. 46). This concern for the obedience to rules can also be argued to extend to the standardisation of nursing skills and practice which occurred during this time in response to scientific and technological advances (Woods, 2002).

The prevailing hospital-based apprenticeship programmes consisted of general nursing (medical, surgical and obstetric nursing) and "Specialist preregistration programs in psychiatry, psychopaedic (nursing children with intellectual disability), and maternity nursing" (Lusk, et al, 2001, p. 199). In 1971, Helen Carpenter, a Canadian nursing academic, was commissioned to review nursing education in New Zealand. One of the recommendations from her report stated that nursing education "…be transferred to the tertiary education system so that student nurses could experience education of a standard equal to that of other professionals" (Prebble, 2001, p. 137). In 1973, following this recommendation, nursing education in NZ began its migration from an apprentice (service) model to that of an educational one in the form of a Diploma in Nursing (Lusk, et al., 2001). The consolidation of a three year comprehensive nursing programme within NZ as the only means of educating nurses continued for nearly 20 years, with the final hospital based programme closing in 1990 (Nursing Review, 2013).

Carpenter's (1971) original recommendation was that nursing move to a tertiary education setting that led to registration and a university degree (Kinross, 1984). This was finally achieved in 1992 with the establishment of an undergraduate degree as the entry level qualification alongside successful completion of the NCNZ state exam for a registered nurse in NZ. Prior to this, for a nurse to obtain a university degree in nursing, they were required to complete an additional three year degree (at either Massey or Victoria University), having first completed their three year nursing education course (Papps & Kilpatrick, 2002).

The hallmarks of scholarly enquiry can be identified throughout nursing education in NZ. While critical thinking was not overtly mentioned, Nightingale signalled this in the 1880s with her call to observe and reflect. With the advent of the degree came the requirement that critical thinking be incorporated within any undergraduate programme of study leading to nursing registration in NZ (NCNZ, 2010). Critical thinking as a discrete concept has been an expectation in NZ nursing for some time. As Woods (2002) claims:

The complexities of practice demand that nurses be critical thinkers, able to locate relevant, up-to-date and accurate information in order to make wise clinical judgements. On entry to the profession, the newly graduated nurse is expected to be a critical consumer of research approaches. In a professional, legal and social context which demands accountability and advocacy, nurses are required to be spirited thinkers, accurate recorders and articulate portrayers of their practice (p. 40).

Thesis overview

The following section provides an overview to this doctoral thesis. The overview identifies the contents and purpose of each chapter.

Chapter 1   Introduction and Background: The critical thinking nurse caught in a perpetual conflicting paradox

This chapter introduces the topic, the research aims, and the research questions that will be addressed to meet the aims. It also includes an introduction of the concept and complexity of critical thinking and what it means in nursing practice. This is followed by a personal reflection of aspects of my professional experience that has resulted in my interest in pursuing this area of research.

Chapter 2   Literature Review: Critical thinking in nursing practice

This chapter firstly reviews the literature to examine the debate around the term "critical thinking" and attempts to develop a useful definition of the concept. It then examines the use of critical thinking in nursing practice. This includes the way in which professional nursing bodies advocate the use of critical thinking, how it is supposedly taught and learned, and how it is influenced by professional organisational and political practices.

Chapter 3   Methodology and Methods: Critical discourse analysis and the power of language

This chapter introduces and explains the critical discourse methodology that is used to examine the research questions. It then describes how the methodology will be used to examine five key documents that prescribe and influence the use of critical thinking in nursing practice in NZ.

Chapter 4   Data Analysis: Multiple prescriptions for nursing practice

This chapter uses critical discourse analysis to uncover the way language is used in the five key documents to construct the meaning of critical thinking in nursing practice. Each document was examined separately, beginning with a background description and historical context. This was followed by two levels of discourse analysis to examine the linguistic methods employed to construct the meaning of critical thinking within the documents.

Finally, the results were analysed to reveal five dominant discourses that were employed by the documents to influence critical thinking. These were titled Legal, Professional, Safety and Risk, Evidenced-based practice, and Managerial discourse.

Chapter 5   Discourse Examination: Constraining forces of interconnected chains of discourse

This chapter focuses on the dominant discourses identified in Chapter 4 and examines them in more detail and the way in which they are intended to influence the practice of a nurse. The connections to other influential discourses were also examined.

Chapter 6   Analysis of Sociocultural Context: Rules of engagement for a critically thinking nurse

Chapters 6 and 7 contain the final analysis which examines the sociocultural context for the application of these discourses in nursing practice. In order to further examine the lived experience of nurses who are attempting to apply the often conflicting discourses, two challenging practice examples are explored. This chapter examines the path a critical thinking nurse must take to practice cultural safety within a Māori context.

Chapter 7   Contextualised Understanding: The risks of exercising professional agency

Similarly to Chapter 6, this chapter examines key discourses in the context of the Waikato DHB vaccination policy.

Chapter 8   Discussion and Recommendations:

This chapter reviews the findings of the thesis, discusses limitations of the research and considers the wider implications of the use of critical thinking for nurses. Recommendations are provided for the understanding, teaching and use of critical thinking in nursing practice.

Summary Chapter One

This chapter has provided an introduction to the study, identifying the research questions and the methodology that was employed to answer the questions. It also included a reflective account, outlining my person interest and motivations for the study. The next chapter provides a critical review of the relevant literature that informs this work.

Chapter 2: Critical thinking in nursing practice

Critical thinking is not a matter of deduction and consideration of a just and reasonable outcome, but rather as Kincheloe (2000) argues, critical thinking is really "the ability of individuals to disengage themselves from the tacit assumptions of discursive practices and power relations in order to exert more conscious control over their everyday lives" (cited by Brookfield, 2005, p. 12).

This chapter firstly reviews the literature to examine the debate around the term 'critical thinking' and attempts to develop a useful definition of the concept. It then examines the use of critical thinking in nursing practice. This includes the way in which professional nursing bodies advocate the use of critical thinking, the different theoretical approaches to its teaching and learning, and how it is influenced by professional organisational and political practices.

Defining critical thinking

When discussing the origins of critical thinking, Davies (2011) identifies concepts associated with critical thinking as dating back to the ancient Greeks and the birth of the universities, "in the guise of the study of logic and rhetoric" (p. 255). One of the first proponents of critical thinking in the twentieth century was the renowned pragmatic philosopher, Dewey, who identified it as a form of reflective thought which stems from doubt or confusion. In 1933, he believed the thinker must remain doubtful long enough to ensure a rigorous analysis of all possibilities (cited by Riddell, 2007).

An attempt was made to articulate the nature of critical thinking and its educational impact by the American Philosophical Association when in 1987 they commissioned the Delphi Report (Facione, 1990). The report is the culmination of the considered opinions of a panel of 46 professionals recognised by their colleagues as having expertise in an area of critical thinking. While a small number of experts held differing views and some did not agree with how the details of the findings were articulated, a consensus statement defining critical thinking was reached. It defined critical thinking as:

> *…purposeful, self-regulatory judgment which results in interpretation, analysis, evaluation, and inference, as well as explanation of the evidential, conceptual, methodological, criteriological, or contextual considerations upon which that judgment is based. Critical thinking is essential as a tool of inquiry. As such critical thinking is a liberating force in education and a powerful resource in one's personal and civic life. While not synonymous with good thinking, critical thinking is a pervasive and self-rectifying human phenomenon*" (p. 2).

Furthermore, findings from the Delphi Report identified that critical thinking consists of two components; cognitive skills and affective dispositions, and defined the ideal critical thinker as:

…habitually inquisitive, well-informed, trustful of reason, open-minded, flexible, fair-minded in evaluation, honest in faceting personal biases, prudent in making judgments, willing to reconsider, clear about issues, orderly in complex matters, diligent in seeking relevant information, reasonable in the selection of criteria, focused on inquiry, and persistent in seeking results which are as precise as the subject and circumstances of inquiry permit (Facione, 1990 p. 2).

Facione added that "while CT skills themselves transcend specific subjects or disciplines, exercising them successfully in certain contexts requires domain specific knowledge, some of which may concern specific methods and techniques used to make reasonable judgements in those specific contexts" (Facione, 1990 p. 2).

The Delphi report, then, extended the definition of critical thinking to include elements such as the contextual nature of critical thinking, the skills required to think critically alongside the paradigm which is informing how a particular item is being scrutinised, domain specific knowledge, and the human experience as well.

More recently, Barnett (1997) added the element of collaboration, maintaining that critical thinking "is collaborative in character and must be sustained through shared activity and discourse around shared standards within a community" (cited by, Wass, Harland & Mercer 2011, p. 318). Atkinson (1997) argues critical thinking is a social practice and becomes recognisable only when the cultural context in which it is operating is known. He states "critical thinking may well be in the nature of a social practice—discoverable if not clearly self-evident only to those brought up in a cultural milieu in which it operates, however tacitly, as a socially valued norm" (p. 89).

According to Brookfield, a highly published English critical social theorist, critical thinking involves four steps (Brookfield, 2011):

- "Hunting assumptions" (p. 11). The thinker attempts to uncover the assumptions that are informing their thinking and actions. Brookfield identifies three types of assumptions;
  - "'paradigmatic' (how we see the world). Identifying these assumptions that are imbedded in dominant ideologies are the most difficult to see. Brookfield calls attention here to "democracy, capitalism and patriarchy" (p. 25);
  - "prescriptive' (how we think the world should work and how people should behave)
  - 'causal' (assumptions we have about why things happen the way they do" (p. 25).

- "Checking assumption's (p. 11). The thinker engages in a rigorous review of the accuracy of these assumptions. This review can be informed by past experiences, by the opinion of experts about what is accurate and true, or from research evidence. Brookfield reminds us that "assumptions are rarely right or wrong, they are best thought

of as more or less contextually appropriate. How accurate an assumption is will depend
on the conditions that are in place when the assumption is followed" (p. 25).

- "Seeing things from different viewpoints" (p. 12). The thinker looks at their assumptions
  from differing points of view. Critical thinking involves values and beliefs and is not just
  a rational mental process. Therefore there is a requirement to remain aware of why we
  are engaging in critical thinking and how this will "improve a situation" (p. 25).

- "Taking informed action" (p.13). The thinker ensures that the actions derived from our
  thinking have the desired outcomes. Critical thinking is an endeavour which is driven by
  the desire to "take informed actions that are grounded in evidence, can be explained to
  others and stand a good chance of achieving the results we desire" (p. 24).

Most of the remaining contention regarding critical thinking resides around a philosophical
position held by the opinion holder. Mason (2007) describes various philosophical positions.
One is that critical thinking is a set of specific skills, for example the ability to examine ideas and
deduce possible outcomes. Secondly, it is a personal characteristic which enables a critical
disposition, and if this is so, then the person engages in critical thinking as a moral endeavour,
that the thinking is valued as just and right. Thirdly, that critical thinking is comprised of
knowledge and understanding about specific concepts. Mason maintains that other researchers
include a fourth position; that the knowledge required for critical thinking is discipline specific.
This position holds that one can only think critically within the parameters of a discipline, and
then only once in-depth knowledge of the discipline is acquired.

Brookfield (2011) argues that across the disciplines there are five intellectual thinking traditions
which inform their respective definitions of critical thinking. Each of these disciplines has
divergent ideas about critical thinking and he maintains that this is the foundation of the differing
understandings of critical thinking. These five critical traditions are:

- Analytic philosophy and logic: Brookfield maintains this is the most influential tradition
  informing how critical thinking is understood. This tradition argues "….if one can
  understand how bias and prejudice masquerade as empirical fact or objective
  interpretation, one is better placed to know what to believe and what to do" (p. 33)
- Natural Sciences: Hypothetico-deductive method: Brookfield maintains this is
  considered by most people as "… the apex of scientific reasoning" (p. 38). A critical
  thinker in this tradition is always open to challenging and reviewing hypotheses and
  believes in the "provisional nature of knowledge" (p. 38).
- Pragmatism: "The experimental pursuit of beautiful consequences" (p. 39). Pragmatists
  believe the way to develop knowledge and further a democratic existence is through "…
  1. constant experimentation, 2. learning from mistakes, and 3. deliberately seeking out
  new information and possibilities" (p. 39). Brookfield cites Dewey in claiming a critical
  thinker in this tradition "requires constant critical analysis of assumptions" (p. 41).

- Psychoanalysis: Living an integrated authentic life. "…through critical analysis of our experiences we can identify assumptions we hold that are preventing us from realising our inner potentialities. Critical thinking is employed to restore the connection between ones inner yearnings and one's outer work and love commitments" (p. 46).
- Critical theory: speaking power to truth. This tradition is overtly political and its "purpose is to help bring about democracy" there is an emphasis on noticing dominant ideologies and the "process of ideological manipulation" (p. 49). Critical thinkers in this tradition look at "abuses of power and the way systems and structures deliberately exclude certain groups" (p. 50).

Moore (2011) further argues that critical thinking "refers to a multiplicity of practices, ones that are rooted in the quite individual nature of the different disciplinary language (and thinking) games" (p. 271). He drew on the thinking of Wittgenstein (1958), who argued that most philosophical disputes exist due to each discipline presenting arguments claiming a definitive truth. Wittgenstein reminded us that language does not permit such a possibility. Language assumes various meanings dependant on the context in which it is being used (Moore 2011). The implications for critical thinking appear clear for Moore, that teaching generalised critical thinking skills will not prepare students for the unpredictable and dynamic world their disciplines reside in. They need to be immersed in the thinking and language of their discipline and from here "consider (and to compare) the distinctive critical modes of their study" (Moore, 2011, p. 274).

Brookfield (2011) would agree that students need to be aware of the knowledge claims and the assumptions of the experts within their fields of study. He sees uncovering the assumptions in what the discipline holds as "legitimate knowledge" (p. 28) as a generalisable notion of critical thinking across all disciplines. At the heart of this knowledge is the language used to describe concepts. Brookfield refers to this as the "grammar of the subject" - a term first coined by Peters in 1973 (p. 28). The grammar of the subject is then further defined as "content grammar the building blocks of the subject that every student needs to know ……" and the "…epistemological grammar of a subject… "Which …. refers to the processes by which we determine disciplinary knowledge to be true" (p. 28).

In summary, the exact nature and attributes of critical thinking have been debated for many years. The Delphi report and the insights of researchers such as Facione, Brookfield and Moore have done much to clarify the concept. At a minimum it can be regarded as a process whereby the thinker is required to be aware of and reflect on the underlying ideology, assumptions, power and hegemony that may be impacting on their decision making. In the context of nursing practice, a nurse must also incorporate the theoretical and philosophical perspectives and the subject knowledge that underpin the profession.

Critical thinking in nursing practice

Despite the debates surrounding the defining of critical thinking, there appears to be consistent support that it should be the ultimate aim of any higher education endeavour (Moore, 2011). This is especially true in the case of nursing where, as is explained below, critical thinking is regarded to be of paramount importance and indeed essential in determining the most appropriate nursing care and ensuring the care is safe and effective.

Critical thinking is compulsory

Nursing within New Zealand is a professional occupation which is regulated by the Nursing Council of New Zealand (NCNZ).The NCNZ, in turn, is regulated by the NZ Government via the Health Practitioners Competence Assurance Act (2003).

The NCNZ sets the standards for both the education and practice of nurses in NZ (NCNZ, 2010). The standards for education are contained in a document titled "Education programme standards for the registered nurse scope of practice" (NCNZ, 2010). Standard 2.5 states that "The programme has a statement of beliefs or underlying assumptions that is congruent with the planning and delivery of the learning experiences, and is based on [4 points, including] the development of critical thinking and nursing inquiry throughout the programme" (page 6). It is clearly, then, mandatory for all NZ nurses to have developed critical thinking.

The NCNZ also determines the standards for nursing practice once a nurse has qualified and registered. These standards are contained in Competencies for Registered Nurses (NCNZ, 2012a, p. 3).This documentation does not specifically use the words "critical thinking" in its prescription, but does use wording that clearly falls within any definition of critical thinking. Some examples are:

> *"Registered nurses utilise nursing knowledge and complex nursing judgment to assess health needs and provide care, and to advise and support people to manage their health."*
>
> *"They [Registered Nurses] provide comprehensive assessments to develop, implement, and evaluate an integrated plan of health care, and provide interventions that require substantial scientific and professional knowledge, skills and clinical decision making.*
>
> *"The registered nurse scope of practice competencies … include being able to demonstrate knowledge and judgement and being accountable for own actions and decisions, while promoting an environment that maximises health consumer safety, independence, quality of life and health".*

In addition to this, NCNZ, within the Registered nurses registration guide (NCNZ, 2015) state that graduates completing a programme for entry to the register of Registered Nurses in NZ meet the following standard. "…intellectual independence, critical thinking and analytic rigour" (p. 3).

As well as the requirements for critical thinking specified by the NCNZ, there is a plethora of other literature maintaining that critical thinking is essential in nursing education and for the provision of safe and effective patient care (Alfaro-LeFevre, 2009; Benner, Hughes & Sutphen, 2008; Brunt, 2005; Distler, 2007; Fesler-Birch, 2005; Martin, 2002; Profetto-McGrath, 2005; Scheffer,& Rubenfeld, 2006; Simpson & Courtney, 2002). Critical thinking is considered by most of these researchers to be essential in order for nurses to be safe and effective practitioners throughout their varied complex practice arenas. "To provide quality care in this environment, nurses need to develop critical thinking (CT) skills that will provide them with expertise in flexible, individualised, situation-specific problem solving" (Brunt, 2005, p. 60).

The regulatory body for registered nurses in Australia, namely the Nursing and Midwifery Board of Australia include critical thinking as one of their domains of competency. Critical thinking and analysis is listed as the second domain and has five standards that the nurse is required to meet to demonstrate critical thinking competence. "The nurse:

- practises within an evidence- based framework.
- uses best available evidence, nursing expertise and respect for the values and beliefs of individuals/groups in the provision of care.
- demonstrates analytical skills in accessing and evaluating health information and research evidence
- supports and contributes to nursing and healthcare research.
- participates in quality improvement activities" (2006, p. 2).

While examples of these standards can be found within the NCNZ competencies, they are not identified specifically as critical thinking competence, but nicely encapsulate the concepts within the widely agreed definitions of critical thinking. They are spread through the document in other domains.

The above literature clearly indicates a dominance of the opinion that the development and use of critical thinking is an important, indeed essential, requirement of nursing practice.

The definition and use of critical thinking in nursing

Early nursing scholars focused only on the intellectual aspects of critical thinking, before Tanner (1997) called attention to the affective domains required for the relational aspects of nursing care (as reviewed by Scheffer & Rubenfeld, 2000). However, there was no agreed specific definition for critical thinking as it related to nursing.

In 2000, Scheffer and Rubenfeld responded to the lack of a definition and utilised the Delphi method in an attempt to gain consensus for a definition of critical thinking for nursing. The final consensus statement was:

*Critical thinking in nursing is an essential component of professional accountability and quality in nursing care. Critical thinkers in nursing exhibit these habits of mind: confidence, contextual perspective, creativity, flexibility, inquisitiveness, intellectual integrity, intuition, open-mindedness, perseverance and reflection. Critical thinkers in nursing practice the cognitive skills of analysing, applying standards, discriminating, information seeking, logical reasoning, predicting and transforming knowledge (*Scheffer & Rubenfeld, 2000, p. 357).

Despite this attempted capture of a consensus, inconsistencies in the definition of critical thinking for nursing still endure. In a recent literature review of critical thinking in nursing education by Chan (2013), differing definitions and terms used to explain critical thinking were identified. Agreement about the components of critical thinking also varied. Chan claimed that there are new components emerging in the literature which warrant further attention and suggested that this indicates that critical thinking as a nursing concept continues to develop. In addition to a lack of cohesiveness, the range of terms used to describe the skills associated with critical thinking further challenge a coherent capture of critical thinking for nursing. These terms include "critical reflection", "clinical decision making", "complex judgement" and "clinical judgement and reasoning" (Benner, Hughes & Sutphen, 2008; Tanner, 2006).

More recently Benner et al., (2010), advocated for the development of clinical judgement and reasoning rather than an emphasis on critical thinking skills. They identified that judgement and reasoning were ways of thinking that had to include critical thinking skills. Cazzell and Anderson (2016) highlight the importance in differentiating between critical thinking and clinical judgement but note it is a seemingly problematic endeavor given the overlap between these two constructs. It would seem while accepting the importance of critical thinking, some researchers are concerned about its focus in nursing. Benner, Tanner and Chelsa (2009) express concern at the attention it holds in nursing. They believe critical thinking is a rational approach to practice that favours logic over emotion. For them, the concern is "...that both the behavioural model and the current emphasis on critical thinking, with their attendant assumptions, overlook and in some ways cover over the possibility of embodied knowing, the role of emotion in skilled judgement, the skill of involvement, and the role of narrative in understanding a patient's experiences" (p. 388). They advocate for critical reflective thinking as a means of improving practice. Other authors would agree and would not separate reflection from critical thinking, identifying reflection as a component of critical thinking (Timmins 2006).

Some researchers question whether critical thinking is a valuable skill at all. According to Riddell (2007), the nursing profession needs to rethink its commitment to critical thinking because she believes that there is little evidence to support the claim that critical thinking improves clinical competence. Her concern is based on the inadequacy of tools to measure critical thinking in nursing, and the subsequent lack of research demonstrating that critical thinking can be learned and applied in practice.

Fesler-Birch (2005) concurs, arguing that "there is a lack of empirical data regarding the relationship between nurses' critical thinking abilities and patient outcomes" (p. 64). Furthermore, Scheckel and Ironside (2006) believe that while critical thinking may be required for some aspects of students' clinical decision-making, it is not adequate for the changing face of clinical practice today. Instead they argue that engaging the students in "narrative pedagogy" advances their ability to engage in "interpretative thinking" and, in doing so, see multiple possibilities for practice (p.159).

These criticisms may arise from the lack of rigour in defining critical thinking and the theoretical perspectives informing the concept. For a sound understanding and use of critical thinking for nursing, more attention needs to be paid to scholars of critical thinking and the philosophical questions underpinning the teaching and learning of critical thinking. Cody (2002) maintains that nursing has taken up a "pseudo critical thinking" frame (p.185). He cites Richard Paul's (1993) definition of pseudo critical thinking - "a form of intellectual arrogance masked in self-delusion, or deception in which thinking which is deeply flawed is not only presented as a model of excellence of thought, but is also, at the same time, sophisticated enough to take many people in" (p.185). Cody believes that nursing has focused the attention of critical thinking on a linear problem-solving method of deduction in an objective manner.

This focus on "cause and effect thinking" leads to interventions which are based on "one reality, one truth" and as a consequence the evaluation of these interventions is based on expectations of conforming to "predefined norms" (Cody, 2002, p.186). Due to this objective linear approach, "alternative visions of reality….. descriptions and explanations of human patterns of meanings, behaviours and relationships are not usually acknowledged, much less explored" (p.186). In light of this, Cody further argues that moving critical thinking forward in a meaningful and "authentic" way is vital, and furthermore that using nursing theoretical frameworks to guide nursing practice is essential. He argues that it is necessary to explore the assumptions that inform nursing actions by engaging with the underpinning nursing theories and philosophies. The expectation is that this will assist nurses to recognise alternatives to nursing actions as they collaborate with others, celebrating the diversity of human experience. This, in part, concurs with Barnett's statement above, about collaborating for critical thinking, and echoes Brookfield's call for the noticing of ideology and assumptions when engaging in critical thinking. This also aligns with the views of Scheckel and Ironside (2006) that narrative pedagogy facilitates thinking from multiple pedagogies, enabling students to "… become comfortable thinking from multiple perspectives amidst the ambiguity and uncertainty of evolving health care situations" (p.160).

Despite the above attempts by nursing scholars to call attention to the requirement that critical thinking includes an engagement with nursing philosophy and theory, the linear problem solving emphasis seems to prevail. Robert and Petersen (2013), in their conceptual analysis of critical thinking, reinforce this. They provide what they consider to be a model case of critical thinking, but that depicts a "pseudo-critical thinking" approach that Cody (2002) warns about:

…A nurse is reviewing the cardiac monitors for 30-year-old Jacob, admitted to the telemetry floor for cellulitis of the leg. Jacob had a peripherally inserted central catheter (PICC) in place to allow infusion of broad-spectrum antibiotics. He had no previous history of cardiac problems, but the nurse noticed frequent runs (4-5 beats) of ventricular tachycardia. The nurse entered the room and assessed the patient. He told the nurse that since his PICC was inserted, he felt fluttering in his chest with any movement. In reflecting on this finding, the nurse reviewed the radiologist's report after the PICC insertion. The X-ray showed a PICC in the right ventricle rather than in the superior vena cava, so the nurse immediately called a doctor and explained the concerns. The physician arrived quickly and adjusted the PICC catheter, and the patient's ventricular tachycardia resolved. Two days after completing his course of antibiotics, the patient was discharged to his home in stable condition (p. 89).

Robertson and Peterson justify their claim of this being a model example of critical thinking by the success of the patient outcomes using elements of a nursing process as described by Lunney, (2009). They state:

The nurse demonstrated knowledge of the case as a whole by considering all the signs and symptoms. The antecedents of a search for understanding truth and the receptivity of critical thinking that feel safe are evident in the safe passage of the patient from the hospital setting to home. The consequences of verification of critical thinking through reasoning are seen in the nurse's final diagnosis and intervention on behalf of the patient (p. 89).

The above example includes all the hallmarks of good thinking using a linear problem solving approach, but does not engage the philosophical aspects that would be required for this to be a good model for critical thinking. Possible aspects that could have been considered were the nurse's agency to have "immediately called a doctor", who explains this error to the patient and how that is conducted, and practical operational constraints. There is no engagement with the underlying assumptions informing the nurse's actions.

In summary, critical thinking according to Cody, requires the ability to question the taken-for-granted assumptions that are informing any idea under scrutiny. Brookfield also argues that critical thinking demands of the thinker the ability to notice ideology, assumptions, power and hegemony. The ability to identify and question assumptions requires a reflective approach and so critical thinking is often considered synonymous with 'critical reflection'. The terms cannot be isolated. Critical thinking is not a matter of deduction and consideration of a just and reasonable outcome, but rather as Kincheloe (2000) argues, critical thinking is really "the ability of individuals to disengage themselves from the tacit assumptions of discursive practices and power relations in order to exert more conscious control over their everyday lives" (cited by, Brookfield, 2005, p.12).

The teaching and learning of Critical Thinking

Alongside the challenges of a definition for critical thinking has been the debate about how it is learned and how it should be taught. This debate has centred around generalist versus specificist perspectives on critical thinking. Philosophical and educational debate surrounding the transferability of critical thinking appears to dominate these debates. Brookfield (1991) advocates for a generalist approach, for critical thinking to be taught as a discipline in its own right and not within a specific discipline. He states:

> *"teaching critical thinking from within a single intellectual tradition can be a grave tactical error which may actually be counter-productive to the development of critical thinking among the many learners ignorant of, or prejudiced against, this tradition"* (p. 7).

When thinking critically, it is important to be willing to use and apply the thinking of many traditions as appropriate. Brookfield maintains this "can be interpreted from the viewpoint of someone developing a situated, practical theory of critical thinking as a matter of tactics and strategy" (p. 7)

Ennis (1992) also argues that critical thinking is a generic skill. He maintains that critical thinking is a "reasonable reflective thinking focused on deciding what to believe or do" (p. 22). "Critical thinking is the correct assessing of statements" (Ennis,1962, cited by, Moore, 2004, p. 5). Ennis maintains that the skills of critical thinking and the attitudinal characteristics required in any critical thinking activity can be taught separately from specific subject matter. His reasoning for this is based on the belief that the skills and attributes of a critical thinker can be learned as a way of thinking in itself and applied across all disciplines (Ennis, 1992). Moore (2004) elucidates and identifies some of the extensive critical thinking skills that Ennis (1962) maintains are essential for correctly assessing statements. These include " grasping the meaning of statements; judging ambiguities, assumptions or contradictions in reasoning; identifying necessary conclusions; assessing the adequacy of definitions; assessing the acceptability of alleged authorities" (Moore, 2004, p. 5). Whilst Ennis acknowledges that differing levels of thinking may apply in differing situations, he maintains that critical thinking skills "exist as a set of independent cognitive abilities which can be taught in relation to any propositional content" (cited by Moore, 2004, p. 5).

McPeck (1992), from a specifist perspective, believes critical thinking is always contextual and intimately tied to a particular subject matter. Whilst acknowledging there are "some very limited general thinking skills" he maintains "…..these skills offer very little to get excited about" (p. 202). He believes that:

> *Critical thinking, like any thinking, is necessarily connected to particular objects of thought. And because these objects of thought can and do differ enormously in scope, quality and variety, I claim that there can be no one general skill or limited set of skills (including formal logic) that could do justice to this wide variety of object of thought"* (p. 202).

Moore (2004), in reviewing McPeak, claims his focus for critical thinking is the notion of 'reflective scepticism' applied to the subject matter being scrutinised. Most importantly, McPeak believes this can only be achieved in a particular domain. The ability to think critically in any domain depends on the thinker having specific knowledge and understanding of content pertinent to the domain under scrutiny. The skills of critical thinking, therefore, cannot be transferred to another domain because different understanding and knowledge will be required in order to apply critical thinking appropriately in each domain (Moore, 2004).

Finally, Moore (2004) identified that as part of their undergraduate degree students from his Australian university "negotiate a wide range of subjects and associated modes of thought—and they usually manage to do this without too much difficulty" (p. 14). He claims that there may be a place for a weaker relativist position rather than an either/or generalist or specifist view. Moore (2004) uses the work of Ballard and Clancy (1995) and Taylor (2000) to reinforce the claim that disciplinary knowledge is always required as a first step for critical thinking, and following this, may have transferable aspects for learning in other disciplines. Moore's concern about the generalist approach to critical thinking is that the:

> *…. positivist terms of this approach; that is, by drawing on a number of general critical thinking heuristics, we can arrive at definitive and final judgements about the rightness and wrongness of propositions, about the correctness and incorrectness of solutions, and about the validity and lack thereof of ideas…. this is far too restrictive notion of critical thinking practices, one has the potential to limit the possibility of dialogue and close down the possibilities of other types of knowledge and critique* (p. 17).

Moore (2004) argues for "plurality" of thought and the importance of bearers of disciplinary knowledge coming together to challenge the basis of thought. For this type of critique to occur, subject knowledge alongside appropriate methods of inquiry are required. "The critical thinking movement, by seeking to establish a site where truth is in some sense unproblematic – a village of truth as it were – does little to advance the potential for dialogue" (p. 17). Clarifying his position he elucidates, "whilst there is unlikely to be any harm for students participating in general thinking programs, it is probably misplaced to imagine that the ideas about critical thinking promoted in them can provide a comprehensive foundation for the many different problems and contexts students will encounter in their studies" (Moore, 2011, p. 263).

Moore's (2011) concern regarding the on-going debate about the generalisability of critical thinking stems from his belief that in the main the debates have been conducted in an abstract way. "The problem with much of the debate…… is that it has tended to occur largely in some 'vitrinous' realm, detached from the domains in which critical thinking actually needs to be applied- that is, in the life-world of the courses that the students actually study" (p. 266). In order to address this concern Moore (2011) conducted a study looking at critical thinking across 3 discipline areas. The findings from this study suggest there is a "diversity of ways students need to be critical in their studies" (p. 271). Moore argues that critical thinking "refers to a multiplicity of practices, ones that are rooted in the quite individual nature of the different disciplinary

language (and thinking) games (p. 271). He drew on the thinking of Wittgenstein (1958), who claimed that most philosophical disputes exist due to each discipline presenting arguments claiming a definitive truth. Wittgenstein reminded us that language does not permit such a possibility. Language assumes various meanings dependant on the context in which it is being used (Moore 2011). The implications for critical thinking appear clear for Moore (2011), that teaching generalised critical thinking skills will not prepare students for the unpredictable and dynamic world their disciplines reside in. They need to be immersed in the thinking and language of their discipline and from here "consider (and to compare) the distinctive critical modes of their study" (p. 274).

Brookfield (2011) would agree that students need to be aware of the knowledge claims and the assumptions of the experts within their fields of study. Uncovering the assumptions in what the discipline holds as "legitimate knowledge" (p. 28), he sees as a generalisable notion of critical thinking across all disciplines. At the heart of this knowledge is the language used to describe concepts. Brookfield refers to this as the "grammar of the subject" - a term first coined by Peters in 1973 (p. 28). The grammar of the subject is then further defined as "content grammar the building blocks of the subject that every student needs to know ……" and the "…epistemological grammar of a subject… "Which "…. refers to the processes by which we determine disciplinary knowledge to be true" (p. 28). Cody's (2002) belief that nursing needs to move from a pseudo critical thinking perspective to one which embraces a more philosophical connection to nursing theory could address this issue for nursing. However critical thinking works at its best, Brookfield (2011) believes, when all thinking traditions work to inform each other.

This certainly resonates for nursing practice, given the complexity of the landscape in which nursing practice is carried out. Nursing pulls its theoretical base from many disciplines and while it may be considered holistic in its approach, authors will argue that the theoretical base is predominately from a scientific methodology (James, 2010). This being so, it is not surprising that nursing has focused its critical thinking in a deductive and objective way. The increasing complexity of nursing has meant nurses engage in "high stakes decisions" (Kaddoura, Van-Dyke & Yang, 2016, p. 350). The outcomes of critical thinking in supporting these decisions can have implications and consequences for the person in care and the nurse.

Are critical thinkers really wanted in nursing, in a health care environment that values technical rationality? Critical thinking is potentially hampered in a nursing world of policies and protocols. Benner, Hughes and Sutphen (2008) draw attention to one such consequence of technical rationality (although they do not name this as such); the "… tension and confusion that emerges when standing orders exist in practice traditions such as nursing and medicine" (p. 4). Practices such as standing orders are not routinely questioned as they stem from examined knowledge based on sound research and evidence.

As Schon (1987) claims, technical rationality is based on a positivist perspective and "… holds that practitioners are instrumental problem solvers who select technical means best suited to

particular purposes. Rigorous professional practitioners solve well-formed instrumental problems by applying theory and technique derived from systematic preferably scientific knowledge" (pp. 3-4).

Potential professional, organisational and political practices that may influence critical thinking in nursing

The wide-ranging elements that contribute to effective critical thinking are potentially informed and influenced by many factors. This research project aims to examine some of the major factors. This section reviews literature that has identified some of these.

Professional disciplinary knowledge and identity

Caring is argued to be the mainstay of what defines nursing practice and pivotal to nurses professional identity (Sargent, 2012). Articulating Nursing as a profession has led the way in the "professionalization of care" (Kirkman, 2005). As a construct defining caring is problematic not only at a conceptual level but also in determining what it means to care. Nursing has endeavoured to qualify the definition by de-emphasising that which can be done by anyone and focusing on the more technical, specialised notions of care (Kirkman, 2005).

According to DalPezzo, (2009) "Nursing care is a skilled, safe, high quality, holistic, ethical, collaborative, individualised, interpersonal caring process that is planned and designed based on the best evidence available, and results in positive patient outcomes, optimisation of health, palliation of symptoms, or a peaceful death" (p. 261). The values and beliefs inherent in the professional guide their thinking and informs their professional identity. As a concept defined in this way, the discourse of care can be seen to be socially determined, i.e. defined by social practices and also defining social practice (Fairclough, 2010).

Any decisions a nurse makes in practice will be informed and affected by their professional disciplinary knowledge and their professional identity. The two concepts are inextricably linked. Fawcett and Desanto-Madeya (2012) state that nursing is a distinct discipline with a discrete body of knowledge that underpins the practice of nursing. This knowledge is derived from philosophical and theoretical assumptions about what nursing is and does (p. 9).

Professional identity in nursing is defined by Fagermoen (1997) as "the values and beliefs held by nurses that guide her/his thinking, actions and interactions with the patient" (cited by ten Hoeve, Jansen & Roodbol, 2013, p. 303). The provision of safe, appropriate and patient responsive nursing care requires both the ability to utilise disciplinary knowledge and the professional self-confidence to use this knowledge.

In defining the term professional discipline, Smith and McCarthy (2010) draw on Donaldson and Cowley (1978) and maintain that certain characteristics are deemed essential, stating "…each disciple offers unique perspective and has a distinct, identifiable body of knowledge that is developed studied and advanced by its students and members" (p. 44). Alongside this is the requirement that this knowledge has a purposeful benefit to society.

An important distinction made by Smith and McCarthy is the separation of the practice informed by professional disciplinary knowledge and that of technical practice. This echoes the view of sociologists Jamous and Peloille (1970), who identify professional work as encompassing a … "combination of technically definable activity and the formation of professional judgment". They name these two activities 'technicality' and 'indeterminacy' and argue that professionalism is distinguished from other occupations as there is a higher proportion of indeterminacy than technicality within their work. The indeterminate aspect of the work demands a professional call on knowledge, both tacit and experiential, to make practice judgments (cited by Traynor, Boland & Buus, 2010). Smith and MacCarthy (2010) maintain that professional knowledge is derived from "….philosophies, ethics, theories, research and the art of the discipline" (p. 44). Of particular importance for this research is the attention they call to the "diversity of theoretical perspectives" that inform nursing's disciplinary knowledge. This offers a challenge to the rigorous critiquing of evidence within nursing practice because multiple theoretical perspectives need to be critiqued prior to settling on which evidence might best fit a clinical situation.

Alongside this discrete body of knowledge, a profession is also defined as having the ability to make autonomous decisions and have control over the field of work (Traynor, Boland & Buus, 2010, p. 1584). This is an expectation within the scope of practice for a NZ Registered Nurse (NCNZ, 2012a). Within the NCNZ Domains of Competence, nurses' professional disciplinary knowledge underpins the ability of a nurse to meet competency. In addition NCNZ states that registered nurses must "… practise independently and in collaboration with other health professionals, perform general nursing functions and delegate to and direct enrolled nurses, healthcare assistants and others" (NCNZ, 2012a, p. 13).

In order for nurses to make clinical decisions in an autonomous manner, professional confidence is essential. This involves not only the ability to critically think, but also a clinical context which enables it.

Professional knowledge and judgement

Eraut (1994), an English educationalist, maintains that professional judgement allows the practitioner, in the face of uncertainty, to apply their learning from many experiences to make 'good' judgements. He identifies two different components involved in professional knowledge and judgement, these being propositional knowledge and process knowledge.

Within propositional knowledge Eraut (1994) differentiates three subcategories. Firstly, knowledge based on discipline specific theories and concepts, secondly the ability to generalise and engage practical principles within a discrete professional arena and finally the ability to formulate "specific propositions about particular cases, decisions and actions" (p. 103).

Of importance for this study is Eraut's citing of Hirst (1985) in identifying the importance of a critical perspective when "judging the validity of a profession's generalisations and practical

principles" (p. 103). Thinking critically about the knowledge informing an action is an essential ingredient within professional judgement. Professional judgement requires not only a 'technical rational' approach when considering the theoretical knowledge to be employed in any action but also an interpretative approach. Thinking critically becomes essential for determining what knowledge is most useful.

In contrast, process knowledge, while informed by, and dependent on, propositional knowledge, differs and Eraut calls on Ryle's (1949) distinction between 'knowing what' and 'knowing how' (p. 107). Eraut identifies process knowledge as how to perform as a professional. For Eraut, process knowledge in professional work involves five components: "acquiring information, skilled behaviour, deliberate processes, e.g., planning and decision making, giving information and metaprocesses for directing and controlling one's own behaviour" (p. 107). Being able to call on propositional knowledge to enable professional work is essential.

In a similar vein, Benner et al., (2008) delineate between the technical rational approach and the more undetermined aspects of professional knowledge. They refer to the work of Aristotle in distinguishing between 'techne' and 'phronesis'. Citing Dunne (1997), Benner et al., maintain that techne refers to "the making of things or producing outcomes" (p. 91). Kinsella and Pitman (2012) draw on the work of Flyvbjerg (2001) to define Aristotle's notion of techne, determining it to be a "…context-dependent, pragmatic, variable, craft knowledge and is oriented toward practical instrumental rationality governed by a conscious goal" (p. 2). They maintain that this construct is understood in modern terms as "technique, technical and technology" (p. 2).

The concept is further defined by Dunne (1997), in claiming that techne is "the activity of producing outcomes and it is governed by a means-ends rationality where the maker or producer governs the thing or outcomes produced or made through gaining mastery over the means of producing the outcomes, to a point of being able to separate means and ends" (cited by Benner et al, 2008, p. 91). The ability to apply standardised and universal principles to clinical situations is predicated on this belief that there is a predetermined rational and predictable outcome available to an experienced clinician.

However, this is not the case for most of the work of a nurse, given the indeterminate and complex nature of clinical practice. The need to respond to uncertainty, complexity and unique clinical circumstances requires a nurse to call on professional knowing learnt thorough practical reasoning. Benner et al., (2008) identify this as phronesis. It includes "reasoning about particular, across time, through changes or transitions in the patient's and/or clinician's understanding. (p. 91). Kinsella and Pitman (2012) interpret Aristotle's notion of phronesis to mean "…an intellectual virtue that implies ethics. It involves deliberation that is based on values, concerned with practical judgement and informed by reflection. It is pragmatic, variable, context-dependent, and oriented toward action" (p. 2).

Benner refers to this type of reasoning as a "…form of puzzle solving or the evaluation of immediate past "hot" history of the patient situation" (p. 91). When engaging in clinical

reasoning in this way, it is essential that the nurse be mindful of the clinical parameters in which they are working in order to ensure "good practice". According to Benner et al., (2008) nursing requires both techne and phronesis, valuing both the ability to employ rationales, calculations, standards and procedures alongside the more indeterminate professional reasoning required to provide appropriate care.

Competent practice

Nurses practising within NZ are required, each year, to demonstrate that they meet all the Domains of competency as defined by the NCNZ (2012a). Assessing competence is deemed to be necessary to maintain professional standards, ensure accountability for professional practice and to offer a means to measure quality and cost effectiveness of a nurse's performance (Fordham, 2005; Manley & Garbett, 2000). However, defining the exact nature of nursing competence is difficult. Several divergent and confusing definitions have been offered (Cowan, Norman, & Coopamah 2005; Fordham, 2005; Girot, 1993; McMullan et al., 2003). Tensions arise due to inconsistencies in the terminology used within definitions of competency and the characteristics inherent within the notion of competence (Fordham, 2005).

NCNZ (2012a) offers definitions to guide how competency is to be articulated and assessed within a New Zealand context. They maintain that competence is "….The combination of skills, knowledge, attitudes, values and abilities that underpin effective performance as a nurse". That to be competent a "… person has competence across all domains of competencies applicable to the nurse, at a standard that is judged to be appropriate for the level of nurse being assessed. Finally competency is "… A defined area of skilled performance" (p. 32). Despite definitions existing for determining such competencies, scholars argue that the unpredictable and indeterminate nature of professional nursing practice challenge the usefulness of competency based assessment and that critical thinking and critical reflection are required within competency assessment as means of assessing nursing practice in a holistic manner (Cowan, Norman, & Coopamah, 2005; Fordham, 2005; Gardner, et al., 2008; Girot, 1993; Watson, et al., 2002).

Reeves, Fox and Hodges (2009) provide a useful review of the tensions surrounding the use of competency frameworks and highlight some significant concerns. One of these is the potential for competency approaches to limit constructs such as the components involved with critical thinking and reflection. Another concern is that the frameworks focus on task mastery and outcomes that encourage a reductionist approach to measuring practice by privileging techno-rational aspects and discounting practice complexity. In addition they signal a concern about how competency frameworks are developed. They state that;

> *Even when the development of competencies involves large samples of practitioners, participating clinicians are usually required to rate or comment on a pre-determined menu of best practice options, created again, by professional experts and leaders. While such processes convey a sense of legitimacy and rigor, they nevertheless reflect*

and reinforce the current thinking of a limited few who occupy dominant professional positions (p. 452).

While these frameworks offer a discipline the ability to define their profession and identify the activities that make up the profession, they also have the capacity to normalise and set parameters about what is legitimate nursing practice. Opportunities to engage in critical thinking and facilitate innovative or emergent responses for the delivery of robust nursing practice can become constrained or disabled.

While the ability to apply critical thinking (or critical reflection) to nursing practice is considered essential for a nurse to demonstrate competence, as a construct this is difficult to measure (Cowan, Norman, & Coopamah, 2005; Girot, 1993; May et al., 1999). Due to the difficulty in defining critical thinking and assessing it within competency assessment, as identified above, practitioners often focus on the more readily measurable aspects of their practice to demonstrate competence. By doing this, the technical and more easily quantifiable aspects of nursing practice will be privileged over the less tangible aspects of nursing practice.

Evidence-based practice

Of significant concern for this study is the determination of what evidence a nurse should follow for safe, effective and patient-responsive nursing care. The significance of the impact of evidence based practice (EBP) on nursing decision making is clear. EBP is supported by research and by professional and organisational practice via guidelines, procedures and protocols, rules and regulations. It is, most importantly, sanctioned as an expectation of competence within the NCNZ scope of practice.

The EBP movement has become the dominant means by which clinical decisions within health care are determined (Porter & O'Halloran 2008). Sackett, Rosenburg, Gray, Haynes, and Richardson (1996) who are considered to be the most influential advocates of EBP, define evidenced-based medicine (EBM) as 'the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients'(p. 71). In qualifying this definition, they highlight the need to integrate practitioners' clinical expertise and research-based clinical evidence alongside the "….thoughtful identification and compassionate use of the individual patients' predicaments, rights, and preferences in making clinical decisions about their care" (p. 71). A review of nursing definitions for EBP finds them echoing this definition (see Profetto-McGrath 2005).

Mulhall (1998) draws on the work of Sackett et al. in defining EBP for nursing. "Evidence based care concerns the incorporation of evidence from research, clinical expertise, and patient preferences into decisions about the health care of individual patients" (p. 5). Fineout-Overholt, et al., (2005) purport that when EBP is utilised within a 'context of caring' it facilitates sound

clinical decisions and optimal patient outcomes are enabled. The value of EBP for safe and effective nursing care and improved patient outcomes is well supported in the literature (Brady & Lewin, 2007; Fineout-Overholt, et al., 2005; Mantzoukas, 2009; Mulhall, 1998; Peterson, et al., 2014) and there are journal articles, on-line sites and best practice sheets dedicated to support the adoption of EBP within nursing (see, The Joanna Briggs Institute, Ebsco Nursing Resources (evidence-based practice sheets), Cochrane database of systematic reviews).

Advocates of the EBP movement maintain that all of the components of EBP have equal importance; good evidence involves the integration of evidence from robust research, the expertise and experience of a competent practitioner, alongside the values and desires of the patient (Bradley & Lewin 2007). Furthermore DiCenso, Guyatt and Ciliska (2005) call attention to important skills required by nurses for effective application of EBP. A nurse must be able to

> *…define a patient problem precisely and ascertain what information is required to resolve the problem, to conduct an efficient search of the literature, to select the best of the relevant studies, to apply the rule of evidence to determine their validity, to extract the clinical message, to determine how the patient's values affect the balance between advantages and disadvantages of the available management options, to involve the patient appropriately in the decision, and to implement and evaluate the management plan* (p. 6).

Nurses are required to think critically in order to achieve EBP in this way, and as such, critical thinking is seen as essential for supporting rigorous evidence-based practice (Jones, Crookes & Johnson, 2011; Profetto-Mcgrath, 2005).

Mulhall (1998) identified the need to ensure that EBP in nursing is distinct from EBM. Nurses "…need to be clear as to what nursing is, and what nurses do before we can identify the types of evidence needed to improve the effectiveness of patient care" (p. 4). Nurses need to call on "many different ways of knowing and many different kinds of knowledge ……" Knowledge, or evidence, for practice thus comes to us from a variety of disciplines, from particular paradigms or ways of "looking at the world", and from our own professional and non-professional life experiences (Mulhall, p. 5). In saying this, Mulhall draws attention to the usefulness of scientific and economic evidence, but cautions that nurses and those in care will need other evidence to address concerns that cannot be answered by scientific and economic evidence.

Rolfe (1999) applauded Mulhall's attempt to caution nursing to be wary of adopting EBM into nursing EBP and her position that nursing should use EBM on its own terms. However, he signalled a concern that adapting EBM is not beneficial to nursing practice and to those seeking nursing care. He argues that EBP has been dominated within nursing by research evidence to the detriment of practitioner wisdom and experience. He also argues that the application of EBM within nursing "…has seen a regression back to what Schon (1983) described as the technical rationality paradigm of practice based solely on the findings of quantitative research" (Rolfe 1999, p. 434). Rolfe calls for nursing to base their EBP on a "…model of reflective practice rather than on a model of research-based practice" (p. 434). This highlights the

importance of nurses to employ critical thinking within their decision making processes. Appropriately managing information between competing knowledge claims to ensure robust nursing care requires the questioning of taken-for-granted assumptions inherent in both.

Managing competing knowledge claims also requires the ability to recognise ideological processes that enable some processes and silence others. Holmes, Perron, and O'Bryne (2006) argue EBP contains a hierarchy of knowledge which disables approaches to healthcare by determining what evidence is worthy and what is not for best practice. They believe EBP enables "a system of exclusion of evidence that does not align with the dominant discourse" (p. 98). Glasby, Walshe and Harvey (2007) concur, maintaining that where the evidence for practice comes from qualitative studies, practitioners' experiential knowledge and the 'lived experience' of those receiving care is subjugated by the evidence from quantitative research methods. They maintain that evidence is subjected to a system of hierarchy in which 'traditional research', systematic reviews and randomised control trials are situated at the top.

This is also clearly evident within nursing from the work of Petersen et al., (2014). They present the Level of Evidence table from Polit and Beck (2012) and the Evidenced-based Care Pyramid from the American Association of Critical Care Nurses (2012). In both of these models, experimental research sits at the top and qualitative research at the bottom. Patient experience isn't mentioned, and professional experience requires quantitative measures to be used as a recommendation for EBP (p. 62).

Structuring evidence in this way has benefits for organisations with a focus on cost containment and standardisation of care. Glasby, Walshe and Harvey (2007) maintain that "traditional notions of evidenced-based approaches" that focus on quantitative methodologies, are attractive because they have "relatively simple 'rules' as to what constitutes valid evidence, how to judge quality and how to synthesise findings" (p. 325). This is attractive because it simplifies what needs to be considered in decision making by placing well defined parameters around what we need to know about the world. This simplicity is seductive. It enables a 'focus on effectiveness' as a priority of decision making which is desirable in health systems which want services based on 'best evidence' and 'best value for money' (Glasby, Walshe & Harvey, 2007). However, Glasby et al., caution that effectiveness is not the only measure of importance within health care. Given the complexity within the provision of health and social care practice, other factors such as "…acceptability, appropriateness, and access" warrant attention (p. 326).   In light of this, they facilitated a seminar series involving, researchers, policy makers, managers, practitioners and service users to address the need for a more comprehensive approach to what constitutes evidence in EBP. The findings from the seminar highlighted that, due to the diversity of questions in health and social care, a diverse range of evidential approaches was required. However, agreement about the need for this diversity was not universal and unsurprisingly in some cases there remain irreconcilable differences (Glasby, Walshe & Harvey, 2007).

Eighteen years on from Rolfe's (1999) concern regarding this dominance of EBP on nursing practice, it appears that his concerns are justified. Quantitative evidence continues to be privileged over other forms of evidence and these impact on practitioner and patient knowing when deciding the best evidence for consumer care. This is of concern to a profession such as nursing which relies, as Mulhall claims, on incorporating many ways of knowing for providing effective nursing care (Mulhall, 1998).

NZ Healthcare context

In 2009 the NZ government signalled a change in health policy. The intention of this policy, named "Better, Sooner, More Convenient in the Community" was to streamline the health service, creating a system in which the population of NZ would experience a coherent flow between all health services- whether this is in the primary, secondary or tertiary area (Ministry of Health, 2011). This endeavour relied not only on improved co-operation and communication across the sectors, but also amongst healthcare workers.

A central tenet of the policy was a drive to keep people healthy and living well in the community. There was an underlying assumption that individuals will become actively engaged in maintaining and improving their health. The patient is at the centre of healthcare practices and the healthcare workforce is responsible for working with the patient to achieve healthy outcomes for their patients. To achieve such an outcome requires "a move away from an isolated professionally dominated top-down approach" to a collaborative approach across the healthcare system (French, 2010, p. 249). This is a challenging proposition given the continued historically positioned power and control the medical profession holds within our healthcare system and in relation to other healthcare professionals such as nurses.

A caution has also been sounded by French (2010), who identifies this type of policy as 'New individualism' which has the potential to blame the system, or healthcare protagonists if they fail to deliver services that individuals require for achieving healthy lives (French, 2010).

A government, via neoliberal ideology, has the ability, through the use of one-size-fits-all policies to regulate the conditions by which citizens can exercise their autonomy and freedom of choice. Duncan (2007) maintains that neo-liberal policies "*seek to govern by means of the free-market*" (p. 195, italics in source). A free-market approach is believed by neo-liberalists to enable more efficiency and responsiveness to consumer demands. What may appear as a hands off governmental approach is however not the case. Through the mechanisms available within a free market, governments can enforce "cost control (through competition) and obedience to policy objectives (through purchasing agreements and contracts) among the providers of health and social services" (p. 195).

Rose and Miller (2010) claim that when governments apply a market driven approach to the provision of healthcare, the power for decision making becomes located within management frameworks rather than with health experts. Their position is worth quoting in full:

> *Monetarisation has played a key role in breaching the enclosures of expertise within the machinery of welfare. For example, when contemporary British hospitals are required to translate their therapeutic activities, from operating theatres to laundry room, into cash equivalents, a new form of visibility is conferred upon them, new relations established and new procedures of decision making made possible. As we have already argued, making people write things down, and the nature of the things people are made to write down, is itself a kind of government of them, urging them to think about and note certain aspects of their activities according to certain norms. Power flows to the centre or agent who determines the inscriptions, accumulates them, contemplates them in their aggregated form and hence can compare and evaluate the activities of others who are merely entries on the chart. Managers rather than consultants become the powerful actors in this new network, and power flows from the cabinet office to the operating theatre via a multitude of calculative and managerial locales, rather than in the other direction. This is not an attempt to impose a power where previously none existed, but to transform the terms of calculation from medical to financial, and hence to shift the fulcrum of the health network. Far from autonomizing the health apparatus, these new modes of action at a distance increase the possibilities of governing it* (p. 298).

The government is enabled in this way to exercise powerful control and influence via contracts and funding to direct the provision of healthcare. Organisations wishing to access governmental funds need to comply with centralised policy and compete for contracts.

In keeping with this agenda, the "Better, Sooner, More Convenient in the Community" policy aim is to increase support and management of people with chronic conditions in the community, and so reduce the pressure on the secondary and tertiary health service. The government has signalled that this policy is designed to 'deliver more care within available resources' (Ministry of Health, 2011, p. 4). This statement signals a desire by the government to get more efficacy and efficiency from health funding and for the changes to be implemented at no extra cost. Litchfield and Jonsdottir (2008) alert nurses to the effects the health care environment has on the disciplinary knowledge of nursing. They maintain that healthcare systems around the world are 'shaped' by the need to be resourceful and contain costs, particularly in the light of technological advances that offer more healthcare options for curative and preventative treatments. They state "…the health missions of service providers/funders define the nature of the work of nurses as employees to be managed as part of their pool of resources" (p. 79).

Traynor, Boland and Buus, (2010) in an English study of nurses' professional identities, identified similar tensions on nurses' decision making abilities. They noted that nurses moderated between technical nursing activities (policies and guidelines) and indeterminate features (intuition and instinct) in making decisions by using practice experience. The ability to moderate decisions in this way was disrupted by "heavy workloads and other contingencies of daily work" (p. 1590). Their research identified the potential impact organisational structures such as workload allocation and resources have on nurses' decision-making processes.

The shift to care for more people at home and in their communities has been met with substantial support in the UK (Bond & Holland, 2010). According to Watkins (1993) "The purpose of community care is to promote privacy, dignity and independence and provide resources for living. It is a philosophy, not a place" (p. 436). The notion of community care, however, is potentially problematic and should not be done without the resources to do so. Bond and Holland (2010) report the British experience of the NHS and the Community Care Act 1990. The community care aspects of the act have received negative reviews across the board due to the lack of resources provided to implement community care. They highlight the pressure healthcare practitioners are exposed to in a system that set out to integrate and streamline patient care, and fell well short of the mark (Bond & Holland, 2010).

In the NZ Primary Health Care Strategy (King, 2001), the role and scope of nursing was signalled. The need for nurses to have advanced knowledge and skills facilitated by national education and career frameworks was seen as "crucial to the implementation of the Strategy" (p. 23). This expectation continued with the current Better, Sooner, More Convenient in the Community policy because there is a requirement for nurses to continue advanced education, deliver more specialised care, increase team work, and work in ways which ensure a coherent flow for the public between healthcare services (Ministry of Health, 2011).

Meeting the increasing expectations signalled in both of these policies impacts on the role nurses will have in the provision of healthcare to the New Zealand population and warrants increased professional support. This is particularly so given the Minister's expectation that these changes will occur within the existing resources. Streamlining and integrating services to offer more care to people with chronic conditions in the community will place more burden on nurses both in terms of delivering and leading care initiatives. Increased support for nurses' practice development and professional identity, in the face of these expectations by enhancing critical thinking and decision-making to meet the population's health needs is therefore worthy of investigation.

Chapter summary

It is clear from the literature that critical thinking underpins professional practice by supporting nurses to provide safe, appropriate and patient responsive nursing care. The ability of nurses to think critically enables them to make clinical decisions in an autonomous manner. The ability to practice in this way is considered the hallmark of a competent practitioner and requires professional confidence. It also depends on having a clinical context which enables critical thinking to occur. There are multiple professional, organisational and political discourses that influence critical thinking within practice contexts and consequently influence nursing practice. An investigation into the impact of these discourses is warranted. The next chapter presents the methodology and methods employed to conduct this critical discourse analysis.

Chapter 3:   Methodology and Methods: Critical discourse analysis [CDA] and the power of language

"…the power to control discourse is seen as the power to sustain particular discursive practices with particular ideological investments in dominance over other alternative (including oppositional) practices" (Fairclough, 1995, p. 2)

The aim of this chapter is to present the theoretical and methodological framework that informed the methods used in this study. Within this section the CDA process adopted in the study is explained and also the specific analytical tools used in order to analyse the selected texts and provide a contextualised interpretative analysis.

The chapter is divided into four parts. Each part discusses the methodological approaches that were adopted and identifies their appropriateness for this research study. In Part One, critical discourse analysis is explained and contextualised. The CDA approach utilised in this research was informed by the work of Fairclough (1992, 1995, 2001 and 2003) and Huckin (1997). Part Two outlines critical social theory and a social constructivist approach with their application to the research. Part Three reviews the methods and procedures employed to collect analyse and present the findings from the research. In Part Four, an overview of research rigour and trustworthiness is provided.

Critical Discourse Analysis

Introduction

Critical discourse analysis, which is a research approach that is used across a wide range of disciplines, is not considered a single methodology but rather a collection of methodological approaches (Fairclough, 2001; Huckin, 1997; van Dijk, 2001; Wodak 2001). CDA originates from critical linguistics and critical theory (Blommaert, 2005). Fairclough (2001) maintains that CDA has its roots in critical social theory, specifically Marxist thinking from the Frankfurt School. CDA is influenced by Gramsci (1971) and his notion of hegemony, by Althusser (1971) with his notion of ideology and by Habermas's (1984) communication-based version of critical theory for emancipation. CDA is also influenced by the French philosopher Foucault's ideas about discourse as systems of knowledge. In addition, CDA is informed by Bakhtin (1986), a Russian sociologist, whose theory of historical structuralism defined language as social communication and by Halliday's (1978) structural linguistics for the analysis of texts (Fairclough, 2001; Phillips & Jorgenson, 2002). Linguistic methodology is considered crucial to CDA because it provides the means with which CDA researchers can analyse the way in which texts relate to, and create, social meaning (Blommaert, 2005). Fairclough (1995) believes the application of a rigorous linguistic analysis is essential in any robust CDA endeavour and argues for a systematic and consistent approach to this work.

CDA is argued to be interdisciplinary (Fairclough 2001; Wodak 2001). In defining the interdisciplinary nature of CDA, protagonists maintain that CDA requires differing theoretical perspectives to work together and inform each other within the research. Chouliaraki and Fairclough (1999) state:

> *We see CDA as bringing a variety of theories into dialogue, especially social theories on the one hand and linguistic theories on the other, so that its theory is a shifting synthesis of other theories, though what it itself theorises in particular is the mediation between the social and the linguistic – the 'order of discourse', the social structuring of semiotic hybridity (interdiscursivity). The theoretical constructions of discourse which CDA tries to operationalise can come from various disciplines, and the concept of 'operationalisation' entails working in a transdisciplinary way where the logic of one discipline (for example sociology) can be 'put to work' in the development of another (for example, linguistics)* (p. 17).

In addition, CDA is "critical" due to the attention paid to concepts of ideology, hegemony and reification. Through the analysis of discourses, there is a commitment to identifying power and ideology to uncover the taken-for granted assumptions that are informing the particular way meanings are conveyed within the discourses.

Fairclough (1995) maintains that "the power to control discourse is seen as the power to sustain particular discursive practices with particular ideological investments in dominance over other alternative (including oppositional) practices" (p. 2). He understands ideology to be "…. significations/constructions of reality (the physical world, social relations, social identities), which are built into various dimensions of the forms/meanings of discursive practice, and which contribute to the production, reproduction or transformation of relations of domination" (Fairclough, 1992, p. 87).

Fairclough (1995) also maintains that ideology is located within discourse in both "language structures" (form and style) and "language events" (actions) and both must be analysed in order to fully examine ideological effects (p. 70). Arguing that while the way language is structured may adhere to particular ideological processes, this does not mean that the ideological position offered will be interpreted and taken up as intended. In addition, analysing only the language event itself, and not the language structures, while allowing an analysis of how ideological positions can be transformed by interpretation, lends the analysis to "… an illusory view of discourse as free processes of formation unless there is simultaneous emphasis on structures" (Fairclough, 1995, p. 71). "To research meaning-making, one needs to look at interpretations of the texts as well as texts themselves, and more generally how texts practically figure in particular areas of social life …" (Fairclough, 2003, p. 15).

For Huckin (1997), whose interpretation of Fairclough in part informs my work, this means the text is interpreted not only as "words-on-the-page" but includes how the words translate into particular social contexts. This interpretation will not be universally held, because consumers of the text may differ in the meaning attributed to the text. "Words and actions operate

'discursively' in the sense that they are subject to, and only meaningful within, a wider social and political discourse that sets boundaries about how people understand what is reasonably thinkable, practically possible or ethically acceptable" (Duncan, 2007, p. 2).

Researching meaning-making in this way requires the texts to be analysed as part of the social context in which they exist. This involves calling on the appropriate theoretical lenses required to critically examine the multiple discursive factors that impact the nurse's practice in relation to being a critical thinker.

Defining discourse

One of the most challenging aspects of this study was identifying a solid theoretical process for defining and then identifying discourse. Cheek (2004) highlights the importance of clearly defining what is meant by discourse within any discourse analysis in order to provide theoretical rigour within the work. However, Alvesson and Karreman (2000, 2011) state that there is no consensus on what discourse means and how it is used, and suggest that the term is most often used by writers without defining or discussing what it means, thus glossing over a definition as if there is a general agreement on what it is.

While explanations of discourse have been provided in some studies, these are often vague and general and very difficult to distil in a manner that allowed a clear way into recognising and naming a discourse. In explanation, Burr, (1995), Cheek, (2004), and Weiss and Wodak (2003) argue that defining the concept "discourse" is problematic due to the complexity of the construct and as such it can be defined in various ways depending on the theoretical background of the definer.

Van Dijk (2011) agreed and acknowledged the frequent requests made to discourse scholars to offer a definition of discourse by offering ten major properties that have been "highlighted within decades of research in various areas of the field" (p. 3-5). The ten properties he identified are as follows:

1. Discourse is "… a form of social interaction" (p. 3). As humans socially interact they do so in ways that are considered appropriate based on shared understandings. These appropriate interactions create social order within societies.
2. Through the construction of social order, discourse offers positions of power and domination by way of "preferential access to and control over, public discourse" (p. 3). Access to public discourse by certain groups and not others gives rise to inequality.
3. "Discourse as communication": discourse offers the means by which "expression and communication of beliefs among language users occur" (p. 4).
4. Discourse is contextually situated: discourse occurs within our daily lives and provides the frameworks by which we understand, social situations, social identities, and how to

appropriately interact in any given social situation. These include across cultural contexts and may take account of historical influences.

5. Discourse is not limited to text and talk but includes all semiotic properties such as, gestures, art, and dance.

6. Linguistic analysis is of central importance in understanding discourse. The core property of discourse "…is undoubtedly the use of natural language as the unique human ability to produce and understand well- formed, meaningful and appropriate combinations of words, sentences or other rule-based language use" (p. 4).

7. Discourse is a "complex, layered, multidimensional object or phenomenon" (p. 4). It involves three interrelated aspects of natural language. The manner or form in which the words, sounds, pictures are presented, alongside the meaning and the social actions attributed as part of the discourse. The complex nature of these dimensions do not operate in isolation, "… well-formed discourse expressions are interpreted as meaningful and performed as appropriate social actions" (p. 4).

8. Discourse operates in sequences and hierarchies. The interpretation of discourse is navigated sequentially; the meaning of the text is detected through the staging of "sounds, words, sentences …" (p. 5). Each adding to the other and scaffolding understandings as they build on to each other.

9. Discourse may be studied in an abstract form, as an "object consisting of abstract structures" or as a "dynamic, changing sequence of events" (p. 5).

10. Discourse is presented in a variety of "types and genres" (p. 5).

Parker (1992) claims, "Discourses do not simply describe the social world, but categorise it, they bring phenomena into sight" (pp. 4-5). He argues that discourses enable something to become known; once a concept or object has been described within discourse it becomes 'real' to us. In addition, discourses will offer a method by which we attribute significance of a concept or object by offering "frameworks for debating the value of one way of talking about reality over other ways" (p. 5). Parker claims a useful "working definition" of discourse is "a system of statements which constructs an object" (p. 5). He further adds caveats to this definition by proposing conditions that are required in order to ensure rigour in identifying "objects". These conditions he refers to as seven criteria. In the first instance he claims discourse is found "at work in texts" (p. 6).

In terms of critical thinking, Rubenfeld and Scheffer (2015) state that critical thinking is required for "safe, effective and efficient care" (p. 10). It can therefore be argued that this narrative calls on professional and organisational discourses in order to provide meaning for critical thinking in terms of safety, efficiency and effective care. Parker (1992) claims, of importance here, in ascribing meaning to the text, is noticing the "connotations, allusions and implications that the texts evoke" (p. 7). Differing discourses will be recognisable to the reader depending on their frames of reference.

The second criterion is that "a discourse is about objects" (p. 8). In keeping with Foucault (1972) discourses are "practices that systematically form the objects of which they speak" (p. 49). Discourse offers us descriptions of objects and a way of talking about the objects. The language we use within discourse to describe critical thinking (discriminating, analysing, evaluating etc.) enables critical thinking to be objectified, and thus known.

Thirdly, "a discourse contains subjects" (p. 9). Parker maintains "A discourse makes available a space for particular types of self to step in. It addresses us in a particular way" (p. 9). Parker refers to Althusser (1971) and his notion of ideology and the power of discourse in calling on people to be a particular kind of person. In addition, the discourse offers how and what can be spoken and who has the rights to speak. Within the discourse of professionalism, critical thinking attributes of professional knowledge, judgment, and clinical decision making offer speaking rights to nurses as legitimatised health care professionals. For example, a nurse is enabled to offer professional advice about health practices such as vaccination and health screening to the public. They call on their professional knowledge, judgements and decision making to determine how this is to be appropriately done.

Fourth, "a discourse has a coherent system of meanings" (p. 10). Within a given cultural context, a discourse will consist of a coherent structure of statements that relate to the same topic. Parker acknowledges the statements may not be "watertight" and some may contradict each other. However the discourse will present a coherent "picture of the world" (p. 12). Fifth, "a discourse refers to other discourses" (p. 12). Discourses do not operate in isolation. Sixth, "a discourse reflects on its own way of speaking" (p. 14). And finally "A discourse is historically located" (p. 15). "Discourses are not static" (p. 15) important to locate the discourse in the context in which it emerged.

He adds three important "auxiliary criteria" (p. 17). These being that "Discourses support institutions (p. 17). They "… reproduce power relations" (p.18) and they "…. have ideological effects" (p. 19).

Within CDA, defining discourse also becomes important due to the interdisciplinary nature of the analysis and the requirement to analyse discourse within the wider social arena. For many CDA scholars, the work of Foucault (1972) is drawn on to understand discourse (Fairclough, 1995). Swingewood (2000) states that Foucault believed that "A discourse is everything written or spoken about a specific practice based on specialist knowledge and bodies of experts which has the effect of controlling those who lack knowledge ….." (p. 197).

Fairclough (2001) adds that "Discourses are diverse representations of social life which are inherently positioned- differently positioned actors 'see' and represent social life in different ways, as different discourses" (p. 123). Fairclough (1992) claims discourse provides us with our understanding of ourselves as social beings ("social identity and subject positions, for social subjects and types of self"), how we are to relate within social contexts ("construct social relationships between people") and constructs our understandings and beliefs via the

presentation of knowledge (p. 64). He notes that "discourse is a mode of action, one form in which people may act upon the world and especially upon each other, as well as a mode of representation" (p. 63). In addition, Fairclough maintains discourse both shapes and is shaped by the social world, "Discursive practice is both constitutive in both conventional and creative ways: it contributes to reproducing society (social identities, social relationships, systems of knowledge and belief) as it is, yet also contributes to transforming society" (p. 65). The use of critical thinking within nursing practice is enabled by how it is understood, used and sanctioned within practice. The understanding of critical thinking and the ability to use critical thinking will both shape and be shaped by multiple discourses.

Furthermore, Fairclough (1995) argues that discourses do not function in isolation from each other and that some discourses can dominate others. This occurs due to an unequal access to power. Protagonists of CDA maintain that power and control are unequal amongst societal groups (Fairclough 1995, 2001; Huckin, 1997; van Dijk, 2001; Wodak 2001). Power is unevenly distributed between those who are involved in particular discourses, and also in how discourses are developed, understood, and accessed.

Certain groups can claim "truth and rightness" with discourse via discursive closure. Deetz (1992) explained that discursive closure occurs when any source of conflict is prevented and can occur in several ways. The most common method is to prohibit group members from engaging in ways that could elicit conflict. Prohibition occurs by denying members the right to speak, preventing their access to the space to speak, sanctioning speaking only to those with particular expertise and denying members the knowledge and skills required to speak. Closure is also facilitated by privileging particular discourses and marginalising others. The dominance of the technical rational discourse and the limited involvement of nurses in the creation of policies, protocols and evidence-based best practice guidelines is an example of this.

Fairclough's CDA methodology

The methodological approach employed in this research is based on Fairclough's critical discourse analysis methodology (1992, 1995, and 2003). Fairclough (1995) uses a three-dimensional method to analyse discourse. He maintains that a three-dimensional approach is required because discourse operates 'simultaneously' at a textual level (spoken or written), within discourse practice (where texts are produced and interpreted) and within a social-cultural context. The approach offers the researcher an "*interpretation* of the relationship between the (productive and interpretative) discursive processes and the text, and *explanation* of the relationship between the discursive processes and the social processes" (p. 97). Fairclough believes that the link between the text and socio cultural practice is facilitated by discourse practice:

> *A special feature of the approach is that the link between sociocultural practice and text is mediated by discourse practice; how a text is produced or interpreted, in the sense of*

what discursive practices and conventions are drawn from what order(s) of discourse and how they are articulated together, depends on the nature of the sociocultural practice which the discourse is part of (p. 97).

Fairclough (2003) argues further that, for any robust analysis of a text there must be an analysis of the sociocultural practice in which the text is situated, "…the socially 'constructive' effects of discourse" must be identified. However there can be no real understanding of these effects without "… looking closely at what happens when people talk or write" (p. 3). Fairclough (2003) identifies three separate, yet inseparable features within the moments of talking and writing which facilitate meaning-making. These are, "The production of the text, the text itself, and the reception of the text" (p. 10). It is not possible to offer a definitive interpretation of the meaning in the texts or how the text will be understood by the reader. It is only possible to look for evidence on what may have been intended by the authors and what could be understood by the reader.

Within this study, the producers of the text include three professional nursing bodies, NCNZ, NZNO, NZCMHN and two textbooks, (Crisp, J., & Taylor, C. (2013) *Potter & Perry's Fundamentals of Nursing.* Sydney: Elsevier and Rubenfeld, M. G., & Scheffer, B. K. (2015; 3 ed.) *Critical thinking tactics for nurses: Achieving the IOM competencies*).

The interpreters of the text are most likely to be registered nurses in practice, nurse educators or students of nursing. Consuming a text is assisted by "internalised social structures, norms and conventions" (Fairclough, 1992, p. 80) and depends on a shared understanding of the discursive event. For example, the thinking required for nursing assessment relies on disciplinary knowledge, understanding the practice conventions of undertaking and recording an assessment and the sociocultural and contextual implications surrounding the assessment taking.

Fairclough (1992) claims the interpretation of text is "…an active process in which the meanings arrived at depend upon the resources employed and the social position of the interpreter, and one can construe texts as merely producing ideological effects upon a passive recipient only if one ignores this dynamic process." (p. 29)

Fairclough (2003) claims his three-stage process (figure 1) requires a continuous analysis between three phases. This involves, firstly, the description of the text, focusing on how language is used and meaning is constructed. Secondly, interpretation at the discourse practice level (the production and interpretation of the text), and in the third stage the interpretation and explanation at a sociocultural level to understand the ideological impact of the documents, "…"how power relations work across networks of practices and structures" (p. 16).
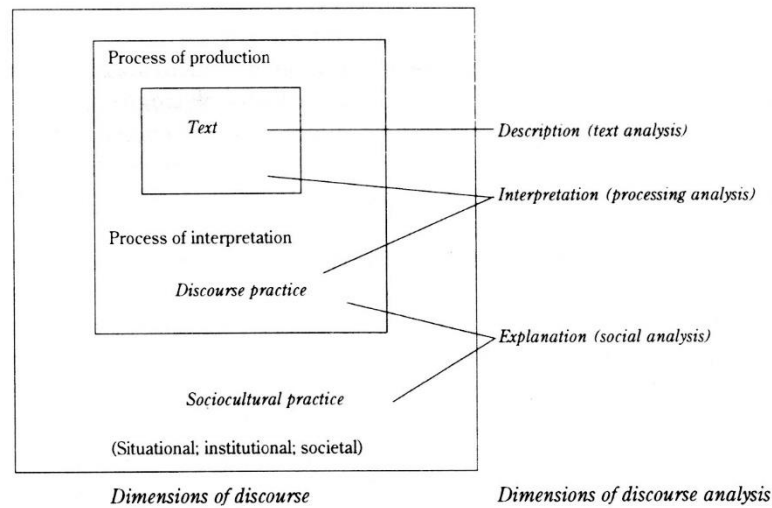
Figure 1: Fairclough's model of the interrelationships between the dimensions of discourse and dimensions of discourse analysis that provides a framework for CDA (Fairclough, 1995 p. 98)

For this study, the focus of the work was on dominant professional and organisational discourses, firstly in order to uncover assumptions about critical thinking within nursing theory and clinical practice, and then how these discourses position and influence nurses' professional identities. In keeping with CDA, an analysis of specific texts, discourse practice and social practice was undertaken. To achieve this, analytical tools derived from CDA, social constructivist theory and critical social theory were worked together in order to analyse the selected texts and support a contextualised interpretative analysis, stage three of Fairclough's framework.

Critical social theory

The discipline called "critical theory" originated from the Frankfurt School. The school's birthplace was the Institute of Social Research at the University of Frankfurt in Germany. A sociologist and economist named Felix Weil established the Institute of Social Research in 1924, with the support of another socialist named Kurt Gerlach. Their aim was to establish a place where Marxist ideas could be discussed (Crotty, 1998). Following the change of directorship to Max Horkhiemer in 1929, the focus on Marxist ideas declined in favour of critical theory (Carr, 2000). It is argued that this focus of the institute, and particularly the Frankfurt School, very quickly became philosophically eclectic in its critical perspectives. This was due to the differing influences of the philosophers, sociologists and economists associated with the beginnings of the institute (Crotty, 1998; Kincheloe & McLaren, 2000). Authors argue that the differing influences within the school are very removed from the foundations of Marxist thought (see Crotty, 1998). Jay (1973) claims "the Institute presented a revision of Marxism so

substantial that it forfeited the right to be included among its many off-shoots" (as cited in Crotty, 1998, p. 126). However, not all scholars agree. "Most analysts of Frankfurt School philosophy and social science are content to accept its broadly Marxist character, while recognising that the Marxism in question is no purist form but a neo-Marixism or post Marxism containing a strong mixture of elements drawn from other sources" (Crotty,1998 p. 126).

Despite these debates, Carr (2000) maintains that the term critical theory originating from the Frankfurt school attracts two meanings. The first is the use of the term to collectively identify the 'body of work' generated from the scholars of the Frankfurt School. Secondly the term 'critical theory' has come to depict "particular process of critique, the origins which owe multiple allegiances" (Carr, 2000, p. 209).

Whilst there are many variations of critical theory and no agreed unified approach (Kincheloe & McLaren 2000; Crotty, 1998; Brookfield, 2005; Cresswell, 2013), Creswell (2013) maintains that amongst these variants are central themes of interest to critical researchers. These are: "the scientific study of institutions and their transformations through interpreting the meanings of social life; the historical problems of domination, alienation, and social struggles; and a critique of society and the envisioning of new possibilities" (p. 30). This thinking is echoed by Clare (2003) who maintains that central to critical theory is its transformative agenda.

Critical theorists believe that the goals and wishes of members of society are controlled or manipulated externally by the 'social structures' of agencies, such as organisations. These social structures shape meaning, and influence actions within organisations. While people individually or collectively can resist this control, there is also the possibility that the "ability to alter subjective meanings cannot be achieved by individuals" (Clare 2003, p. 126). For change to occur, culture, relations of power, ideology and hegemony must be uncovered and analysed. The aim or goal of critical research is to study these themes in such a way as to unmask domination and provide a critique of organisational practices that offers transformation and emancipation of members within their workplace (Deetz, 2001).

Brookfield (2005) claims that critical theory is underpinned by Marxist understandings of social inequality and the domination of certain groups by others. Typically this work endeavours to uncover the ideology that supports dominance and inequalities, and in doing so, bring about social change and emancipation. Brookfield (2005) quotes Fay's (1987) statement, that "Critical theory wants to explain a social order in such a way that it becomes itself the catalyst which leads to the transformation of this social order" (p. 7). Applying critical theory to this CDA, enables identification and interpretation of professional and organisational practices which determine how critical thinking is understood, enabled and possibly suppressed. The hope is that this will offer strategies for the use of critical thinking within nursing practice and to strengthen nurses' professional identities.

Mumby (2001) argues that the importance of a communicative understanding of organisational power is central to critical theory. Power in this context is portrayed as a "struggle over

meaning" (p. 601). The members of an organisation who are able to manipulate and express meaning in a way that serves their own purposes will hold control and sustain positions of power (Mumby, 2001). According to Mumby (2001), "critical theorists show how management theory functions ideologically by reifying and naturalising a particular way of knowing, thus excluding as illegitimate other forms of representing knowledge claims" (p. 601), and in doing so exclude as false, other forms of representing knowledge. Carr (2000) echoes this in arguing "Critical theory aims to produce a particular form of knowledge that seeks to realize an emancipatory interest, specifically through a critique of consciousness and ideology. It separates itself from both functionalist/objective and interpretive/practical sciences through a critical epistemology that rejects the self-evident nature of reality and acknowledges the various ways in which reality is distorted" (p. 209).

To understand how management theory functions in this way, three central concepts need to be clarified. Firstly, ideology. This term commonly refers to "a system of ideas, which legitimates and guides social action" (Clare, 2003 p. 134). These ideas and resulting actions are seen as normal and common-sense, -so much so, that they are invisible to those who hold the ideas to be true (Buchanan, 2010). Althusser maintains we "live out the requirements of the prevailing ideologies while doing so under the illusion that we have freely chosen our way of life." For Althusser, ideology is "the experience of being the authors of our own actions" (cited by Burr, 2003, p. 120).

Secondly, hegemony. This is a concept defined by Gramsci in 1971. It is thought that he coined the term as code for ideology whilst a prisoner during World War II (Buchanan, 2010). Considered to be related to ideology, hegemony occurs as power relations between "competing interest groups" (p. 287) (Mumby & Meace, 2011). Hegemony then is the ability of a dominant class or culture in a society to exercise power and control. This control is enabled via societal structures, such as schools, churches and family. These structures are used to create a shared world view that serves the dominant group (Clare, 2003). "There is no need for coercion or overt mechanisms of control", as the control is not questioned. It is part of the "common sense view of their social world" (Clare, 2003 p. 134). Mumby (2001) offers a helpful capture of Gramsci's definition of hegemony, in clarifying it as a shift from ideology. Hegemony is a "dynamic conception of the lived relations of social groups and the various struggles that constantly unfold between and among groups. As such, hegemony can be viewed as a process that is communicative in character, involving attempts by various groups to articulate systems of meaning that are actively taken up by other groups" (Mumby, 2001 p. 589).

 Thirdly, the concept of reification. Reification relates to 'The transformation of intangible human qualities, such as thoughts, ideas, and values, into physical objects" (Buchanan, 2010, p. 404). Organisational members endeavour to reify organisational structures that serve their interests (Mumby, 2001). Within organisations, particular sectional interests (or the interests of particular groups of people) "are often universalised and treated as if they were everyone's interests, enabling a false consensus" (Deetz, 2001, p. 27). This has particular significance in this project

because a nursing example of this is the creation of policies and protocols for patient procedures and mandatory standing orders. These are portrayed as, and usually experienced as, examples of evidence-based best practice, ensuring patients receive, and healthcare practitioners deliver, good care.

Habermas, a German philosopher from the Frankfurt School is the most significant contemporary scholar of critical theory (Crotty, 1998; Macey, 2000; Brookfield, 2005). As Brookfield (2005) records from Habermas (1992a), his relationship with Marxism philosophy was partial, claiming Marxism offered a way of understanding capitalism and provided " the impetus and the analytical means to investigate the development of the relationship between democracy and capitalism" (p. 223). According to Crotty (1998), in offering a critique of Marxian theory, Habermas maintained that "Marx's focus on production is an inadequate base on which to ground a socially and historically developing rationality" (p. 142). Brookfield draws attention to Habermas's 1979 critique of Marx for the manner in which he " localised the learning process important for evolution in the dimension of objectifying thought—of technical and organisational knowledge, of instrumental and strategic action, in short of productive forces" (p. 224). For Habermas (1970), a "critical theory of society can no longer be constructed in the exclusive form of a critique of political economy" (Brookfield 2005, p. 224).

Habermas believes the human life world can be categorised by three territories, "work/labour, social interaction, and power" (Deetz & Mumby 1990 p. 34). Habermas argues that "human beings constitute their reality and organise their experience in terms of cognitive (or knowledge-guiding) interests" (Crotty, 1998 p. 142). Within the territory of work, knowledge is generated in order to allow humans to exercise technical control over the world around them. Habermas referred to this as instrumental action. In the social interaction territory, Habermas is referring to communicative action, where humans use knowledge to "generate mutual understanding" (Deetz & Mumby, 1990). Understanding is generated through language and shared norms. Habermas maintains that "These two forms of action, instrumental and communicative action, together with the exercise of power and domination (an issue that has, of course, preoccupied him from the start), constitute the basis for his well-known threefold typology of human knowledge" (Crotty, 1998 p. 142). At the heart of Habermas's theory of communicative action is the 'reclamation of reason'. Focusing on claims of truth and rightness, acts of speech should be undertaken in conditions where all are equal and free (Brookfield 2005). As Anthony Giddens (1991) observes, "The ideal speech situation, held to be immanent in all language use, provides an energising vision of emancipation. The more social circumstances approximate to an ideal-speech situation, the more a social order based on the autonomous action of free and equal individuals will emerge" (cited by Crotty, 1998 p. 144).

Mumby (2001) cites Deetz (1992a) who, in applying the work of Habermas, has developed a conception of power "that is situated within a socio-historical framework that places issues of communication, identity and meaning formation" of central importance (Mumby, 2001, p. 603). Deetz maintains that organisations have become sites of political decision making and as such

influential in the development of "our identities" as social beings as well. Arguing that "corporations have colonised the life world (our sense of community) and the institutional forms associated with it (e.g. education, interpersonal relations, family)" (Mumby, 2001, p. 603). Organisations are then able to reproduce their member's concerns and identities in ways which benefit the organisation. For example "technical forms of rationality such as communications become reduced to instruments of efficient information transmission" (p. 603) this allows the organisation to form a "corporate individual" via discursive closure. Deetz (1992a, 1995) argues for a "communication-based model in which democracy is the product of open communication among a variety of stakeholders in organisations, rather than the unproblematic product of a supposedly already existing democratic society, as narrowly defined though politics of individual expression and voting rights" (cited by Mumby, 2001, p. 603).

It is because of this application of Deetz' work that I can recognise the appropriateness of the application of critical theory within my research question. I make the assumption in this research that the expression of critical thinking in nursing is controlled within the profession and organisations, for the benefit of political and organisational interests, and that such control is inherent in political, professional and organisations' policies, protocols, staffing and workload allocation programmes. I propose that there is an expectation of technical rationality and the strategic management to create the professional nurse. I also assume that employees do not have equal power, and that democratic participation in establishing organisational rules and regulations does not occur.

The limitations of critical theory lie firstly with the focus on the totalising view of power. There is an assumption within this framework that individuals in organisations are passive, and little attention is given to resistance (Mumby, 2001). Clare (2003) maintains that there is a difficulty in critical research with the "idiosyncratic and individualised focus of transformative action" (Clare, 2003 p. 137). The ideas generated in the research can remain general when they describe personal ideology and not demonstrate individual or collective action. "The critical approach does not always provide the conditions by which criticism can develop in a practical direction and produce emancipatory action" (Clare, 2003 p. 137). Critics also argue that predisposing ideology at the forefront of the research process, limits the emergent and descriptive elements of interpretative research (Taylor & Trujillo, 2001).

I do not envisage these limitations affecting my research because my interest lies in the discursive control of employees and I am therefore not interested, at this stage, in focussing on attempts by individuals to resist this control. The ability to generate research findings that can be translated into emancipatory action will depend on my ability to make links between personal insights and socio-political conditions. Strategies for change, or the potential for action, may subsequently develop through in-depth exploration of perceived constraints on individual or group action (Clare, 2003).

Social Construction

A post-structural approach posits that it is through discourse that our understanding of the social world is determined. Discourse provides the meaning, or sense-making of social reality (Cheek, 2000; Phillips & Jorgenson, 2002). Discourse in a post-structural lens is never static or closed, but is flexible, indeterminate and constantly evolving. Phillips and Jorgenson (2002), drawing on Laclau and Mouffe (1985), identify the poststructuralist notion of 'discursive struggle' (p. 6). Differing discourses struggle with each other in order to colonise meaning and "achieve hegemony" (p. 7). By achieving this dominance over meaning, the interests of some social actors are enabled, whilst others are inhibited. This resonates with the claim made by Deetz (1992) above and reinforces the need within critical research to be aware of how meanings can carry privileged interests (Alvesson and Karreman, 2000).

As a post-structural methodology, social constructionism rejects ontological consistency and maintains reality is not something that can be discovered but rather reality comes to be known. It is through language located within particular sociocultural moments that reality becomes known to us (Schwandt, 2000). As Gergen (2009) states, "What we take from the world depends on how we approach it….depends on social relationships of which we are a part" (p. 2).

Burr (1995, 2003) maintains there is no universal definition for a social constructionist approach. Calling on a family metaphor she maintains there are commonalities amongst the approaches, similar to family members resembling each other but no one feature or characteristic is shared by all. Burr (2003) identifies four themes that a social constructionist approach assumes. Firstly, that a critical stance is required when considering how we understand "the world, including ourselves' (p. 3). We interpret and make meaning based on the assumptions we hold about what we understand to be real (reality). Gergen (2009) reinforces this notion, arguing that reflecting on taken for granted assumptions is 'vital'. "The generation of good reasons, good evidence, and good values is always from within a tradition, already accepted are certain constructions of the real and the good and implicit rejections of alternatives" (p. 12). It is by utilising critical reflexivity that we can suspend our knowing, our taken-for granted assumptions and attempt to 'see' differing perspectives. We are required to "…place ones premises into question, to suspend the obvious, to listen to alternative framings of reality, and grapple with comparative outcomes of multiple standpoints" (p. 12). Within this study a critical stance is required to identify how critical thinking is described within the documents and how these descriptions construct the meaning of critical thinking within nursing practice. In addition uncovering the assumptions inherent in these understandings will assist shed light on the impact these assumptions have on the construction of nurse's professional identities as critical thinkers.

Secondly, how we understand "the world, the categories and concepts we use" (p. 3) have historical and cultural antecedents. Our interpretations are located in a particular time and social

context. Important within historical and cultural moments are the "social and economic arrangements prevailing in that culture at that time" (p. 4). Critical thinking in nursing education within NZ can trace its history to the move from an apprentice model in the early 1970s to that of tertiary based education programmes. This move arose following social expectations of this time, that the production of a professional required education programmes that encouraged academic inquiry (critical thinking can be assumed as part of this academic enquiry). This academic enquiry was required to ensure the development of an "evidence-based health professional" (Prebble, 2001, p. 138).

The third theme Burr maintains a social constructivist believes is it that our understanding of the 'world' is derived from and transformed by our social interactions. We construct meaning via our ways of being together. Meaning is constructed via social relations. Our day to day activities are the sources from which we deride out shared understandings of our social world. Gergen (2009) maintains, "Constructions gain their significance from social unity. Words themselves do not describe the world, but if they function successfully within relationship (offer shared meaning and understanding) they become a way to describe the truth. This is located however within socially relevant moments (groups)" (p. 11) "As we describe and explain so do we fashion our future…. language bound within relationships and our relationships are bound within broader patterns of practice" (p. 11). Words like nurse, patient, care, and competency needed for nursing rely on discourses. Without shared languages for description and explanation these would not exist.

Lastly, in the fourth theme Burr maintains that these socially negotiated understandings in turn rise to social action. Our understandings or knowledge of the world directly informs the actions we take. "Descriptions or constructions of the world therefore sustain some patterns of social action and exclude others" (p. 5). Of importance within this construction of knowledge and action is the recognition that within our understandings (meaning –making) some ways of being (social action) will be enabled and others disabled. This is of significance for this study which identifies differing discourses that impact critical thinking, some enabling and others disabling action from the outcomes of critical thinking. Power relations influence what is possible and what is limited, and possibly disallowed. How nurses may be able to act and how they may treat others as outcomes of critical thinking will be impacted on by these power relations.

The ability of a nurse to employ critical thinking and take action amidst powerful discourses is determined by their ability to claim 'speaking rights' within the available discourses. From a social constructionist perspective the ability for people to achieve the right to speak and be heard is dependent on how they are positioned within the available discourses. These positions referred to as subject positions are the "the process by which our identities are produced" (Burr, 2003, p. 111).

Parker (1992) maintains that discourses 'call' to us in a particular way and the way we are called and the manner in which we listen and respond as a particular person (our identity) is

determined by discourse. Identifying this as a 'position call', Drewery (2005) borrows from Wittgenstein (1958) and identifies how people 'know how to go on' when they respond to a position call (p. 314). Within a professional discourse a nurse knows how to 'be a nurse' based on their understandings of the profession. They take up the 'call' to be a nurse in caring for others and may undertake a nursing assessment, make professional decisions, use nursing terminology and develop therapeutic relationships utilising professional boundaries in ways sanctioned within discourse. In the shadow of management discourse, or when the professional discourse connects with other dominant discourses such as risk, the positioning of the nurse as a professional may be subjugated. The ability to accept or resist position calls and to claim speaking rights is determined by the authority or agency a nurse has within the subject position offered within the prevailing discourse. This is important in this study because the interplay of professional, political and organisational discourses positions the nurse and potentially affects the ability of the nurse to critically think or make it impossible to do so.

The interplay of discourses within the historical, social, cultural, and political context in which they operate influences critical thinking through their actions on the nurse as a person and as a professional. Fox (1994) clearly identifies that the meaning of critical thinking is defined within a socio-cultural context. Understanding what is meant by critical thinking and how to use it does not easily translate across cultures. She states:

> *This thing we call "critical thinking" or "analysis" has strong cultural components. It is more than just a set of writing and thinking techniques—it is a voice, a stance, a relationship with texts and family members, friends, teachers, the media, even the history of one's country. This is why "critical analysis" is so hard for faculty members to talk about; because it is learned intuitively it is easy to recognize, like a face or a personality, but it is not so easily defined and is not at all simple to explain to someone who has been brought up differently* (p. 125).

Atkinson (1997) concurs and as identified in Chapter 2, he maintains that critical thinking is a social practice. He argues that "critical thinking is cultural thinking" (p. 89) and that thinking critically is determined by the 'worldview' that is informing the "particular ways to think" (p. 88). I believe this is particularly relevant for understanding critical thinking in nursing. The discursive influences operating within socio-cultural practice influence both the person and the profession and determine what can be thought, and what actions will be enabled, constrained or prohibited.

I have represented the elements that depict critical thinking as a social practice in Figure 2 below. This illustration identifies the way in which critical thinking is situated within historical, social, cultural and political practice. The components of critical thinking arising from both the 'person' and the 'profession' intersect to inform judgement and decisions that inform nursing actions. These are always influenced by many competing and complementary discourses. The broken lines represent the permeability of the boundaries between these constructs and also the possibility for change.
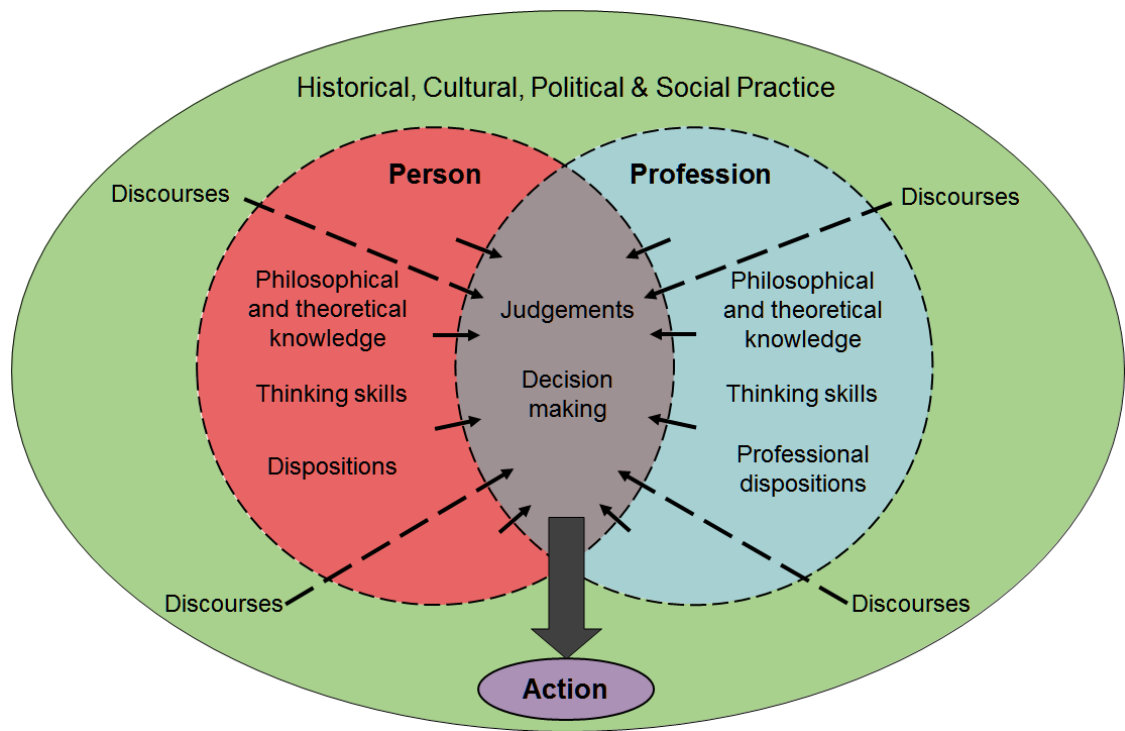
Figure 2: The landscape of critical thinking

This figure depicts critical thinking as a social practice and the way in which multiple forces interconnect to inform and influence nursing action.

Analytical Methods

Document Selection

Documents were selected which overtly and with intent seek to influence the practice of nursing within New Zealand. These texts were analysed with the intention of exploring their relationship to critical thinking and the professional identities of nurses and the discourses that inform the texts. The following documents have been analysed:

	Author	Document	Position
1	Nursing Council of New Zealand (NCNZ)	Competencies for registered nurses (2012).	Regulatory function
2	New Zealand Nurses Organisation (NZNO)	Standards of Professional Nursing Practice (2012)	Professional
3	Te Ao Māramatanga New Zealand College of Mental Health Nurses (NZCMHN)	Standards of Practice for Mental Health Nursing in Aotearoa New Zealand (2012)	Professional
4	Rubenfeld, M. G., & Scheffer, B. K.	Critical thinking tactics for nurses: Achieving the IOM competencies (2015; 3 ed.).	Textbook
5	Bronwyn Jones in Crisp, J., & Taylor, C. *Potter & Perry's Fundamentals of Nursing.* (2012; 4th ed.).	Chapter 5: Critical thinking and nursing judgement	Textbook

These documents influence in a prescriptive way how nursing practice should be performed and provide information which informs nurses' professional identities.

The critical thinking text, Critical Thinking Tactics for Nurses, was selected as the authors are considered reputable writers and researchers in the field of critical thinking for nursing practice. The text was read as a whole, as per stage one of Huckin's (1997) process. Chapters analysed include: Chapter 1: Why critical thinking? Chapter 2: What is critical thinking?

A second critical thinking document, Critical Thinking and Nursing Judgement, was selected because it includes a New Zealand context, is considered a reputable text, is widely disseminated and is the latest edition of the text referred to by the New Zealand Nurses Organisation in their professional standards document.

Analysis of the text:

The CDA method employed was based on that used by Huckin (1997) and developed from Fairclough (1992). This involved engaging with the text in an uncritical manner and then analysing the text in a critical manner.

A modified version of Huckin's (1997) two stage process for analysing text was employed. The texts were analysed with the intention of noticing how they generated meaning and represented reality about critical thinking in the work of nurses, and how this impacted on the construction of their professional identities ("social identities"). This included, an analysis of the discursive influences in the construction of how nurses are required to perform nursing within the practice arena ("social relations") (Fairclough, 1995).

This research project takes the form of a thematic analysis rather than a close textual analysis. In keeping with Gilbert (2005), as a sociological study this work is more focussed on discourse practice than a close engagement with linguistic analysis. Fairclough (1992) maintains that the interdisciplinary nature of CDA requires that such approaches are possible. In Huckin's (1997) words:

> *CDA is not a linguistic theory and therefore does not provide a complete grammar of syntactic, phonological, or other linguistic elements for any particular language. Nor does it aim to describe any particular text in exhaustive detail. Instead, it tries to point out those feature of a text that are most interesting from a critical perspective, those that appear to be textual manipulations serving non-democratic purposes* (p. 89).

This is supported by Smith (2007) in her use of thematic analysis to capture general themes in the construction of nurse practitioner identities in the press. Fairclough (2003) also states that "textual analysis is inevitably selective: in any analysis, we choose to ask certain questions about social events and texts, and not other possible questions" (p. 15).

Stage one: Uncritical review

Texts were read in a generalised uncritical way, reading for the meaning within the writing and accepting it as it is presented. The next stage required a critical review that added to stage one and went from looking at the text as a whole to reading sentence by sentence and then reading and analysing words and phrases. Huckin (1997) warns about not losing sight of what is noticed in stage one during the critique in stage two of the analysis. He believes this allows the researcher to notice 'features' in the writing which "…have the potential of misleading the

unwary reader" (p. 81). A running log was kept in order to capture such observations. A summary of these observations is provided within Chapter 4.

Stage two: Critical review

The critical examination of the texts involved a textual analysis and the analysis of discourse practice. This was achieved using Huckin (1997) method of analysing the text as a whole, then at a sentence level followed by words and phrases.

Fairclough (1992) reminds us of the "overlap" between the analysis of the features of the text and the analysis of discourse practice. At times the "formal features of the text are more salient" and the focus of the analysis will be textual. In other instances the "productive and interpretative processes are most salient" and these will be analysed within a discourse practice frame (p. 74). Finally the social practice arena was examined to provide a contextualised analysis.

Analysis of the text as a whole

Huckin (1997) maintains the critical analysis should begin by looking at the document as a whole. He explains that this is where the "textual manipulations" will have "their most powerful effect" (p. 81) and thus advocates that the researcher pay attention to the following textual characteristics:

> **Genre**: This is the format employed to present the text. Fairclough (1995) describes genre as "a socially ratified way of using language in connection with a particular type of social activity" (p. 14). The genre of a text involves not only the way a text is presented but also what social practices are involved, and how these practices are depicted. This enables those interacting with the text to be positioned in certain ways. Huckin (1997) argues that analysing the genre allows the reader to uncover and expose the intentions of the writer.

> Fairclough (2003) offers a useful method for analysing genre by specifically looking at "Activity, Social Relations and Communication Technology-what are people doing, what are the social relations between them, and what communication technology (if any) does their activity depend on?" (p. 70). He also reminds us that identifying genre requires the reader to recognise the particular taken-for-granted or generally accepted features and writing disciplines that are used to produce and consume a particular text (Fairclough, 1995). In addition, he states that it is crucial to identify more specifically the 'ideal' text. This ideal provides the benchmark by which other texts are measured… (p. 13).

> Another author states that the "rules" of text formation from a particular genre can provide power to the writer of the text (McGregor 2003).

The structure of the document is determined by employing a particular genre (or genres) and sets out to achieve a particular purpose or goal. In this way the writer is able to shape "disciplinary practices", and in doing so, the scope of practice for the nurse.

Framing: This is the way in which the content of the text is presented. It includes the style or perspective of the text and may include visual aids. Framing reflects the way the author(s) wishes the document to be experienced by the reader. Huckin (1997) argues that concepts will be presented within documents in ways which offer particular perspectives and refers to framing as offering an angle or a slant (p. 82). Fairclough (2001 p. 132) states that "A frame is a representation of whatever can figure as a topic, or 'subject matter', or 'referent' within an activity". These, then, offer ideas or assumptions about a nurse (what a nurse is, and ought to, and ought not to do) and the context within which nurses work. These may be storied implicitly or explicitly within the text (p 66). Bales (2001) states:

> *Essentially, framing has to do with the way an issue is composed: the messengers, visuals and metaphors that are used to convey an idea. The cues that are given to people by the framing direct their reasoning about issues. Given this, it is vital that advocates understand the composition of the frame and what kinds of meta-messages or world views it calls into play* (Bohan-Baker, p.10).

Foregrounding / back- grounding (omission): These concepts relate closely to framing. Foregrounding describes the way in which author(s) emphasise or highlight particular information by giving them textual prominence. For example, they may put them first or use bold font. Conversely, back-grounding is used to de-emphasise concepts considered to be less important. In some cases concepts may be deliberately omitted to avoid scrutiny or perhaps avoid confusion. This is analysed at sentence level in the form of topicalisation, focussing on what the sentence is about. Certain topics may carry over into other sentences offering a particular "slant" or emphasis which influences the reader. Huckin (1997) refers to this as "sentence-level foregrounding" (p. 83).

Presupposition: Ideas within the text may be presented as 'taken-for-granted'. The presentation of ideas in this way is considered by Huckin to be manipulative and suggests there is no alternative view. This was also analysed at a sentence as ideas may be presented as "fact" at the sentence level.

Authorship: This reflects the position held by the author(s) of the text.

Audience: This answers the question of who the text is written to, or for.

Discursive difference: This identifies the use of different styles of discourse within the text that may be used to manipulate readers to believe certain positions (Huckin, 1997).

Agency: This refers to the way subjects are positioned within the text.

Reading words and phrases

The analysis examined the characteristics of the text. The following characteristics were looked for in the text, with particular focus on how they were applied to critical thinking.

Connotations: Words may be presented in ways that infer special meanings. For example in nursing practice the words client, patient, tangata whairoa and consumer are all labels that can be used to describe people receiving care. Each of these has differing connotations depending on the context in which they are used.

Register: This relates to the use of words or phrases to effect a certain level of formality or informality, or technicality. For example, the document may use words to provide a conversational register or authoritative (expert) register.

Modality: This identifies the "tone of statements as regards their degree of certitude and authority; it is carried mainly by words and phrases like *may, might, could, will, must, it seems to be, without a doubt, it's possible that*, etc." (Huckin, 1997, p. 84). The tone employed by the use of verbs and phrases will set the "air" of authority or "deference".

Thematic analysis

This research pays particular attention the way language is used to offer discursive meanings about critical thinking within the texts and also how these discourses then operate within the social world to shape and influence nursing practice. As the intention was to limit the focus here, Owen's (1984) thematic analysis was adopted to facilitate this. Owen specified the following criteria for establishing the presence of themes: a) recurrence, where there was replication of the 'same thread of meaning' even if captured in different words. b) repetition, where words, phrases, or sentences were repeated in the text. This is an extension of criteria a) as it requires the explicit use of the wording not just the implicit as in a). c) forcefulness, where information is emphasised in the presentation of the text (for example using quotation or exclamation marks, underlining, different font size. This also included the register and modality utilised within the documents. Words phrases or sentences that referred either overtly or implicitly to critical thinking or the relationship of critical thinking to nursing practice were of interest for this study. How the discourses were representing the meaning of critical thinking and how this impacted on its application was noted. The connection of the themes to the research questions allowed the

meaning being constructed by the producers of the documents to be revealed and draw attention to the particular perspective being presented. A database was constructed to capture the themes that emerge from the critical review of the documents.

Contextualised Interpretation

Critical social theory and social construction, as discussed above, will be used to perform the analysis and contextualised interpretation of the impact of the texts on nursing practice. Critical theory will underpin a thematic analysis in order to identify how the dominant professional and organisational discourses identified within the research, position critical thinking within nursing theory and clinical practice, and how these discourses position and influence nurses' professional identities.

Addressing issues of research rigor

Throughout this study I have adhered to the theoretical requirements of research conducted using a CDA methodology. As Creswell (2007) asserts, one of the characteristics of a "good qualitative study" is the identification and definition of a "recognized" approach (p. 45). Having provided a detailed account of the methodological approach guiding this study in the above sections, clarifying how this study followed this approach is now required.

This study was motivated by the concerns I held about the prevailing definitional challenges surrounding critical thinking and the professional and organisational practices which enable critical thinking and also those which may hinder or even suppress it. In order to achieve this I considered it essential to analyse documents which hold significant influence over nursing practice in NZ and thus critical thinking. Crowe (2005) claims that not only must the texts under scrutiny 'fit' the research question, but these must also cover a range of perspectives. This was achieved by including three differing, yet substantive, NZ nursing documents and two widely acclaimed texts about critical thinking in nursing practice.

To identify how these documents construct the meaning of critical thinking and shape nurses' professional identities and actions, I needed to uncover the powerful professional and organisational discourses that impact critical thinking in nursing. In order to achieve this, an analysis of structural and political forces was required. Employing the critical methodology of CDA enabled this.

Throughout this work I have set out the decision making processes undertaken in each stage. I have provided a comprehensive account of the methods I employed in this chapter and the analytical processes in Chapter 4 and 5. As Crowe (2005) recommended, I have included literal textual examples within this work to support my findings. I believe these are sufficient to back

my claims. MacCulloch (2010) alerts to the balance required in providing "sufficient direct quotes that illustrate points without swamping the reader needlessly" (p. 82).

This study adopted a thematic CDA approach (Smith, 2007) and, to ensure themes were identified in a rigorous manner, Owen's (1984) thematic analysis was used. The process employed for this has been outlined in this chapter and in Chapter 5. It involved an iterative process that was ongoing throughout this research. The contextualised interpretation demanded of the CDA approach undertaken here has been underpinned by a disciplined engagement with critical social theory and social constructionist thinking. I am mindful that my interpretations do not represent a definite 'truth' and other researchers may draw other conclusions. Nixon and Power (2006) attest to this, arguing that discourse analysis research favours a "…quest for 'meaning' as opposed to 'truth' and paying attention to justification and grounding of interpretative claims" (p. 76).

Finally, Fairclough (2003) reminds us of the selective nature of a textual analysis, arguing that we will be selective in deciding what text to analyse and what questions we will ask of the text. I have endeavoured to provide a reflexive account of my own position within this research and my resulting subjectivity.

Chapter Summary

This chapter set out the CDA research methodology and the analytical methods used within this study. Because of the interdisciplinary nature of CDA, it was important to be clear about the specific CDA process used in the research. This was not a detailed linguistic study, but a study which employed a thematic analysis to identify how the analysed documents present particular meanings about critical thinking, to uncover the discourses that are called on to construct these meanings, and how this in turn positions and impacts nurses' professional identities.

The next chapter provides the beginning analysis of the documents. Chapter 5 will complete this analysis with a detailed scrutiny of the identified discourses.

Chapter 4: Multiple prescriptions for nursing practice

"Essentially, framing has to do with the way an issue is composed: the messengers, visuals and metaphors that are used to convey an idea. The cues that are given to people by the framing direct their reasoning about issues. Given this, it is vital that advocates understand the composition of the frame and what kinds of meta-messages or world views it calls into play" (Susan Bales, interviewed by Bohan-Baker, 2001, p. 10).

Introduction

The following research questions were addressed by examining key professional documents which define and influence nursing practice and both explicitly and implicitly instruct nurses to think critically.

- How is language used to construct the meaning of critical thinking within nursing theory and clinical practice?
- How do professional organisational and political discourses influence critical thinking within nursing theory and clinical practice?
- How do these discourses position and influence nurses professional identities and practice?

The above opening quote by Bales (2001) highlights the powerful influence of 'meta-messages' in documents. The examined documents influence, in a prescriptive way, how nursing practice should be performed and provide information which informs nurses' professional identities. Five texts were analysed to uncover the way language is used to construct the meaning of critical thinking in nursing practice.

1. Competencies for registered nurses (2012a), Nursing Council of New Zealand (NCNZ)
2. Standards of Professional Nursing Practice (2012), New Zealand Nurses Organisation (NZNO)
3. Standards of Practice for Mental Health Nursing in Aotearoa New Zealand (2012), Te Ao Māramatanga New Zealand College of Mental Health Nurses (NZCMHN)
4. Critical thinking tactics for nurses: Achieving the IOM competencies (2015; 3 ed.), Rubenfeld, M. G., & Scheffer, B. K.
5. Chapter 5: Critical thinking and nursing judgement, Bronwyn Jones in Crisp, J., & Taylor, C. *Potter & Perry's Fundamentals of Nursing.* (2012; 4th ed.).

As described within the methodology chapter, the texts were analysed using Huckin's (1997) analytical framework with the intention of noticing the linguistic methods employed to construct the meaning of critical thinking within the documents. The first analysis involved engaging with the text in an uncritical manner and then in a critical manner. The uncritical overview involved examining the document naively to establish the overall message and meaning of the text. Huckin (1997) recommends stepping back from the text and reading as a "typical reader" would.

The aim is to read for the meaning within the writing and accept it as it is presented. (The uncritical reviews are presented in text boxes at the beginning of each document analysis). This was followed by a critical examination in which the text as a whole was analysed looking at discourse practice, followed by analysis of sentences and then words and phrases.

The analysis of discourse practice throughout all five documents involved the identification, through thematic analysis, of the types of discourses present in the documents. Included in this analysis was the identification of the intertextual discourse links. As Fairclough (1995) explains, discourses do not operate in isolation and some discourses will dominate others. In addition to identifying the types of discourse, the analysis also included the way in which the documents were disseminated, who was involved in constructing or producing the texts, who will consume or use them and how they are linked to the wider social context. This is the "space" wherein the text shapes and is shaped by the social arenas in which it is situated. The analysis involved "identifying what types of discourse are being incorporated… what is the history of this type of text; what sources are cited to support its claims, what effect this has on producing a particular type of text, and who controls the publication and dissemination of the text" (Crowe, 2005, p. 58).

As explained in Chapter 3 (Methods), documents were selected that overtly and with intent seek to influence and guide the practice of nursing within New Zealand. The first three documents were chosen because they influence, in a prescriptive way, how nursing practice should be performed and provide information which informs nurses' professional identities. The 4th document was selected because it provides a research capture of critical thinking and the authors are considered reputable writers and researchers in the field of critical thinking for nursing practice. The 5th text was selected because it includes a New Zealand context, is considered to be a reputable text, is widely disseminated and is the latest edition of the text referred to by the New Zealand Nurses Organisation in their professional standards document.

This chapter is divided into two parts. Part A provides analysis of the first three documents. These documents share a common theme because they are all prescriptive professional documents for nursing practice. The other two documents are academic texts and are analysed in Part B. Although this chapter is long, I consider that it was important to keep the components of the first two stages of the textual analysis of the documents in one chapter. Providing the background and history of the documents alongside the first stages of the analysis as a whole enabled a comprehensive and coherent presentation of the findings. This also helped to streamline the transition into the subsequent analysis of the discourses in Chapter 5 and the contextualised analysis in Chapters 6 and 7.

PART A: Professional Document Analysis

Document 1:

Nursing Council of New Zealand (NCNZ): Competencies for Registered Nurses (2007- reprinted 2012).

Background

Nursing, within New Zealand, is a professional occupation which is regulated by the Nursing Council of New Zealand (NCNZ). The NCNZ, in turn, is regulated by the NZ Government via the Health Practitioners Competence Assurance Act (HPCA) (2003).

The NCNZ sets the standards for both the education and practice of nurses in NZ (NCNZ, 2010). The standards for education are outlined in a document titled "Education programme standards for the registered nurse scope of practice" (NCNZ, 2010). Standard 2.5 states that "The programme has a statement of beliefs or underlying assumptions that is congruent with the planning and delivery of the learning experiences, and is based on [4 points, including] the development of critical thinking and nursing inquiry throughout the programme" (p. 6). According to the NCNZ it is clearly, then, mandatory for all NZ nurses to have developed critical thinking.

Each authority appointed in respect of a profession must, by notice published in the Gazette, describe the contents of the profession in terms of one or more scopes of practice. In the NCNZ competencies there are four Domains of Competence within which are more detailed competencies.

Historical context

New Zealand nurses have had their practice regulated since the enactment of the Nurses Registration Act in 1901. This act provided a means of controlling nurse registration through standardising their education and requiring that they pass a state examination prior to entry to the register. This was purported to ensure that standards of practice were achieved to protect public safety (Burgess, 2008). The act was originally administered by the Department of Health through the Inspector General of Hospitals prior to the Nurses and Midwives Act in 1925 when a registration board was established. The appointment of a nurse for the first time as the Registrar was enabled, although the board was chaired by the Governor General.

There were several amendments to the Nurses Registration Act until it was replaced by the Nurses Act in 1971. With this act came the establishment of The Nursing Council of New Zealand (NCNZ) as a separate and independent entity from the Department of Health. In 1977, the Nurses Act was introduced and has remained in force until the present.

The Nurses Act 1977, while undergoing some amendments with regard to patient safety (Vernon, Chiarella & Papps, 2011), made no reference to competence. Instead the focus was on the personal attributes of the nurse -

> *(a) The person is of good character and reputation, and is a fit and proper person to be registered or enrolled in accordance with his application; and (b) In the case of an applicant for enrolment, the person has attained the age of 17 years and 6 months* (Nurses Act, 1977, p. 530).

Following a report from Judge Sylvia Cartwright on the Cervical Cancer Inquiry in 1988, changes were made to the regulation of medical practitioners. Concerns had emerged about the "governance, accountability and ethics of the medical profession" (MOH, 2009, p. 1). Following the enactment of the Medical Practitioners Act (1995), a framework to reduce professional self-regulation was developed. With the enactment of the Health Practitioners Competency Assurance (HPCA) Act 2003, this framework was extended to 20 other regulated health professional groups, including nursing (Ministry of Health, 2009).

Regulatory authorities were identified within the act for all professional groups to register and regulate their particular profession. While an emphasis remains on 'fit to practice,' the requirement that standards of competence be identified for each of these professional groups became a focus. "The principal purpose of this Act is to protect the health and safety of members of the public by providing for mechanisms to ensure that health practitioners are competent and fit to practise their professions" (HPCA Act 2003, s3 (1)).

Although its purpose was to ensure competence, the HPCA Act 2003 does not stipulate what is meant by competence other than to declare that the "…required standard of competence, in relation to a health practitioner, means the standard of competence reasonably to be expected of a health practitioner practising within that health practitioner's scope of practice" (HPCA Act 2003, s5 (1)). There is an expectation within the act that the regulatory bodies define competence, fitness to practice and quality assurance, and that the regulatory bodies "set standards of clinical competence, cultural competence and ethical conduct" (p. 77).

Consequently, definitions of competence are provided in this document, these are: "...The combination of skills, knowledge, attitudes, values and abilities that underpin effective performance as a nurse". Furthermore, in order to be deemed competent "The person has competence across all domains of competencies applicable to the nurse, at a standard that is judged to be appropriate for the level of nurse being assessed" (NCNZa, p. 32).

Uncritical review

NCNZ Competencies (2012a)

The document is written for registered nurses and clearly informs the reader from the outset that it identifies the competencies for a registered nurse. The author is the Nursing Council of New Zealand and the document states that it has the purpose of regulating nursing, and serves to ensure what the nurse is required to do to practice safely and to "protect public safety". As a nurse, this informs me about how I can meet the required domains of competence to maintain my registration.

The language used is comfortable and familiar because I have used these exhaustively with the students across the under and post graduate nursing programmes. The document it is likely to engage the reader when they need to demonstrate they are meeting competencies in order to obtain their annual practicing certificate. The competencies regulate nursing practice; therefore I am bound by these. As I read, I am reminded of the power and influence they hold over nursing. They represent a formal capture of nursing practice.

The competencies are informed by the HPCA Act which mandates NCNZ to regulate my practice; however I am reminded as I read that this connection is not made clear in the competencies. They offer a generic representation of practice and can be applied across an extremely broad and complex healthcare context. I can understand the need to be generic and broad and recognise that this will allow flexibility (a good thing), but am aware of the tensions and questions that arise as a consequence. For example, as I read about how the competencies will ensure public safety, I question whether the document has the comprehensiveness that would be required for this. The document presupposes that safe practice is measurable and can be determined. Yet the measures are varied and, I believe, vague, and this lack of specificity can make presenting evidence problematic. The requirement to refer to other documents for details required to demonstrate competence could be missed by a naïve reader as these are mentioned as indicators and their actual identity and location are not made clear.

Keeping with the intention to be uncritical, I do like the way the nurse is presented as a professional in the opening sentence of the competencies. "Registered nurses utilise nursing knowledge and complex nursing judgment to assess health needs and provide care, and to advise and support people to manage their health. They practise independently and in collaboration with other health professionals, perform general nursing functions and delegate to and direct enrolled nurses, healthcare assistants

and others" (p. 3). This creates a sense of a nurse being influential and their role is of value.

As an academic I also noted there were no references referred to in the document and yet the core values and philosophical paradigm of nursing can be seen in the choice of competencies covered. Nursing Council is positioning itself as knowledgeable with no need to reference others and yet their frame of reference for the competencies must have come from somewhere.

There is a clear expectation that a registered nurse must utilise complex nursing judgement, provide interventions that require substantial scientific and professional knowledge, skills and clinical decision making, and much, much, more. To demonstrate these abilities there would be a need to think through information and shift through options and consider potential outcomes. A multifaceted problem solving approach, this certainly resonates with the hallmarks of critical thinking.

Critical Review

Establishing Authority

This document was written and produced by the Nursing Council of New Zealand (NCNZ) in 2007 (reprinted in 2012, amended in 2016) and sanctioned by the HPCA Act (2003). As the regulatory body for presenting the competencies for nursing practice in NZ, the NCNZ has ultimate authority to prescribe the standards of practice that determine who can be a Registered Nurse (RN) in NZ. This is achieved through the Nursing Council of New Zealand Competencies for registered nurses which definitively sets out the four domains of competence required to meet the registered nurse scope of practice.

The reasons for the strong air of authority can be understood if the role of the NCNZ is considered. The NCNZ is charged with regulating nursing practice to 'protect public safety'. The front page of their document clearly states: Competencies for registered nurses: *Te whakarite i nga mahi tapuhi kia tiakina ai te haumaru a-iwi. Regulating nursing practice to protect public safety.* It also has other purposes such as defining competence, professional standards and the measurement of these. The authors have a substantial responsibility. If a practising nurse was shown to have been meeting the relevant prescribed competencies when a person under their care was harmed, the NCNZ could be held responsible. For this reason the competencies must be comprehensive, clear and unequivocal.

The sense of authority over the reader (RNs) is clear from the outset. This explicit purpose is further identified on page 4 with the statement that a registered nurse is deemed safe to practise when evidence that they meet all four domains of competence is demonstrated. The Nursing Council has the ultimate authority for this decision.

In keeping with the requirements of the HPCA Act 2003, the competencies describe a scope of practice for the reader in language that could be considered as 'commonly understood by persons who work in the health sector'; in particular language that would be expected to be understood by registered nurses. This can be seen by the following description;

> *Registered nurses utilise nursing knowledge and complex nursing judgment to assess health needs and provide care, and to advise and support people to manage their health. They practise independently and in collaboration with other health professionals, perform general nursing functions and delegate to and direct enrolled nurses, healthcare assistants and others* (p. 3).

The document makes reference to "an area of science or learning"; in particular, stating that nurses "…provide interventions that require substantial scientific and professional knowledge, skills and clinical decision making" (p. 3). In addition, they identify for the reader tasks that would be expected to be 'commonly performed'; namely, that nurses provide

> *"…comprehensive assessments to develop, implement, and evaluate an integrated plan of health care, and provide interventions that require substantial scientific and professional knowledge, skills and clinical decision making"* (p. 3).

NCNZ also defines the boundaries within which a nurse may work in terms of educational, legislative, and experiential considerations.

> *Registered nurses may practise in a variety of clinical contexts depending on their educational preparation and practice experience. Registered nurses may also use this expertise to manage, teach, evaluate and research nursing practice. Registered nurses are accountable for ensuring all health services they provide are consistent with their education and assessed competence, meet legislative requirements and are supported by appropriate standards. There will be conditions placed in the scope of practice of some registered nurses according to their qualifications or experience limiting them to a specific area of practice* (p. 3).

The influence of the document is reinforced through links to other documents and this adds to the authority, power and the reach of the document. These documents include:

- HPCA Act (2003)
- Education programme standards for the registered nurse scope of practice (2010).
- Guidelines for Cultural safety, the Treaty of Waitangi and Māori Health in Nursing Education and Practice (2011)
- Code of Conduct for Nurses (2012b)
- Guideline: delegation of care by a registered nurse to a health care assistant (2012c).
- Guideline: responsibilities for direction and delegation of care to enrolled Nurses (2012d).

- Guidelines: Professional Boundaries (2012e)
- Guidelines: Social Media and Electronic Communication (n.d).

Literary tools to drive the message

The information is well spaced out over 34 pages, with one heading per page in the main. The layout and use of a large non-serif font, as well as having the NCNZ logo at the bottom of each page, provides an informal and 'friendly feel' to the document. The informality produced by the logo may of course be unintentional as stylised logos are not usually used in formal documents, particularly legal documents, and, in this case, the logo could be present to depict ownership; a trademark to signify NCNZ proprietorship.

The text is presented in a frame of a comprehensive authoritative guide on the skills, knowledge, attitudes, values and abilities a registered nurse must be able to demonstrate. NCNZ employs an authoritative register to achieve this. These are the minimum standards that are set by a very high authority. This identity and ownership of this authority are constantly reinforced by the NCNZ logo on each page.

The authority of the NCNZ to regulate practice can again be seen in the governing genre and authoritative framing that is adopted in the document. There is an implicit warning throughout that if one does not follow the rules or meet the requirements, they will not be allowed to practice as a nurse.

The opening paragraph begins "Registered nurses utilise nursing knowledge ....", and this *fait-accompli* style is used throughout the document. Definitive statements are used to provide information in an authoritative manner. There is no use of words such as "may", "could", or "should". There is no invitation to question the statements.

The unequivocal tone of the document can also be seen in the wording of the text. Words are active and definitive. For example, 'makes', 'accepts', 'identifies', 'demonstrates', 'uses', 'undertakes'. There is nothing tentative about the terms employed to communicate the actions of the nurse.

As a regulatory document, it is informed by conventions of legal and professional writing. However, the writers have simplified the language to make it accessible to everyday readers. The document is written for registered nurse readers and the accessible language ensures its readability for those new to the profession and students seeking to become registered nurses. In keeping with William's (2004) account of the influence of the plain language movement on legal writing, this shift in genre allows legal texts to be more comprehensible to any reader. This is also in keeping with the principles of clear drafting imposed by the New Zealand Parliamentary Counsel Office (2009) when writing any NZ legislation. Writing in this way is intended to increase the reading audience and therefore the potential influence of the document (Crowe, 2005). It is also consistent with Fairclough's view that consuming a text is assisted by "internalised social structures, norms and conventions" (Fairclough, 1992, p. 80).

While much of the language within the document is very clear and directive, some aspects of the document are vague and leave room for interpretation e.g. "Registered nurses are accountable for ensuring all health services they provide … are supported by appropriate standards" (p. 3). The document offers no clarity about which standards are being referred to and what is 'appropriate'. 'Appropriate' is defined in the glossary as "Matching the circumstances of a situation or meeting the needs of the individual or group" (p. 32). Stating the competency in this way could be argued to allow flexibility and support professional judgement. This being the case, the statements of accountability, legislative requirements and the term 'appropriate' all occurring at the same time, signal the requirement for the registered nurse to critically reflect on what needs to occur within their practice.

The words 'appropriate' and 'adequate' are also used in the competencies. This can be seen in Competency 2.4 and its indicators (underlining added):

> *"Ensures the health consumer has <u>adequate</u> explanation of the effects, consequences and alternatives of proposed treatment options.*
>
> *Indicator: Provides <u>appropriate</u> information to health consumers to protect their rights and to allow informed decisions.*
>
> *Indicator: Facilitates the health consumer's access to <u>appropriate</u> therapies or interventions and respects the health consumer's right to choose amongst alternatives"* (NCNZ, p. 17).

Using vague terms in this way places the responsibility with the nurse for determining what information is sufficient, acceptable, understandable, and is in keeping with the values, beliefs and cultural perspectives of those in care. The nurse is expected to know what content is important and have the professional mandate to discern this. There is the expectation that the nurse can communicate effectively across an extremely broad range of healthcare options in order to facilitate an 'adequate' and 'appropriate' explanation and facilitate access to 'appropriate' alternatives. This signals that critical thinking is essential for both accessing the required information and facilitating a person's choice.

The document is structured in a way that divides the Registered Nurse scope of practice into four 'domains of competence'. The domains are listed along with a number of 'competencies' that describe the attributes the nurse will have within each domain.

The first domain described in the document is 'professional responsibility', and the first competency is also about accepting responsibility.

> *"Accepts responsibility for ensuring that his/her nursing practice and conduct meet the standards of the professional, ethical and relevant legislated requirements"* (p. 9).

Under each competency there is a list of "indicators" that outline criteria for meeting the competency. The indicators offer more specificity to the domains of competence by providing

practice examples. While it is stated that indicators are not "comprehensive or exhaustive", the fact that these examples are documented, positions them as being especially important in the writers mind. The word "indicator" is also highlighted in bold text adding to their significance. For example, the very first indicator in the document is:

> *"Indicator: Practises nursing in accord with relevant legislation/codes/policies and upholds health consumers rights derived from that legislation."* (p. 9).

Foregrounding with the use of indicators in this way emphasises the importance of these examples, but also backgrounds other possibilities by not making them immediately available.

Another example of using foregrounding as a literary tool is the order that items are placed in sentences or lists. This can be seen in the description of the Registered Nurses scope of practice at the beginning of the document. There appears to be foregrounding of scientific knowledge ahead of professional knowledge. The sentence states:

> *"They provide comprehensive assessments to develop, implement, and evaluate an integrated plan of health care, and provide interventions that require substantial scientific and professional knowledge, skills and clinical decision making"* (p. 3).

This appears to foreground and privilege science in the sentence which may indicate greater importance placed on scientific knowledge than professional knowledge by placing it first in the sentence.

An example of backgrounding is seen in the last competency in the document which is placed below the previous one on the same page (p. 30). It could be argued that in this type of prescriptive document, the order of competencies is not important, but this is the only competency that is not on its own page, giving the impression that it may be an afterthought or less important. This competency is about the nurse participating in research that reviews activities and processes to improve quality and standards of nursing. Possible reasons for backgrounding the need for nurses to participate in such research are difficult to determine, particularly when comparing with the Australian National Competency Standards (2006), where participation in such activity is foregrounded.

Positioning subjects

The competencies and indicators begin with verbs that describe the way a competent nurse is practising. Almost every conceivable verb associated with behaviour is used. These include; Provides, Contributes, Demonstrates, Identifies, Undertakes, Administers, Uses, Applies, Maintains, Assesses, Facilitates, Understands, Implements, Evaluates, Discusses. Fairclough (2003) describes the nurse in this way of writing as an "activated social actor". He explains that

participants are described as activated when the author wishes to accentuate their capacity for "agentive action".

Although there was little reference to "nurse" in the actual competencies, the emphasis on the verbs such as "ensures", "uses", and "demonstrates" clearly depicts the nurse as agentic. Nurses are carrying out functions and 'doing' things to consumers. The message is clear that alongside this agency the nurse is also accountable and responsible for the outcomes of their actions.

> *"…being accountable for own actions and decisions…"* (p. 4).

> *"Understands accountability for directing, monitoring and evaluating nursing care provided by enrolled nurses and others"* (p. 11*).*

> *""Registered nurses are accountable for ensuring all health services they provide…"* p. 3).

> *"Accepts responsibility for actions and decision making within scope of practice"* (p. 9)

> *"Accepts responsibility for ensuring that his/her nursing practice and conduct meet the standards of the professional, ethical and relevant legislated requirements"* (p. 9).

The use of the term 'consumers' offers another example of framing in the document. Those a nurse works with are depicted as 'customers' or 'purchasers' by referring to them as 'consumers'. This link to consumerism frames those receiving care as participants in the market place and is in keeping with neo-liberal ideology. Neo-liberalism is further reinforced when combined with the edict that the nurse maximises consumer independence and self-management. This is seen in the following examples:

> *"….promoting an environment that maximises health consumer safety, independence, quality of life and health."(p. 4) and "…advise and support people to manage their health"* (p. 3).

As part of the requirements of a self-regulating profession, in order to maintain a practising certificate, nurses are required each year to declare that they meet the competencies as described in this document. Thus the nurse is measured against the standards by self-surveillance. The nurse will also be measured by others when he/she is directed to be assessed during an external competency review. Clear expectations of competency are expected to be recorded in line with the described competencies and examples.

> *The competencies in each domain have a number of key generic examples of competence performance called indicators. These are neither comprehensive nor exhaustive; rather they provide examples of evidence of competence. The indicators are designed to assist the assessor when using his/her professional judgement in assessing the attainment of the competencies* (p. 6).

Uncovering the discourses

This study is particularly interested in the way language is used within the document to construct the meaning of critical thinking. As explained in Chapter 2, an important component of this language is the recurrence of themes or discourses in the text. All of the phrases that have been identified as contributing to a particular discourse are provided in Table 1 in the Appendix (p.161).

One of the first discourses to be made apparent by the use of literary tools is the legal discourse. The first competency and first indicators state that nurses must adhere to relevant legislation, codes and policies.

In addition to using legal discourse, the Nursing Council engages several other discourses within the document to enable it to meet legislative obligations and communicate requirements to the nurse. In keeping with the legislative requirements, the discourse of professionalism can be seen as a significant discourse operating in the text. It can be assumed the intention is to ensure competent professional practice. Professional knowledge, judgement, decision making, nursing actions and ethics, all form part of the evidence of competent practice.

The four domains of competence in the document are written in ways that enable the practice of the nurse to be measured. The discourse of competency maintains that competency can be assessed when certain predetermined criteria are met (Eraut 1994). Professional judgement, clinical decision making, or articulating professional and scientific knowledge can more easily be quantified than critical thinking, and thus tend to be measured as a benchmark for competency.

As already identified, the discourse of responsibility as a professional is woven throughout the document. Nurses are constantly being reminded of the responsibility they have to act in ways that ensure public safety.

This reveals another discourse; that of safety. Once again, this discourse is constantly reinforced. There is an overarching discourse of safety, because the reason for regulating nurses and ensuring competency is to prevent the risk of harm to the public (HPCA Act, 2003).

The professional discourse links directly to the discourses of care, accountability, responsibility, evidenced based practice as well as scientific, humanistic, cultural, sociological, and psychological discourses. Deciding what the nurse ought, or ought not to do is influenced by legal (the legislated requirements, scopes of practice and competency), professional (nursing actions and decision making), organisational/managerial (follows organisations policies, rules and guidelines), EBP (using research and evidence) and ethical discourses and, as such position the nurse. Thinking critically requires the nurse to reflect on, and uncover the assumptions impacting on practice within these competing discourses. As Fairclough (1995) suggests, discourses do not operate in isolation and some can dominate.

Constructing critical thinking

In the above examples there are multiple discourses at play within the statements that help shape the way a nurse is expected to think. This includes construction of the meaning of critical thinking. Interestingly, the phrase 'critical thinking' is not used within the document. Possible reasons for this are discussed below, but it is clear that the ways of thinking that are prescribed, or the thinking that is required to achieve some of the competencies, include all of the elements of the definitions of critical thinking as discussed in Chapter 2.

An example of wording that clearly indicates that this document is instructing the type of thinking they want a nurse to use (including critical thinking) is:

> *"Reflects on his/her own practice and values that impact on nursing care in relation to the health consumer's age, ethnicity, culture, beliefs, gender, sexual orientation and/or disability."* (p. 13).

This statement highlights the requirement for the aspects of thinking that authors such as Brookfield, Kincheloe and Cody believe define critical thinking. This is reinforced by the following two statements:

> *"Practises in a way that respects each health consumer's identity and right to hold personal beliefs, values and goals."* (p. 13).
>
> *"Registered nurses utilise nursing knowledge and complex nursing judgment to assess health needs and provide care, and to advise and support people to manage their health."* (p. 3).

It is puzzling that the phrase 'critical thinking' is not used within the document. Given the widespread use of the term, and the fact that it is considered requisite for competent nursing practice, it is likely that its omission is deliberate. One possible reason is that it is difficult to assess "thinking". The outcomes of the thinking can be assessed, but not the thinking itself. Hence, more measurable terms such as "communicates effectively" are used.

Regardless, the Nursing Council makes it clear in other documents that graduates completing a programme for entry to the register of Registered Nurses in NZ are required to meet the following standard. "…intellectual independence, critical thinking and analytic rigour" (NCNZ, 2015, p. 3). Further, the following competencies do not necessarily use words that can be associated with critical thinking, but in order to achieve these competencies, engaging in critical thinking is required.

> Competency 3.2: *"Practises nursing in a negotiated partnership with the health consumer where and when possible."* (p. 26).

The term: 'a negotiated partnership' has many implications for the nurse. 'Health consumers' come from all walks of life, from all ages and all cultures, and yet a nurse is expected to negotiate a partnership with all of them. Given the complexity of clinical situations where a nurse practises in a negotiated partnership with a health consumer, critical thinking is required to effectively manage such events.

> Competency 3.3:*"Communicates effectively with health consumers and members of the health care team.*
>
> *"Indicator: Employs appropriate language to context."* (p. 27).

The ability to decide what is appropriate ("Matching the circumstances of a situation or meeting the needs of the individual or group" (p. 32) also requires critical thinking.

Competency 1.2 states: "Demonstrates the ability to apply the principles of the Treaty of Waitangi Te Tiriti o Waitangi to nursing practice". Three of the indicators are:

> *"Understands the Treaty of Waitangi/Te Tiriti o Waitangi and its relevance to the health of Maori in Aotearoa/New Zealand"* (p. 10).
>
> *"Demonstrates knowledge of differing health and socio-economic status of Maori and non-Maori"* (p. 10).
>
> *"Applies the Treaty of Waitangi/Te Tiriti o Waitangi to nursing practice"* (p. 10).

These are vague statements that require links to other documents to obtain clarity. In particular the document: *Treaty of Waitangi, NCNZ Guidelines for Cultural Safety, the Treaty of Waitangi and Maori Health in Nursing Education and Practice* (2011). This document calls on the nurse to

> *"… critically analyse the Treaty of Waitangi and its relevance to the health of Maori in Aotearoa/New Zealand"* (p. 14).
>
> and *"critically analyse the underlying historical, social, economic and political processes that have contributed to the inequalities and disparities in the Maori health status"* (p. 17).

This foregrounds the nurse's responsibility for analysing these issues and backgrounds structural requirements such as the healthcare system and organisational structures. To critically analyse requires critical thinking and an understanding of the impact of colonisation, political, economic and social determinants of health and cultural safety. This is backgrounded within the competencies by placing this requirement in a supporting document which is not overtly or specifically referred to in the competencies.

Document 2:

New Zealand Nurses Organisation: Standards of Professional Nursing Practice (2012)

Background

 The New Zealand Nurses Organisation (NZNO) represents over 46,000 nurses and health workers. They claim to be the leading professional body of nursing in Aotearoa New Zealand. NZNO membership is not exclusively registered nurses, but includes other health workers. Alongside their role as a professional organisation, NZNO is also the nursing union in New Zealand and as such they negotiate salary and working conditions for nurses. It also negotiates on behalf of midwives, hospital aids and other health care workers. In addition NZNO organises and produces submissions and reports on issues impacting on nursing in New Zealand.

Historical context

The introduction of the state registration act in 1901 formalised the requirement that nurses undertook three years of training and successfully completed state examinations for nursing registration. O'Connor (2010) maintains that this did not necessarily lead to an advantage for registered nurses in gaining employment over unqualified workers. Elevating the status of these qualified nurses as a professional workforce began via the establishment of associations of trained nurses. The Wellington Private Nurses' Association was the first established in 1905 (NZNO, 2016; O'Connor, 2010). The Trained Nurses Club emerged in Dunedin in 1907 and following this the Trained Nurses' Associations formed in Auckland and Canterbury in 1908.

In 1909 Hester Maclean, the then Department of Health's assistant director and deputy-registrar of nurses, advocated that the associations become a joint national association. O'Connor (2010) records that the first meeting of the 'New Zealand Trained Nurses' Association (NZTNA) set out the concerns of the association and announced it would represent "… the economic welfare of members, the financial basis of the Association, training, and social issues such as the welfare of women and children" (p. 23). Of note however, is the early connection to managerial influence within the power structures of the Association. O'Connor notes that the central leadership of the Association were very much "agents of the employers" with an overarching agenda of ensuring a "compliant workforce" (p. 24). There was alongside this a concern that the Association be cognisant about the calibre of the membership. Quoting an article from the NZTNA journal, Kia Tiaki (1910), O'Connor identified that the Association had a desire to be more of a 'private club' and that many registered nurses 'would not be desirable as members' (O'Connor, 2010, p. 25).

This less than democratic beginning to the organisation now known as NZNO, offers an example of the potential conflict of trade union versus professional interest groups within NZTNA. Indeed, NZNO (2016) maintains that professional concerns had been at the forefront of the association from the beginning. From an editorial in Kai Tiaki, July 1909 they quote: "We must, however, guard against any element of trades unionism creeping in among us. A nurse must be a woman, working, not in the first place for the sake of money-making, but for the good of her fellow creatures, to alleviate suffering when she can and help towards the health of those who need her care!" Notions of professionalism according to Maclean were reflected in a devotion to duty and "… to be true professionals, nurses had to prove their dedication in the school of hard knocks, whatever that implied" (O'Connor, 2010, p. 28).

The professional work of NZTNA developed via its relationship with the Department of Health, through which it could make recommendations and suggestions regarding nursing practice. The Kai Tiaki journal was another venue for furthering the professionalism of nursing. Articles covered information on a range of nursing practices, and relevant health news. This also included commentary from abroad on matters of relevance to NZ. The international awareness was achieved via the association with the International Council of Nurses (ICN) of which NZTNA became a member in 1912 (O'Connor, 2010). In 1934, the name of the Association changed to The New Zealand Registered Nurses' Association (Inc), NZRNA. This was in response to concerns that the notion of 'trained' was also being used by those with 'experience' rather than formal nursing education.

The unionism work of NZTNA has its roots in the requirement by the Labour government during the mid-1930s, that all workers be represented. This caused dissention in the association, but it was recognised that if the association didn't embrace this role, another union would.

The Second World War stalled the NZTNA application and registration as a union. While the focus of the association was on professional concerns, the welfare and working conditions for nursing practice were also of concern to the Association. It wasn't until 1969 that the association became the recognised negotiating body for its members (NZNO, 2016). This applied to nurses working in government run hospitals and this role continued to develop into the early 1970s. In 1973, in response to continued concern in the private sector over poor wages for nurses, the New Zealand Nurses' Industrial Union of Workers was formed. This later became the NZ Nurses' Union (NZNU). Initially they only represented nurses in private hospitals (NZNO, 2016). O'Connor maintains that "Suspicion about unionism and its incompatibility with 'real nursing' prevailed among public sector nurses" (p. 10) and it wasn't until the "radical health reforms of the 1980s and 1990s, which rendered the 'professionalism for status and rewards' strategy woefully out of date, was the association persuaded to become more industrially active" (p. 11).

In 1993, the NZNA and NZNU amalgamated to become NZNO. In 1996, NZNO extended its brief by forming a division for other health professionals and now represents a "broad range of health professionals" (NZNO, 2016).

The dual role of NZNO as a professional organisation and a union has been problematic for the profession from the beginning of its inception. Although professionalism today would argue against supporting the concept of "the school of hard knocks", the legacy of selfless dedication is worthy of note. That advocating for better working conditions requires union activism signals the political influence in silencing the profession. However some see the union role of advocating for better working conditions as a hindrance to the development of the profession.

Carryer (2002) calls attention to the ongoing impact of this dual role for the professionalism of nursing. She argues that nursing is prevented from becoming a full profession due to the unions need to retain its powerful and significant role in negotiating for nursing wages and conditions. She asks; "Why would it benefit a nursing union to allow any measure which guarantees improved autonomy, status and recognition for its members, thus ensuring that they become to regard the union as less relevant in their working lives?" (p. 156). She maintains that the link between the industrial and the professional functions of NZNO compromise the professional voice in favour of industrial decisions. While acknowledging that the functions of the union are important for nursing, Carryer maintains that they need to be separate entities and "it must be the professional voice which is loud and strong and which shapes the public and government image of nursing" (p. 156). This is a noble notion that is compromised within neoliberal policy that determines worth on free market imperatives.

Uncritical review

NZNO Standards of Professional Nursing Practice (2012)

This document is written for registered nurses who wish to join this professional organisation. I noticed immediately how the document positioned Te Tiriti o Waitangi as the founding document of Aotearoa/New Zealand and the commitment to working in partnership with "Te Rūnanga o Aotearoa, NZNO (Te Rūnanga)". This is unlike the NCNZ Competencies for registered nurses (2012a), which refers to the Treaty only in Competency 1.2 ("Demonstrates the ability to apply the principles of the Treaty of Waitangi Te Tiriti o Waitangi"). The overarching honouring of the Treaty seems more in keeping with our obligations as New Zealanders to a Treaty partnership.

Although NZNO is a nursing union (bargaining agent) and a professional body, the standards identify clearly what 'the profession expects of its members" (p. 4). I believe the concluding paragraph on page 4 which alerts to the obligations of sites where nurses may carry out their work as a nurse signalled NZNO union obligations to protect the rights of its members. The standards seem to emphasise obligations rather than rights for its members. The ability to enact the standards cannot, in my view, be separated from an environment that supports this. This is a challenging dual role.

The document clearly informs the reader from the outset that it is aligned to the NCNZ competencies for a registered nurse and spells out its position alongside NCNZ.

Similarly to the NCNZ competencies, the language used is comfortable and familiar because I have used these with the students across the bachelor and post graduate nursing programmes. These standards would support nurses in capturing examples of their practice to demonstrate competency as is claimed by NZNO. They offer a way of 'benchmarking' practice.

The document is long and covers an extensive range of expectations on the performance of the nurse. I found the tone of the document very directive and full of definitive statements. It was useful that the writers had included the references that informed the document. It was no surprise that nine of the 13 references were from NCNZ. The remaining four were from NZNO and one was a fundamental nursing text: Crisp, J., & Taylor, C. (2007). *Potter & Perry's Fundamentals of Nursing.* Sydney: Elsevier.

While this is not part of the Standards, their website (where the standards can be found) has a page outlining the benefits of joining NZNO. The first reason given for joining NZNO is for their industrial services. This is ahead of professional services which is second in the list. In addition, further down the page is a section identifying why you should join a union and information about what a union is and what they have won etc. I found it interesting there was is no such section for professionalism.

Critical review

Establishing Authority

NZNO, as the largest nursing organisation in the country, has significant influence over the practice of nursing in New Zealand. This influence is gained via the number of members and the collective agency this affords it as a union. As a representative body for nurses in New Zealand, they are a credible author and the expectation that the nurse meet the organisation's standards of practice as set out by the document holds professional power. NZNO calls on the NCNZ to reinforce their own significance and there is a clear alignment of the standards and the NCNZ competencies.

The document has been written to describe the standards of practice expected from a registered nurse in NZ who is a member of NZNO. To this end, the document is constructed to tell the registered nurse what standards are required in order to demonstrate safe, professional practice. The document also serves to support the benchmarking of the nurses' performance, as it sets the criteria against which this will be measured. The standards are "…professionally

developed expressions of the range of acceptable variations from a norm or criterion" (Donabedian, 1981, p. 411).

The document clearly states its purpose in the opening introduction, positioning itself powerfully as 'the voice of the profession' in providing an "…outline of what the profession expects of its members and to promote, guide and direct professional nursing practice" (p. 4) This is achieved in the document by statements describing the knowledge, skills, professional judgements and attitudes required by the nurse in order to demonstrate safe practice. The document clearly identifies that its members are professionally responsible and accountable for meeting these standards.

As with the NCNZ document, the standards are written as definitive statements which are clear and directive. This is seen by the example; "Nurses are responsible and accountable for their practice." (p. 6), and it is in this style of declaration that all other standards are presented.

The standards are also aligned with the NCNZ competencies. This is can be seen in the following quote;

> *While the Nursing Council of New Zealand (NCNZ) is required under the Health Practitioner's Competence Assurance Act 2003 to specify the scope of practice and qualifications necessary to become registered under the Act and set ongoing competence requirements, nursing's professional bodies have a core role in setting standards of practice. A competency set by the NCNZ provides a benchmark against which an assessment of an individual's ability to meet the required standards is made* (p. 4).

The links to other documents, such as the NCNZ competencies and also the Code of Ethics, adds to authority and power and the reach of the document. These professional standards could be argued to be one of the "standards of practice" documents that NCNZ refer to within their competencies. The reach of NZNO is further enhanced by legal and professional discourse. As one of the agencies that is representative of Nurses, NCNZ is directed by the HPCA act (2003) to consult with them when developing the contents of the profession. They must seek feedback about the scopes of practice and how "...to determine the qualifications for every scope" (Burgess, 2008, p. 78).

As the largest professional nursing organisation and union, which supports nursing in industrial and professional issues, NZNO holds a powerful role within nursing contexts. As both a professional organisation and a union, it is an influential author. "Our members are united in their professional and industrial aspirations" (NZNO, 2014). This statement positions NZNO as having a powerful collective voice. NZNO also offers indemnity insurance and the expectation would be that standards are met in order for this protection to be supported.

Literary tools to drive the message

The information in the document is well spaced out and identifies seven standards over 15 pages, with one heading per page. The layout is formal with font size 20 for the heading and a much smaller 9.5 for the descriptor and standards. The term "NZNO Standards for professional practice" appears at the bottom of each page. This could be present to depict ownership; a trademark to signify NZNO proprietorship.

The professional standards also provide a "framework for developing competencies" (p. 4). This indicates an alignment with the NCNZ competencies, giving the document greater influence. To this end, the NZNO standards employ a governing genre (Fairclough, 2003). This purpose-driven genre positions the document as having authority and power over NZNO members. The reader is in no doubt that the registered nurse must demonstrate that they meet all of the standards to meet the expectations of the profession. While not as far reaching as the NCNZ, which regulates all nurses, as a union (bargaining agent) and a professional body, its influence is substantial.

In a similar vein to NCNZ, definitive statements are used to provide information in an authoritative manner. Written as declarations using the word 'Nurses' at the forefront of each of the standards reinforces that the nurse is required to meet all of these standards. Using standards to describe the expectations of a member of NZNO provides a means to measure the performance of the nurse.

As a document of professional standards, it is informed by conventions of professional writing. According to Weiss and Tappen (2015) "…one of the defining characteristics of a profession is the ability to set its own standards" (p. 33). The document is written for the registered nurse and the accessible language ensures its readability for those new to the profession and students seeking to become members of NZNO. In keeping with the International Organization for Standardization (2016) guide on how to write standards, NZNO adheres to the procedure for standard writing. Plain language is used to make the information comprehensible to any reader.

The text is presented in a frame of a comprehensive authoritative guide on the skills, knowledge, attitudes, and judgement a registered nurse, as a member of NZNO, must be able to demonstrate. These are the expected standards that are set by a professional authority, and mandated by its members.

In a similar way to that of the NCNZ competencies, certain examples are foregrounded and therefore privileged by giving them prominence. The document consists of a set of standards with the headings as in the following example: "Standard One: Responsibility and Accountability", written as a heading in font size 20. The very next sentence is positioned in the document as a single sentence and whilst in the smaller font of 9.5, commands attention as it is placed on its own with space around it and the words are composed as a declaration or definitive statement.

In keeping with the NCNZ competences, the first standard is that of responsibility. Nurses are responsible and accountable for their practice and this definitive statement positions responsibility at the forefront of the readers mind. There is also an immediate link to legislative requirements within Standard 1.1 which foregrounds the link to NCNZ competencies:

> *"….work within their scope of practice, based on current nursing knowledge, professional judgement, experience and competence, within their area of practice and job description"* (p. 6).

This is further reinforced in Standard 1.2:

> *"Nurses function within relevant legislation, meeting statutory requirements"* (p. 6).

The requirement to demonstrate evidence based practice (EBP) is foregrounded by its introduction in this first standard, signalling the nurse's responsibility to apply evidence based research. This privileging of EBP is then reinforced in Standard 2;

> *"Nurses base practice within their scope on the best evidence from nursing science and other sciences and humanities"* (p. 7).

While the nurse's responsibility for meeting the standards of practice is foregrounded, unlike the NCNZ and although backgrounded, NZNO acknowledges the responsibility and influence of others in assisting the registered nurse in meeting the standards of practice:

> *Provider organisations have an obligation to provide essential support systems, including human and material resources so that nurses are able to meet the standards for practice. However, these standards for nursing practice have not attempted to address the obligations of such organisations directly* (p. 4).

Within Standard Five: Ethics, the nurse is expected to "…base their practice on a recognised code of ethics (e.g. the NZNO Code of Ethics, 2010)". In Standard 5.1 "Nurses uphold the values found in the NZNO Code of Ethics (2010a)" (p. 11). Definitive statements are used to ensure these are upheld, all of which require the nurse to think critically. These include:

> "…*address ethical issues*", "…*appropriately challenge health care practice*", "…*respect a client's right to live and die in dignity*" and "…*advocate for optimal health care*".

The words used are not overly formal but in some cases carry loaded meaning, for example; 'professional judgement', 'appropriate', 'innovative' and 'creative'. All require further explanation and contextual positioning to clearly communicate what is actually required.

Positioning subjects

Each standard begins by identifying "Nurses" as those referred to in the document. "Nurses are responsible and accountable for their practice" (p. 6). They are clearly depicted as agentic, by positioning the following verbs in a particularly influential manner or by using them repeatedly in the text. These words include: 'ensure', 'use' , 'provides', 'maintain' , 'demonstrate', 'implements', 'evaluates', 'uphold', 'determines', 'identify'. There is also the repeated expectation that the nurses need to determine what is professionally appropriate and to behave appropriately.

Standard 3.1 requires the nurse to "… adhere to professional standards of behaviour and conduct with clients, family whānau members, colleagues and society as outlined in the Nursing Council of New Zealand Code of Conduct (NCNZ, 2012) at all times" (p. 9). The word 'adhere' is a powerful word and positions the nurse as having no choice. According to the Merriam-Webster on-line dictionary (2017), adhere means "to bind oneself to observance… adhere to the rules". This influences the agency of the nurse and backgrounds the thinking process required to behave as a professional.

While these standards are written in a directive manner, there is no professional obligation. Nor is it mandatory for nurses to demonstrate that these are met. Nurses can elect to join NZNO and then there is an expectation that the standards 'guide and direct' their practice. Should a nurse, as a member of NZNO, request advice or support, there could be an expectation that they provide evidence of meeting the standards.

Uncovering the discourses

As with the NCNZ competencies (Document 1), the discourses that are apparent in this document are those of, legislation, professionalism, safety and risk, management and EBP. These discourses also connected to other discourses such as, competence, care, accountability and responsibility. Excerpts from the document that illustrate these discourses are presented in Table 1 in the Appendix (p. 161).

The first standard within the document is that of responsibility. Nurses are responsible and accountable for their practice. There is also an immediate link to legislative requirements within Standard 1.1:

> *"Nurses work within their scope of practice [regulatory, legal discourse], based on current nursing knowledge, professional judgement, experience [professional discourse] and competence [competence discourse], within their area of practice and job description" [organisational discourse]* (p. 6).

As with the NCNZ competencies, there is a presupposition that demonstrating and measuring standards is the most effective means of ensuring safe practice. The document claims:

> *"…These generic standards represent the outcomes against which nursing practice will be measured by consumers, employers, colleagues and nurses themselves"* (p. 4).

To this end the standards are written in ways that enable the practice of the nurse to be measured. As with the NCNZ document, the discourse of competency maintains that competency can be assessed when certain predetermined criteria are met (Eraut, 1994). Professional judgement, clinical decision making, or articulating professional and scientific knowledge can more easily be quantified than critical thinking, and thus tend to be measured as a benchmark for competency.

Te Tiriti o Waitangi is not positioned within a single standard as in the NCNZ competencies, but is foregrounded following the introduction to the text as having an overarching position within the standards and, as such, in relation to nursing practice.

> *Te Rūnanga is an integral part of NZNO membership and this relationship reflects the Treaty commitment. The intention of this commitment is to realise the place of Te Tiriti o Waitangi within NZNO as the wider organisation and its future moemoeā (aspirations and dreams). NZNO recognises the uniqueness, values and contributions of each party within this relationship. Together, Te Rūnanga and NZNO will work with collaborative intent to create, implement and monitor kawa/policy that will be intrinsic throughout organisational tikanga/procedures and activity* (p. 5).

This statement calls on not only legal discourse in highlighting Treaty obligations but also, professional, safety and management discourses.

Within the standards, fragments of managerial discourse are evident and offer a particular slant to the conditions surrounding the provision of care. There is a sense that the relationship with the employer (as would be the case with a union) is present, and communicated via employment expectations. This is seen framed in the following example by the reference made to a 'job description',

> *"Nurses work within their scope of practice, based on current nursing knowledge, professional judgement, experience and competence, within their area of practice and job description"* (p. 6).

and in the following reference to risk management plan and continuous improvement,

> *"Nurses identify hazards and risks to client safety and participate in developing and implementing a risk management plan through continuous quality improvement"* (p. 7).

and also in this statement identifying the responsibility to appropriately use resources to ensure a safe working environment:

> *"Nurses are active in designing, implementing and evaluating workload measurement tools to ensure appropriate use of resources to meet client needs and ensure a safe working environment"* (p. 13).

EBP is another discourse that is clearly signalled within the standards and its repeated reference signals the importance this holds as a requirement for nursing practice.

> *"Nurses demonstrate knowledge and appropriate utilisation of evidence-based policies"* (p. 7).

> *"Nurses demonstrate evidence of application of evidence-based research in practice"* (p. 6).

> *"Nurses interpret, critique and use current evidence from research and other credible sources to make practice decisions"* (p. 7).

Constructing critical thinking

While the actual wording, 'critical thinking', is absent within the document, its use is implied and strongly advocated. This is evident in statements such as those found in Standard 2.2;

> *"…interpret, critique and use current evidence from research and other credible sources to make practice decisions"* (p. 7).

and Standard 4.4;

> *"Nurses use reflection to critically analyse their practice, identify any gaps in knowledge and take steps to address these"* (p. 10).

There is also evidence throughout the document of other words, which are used that if not synonymous with critical thinking, overlap with aspects of its definition. These include 'professional judgement', 'take action', 'nursing knowledge', 'decision making' and 'evaluation'. These words particularly resonate when read in the context of the document excerpts. For example, in the following statement, critical thinking becomes activated in the term 'nursing knowledge', when it is aligned to the requirement to meet stated and implied needs:

> *"Nurses apply current nursing knowledge using a documented systematic approach to meet the stated and implied needs of clients / family / whānau / hapū / iwi"* (p. 7).

Nonmaleficence (doing no harm) is an ethical principle that a nurse is expected to uphold. This involves the "Avoidance of harm and the prevention of future harm. In a situation of where harm is unavoidable, the harm is minimised" (NZNO, 2010, p. 12). NZNO (2010) recognises that "Contextual variations on the meaning and value of harm will influence exploration and outcome in the consideration of maleficence" (p. 12). Critical thinking is essential for the nurse to engage with ethical dilemmas and uphold ethical practice. Navigating situations with clients that supports harm minimisation can be challenging and thinking critically could be argued to be essential for this to occur safely.

Standard 3.2, states that the nurse must "work in partnership with Tangata Whenua to ensure that mātauranga (Māori ways of knowing), beliefs and values are upheld within the practice context". Structural impediments that are based in dominant ideology can disrupt the ability for this to occur. Due to the 'taken for granted' nature of healthcare practice which may minimise or devalue cultural practices, the ability for these impediments to be recognised and 'successfully' managed requires critical thinking. Examples of such practices could include the administration of visiting restrictions, shared toilet facilities, and mixed gender rooms. Each of these need to be considered in ways that honour the unique social and cultural practices of those receiving care.

Document 3:

New Zealand College of Mental Health Nurses: Standards of Practice for Mental Health Nursing (2012)

Background:

Te Ao Māramatanga, New Zealand College of Mental Health Nursing (NZCMHN) is the professional body for practising mental health nurses in New Zealand. Their mission statement is: "Partnership, Voice, Excellence in Mental Health Nursing" and their focus is solely on those nurses who practise as mental health nurses. The college identifies its role to include the representation of member's professional interests, to promote mental health nursing as a speciality, to advance education and clinical expertise, guide members in professional practice via their national standards of practice, and promote political awareness. The college is committed to ensuring that mental health nursing education and practice is "culturally safe and encompasses the three articles of the Treaty of Waitangi and the principles of Kawa Whakaruruhau[1]".

Historical context:

Formalised mental health nursing education within NZ emerged in response to the belief by medical superintendents that knowledge and skills were required to ensure the provision of safe and humane care for patients within psychiatric asylums (Prebble, 2001, 2012). Developed as a separate education and qualification from its general and obstetric counterparts, these nurses were registered as Mental Health Nurses by the Department of Mental Hospitals from 1907. In 1944 the Department of Health assumed responsibility for psychiatric hospitals (Workforce Development Group, 1988) and at the same time the Nurses and Midwifes Amendment Act was passed, under which a NZ Register of Psychiatric Nurses was established (Prebble, 2012). As with General and Obstetric nurses, successful completion of a three year training programme and passing of a state registration exam was required to gain registration as a Registered NZ Psychiatric Nurse.

In 1971 the Ministry of Health commissioned Helen Carpenter, a nursing scholar from Canada, to review nursing education in New Zealand. Her report to the Ministry recommended that nursing education be moved from a hospital based training system to a tertiary education system. This move would see the establishment of a comprehensive nursing programme that produced nurses able to work across all specialities. Prebble (2001) maintains that during this review of nursing education, Carpenter believed the training of psychiatric nurses was inferior to that of their general counterparts. Coupled with the 'mainstreaming and de-institutionalisation'

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[1] Cultural safety in nursing education in Aotearoa

that was occurring at this time, it appeared that Carpenter believed that training psychiatric nurses as a separate discipline would not be required and she recommended the closure of psychiatric programmes and a strengthening of the "mental health component" in general nursing programmes. This was to be an interim measure prior to the establishment of comprehensive nursing programmes (Prebble, 2001, p. 137).

Research and reviews into the outcomes for mental health practice following the shift to comprehensive education indicated that mental health nursing did not fare well (see Prebble, 2001). These reviews identified that those completing comprehensive programmes were not well enough prepared for work within mental health practice. The recognition that further educational preparation and support was required, led to the establishment of post registration education in mental health. New-to-practice nurses wishing to work in Mental Health areas needed to undergo further specialist education. The current version of this education programme is called the "New entry to specialist practice (NESP): mental health and addiction nursing programme" (Te Pou, 2017). The purpose of this programme is to support the development of professional practice and mental health and addiction nursing skills. Nurses are required within this programme to complete a Postgraduate Certificate in Mental Health and Addiction Nursing. The NZCMHN is a leading advocate of this requirement and for the advancement of mental health nursing as a specialty discipline.

Tracing the founding history of the College of Mental Health Nurses is difficult. It is not clear whether it emerged in response to a professional mandate to elevate the professional status of mental health nursing, or in response to worsening working conditions.

In 1987 a national organisation to represent the professional interest of mental health nurses was established and was named Te Ao Maramatanga (O' Brien & Morrison-Ngatai, 2004). This name was gifted to New Zealand mental health nurses by Ralph Love, a Kaumatua from Poneke, Wellington. The name was later used as the name for the current NZCHMN.

According to Martyr (1999), New Zealand mental health nursing representation emerged in the early 1990s in response to the impact of the 1990 health reforms. Concerns that mental health nurses held regarding their job security and conditions of employment during this time led to the formation of the "Otago Association of Nurses Working in Mental Health" (p. 33). This association did not intend to nationalise. The intention was to form a national body from a collection of similar regional associations. New Zealand nurses were at the time joining branches of the Australian College of Mental Health Nurses as individual members.

In 1993, following a constitutional amendment within the Australian college, New Zealand was invited to join as a separate branch and in recognition of this, the college became the 'Australian and New Zealand College of Mental Health Nurses Inc.' The College enjoyed strong membership and was active in generating research, running conferences and participating in policy formation. The professionalism of mental health nurses was high on the college's agenda and they produced a number of publications to support this. The first of the Standards of

Practice, the forerunner to the Standards of Practice analysed here, was written in 1995. In September 2002, due to concerns by New Zealand members about how "national sovereignty" could be addressed, New Zealand formed its own College which resulted in the formation of "Te Ao Māramatanga, New Zealand College of Mental Health Nursing" (O'Brien & Morrison-Ngatai, 2004).

Uncritical review

NZCMHN Standards of Practice for Mental Health Nursing in Aotearoa New Zealand (2012)
The document is written for registered nurses who wish to join this professional organisation. As with NZNO standards of practice, this document positioned Te Tiriti o Waitangi as the founding document of Aotearoa/New Zealand. "Culture and knowledge are dynamic and combined with relevant clinical practice".   These Mental Health Standards of Practice provide a mental health nursing perspective pertinent to Aotearoa New Zealand. The uniqueness of the Standards of Practice are underpinned by a treaty of 'wisdoms' (Te Tiriti o Waitangi / The Treaty of Waitangi, 1840). From this foundation emerge principles that identify cultural esteem as the core tenet of mental health and wellbeing of all peoples. And as such, we in the field of mental health are tasked with generating specific and diverse interventions, policies, activities and practices that serve the mental health needs of individuals, their families and communities" (p. i). The connection of culture to wellbeing as a guiding tenet made this document quite different from the other two professional documents because while culture is present in the other documents, it is not foregrounded like this. I liked this stand for practice because it clearly connects the importance of cultural identity for mental health.   The standards clearly articulate that mental health nursing is a specialty. I have some reservations about this as a claim. Being educated in a comprehensive programme and having worked in both mental health and 'general' health, I struggle with the demarcation of practice. Both physical and mental health form part of a person and these interrelate in all areas of practice. On-going education is required wherever a nurse practices and should be the focus.   There is weight given to the requirement for those intending to be a mental health nurse that education in the form of a postgraduate qualification in mental health is completed. While all new graduates wishing to work within a District Health Board in NZ are required to complete one postgraduate paper, for those in mental health the requirement is two. I interpret this as indicating a lack of faith in the preparation of

nurses in the undergraduate programmes, and a marketing strategy of universities to increase education demands and increase student numbers. I wonder if the intention to increase the status of mental health nursing in this way is misguided, and if this may in fact be a barrier to attracting graduates because mental health nursing requires more educational input.

I didn't perceive the same strong connection to NCNZ competencies within these standards, which I found interesting. In fact, the only overt mention of NCNZ competences is in standard 5 and as a reference in the bibliography. Unlike NZNO, who preface NCNZ from the outset, NZCMHN call on the Ministry of Health (MOH) 2008 document Let's get real as a guide. "The Standards of Practice are concerned with the performance of Mental Health Nurses in Aotearoa New Zealand and include practice outcomes and attributes of knowledge, skills and attitudes. The values, attitudes and seven Real Skills identified in Let's Get Real (Ministry of Health, 2008) which underpin the provision of effective mental health and addiction services in Aotearoa New Zealand are reflected in these Standards" (p. 6).

Similarly to the NCNZ competencies and the NZNO standards, the language used is comfortable and familiar because I have used these with the students across the nursing programmes. They, like NZNO standards, would support nurses in capturing examples of their practice to demonstrate competence.

The document is long and covers an extensive range of expectations on the performance of the nurse in terms of practice outcomes and attributes of knowledge, skills and attitudes. I found the tone of the document very directive and full of definitive statements. It was useful that the writers had included the references that informed the document. Only 2 of the 17 references were from NCNZ.

Critical Review

Establishing Authority

The document was written and produced by the NZCMHN in 2012. The purpose of the NZCMHN standards is to define and describe mental health nursing practice. This purpose-driven genre positions the document as having authority and power over the practice of mental health nursing in NZ and also dictates who can use the title 'mental health nurse'. The reader is in no doubt that the registered nurse must meet particular requirements in order to be a mental health nurse in NZ. While not as far reaching as the NCNZ, which regulates all nurses, as a professional body its influence is far reaching.

As the only mental health professional nursing college which supports nursing practice within mental health and addiction practice, NZCMHN holds a powerful position within nursing contexts. NZCMHN identifies itself as a professional college and as such has academic and professional prestige and hence influence. A college is defined as: "An organised group of professional people with particular aims, duties, and privileges" (Oxford Dictionaries online, 2016). Given the historical academic positioning of mental health nursing as inferior to that of general nursing, the decision to call the professional group a college could be interpreted as a deliberate ploy. Motivated by the desire to elevate the professional standing of mental health nursing in the minds of nurses and in those the college interacts with, the employment of an academic title such as that associated with the term 'college' makes sense.

As the representative body for mental health nurses in New Zealand, they are a credible author and the expectation that the nurse meets the College's standards of practice as set out by the document holds professional power. NZCMHN calls on the NCNZ to reinforce their own significance in the opening introduction, identifying that they build on the NCNZ competencies. "Mental Health Nursing is a specialised branch of nursing practice that builds on the competencies expected of all nurses who practice in Aotearoa, New Zealand" (p. 4). This connection is reinforced in Standard 5.

Links are also made to other documents such as "The values, attitudes and seven Real Skills" identified in "Let's Get Real" (Ministry of Health, 2008), and this adds authority, power and the reach of the document. These could be positioned as one of the standards of practice that NCNZ refer to within the competencies. NZCMHN also align with NZNO in strategic planning for advancing professionalism of nursing.

Literary tools to drive the message

The information is well spaced over 16 pages and identifies six standards. Each standard is presented over two pages with a central heading on the first page. The standard is first defined and a rationale offered, thus foregrounding the significance of the standard by justifying their presence and stating their relevance. This is followed by the practice outcomes and then the attributes of knowledge, skills and attitudes required of the nurse.

The layout is formal with font size 24 for the heading and much smaller 14 for the rationale, practice outcomes, attributes, skills and knowledge. There is a logo on each page located on alternate corners throughout the document. The logo represents Ranginui- Sky Father (left profile) and Papatuanuku – Earth Mother. This depicts "our humanity" (NZCMHN, Appendix, p. 179). The logo was formally adopted by the NZCMHN in 2004 and called Rangi and Papa. It represents the new Te Ao Maramatanga- New Zealand College of Mental Health Nurses, following the separation from the Australian College of Mental Health Nurses.

The text is presented in a frame of a collective professional voice; "Ehara taku toa i te toa takitahi, engari he toa takitini. *My strength is not that of a single warrior but that of many"* (motto, p. i)*.* The collective approach provides legitimate professional power and influence to the document, which determines:

> *"specific and diverse interventions, policies, activities and practices that serve the mental health needs of individuals, their families and communities"* (p. i).

The declaration of being in service to others positions mental health nursing as offering morally good practice.

As a form of manifesto, the document offers rules and principles which clearly articulate its purpose. As Wodak and Weiss (2004) identify, manifestos have "certain rules and expectations according to social conventions, and specific social purposes" (as cited by Higgins, p. 84). The NCMHN document is clear in regard to the social conventions and purpose of the document;

> *"…these Mental Health Standards of Practice provide a mental health nursing perspective pertinent to Aotearoa New Zealand. The uniqueness of the Standards of Practice are underpinned by a treaty of 'wisdoms' Te Tiriti o Waitangi / The Treaty of Waitangi 1840"* (p. i).

There is an absolute commitment to honouring the treaty "as a working partnership model", declaring that "Clinical and cultural excellence in mental health nursing is the goal of us all" (p. i).

The document begins with a foreword identifying the rich cultural and clinical heritage that informs the Mental Health Standards of Practice. This clearly identifies their purpose as providing;

> *…a mental health nursing perspective pertinent to Aotearoa New Zealand. The uniqueness of the Standards of Practice are underpinned by a treaty of 'wisdoms' Te Tiriti o Waitangi / The Treaty of Waitangi 1840. From this foundation emerge principles that identify cultural esteem as the core tenet of mental health and wellbeing of all peoples. And as such, we in the field of mental health are tasked with generating specific and diverse interventions, policies, activities and practices that serve the mental health needs of individuals, their families and communities* (p. i).

The Standards identify Mental Health Nursing as a "specialised branch of nursing practice that builds on the competencies expected of all nurses who practice in Aotearoa, New Zealand" (p. 4). There is no reference to NCNZ here, however the competencies referred to in the document could be considered to be NCNZ competencies as these are stated to be expected of all nurses in NZ.

In a similar vein to NCNZ and NZNO, definitive statements are used to provide information in an authoritative manner. Written as declarations and using the phrase 'Mental Health Nurse' at the

forefront of each of the standards reinforces that the nurse is required to meet all of these standards. Using 'standards' to describe the expectations of a member of NZCMHN provides a means to measure the performance of the nurse. Like the NZNO document, these standards offer criteria to measure performance.

As with the other professional standards documents, the document is informed by conventions of professional writing. The NZCMHN define within these standards the criteria and characteristics required for a professional mental health nurse in NZ (Weiss and Tappen, 2015). The document is written for the registered nurse and the accessible language ensures its readability for those new to the profession and students seeking to become future members of NZCHMN.

The standards present an authoritative account of the professional expectations of mental health nursing in NZ for its members. This is achieved via the provision of standards of nursing practice in terms of "…practice outcomes and attributes of knowledge, skills and attitudes" (p.6) that a member of NZCMHN must be able to demonstrate. As with NZNO, the identity and ownership of this authority are constantly reinforced by the NZCMHN trademark in the form of an emblem on each page of the standards. Written as declarations, it is clear that the standards are unequivocal. This is seen by the use of definitive words such as 'establishes', 'provides', and 'promotes' throughout the document. Rationale are offered within the standards and this adds authority to the significance of the standards and further positions them as having justifiable importance. There is also, albeit tentative, a link to critical thinking in offering an explanation of the 'thinking' behind the standards.

The standards are positioned alongside the NCNZ competencies; however this is not as clearly evident as in NZNO. The standards require that a member of NZCMHN demonstrates an understanding of the NCNZ competencies for registered nurses and that they meet these, as a requirement for meeting standard 5 of the NZCMHN standards for practice. More visible is the link to the Ministry of Health as they state:

> *"The values, attitudes and seven Real Skills identified in Let's get real (Ministry of Health, 2008) which underpin the provision of effective mental health and addiction services in Aotearoa New Zealand are reflected in these Standards"* (p. 6).

Positioning subjects

Unlike NZNO and NCNZ, the words 'responsibility' and 'accountability' are not introduced in the beginning of the document. Nor are they used in the first standard which relates to the requirement that mental health nurses recognise Māori as the first people of the land and that the nurse understands …

> *"the place of Te Tiriti o Waitangi in nursing care and acknowledges the diversity of values, belief systems and practices of people and cultural groups within New Zealand society"* (p. 2).

Despite the foregrounded approach of the significance of the Treaty, Te Tiriti o Waitangi is positioned within a single standard in the NZCMHN standards. This is unlike the NZNO professional standards of practice but in keeping with the NCNZ competencies.

Accountability and responsibility are located as a required attitude in Standard 2 as the fourth and last attitude listed:

> *"Accepts accountability and responsibility for their interactions with individuals with mental health issues and family/whanau"* (p. 5).

In this next example accountability is linked clearly to professional, legal, ethical and socially determined standards. Nurses are positioned as obligated, which is a powerfully emotive way to construct this requirement.

> *"Professional accountability involves an obligation to recognise socially and professionally mandated policies and to maintain legal and ethical standards."* (p. 12).

As identified in Chapter 2, some scholars maintain that one of the characteristics of critical thinking is an awareness of the philosophical foundations that influence the way meaning is constructed and understood. NZCMHN require that a mental health nurse be able to communicate an individualised philosophy of nursing practice.

> "*Articulates their individual philosophy of practice"* (p. 10).

This is a potentially influential catalyst for the support and influence of critical thinking within mental health nursing practice.

The significance of relationship and partnership is foregrounded within this standard and also in Standard 2. This signals the importance placed on this aspect of care and expectation of performance in mental health nursing. This is also seen in the following examples:

> *"The Mental Health Nurse demonstrates an understanding of the definitions of Partnership, Protection, Participation and tino rangatiranga or self determination in relation to Mental Health Nursing practice"* (p. 2)

> *"Mental health promotion strategies are developed in partnership with people with mental health issues and families/whanau"* (p. 8).

The standards clearly depict the knowledge, skills and attitudes expected of a mental health nurse. There is however a particular emphasis on the requirement that a nurse demonstrates particular values and also values and respects those receiving care. These concepts are repeated numerous times within the document.

Alongside 'values' and 'respects', the following words were noticed to be positioned in a particularly influential manner or were used repeatedly in the text. 'Demonstrate(s)', 'maintain(s/ing)', 'engages', 'provides', 'evaluates', 'ensure(s)', 'accepts', 'identify', 'evaluates', 'determines'.

As with the case of NZNO, while these standards are written in a directive manner, there is no professional obligation to adhere to them. Nor is it mandatory for nurses to demonstrate these are met. Nurses can elect to join NZCMHN and then there is an expectation that the standards "guide and direct" their practice.

For nurses new to mental health there is a requirement that they complete a postgraduate certificate in mental health and addictions; an indication that speciality knowledge is required to work as a mental health nurse. They also state the requirements that need to be met for a nurse to call themselves a mental health nurse.

> *The Mental Health Nurse is a registered nurse who is a graduate of a nursing education programme with a specialisation in mental health nursing and is registered by the Nursing Council of New Zealand to practise in the specialty of mental health. This includes nurses who have completed a hospital based specialist undergraduate programme, or a tertiary education undergraduate programme followed by a postgraduate programme in the specialty of mental health nursing* (p. iii).

Uncovering the discourses

Even though this document is more of a specialty document that identifies the standards for specialty practice, the discourses that are revealed can be classified under the same headings as those in Documents 1 and 2. Once again the dominant discourses are legal, professionalism, competence, management, evidence-based practice, and safety. Excerpts from the document that illustrate these discourses are presented in Table 1 in the Appendix (p. 161).

Like other professional documents, the interconnectedness of the discourses is evident in the way the standards have been constructed. This can be seen in the following examples (identified discourses added):

> *"Professional accountability (professional discourse) involves an obligation to recognise socially and professionally mandated policies (management & professional & evidence discourse) and to maintain legal and ethical standards (professional, safety and legal discourse)"* (p. 12).

As with NZNO, there is a presupposition that demonstrating and measuring standards is the most effective means of ensuring safe practice. The Standards clearly articulate the expected performance of the nurse and the evidence required in order to demonstrate this. The standards are written in ways that enable the practice of the nurse to be measured. There was however a slightly different flavour to the measuring of these standards because competence was

backgrounded in favour of having certain attitudes, meeting skills and demonstrating knowledge. This can be seen in the following examples:

> *"Integrates theoretical knowledge and principles into therapeutic relationships"* (p. 5).

> *"Makes appropriate clinical decisions based on comprehensive nursing assessments"* (p. 7).

> *"…understanding of: The theories of therapeutic relationships and effective communication. The ethical and legal frameworks that support therapeutic relationships"* (p. 4).

> *"Advocates for services that are free from discrimination and sensitive to an individual's cultural identity and wellbeing"* (p. 3).

Legal discourse is drawn on within the document to clearly identify the requirements that the nurse meet all legislated obligations. These expectations were worded in such a way that evidence that these obligations had been met could be provided. The connections to professional, managerial and safety discourses are also present.

> *"Utilises a framework for ethical decision making and practises in accordance with legislation, policies and codes of conduct"* (p. 12).

> *"Practises in accordance with legislation relevant to the mental health practice setting"* (p. 12).

> *"Identifies the relevance of health policies to practice"* (p. 12).

Professional discourse is present within all of the examples from the text. The connection to the discourse of care can also be seen in the following examples:

> *"Mental health nursing practice reflects contemporary health care standards, theories, models and philosophies of care"* (p. 6).

> *"Evaluates the plan of care in collaboration with people with mental health issues, families/ whānau and other relevant providers"* (p. 7).

Evidence-based discourse is a significant discourse within these standards.

> Glossary: *"Evidence Based Practice: A process of integrating the best available evidence with professional expertise to guide professionals in decision-making regarding the care of individuals. It requires critical appraisal"* (p. 14).

> *"…understanding of: Current evidence underpinning professional practice"* (p. 10).

> *"Utilises a range of interventions underpinned by appropriate evidence"* (p. 7).

> *"Recognises the role of research and evidence in informing professional practice"* (p. 11).

Unlike in the other professional documents, the actual wording 'safety' and 'risk' are not evident in word form within the document. This is somewhat unusual given the emphasis of these concepts within mental health services. There is, however, a clear relationship to safe practice and prevention of harm to the public within the standards. This is evident in the following examples:

> *"…understanding of: The influence of their own values, beliefs and attitudes in their interactions with others"* (p.2).

> *"…understanding of: The philosophy and principles of recovery and wellbeing (p. 4).*

> *"Applies principles of recovery and wellbeing in relationships with all people affected by mental health issues"* (p. 5).

> *"Evaluates the plan of care in collaboration with people with mental health issues, families/ whānau and other relevant providers"* (p. 7).

> *"Evaluates their own practice with regard to the reduction of stigma and discrimination"* (p. 9).

> *"…understanding of: The association of language, communication styles, spiritual beliefs and practices to mental health, wellbeing and cultural identity"* (p. 2).

Constructing critical thinking

In keeping with NCNZ competencies for registered nurses, the actual wording 'critical thinking' is absent in the document. This could be perceived as back-grounding but more likely omission. However it can be assumed in the following examples:

> *"Facilitates access to culturally appropriate models of care"* (p. 3)

> *"…understanding of: Current evidence underpinning professional practice."* (p. 10)

> *"Evaluates the evidence base for professional practice"* (p. 10)

> *"Recognises the role of research and evidence in informing professional practice. "* (p. 11)

> *"Makes appropriate clinical decisions based on comprehensive nursing assessments."* (p. 7)

In addition, the definition of evidence-base practice (EBP) as provided in the Glossary clearly identifies critical thinking as an essential component for using an EBP framework.

> *"Evidence Based Practice: A process of integrating the best available evidence with professional expertise to guide professionals in decision-making regarding the care of individuals. It requires critical appraisal."* (p. 14).

It is worthy of note that this link to critical thinking is placed in the Glossary and as such is backgrounded.

Similarly, the following examples do not use the term 'critical thinking', but it could be argued that in order to fulfil their requirements, the nurse needs to engage the critical thinking tactics of reflection, facet personal biases, open-mindedness, and perseverance.

> *"The Mental health Nurse demonstrates understanding of: The influence of their own values, beliefs and attitudes in their interactions with others"* (p. 2).

> *"The cultural, social, economic and political barriers hindering access to mental health services" (*p. 2).

> *"Seeks opportunities to extend understanding of diversity and difference"* (p. 3).

> *"The therapeutic use of self in Mental Health Nursing"* (p. 4).

> *"The theories of therapeutic relationships and effective communication"* (p. 4)

PART B: Academic Textbook Analysis

Document 4:

Critical thinking tactics for nurses: Achieving the IOM competencies (3rd ed.). Rubenfeld, M. G., & Scheffer, B. K (2015). Chapter 1 & 2.

Background

The text was written and produced by Rubenfeld, M. G. and Scheffer, B. K. These authors are nurse educators from Eastern Michigan University in the United States of America. The first edition was written in 2006, followed by the second edition in 2010, and this edition in 2015. As the third edition, the text can claim some standing as an instructional success. The author's objective is to operationalise critical thinking, to enable nurses to employ 'tactics' ("practical strategies") for critical thinking. TACTICS is a mnemonic for *Tracking, Assessing, Cultivating Thinking to Improve Competency-based Strategies.* The text is written for a wide audience and the hope they hold is that its 'practical qualities' and 'user friendly language' will assist "busy clinicians, students, and educators" to "hone their critical thinking skills" (p. vii & viii).

Uncritical review

> **Critical thinking tactics for nurses: Achieving the IOM competencies**
>
> From the moment I began reading the first chapter of this text there was the sense that the writers (Rubenfeld & Scheffer) were talking to me with the intention of convincing me to keep reading. "We will tease your brain to consider why" (referring to 'why' questions). There was a stated desire to take me on an exciting venture and the attempt was to engage me as a reader and engender excitement about critical thinking. The book begins with positioning the 'why critical thinking' rather than 'what critical thinking is' to position the importance (how vital) critical thinking is and to engender excitement.
>
> The authors position themselves as experts on critical thinking in nursing and they were selling me a way to bring critical thinking into the real world. I found this sales presentation distracting because it was somewhat annoying, however I did think they were writing in an 'engaging' way because they continually attempted to position the relevance of critical thinking for the reader. As an educator, this offers something useful, a means to inspire students and to convey the practicalities of an abstract concept such as critical thinking. Having some practical 'tools' was a great motivator for me to keep reading.

They called on authors and studies I was familiar with which gave them credibility. The authors also used dramatic language, e.g. "dire need of critical thinkers" (pg 1). Interestingly, I agree we are in 'dire' need of critical thinkers and this really resonates for me, however with the following positioning of the context was uncomfortable. Clinicians make a *"jillion decisions" every day…. decisions may be made in seconds and can have serious consequences. All decisions must be accurate and made in a timely manner"* (pp. 1-2). The subtext being: 'and they had better get their decisions right' and 'as an outcome of 'thinking' these will be measured and evaluated as right or wrong'. The aim then is to ensure certainty amidst uncertainty. The author quotes Schon (1983) and his notion of nurses having to think and make decisions amidst contextual 'mess', in his words the "swampy lowlands" (p. 3).

They call attention to a complex healthcare context which is fraught with decision points where mistakes can occur, mistakes which need to be avoided. I considered this somewhat dramatic and could engender fear in the reader, particularly a student or someone new to the profession.

Critical thinking is described as beneficial to all stakeholders with an explanation of why, and useful examples are given to make connections to practice. There is an absence, however, of consideration of how to proceed when the stakeholders have competing needs and the outcomes of the critical thinking of separate stakeholders are in conflict. Critical thinking is positioned only as increasing satisfaction for all in healthcare.

The first chapter I reviewed has a picture of a question mark on what looks like a plinth and, to me, looks like a doctor dressed in old fashioned coat and bloomers, although this could be a skirt. There seems to be a stethoscope and scissors and other indistinguishable things in their pocket (? scissors, forceps…). I found this picture annoying and distracting because I couldn't relate it to the context of the words. It seemed that critical thinking was being put on a pedestal. In the second picture there was a repeat of the image of the person standing on the dot of the question mark and holding on to the top. The person looks as if he/she was being carried away because the hair and coat appear to be caught by an up-draught of wind. I concluded that the message was: 'how critical thinking will carry you places'. I was interested to see what reference was made to the illustrations and found them described as "humorous sketches" (p. xii) designed by cartoonists.

In chapter two, the actual definition of critical thinking is explored. I found that the use of a metaphor of a bridge to connect information to action was useful to position how critical thinking brings these together. For those, who like me, had seen the Indiana Jones movies (used as an example by the authors), the link to being in a fearful place and needing to safely find your way out when necessary information may be

invisible, was not lost. The drama of such an event could assist in making connections. I like the use of metaphor and use it often when I teach. I am mindful, however, of how culturally appropriate metaphors need to be and for this reason the metaphor may not resonate for all who read it.

As an academic, I appreciated how the authors acknowledged their Western thinking traditions and their attempt at providing a historical overview. Definitions of critical thinking are provided and discussed with emphasis on their own research and claims. They call on other research and theory to support and position their work, which is sound. There is a clear connection made to the American Philosophical Association (APA) to support the methodology they used to develop a definition of critical thinking. They researched expert nurses' definitions of critical thinking across 9 countries and 23 US states over three years. This extensive study, carried out in 2000, reached an 88.2% consensus on the final statement. The use of statistics to quantify unity with the decision was interesting and indicates a desire to add validity and reliability to their findings.

The authors summarise their view of the importance of critical thinking and the characteristics of a critical thinking nurse as follows:

> *Critical thinking in nursing is an essential component of professional accountability and quality in nursing care. Critical thinkers in nursing exhibit these habits of mind: confidence, contextual perspective, creativity, flexibility, inquisitiveness, intellectual integrity, intuition, open-mindedness, perseverance and reflection. Critical thinkers in nursing practice the cognitive skills of analysing, applying standards, discriminating, information seeking, logical reasoning, predicting and transforming knowledge* (Scheffer & Rubenfeld, 2000, p. 357).

The definition covers most aspects that I find valuable in defining critical thinking. However I don't believe enough attention is placed on the philosophical positions that may be shaping the thinking and informing judgements and decisions. Critical thinking is operationalised through the nursing process. The nursing process referred to is that developed by Yura and Walsh (1967, 1988). The reader is taken through the nursing process with links to critical thinking at every stage. That these authors were cited as the developers of the nursing process was a surprise to me as I was not familiar with them. The use of deficit language, such as "sensory deficits", "impaired physical mobility", "mobility deficits" (p. 51), and a problem focus within their capture of the nursing process, I believe, demonstrates a philosophical stance and the ideology and power that shapes this language disappointed me. In addition, the noticing of the patients' strengths was minimised and not utilised as well as could be expected. The application of the nursing process was challenging from my philosophical position.

In the preface of the text, the authors state: "Throughout this text, we often use the terms *critical thinking* and *thinking* interchangeably. We acknowledge that these terms are not synonymous in other contexts; however, within health care, we believe that all thinking is critical" (p. vii). This is a problematic statement for me because the intention, I thought, was to offer a clear capture of critical thinking and following their years of research, I would have expected them to be more cautious about mixing these two terms.

Critical Review

Establishing Authority

The authors command a clear sense of authority over the topic. They stress their importance by identifying their research and practice experience. They claim to have written, "Hundreds of thousands of articles and thousands of books". They have developed and facilitated…. courses and whole curricula, and even institutes designed to improve thinking" (p. 5). The authors' entitlement to sell their message about critical thinking to the reader is established by positioning their authority through their significant academic contribution to the topic and their vast experience. They are both identified as "Professor Emerita" on the very first page of the text (p. i). This scholarly title adds academic prestige and further attests to their credentials.

The link to the US based Institute of Medicine (IOM) competencies further reinforces the authority as a credible healthcare text. Achieving competency is a professional responsibility and as such this connection carries weight.

The authors align their capture of critical thinking with the American Philosophical Association to assist the positioning of their credibility and expertise. The authors' work is often cited by other authors and reference is made to this community of critical thinking scholars within their text. Descriptions of their qualifications and professional affiliations are provided on the inside page of the book and this attests to the credibility of their professional standing.

Rubenfeld and Scheffer (2015) identify themselves as well-known researchers, writers and teachers of critical thinking. They call attention to the years of study they have conducted within the area of critical thinking and cite within the text this work. There is an identification of their personal sense of excitement engaging with and exploring critical thinking.

Literary tools to drive the message

The document is presented in the style of a textbook. The authors maintain that it is a text, referring to: "this text" (p. vii). There is evidence of a mixing of genres within the text, which can be aligned to the competing agendas of the writers. Firstly, as an authoritative text it utilises the genre of the textbook: "It is true that a defined pedagogic model is underlying in the textbook,

where the role of the writer as a disciplinary expert is to instruct a lay or semi-lay student in a specialized subject matter" Parodi, (2014, p. 79). This is clearly demonstrated in the authoritative stance of the writing, seen for example in the opening preface of the book;

> *"The conceptualisation of critical thinking throughout this text comes from our years of research in this area, most notably our Delphi study…"* (p. vii).

Another genre taken up by the authors, in keeping with the need of the authors to target the retail market, is that of a conversational style, utilising an informal register. They also engage the reader with questions and write as if speaking directly to them. For example, "… we want you to let your curiosity and questioning attitude lead the way into this exciting adventure" (p. 3). This particular message seems to be massaging the reader's ego by suggesting that they are curious and have a questioning attitude, which may help to motivate the reader.

In addition, the authors speak to the reader in a way that suggests they understand the reader and are there as support. For example, "Don't get overwhelmed by this complexity. We are going to help you dissect, or unpack things to get a better look at the thinking involved" (p. 9). This friendly relational style was reinforced by the use of "humorous cartoons".

The text is presented in a frame of a credible and expert voice with years of research to support their writing (p. 6). Alongside this, they call on other credible and well known critical thinking scholars and experts to support their claim; "…nursing in particular, is in dire need of critical thinkers. If you don't believe us look at …" (p. 1) and identifies these other authors within an extensive table.

The language within the text assists the framing of critical thinking as an extremely important construct for nursing. This can be seen in the use of words and phrases such as "dire need", decisions can have "very serious consequences", "decisions must be accurate", and "critical thinking is vital". The authors further reinforce the importance of critical thinking with substantial claims, for example:

> *"…the delivery of safe, effective and efficient care has always been the underlying goal of good nursing care. Critical thinking is essential to achieving these goals"* (p. 10).

To add emphasis within the document, the authors frequently change font, employing italics, capitals, and bold font. For example, the mnemonic: **TACTICS** (p. 7). Writing in this way immediately draws the reader attention to these concepts as ones to note. The repeated use of the word 'TACTICS' is a constant reminder of the desire to frame critical thinking in a seen and measurable way.

The authors identify the tensions of discursive practice in critical thinking and yet this is backgrounded and referred to only fleetingly with no philosophical engagement with the discursive positions that they identify. This is seen in the following examples:

A quote from Paulo Freire (1998, p. 80): *"To stimulate questions and critical reflection about the questions, asking what is meant by this or that question, is fundamental to curiosity. Otherwise, all we have is the passivity of students in the face of the discursive explanations of the teacher and answers to questions that have not been asked"* (p. 5).

The statement that: *"Studying CT by itself is a wonderful philosophical activity, but as nurses we must look at CT in action. CT is a tool to be used in the muddy world of healthcare"* (p. 8).

A quote from Hansten and Washburn (1999, p. 39) and their view that administrators: *"…must have advanced abilities to think critically….. to improve clinical systems, decrease errors and sentinel events, and engage staff involvement to refine patient care systems"* (p. 18).

Backgrounding the potential discursive positions that may arise for nurses as they think critically, minimises the contextual complexity in which the outcomes of critical thinking (the actions) will be occurring. This is in keeping with the foregrounding that maintains that critical thinking can be done with ease.

Positioning subjects

The authors claim that the text is written for:

"…clinicians in various areas of practice, nursing students and educators in clinical and academic settings who want to hone their critical thinking abilities and help others do the same" (p. vii).

As an American text, the readership uptake in NZ may be limited, particularly for nursing students, unless they are directed to it within course reading or assignments. Nurse educators looking for practical applications and examples could find this useful. The publishers do engage this audience by sending inspection copies for educators to review.

The authors call on the professional identity of the reader because they frame critical thinking as an essential component of professional identify and esteem. This is seen in the following examples:

Clinicians who think critically have more confidence in their reasoning. Confidence in reasoning allows nurses to speak their minds, to openly identify potential errors and near misses, to contribute to team meetings, and to provide solid rationales for their decisions. Confidence empowers them to make valid contributions and decisions relates to patient care and unit concerns (p. 11).

"CT is important to job satisfaction because it helps the clinician attain and maintain a professional nursing self-image" (p. 11).

"Good clinicians rely on professional ethics and intellectual integrity to reinforce their thinking….CT empowers decision making and enhances job satisfaction" (p. 12)

"CT leads to empowered decision making, job satisfaction, and expertise in practice for clinicians" (p. 23).

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The following words were noticed to be positioned in a particularly influential manner or were used repeatedly in the text, foregrounding their importance in identifying the expectations of the actions of a nurse. For example, nurses need to provide 'safe', 'effective' and 'efficient' care and they need to do this in an 'appropriate' way. Using critical thinking is 'vital', and 'essential' for 'decisions'. Nurses need to be 'questioning', and always 'thinking'. Nurses turn 'information' and 'knowledge' into actions via the use of critical thinking.

Uncovering the discourses

The discourses identified within this text are presented in Table 2. There was a significant correlation between the discourses identified in this text and the professional documents. Similarly the interconnectedness of the discourses is evident with more than one discourse identified in each example.

The link to competency is foregrounded from the outset and this is privileged as a means of identifying the benefit of critical thinking to the professional development of the nurse. The authors cite Benner (1984*):*

> *"Another way CT benefits clinicians is by helping them move from novice to advanced beginner to competent to proficient and ultimately to expert" (*p. 13).

Legal discourse is presented as self- regulation and critical thinking is positioned as essential for a self-regulating profession. The links to measurable criteria as required by a regulator is evident in the connection made to needing standards:

> *"How could one manage self-regulation and accreditation standards without applying standards, discriminating, and intellectual integrity?"* (p. 19).

There was a significant link to the need for critical thinking in the delivery of safe care. The connection to safety and risk discourse was evident in the following examples:

> *Nursing is concerned about critical thinking because it deals with "split-second decision making to keep people safe"* (p. 31).

> *"…great nursing requires thinking and doing. One without the other either does not work or can be very dangerous"* (p. 53).

> *"…the delivery of safe, effective, and efficient care has always been the underlying goal of good nursing care. CT is essential to achieving these goals"* (p. 10).

> *In addition to safe care, CT is important for effective and efficient care. Effective care is individualised and accurate. It employs the correct interventions for the health situation at hand. Efficient care requires timely thinking so that resources are used appropriately* (p. 11).

The last two examples link directly to the discourse of care (professional discourse) and management discourse.

The authors position critical thinking as essential for the healthcare management in order to provide quality care within fiscal responsibility. They position critical thinking as "… the only way to find solutions to what some view as polarised interests" (p. 17). They claim:

> *"Polarity management is one strategy for using CT to analyse commonalities and then find creative ways to deal with other issues"* (p. 18; calling on, Yoder-Wise, 1995).

> *"… administrators must have "advanced abilities to think critically… to improve clinical systems, decrease errors and sentinel events, and engage staff involvement to refine patient systems"* (p. 18, quoting Hansten & Washburn, 1999, p. 39).

Within professional discourse critical thinking is aligned as necessary for the nursing process and professional identity.

> *"You need a series of steps or a process to convert information into knowledge….. you must translate that knowledge, which is very abstract, into practice actions, which are very concrete* (p. 28).

> *"Clinicians who think critically have more confidence in their reasoning." "Confidence empowers…" "CT is important to job satisfaction because it helps the clinician attain and maintain a professional nursing self-image"* (p. 11).

> *"One of the jobs is the everyday reality of CT within the context of nursing process, that is, what nurses do every day in patient encounters".* They describe great nursing with the following formula*: "patient + You (nurse) + Thinking skills + knowledge + Nursing process = great nursing"* (p. 47)

Constructing critical thinking

The authors maintain (calling on Lunney's work 2008, 2010) that

> *"without the necessary critical thinking, diagnoses may be inaccurate and therefore affect the quality of health care as the nurse heads down the wrong path in patient care"* (p. 8).

They reinforce this notion that nurses must 'head down the right path' by emphasising that nursing actions need to be appropriate.

The terms 'thinking' and 'critical thinking' are used interchangeably by these authors. While acknowledging the confusion in defining critical thinking at the outset of their text, they proceed to minimise this confusion by arguing that "…all thinking is critical" (p. vii). As authors with years of experience in researching, teaching and writing about critical thinking, this is puzzling and seems flippant against the backdrop of tension and concern in defining critical thinking and the

belief in its specific value for professional nursing practice. Yet, on the other hand, there is a clear link made between the application of critical thinking and nursing practice via the nursing process, and the authors identify critical thinking as a tool for ensuring safe, effective and efficient care. "Nursing is concerned about critical thinking because it deals with "split-second decision making to keep people safe" (p. 31). Positioning critical thinking as a tool, they frame their writing as offering concrete suggestions on improving critical thinking.

The authors also stress the importance of critical thinking moving from "abstract concepts to practical contexts", saying that thinking is valuable only when it can be seen. In this way an intangible concept can be made visible and therefore measured. As a measurable concept it is then able to be quantified in terms of providing evidence. The authors use a metaphor of a bridge (as in the movie Indiana Jones) to illustrate how critical thinking is often invisible and needs to be made visible.

The importance of recognising critical thinking is further reinforced in the link to achieving the five healthcare competencies of the Institute of Medicine (IOM). Critical thinking is identified as a requirement to meeting these competencies. In order for this to be attained, critical thinking needs to be quantified. The text assists nurses to achieve this by offering a means of making critical thinking visible. This connection to the IOM competencies also adds to the influence and importance of the text.

The application of critical thinking is foregrounded within the text because the authors' primary intention is to "bring critical thinking into the real world of healthcare delivery" (p. vii). The authors maintain that critical thinking needs to be seen, as illustrated in the following quotation:

> *"Appreciating critical thinking means seeing it in action, to fully appreciate critical thinking in action, one really needs to combine descriptions of thinking with the actions that thinking produces"* (p. 8).

The use of powerful examples places the importance of critical thinking as a means of navigating complexity at the forefront of the readers mind:

> *…key matters which require more or better thinking are the information and technology explosions; dwindling resources; cost containment; third party payer gatekeeping; demographics; morbidity and mortality data; global economics and potential epidemics, patient safety, and the failure to rescue; and emergent ethical dilemmas such as the right to life, prolongation of life without quality and stem cell research* (p. 6)

Critical thinking is identified as a requirement for complex decision making and the need to engage all dimensions of critical thinking is necessary for this to occur. However, the ease with which this can occur is foregrounded, which minimises the time, energy and emotional commitment that is required to critically think. This is demonstrated in the next example:

> *Throughout this process, the clinician moves away from the context-free rules of novice decision-making to more sophisticated levels of thinking. Thinking is essential to expert*

nurses, who can imagine the whole of a situation from a few details. They use reflection in action; they have learned to trust their intuition. And they do all of this consistently. Expert nurses engage all CT dimensions so naturally and with such ease that their decisions look effortless (p. 13).

By using the word thinking and critical thinking interchangeably and arguing "…all thinking is critical (p. vii), the authors are setting up in the reader's mind that all thinking in nursing is critical. This adds to the confusion in defining critical thinking and just what it entails. When coupled with the comment that there is "thinking or non-thinking" care (p. 10), the presupposition that all thinking is critical is further reinforced.   "…great nursing requires thinking and doing. One without the other either does not work or can be very dangerous" (p. 53).

There is an emphasis within the text that concrete examples are required to bring critical thinking to the real world. This reinforces the assumption that thinking needs to be visible and the results of such thinking measured. Nursing actions as outcomes of thinking are the means by which critical thinking will be measured:

"You need a series of steps or a process to convert information into knowledge….. you must translate that knowledge, which is very abstract, into practice actions, which are very concrete (p. 28).

Document 5:

Chapter 5: Critical thinking and nursing judgement. Bronwyn Jones in Crisp, J., Taylor, C., Douglas, C., & Rebeiro, G. *Potter & Perry's Fundamentals of Nursing.* (2012; 4th ed.).

Background

The text was written and produced by Potter and Perry in 2012. The first edition of this text was released in 2001, the second in 2005 the third in 2009, and the fourth in 2012. The chapter focused on for this study is Chapter 5 of 46 chapters. The text is described as the leading fundamentals text for nursing students in Australia and New Zealand (Elsevier, 2016).

Chapter 5: 'Critical thinking and nursing judgement' is written by Bronwyn Jones. She is an Adjunct Associate Professor in the School of Nursing and Midwifery at Edith Cowan University in Western Australia. Her qualifications include: RN, BAppSci (Nsg), MAppSci (Health Studies) and PhD. The Editors state that the text is supported by "the Fundamentals of Nursing: clinical skills workbook 2nd edition". This is a significant link as the Editors also claim the workbook is "directly aligned to the National Competency Standards for the Registered Nurse for Australia and New Zealand" (Elsevier. 2016).

Uncritical review

Potter & Perry's Fundamentals of Nursing. Chapter 5: Critical thinking and nursing judgement.
On reading the first sentence I paused and then returned to re-read it again. "Although the responsibility of making clinical decisions may seem frightening…" (p. 75) Responsibility for making decisions and fear stood out in these first few words and I wondered how that might be for a student new to nursing education. These words were quickly followed by a positioning of nursing as a rewarding and challenging profession with endless variety. The tone of this writing was energetic and demanding. Nursing decision-making was positioned as quite an adventure. There is no question that the nurse needs to think critically in order to provide the "…very best nursing care" (p. 75). The author identified that critical thinking was not a "step-by-step linear process", but a cyclical process, and yet refers to CT as being a "logical thought process" (p. 75). This is only a part of critical thinking and capturing it in this way seems to me to privilege the rational, objective aspects of thinking.

The author positions the nursing process as the means by which nurses use critical thinking. "The specific critical thinking competency in nursing is the **nursing process**" (p. 79).

The definition of critical thinking, however, I found vague and more of an explanation than a definition. Calling on the APA definition of critical thinking, the author then aligns examples of some of these definitions with those required in nursing.

Later in the chapter, Paul and Elder's (2005) description of critical thinking is provided. The connection is made to more measurable aspects of critical thinking processes (termed critical thinking competences) was very clear, these being: problem solving and decision making. These are then parcelled together as clinical judgements. A model for making clinical judgements is provided. I think this is useful and I like Tanner's (2006) model. In keeping with a measurable approach, I was not surprised to see standards for critical thinking included and an example of how these were set. "Critical thinking included intellectual and professional standards. These standards are the criteria for determining the soundness, justness and appropriateness of critical decisions and judgements" (p. 82).

The author refers to legislation, treatment guidelines, institutional practice guidelines, and professional organisations' standards that need to be achieved and cite the Nursing Council of New Zealand Competencies as a measure. I thought the process of critical thinking had been storied as an engaging, challenging and rewarding activity. There was no downside in terms of conflicting evidence, conflicting positions, - just a streamlined process that, if done well, would ensure the "comprehensive care of clients".

Critical review

Establishing Authority

Bronwyn Jones (2012) is listed in the textbook as one of the contributors. Her credentials are listed alongside her professional title and the name of the university where she is an Adjunct Professor. This title alongside her qualifications adds authority and credibility to her writing. The textbook is an Australian adaptation and is edited by four reputable Australian writers. While this was highlighted previously, there is significant positioning of the authors as highly successful and credible. "Welcome to the fourth edition of the most successful fundamental text book ever to be published for nursing students across Australia and New Zealand" (p. xxii). The textbook as a repository of information has a long history in providing theoretical evidence and as such the ideas presented within them have influence.

Textbook credibility relies on the reputation of the author, publisher, content and the currency of the information presented in the text. Given this, the authors' identification and position within the discipline is pivotal to the impact and power the book will hold. Authors can enhance this influence by calling on other credible references and referring to organisations which have a powerful influence on the practice of nursing. This is evident in the links they make to their claims and the requirements of professional nursing standards and regulatory bodies. Alongside this they call on other credible and well known critical thinking scholars and experts to support their claims and add to their authority - e.g. Alfaro-LeFevre, 2010; Tanner, 2006; and Riddell, 2007.

The author also calls on other prominent writers and researchers to further reinforce her authority and position. In addition she reinforces the relevance of the standards for critical thinking by referring directly to the NCNZ and Australian professional nursing standards and "measurement of competence" (p. 82).

Literary tools to drive the message

As with Rubenfeld and Scheffer (Document 4), there is evidence of a mixing of genres within the text which can be aligned to the competing agendas of the writers. Firstly, as an authoritative text, it utilises the discourse of the textbook. This is clearly demonstrated in the authoritative stance of the writing, seen for example in the opening preface of the book;

> *"The clinical examples and critical thinking questions throughout this text underscore how putting this nursing knowledge and skill into practice can mean the difference between……..patient recovery and independence and……costly and life threatening complications, functional decline and disability"* (p. xxii).

There is a shift in genre through the social relations employed in the text which is also evident within Rubenfeld and Scheffer's text. As Chiapello and Fairclough (2010) identify, the move from that of expert advice giver to the use of a conversational register is employed to accommodate differing motives of the writer. This move in social relations taken up by the author is in keeping with the need to sell books by using a conversational style, engaging the reader and writing as if speaking to them. For example, "Now, as nursing students many of the principles can be applied…" Mixed with the formal third person style; "This unit introduces the reader to the nursing process…" (p. 75).

The text is presented in a frame of a credible and expert voice with years of textbook writing;

> *"Welcome to the fourth edition of the most successful fundamental text book ever to be published for nursing students across Australia and New Zealand"* (p. xxii).

The intellectual standards required for critical thinking are captured in the document first and as such are foregrounded in the mind of the reader. "Critical thinking includes intellectual and professional standards" (p. 82). The author then goes on to define intellectual standards as different from professional standards. Distilling out the qualities inherent in the standards in such a way reduces each into parts, rather than an interrelated or integrated whole. Such a reductionist approach foregrounds binary thinking over complexity.

The following words or phrases were noticed to be positioned in a particularly influential manner or were used repeatedly in the text:

> 'safe', 'effective', 'efficient health care', 'reflection', 'judgement', 'accurate', 'appropriate' or 'appropriateness', 'crucial', 'essential', 'safety', 'decision making', 'reasoning', and 'professional responsibility'.

The need for critical thinking in the increasingly complex environment is foregrounded. The link between critical thinking and the nursing process is introduced at the very beginning of the text, positioning the nursing process as a framework for the use of critical thinking.

> *"This unit introduces the reader to the nursing process which provides a systematic framework for the use of logical thought processes or critical thinking to collect, analyse and synthesise client data crucial to clinical decision making in the best interests of the client"* (p. 75).

While it cannot be assumed to know what is in the authors mind, the use of measurable terms such as 'unit' and 'data' within this paragraph, alongside the words 'logical' and 'systematic', are once again illustrations of measurement and in this context are foregrounded over complexity.

Positioning subjects

The intended audience for this textbook chapter is predominantly nursing students. It is a recommended textbook across many Schools of Nursing within Australasia. As such this textbook has a wide reach and a significant influence on the understanding and development of critical thinking for nursing students in NZ.

This text would also be read by nurse educators and may also be known to nurses in clinical practice working with nursing students. Alongside this, the publishers sent inspection copies to nurse educators to review and this is a powerful marketing strategy.

The author identifies critical thinking as being essential and required by all nurses and must be demonstrated in order to graduate from an undergraduate nursing programme and be able to register to practice as an RN:

> *"Learning to become a critical thinker is a requirement for graduates of all nursing undergraduate programmes and for entry to practice as a beginning registered nurse"* (p. 77).

Nursing students are positioned as embarking on an adventure of learning and entering a challenging and rewarding profession. The challenge of clinical decision making is presented as 'frightening', suggesting that students have something to fear.

> *"Although the responsibility of making clinical decisions may seem frightening to a new student, it is a rewarding and challenging profession."* (p. 75).

This seems to be done to reinforce the positioning of accountability and responsibility nurses have for their practice, lending weight to the requirement that they think critically so that patients receive the "… very best care" from the nurse (p. 79).

Uncovering the discourses

While the intention of writers cannot be claimed as known, it can be detected within the discourses presented within the text. The author utilises legal, professional, safety, caring, accountability/ responsibility, scientific, and economic discourses to enable meaning-making. These are collated in Table 2.

The discourses of safety, professionalism, care and management are connected to and foreground the nurse's professional responsibility for clinical judgements, decisions and actions. This is evident in the following quotes:

> *"Nurses have the important responsibility of making accurate and appropriate clinical decisions"* (p. 77).

> *"In clinical situations, it is important for the nurse to think critically so that the client ultimately receives the very best nursing care."* (p. 75).

> *"The development of the critical thinking skills of challenging assumptions, reflecting on experience and questioning one's usual way of thinking while promoting patient safety through the process of clinical judgement and decision making is crucial to the delivery of high-quality patient care."* (p. 77; referring to Ashcraft, 2010).

The discourse of professionalism clearly depicts critical thinking as a requirement for the nursing process to support assessment, knowledge, judgement, decision making and the provision of care. This is seen in the following examples:

> *"An essential component of critical thinking and clinical decision making is the nurse's specific knowledge base"* (p. 77).

> *"Critical thinking model demonstrates how nursing process and critical thinking combine to assist in providing the best care for patients."* (p. xxvii).

"The ability to think critically though the application of knowledge and experience, problem solving and decision making is central to professional nursing practice." (p. 78).

"The specific critical thinking competency in nursing is the nursing process." (p. 79).

In keeping with the other documents analysed in this study, there is an emphasis on the need to measure the outcomes of nursing practice. This can be seen in the following example that identifies the need to meet professional standards:

> *Critical thinking includes intellectual and professional standards. These standards are the criteria for determining the soundness, justness and appropriateness of critical decisions and judgements. The use of intellectual standards involves a rigorous approach to clinical practice and cannot be done haphazardly. When a nurse considers a client problem, it is important to apply standards such as preciseness, accuracy and consistency to ensure clinical decisions are sound and valid.* (Jones, p. 82).

In defining the professional standards required for critical thinking, the connection to professional, legal, ethical, and care discourses is signalled. The reader is left in no doubt that the nurse is responsible for considering all of these discourses in order to provide the "highest level of nursing care" (p. 82).

> *Professional standards for critical thinking refer to ethical criteria for nursing judgements, criteria to be used for evaluation and criteria for professional responsibility. Application of professional legal and ethical standards requires that nurses use critical thinking for the good of individuals or groups* (calling on Freegard, 2007).

Constructing critical thinking

The author strongly advocates for 'critically reflective practice', identifying the process of critical reflection and providing examples of critical thinking questions useful in facilitating this. Critical thinking questions are used throughout the text to "provide an opportunity to focus on the content using critical thinking and reflection to achieve deeper understanding and meaningful learning" (p. xxv). There is a reference to the need within the reflective process to identify underlying "assumptions, beliefs, values or cultural norms" and to "identify structural or contextual (e.g. socio-political, economic, organisational) factors" that could be influencing their thinking and behaviours, and asks "who's interests are being served by these norms and influences?" (p. 77). The questions are framed to identify whether the answers are "consistent with professional nursing practice" (p. 77). This strongly suggests that the questions are used to develop the professionalism of the nurse rather than addressing possible structural impediments to critical thinking or the outcomes of critical thinking.

Despite the emphasis on critical reflection, and not just cognition for critical thinking, the wording throughout the chapter creates ambivalence about this. This is illustrated in the following quote:

> *It is clear that critical thinking requires not only cognitive skills but also an ability to ask questions, to remain well informed, to be honest in facing personal biases and always be willing to reconsider and think clearly about issues* (p. 75).

The use of the word 'clear' in this sentence suggests that as a concept, critical thinking is obvious. There is a flavour of logicality framed in these captures that privileges rationality. This is reinforced in the following quote where the connection to the nursing process is made:

> *"...the nursing process which provides a systematic framework for the use of logical thought processes or critical thinking to collect, analyse and synthesise client data crucial to clinical decision making and the best interests of the client"* (p. 75).

As depicted in the above quotation, critical thinking is presented as a construct that is logical and enables a methodical and orderly process that is essential for the nurse to deliver "the very best nursing care" (p. 75). The author conceptualises critical thinking as a process expressed through clinical judgement and decision making that is operationalised through the nursing process. The clinical judgement model developed by Tanner (2006) is used by the author to further demonstrate the link between critical thinking and decision making.

The author maintains that critical thinking consists of both intellectual and professional standards. The use of the words, 'appropriate', 'justness', 'soundness', 'rigorous', 'preciseness', 'accuracy', 'clarity', 'precision', 'relevance' and 'consistency' in the following paragraph highlight the need for "intellectual standards" when thinking critically. This capture reinforces a strong sense of rationality and is reinforced by the use of the phrase "cannot be done haphazardly" (p. 82).

> *Critical thinking includes intellectual and professional standards. These standards are the criteria for determining the soundness, justness and appropriateness of critical decisions and judgements. The use of intellectual standards involves a rigorous approach to clinical practice and cannot be done haphazardly. When a nurse considers a client problem, it is important to apply standards such as preciseness, accuracy and consistency to ensure clinical decisions are sound and valid* (p. 82).

> *"The use of universal standards of clarity, accuracy, precision and relevance means that the nurse has command of these standards"* (p. 82, calling on Huckaby, 2009).

The author backgrounds the complexity of critical thinking and, although calling attention to the non-linear nature of critical thinking, does not fully explain the "cyclical process" (p. 75) referred to. She backgrounds this complexity in favour of a systematic, logical approach.

The author also provides standards for critical thinking and assumed in this is the ability to make critical thinking visible and measurable, as can be seen in the following quotation:

> *"…standards are the criteria for determining the soundness, justness and appropriateness of critical decisions" "…it is important to apply standards such as preciseness, accuracy and consistency to ensure clinical decisions are sound and valid"* (p. 82).

An actual definition of critical thinking is not provided by the author, but instead the process of critical thinking and its components are explored. The author calls on the definition by Paul and Elder (2005) to more fully describe critical thinking in the second to last page of the chapter:

> … a process of reasoning and judgement which individuals use to assess goals and purposes, questions and problems, information and data, conclusions and interpretations, concepts and theoretical constructs, assumptions, implications and consequences, points of view and differing frames of reference (p. 82).

Chapter Summary

The analysis in this chapter has exemplified the first two levels of discourse analysis as described by Fairclough (1995, 2003) and Huckin (1997). In this chapter, five documents were analysed that have significant influence over nursing practice. This influence is achieved through their power in prescribing nursing practice and in constructing nursing identity. The documents were examined to identify ways in which the meaning of critical thinking was constructed and what discourses were drawn on to achieve this.

The analysis articulated the processes employed within the documents to establish their authority. It also identified literary tools that the authors engaged to manipulate the way the reader interpreted the meaning of their messages, and the way in which the consumers of the texts were positioned.

The analysis also identified several discourses which were influential in defining critical thinking and articulating its use within nursing practice. Owen's (1984) thematic analysis was employed to further refine these and identify dominant discourses to be discussed in the next chapter.

Chapter 5 will complete the first two levels of this CDA by providing an account of how these discourses impact critical thinking, the context in which it occurs, and its effect the construction of a nurse's professional identity.

Chapter 5: Constraining forces of interconnected discourses

The interconnection of the law with the duties of a professional is the means by which nurses are regulated and is the primary function of the Nursing Council of New Zealand.

Introduction

This study has focused on how key documents construct critical thinking and their influence on nursing practice in NZ. In the description and analysis within Chapter 4, several discourses were found to be influential in determining how language is used to construct the meaning of critical thinking within nursing theory and clinical practice. The aim of this chapter is to offer an analysis of the way the discourses within the documents seem to position critical thinking for a nurse.

The documents engage several discourses that impact the way critical thinking may be defined, understood and utilised in nursing practice. The effect of these definitions and understandings is noticed through the differing positions offered within the discourses. The documents are written in such a way that discourse connections are involved and can be seen at times to link and in other times to offer contradiction. As illustrated in Appendix Tables 1 and 2, (p. 156; 172) more than one discourse was identified in each of the examples presented. This clearly illustrated the connections between the discourses that were operating and signalled the potential for discourses to offer competing, conflicting or complementary impacts for the nurse. The discourse options a nurse may draw on will also be influenced by the larger socio-cultural context and this is addressed in Chapters 6 and 7.

Distilling out separate discourses was problematic due to the extent of interconnection between them. It could be argued that all of them are equally significant. The ability of the discourses to interconnect and draw on each other to position the actions of a nurse has a powerful hold over the thinking of the nurse, be it critical or not.

The discourses were identified using Owen's (1984) thematic analysis. Owen claims that themes can be identified if they meet criteria related to recurrence, repetition and forcefulness (see Chapter 3, p. 45 for more detail). Following this analysis, it became apparent that some discourses dominated over others in the influence they held over critical thinking. Legal, professional, safety and risk, managerial, and evidence-based practice discourses were identified because they all met Owen's criteria.

Owen's first criterion of recurrence was particularly useful for this analysis as in the professional documents the term, 'critical thinking', was not specifically used. The discourses were identified by the recurrence of words, phrases and sentences that were synonymous with, or congruent

with the meaning of critical thinking. As seen in Table 1 of the Appendix (p. 161), each relevant excerpt was coded as either 'denoted' or 'implied'. They were classified as denoted if they used words or terms that described concepts that were clearly aligned with the meaning of critical thinking. Alternatively, they were coded as implied if their link to characteristics of critical thinking was not overt but present within described activities.

The second criterion that of repetition was met by the frequent use of the term 'critical thinking' and this was particularly apparent in the two academic texts. Examples are provided in Table 2 of the Appendix (p. 175).

There was also evidence of Owen's final criterion of forcefulness, exemplified by characteristics such as the authoritative tone of the wording which was observed across all of the documents. Other forceful characteristics were the use of font changes within the academic texts and the use of indicators within the NCNZ competencies.

Legal discourse can be argued to hold the most significant power and authority over directing the ability of a nurse to engage with critical thinking in order to make clinical practice decisions. The legal discourse linked directly to professional discourse and the discourses of care, accountability, responsibility, and evidence based practice as well as scientific, humanistic, cultural, sociological, and psychological discourses. Influencing all of these, and directly connected to legal discourse, is an overarching discourse of safety, as the purported reason for regulating nurses and ensuring competency is to prevent the risk of harm to the public (MOH, 2009).

For the purposes of managing such a range of discourses, the discourses of regulation and competency were situated within the legal discourse. As a profession, nursing is legally regulated both at a government level (HPCA Act) and at a professional level (NCNZ). The interconnection of the law with the duties of a professional is the means by which nurses are self-regulated and is the primary function of the Nursing Council of New Zealand. Similarly, the discourses of care, ethics, accountability and responsibility were situated within the discourse of professionalism. This decision is supported by Kong's (2014) definition of a regulated professional. The aforementioned discourses all contribute to describing and determining the nursing profession by their "very strong normative function in shaping and forming the profession" (Kong, 2014, p. 3).

The findings identified that five dominant discourses were evident in the documents. As identified above, these were:

- Legal discourse (discourse of regulation: discourse of competence).
- Professional discourse (discourses of care, ethics, accountability and responsibility).
- Safety and risk discourse
- Evidence-based practice discourse
- Managerial discourse

Each of these has been defined separately below, but it must be emphasised that the interconnectedness of the discourses is particularly important because the construction of critical thinking and its use in practice is heavily influenced by these connections. As described in Chapter 4, when connections between discourses are present, they will at times complement, contradict, compete and/or dominate each other. This, in turn, will position the nurse's critical thinking options in a particular way and potentially exclude other possibilities.

The influence of the discourses

Legal discourse: Keeping in step with the law

This is the most influential and pervasive discourse evident across the documents in relation to critical thinking and its influence on nursing practice. The presence of legislation is seen explicitly, when it appears in word form within the text, and also implicitly in its influence over all of the other discourses. Discourses of regulation and competency, as part of legal discourse, are called on to add specificity and further the reach of legal discourse.

The New Zealand legal system is complex and engages several institutions that enable laws to be formulated and enforced (Burgess, 2008). In keeping with other similar democratic countries, laws generated by the State via these institutions are the means by which nations seek to control populations and by doing so ensure social order (Burgess, 2008; van der Burg, 2009).

Several pieces of legislation directly influence the practice of nursing in New Zealand. The primary function of such legislation within the New Zealand Health and Disability sector is to protect the public from harm. The HPCA Act (2003) is the legislation that controls all professionals involved in the provision of healthcare in New Zealand. There is of course other legislation that also relates to nursing practice, for example the Crimes Act (1961), Privacy Act (1993), Mental Health Compulsory Assessment and Treatment Act (1992), Contraception, Sterilisation and Abortion Act (1977), Health and Disability Services (Safety) Act (2001), Medicines Act (1981) and Treaty of Waitangi Act (1975). A registered nurse is accountable and responsible for adhering to, and upholding, all relevant legislation.

The HPCA Act (2003) is responsible for regulating nursing practice in order to protect the health and safety of the public (MOH, 2012). It does this via two mechanisms; via its position as a state regulator and through a degree of self-regulation via NCNZ. Self-regulation is achieved by NCNZ through their prescription of a scope of practice and the requirement that nurses provide evidence of meeting its competencies. The HPCA Act (2003) mandates NCNZ to regulate nursing practice and any nurse wishing to practice must be registered with the NCNZ. In this regard, the HPCA Act (2003) is one of the most influential pieces of legislation for the nurse.

Perhaps the most significant and powerful effect of legal discourse is seen in the provision of the legal definition of nursing practice in New Zealand. As Parker (1992) claims, it is through

discourse that phenomena become recognised. NCNZ provides the means by which nursing practice becomes legitimately recognised by nurses and by others. Their definition describes the scope of practice, function, and meaning of a registered nurse. "The Nursing Council's Competencies for Registered Nurses describe the skills and activities of registered nurses" (NCNZ, 2016). In doing so it provides the parameters of the profession. It then regulates the practice of nursing by demanding evidence of clinical competence, cultural competence and ethical conduct. Nurses have a mandate to deliver care that is defined, sanctioned and regulated via this legal discourse.

The discourse of regulation: The inflexibility of the law versus the flexibility required for critical thinking.

The New Zealand government (the 'State') uses the HPCA Act (2003) to maintain its authority for directing the overall framework for regulation. However, within the act it "allows a high level of self-regulation for health practitioners" (MOH, 2012, p. 1). The role of the NCNZ is to enact its devolved responsibility for the regulation of nursing in a manner that meets the government's agenda. Regulatory discourse can be seen at work at both State level and a professional one within the documents. As an insider to the profession, a nurse is aware of the contextually complex and situated nature of nursing practice. The State, as an outsider to the profession, does not have an understanding of the unique characteristics of nursing practice. Van der Burg (2009) states, that unlike the professional who works with "local, practical knowledge, the State relies on general, theoretical knowledge" (p. 151). The push and pull of general theoretical aspects and the more indeterminate features of a nurse's work is evident across the documents.

Scott (1998) maintains that the State, in order to understand and control the complexity of those it is governing, simplifies the complexity by assessing "the life of their society by a series of typifications" (p. 76). Van der Burg (2009) summarises the 'typifications' as methods the state uses to "simplify, standardize, measure, count and aggregate" activities of practitioners (p. 151). The state focuses on

> … clear cut minimum rules rather than on aspirations and values. It is interested in the output of the professional rather than in the practice itself...and the products the practice delivers and to judge these in terms of quantitative criteria (p. 151).

The State's interest is in the measurable outcomes of the professional's work in order to make the profession 'legible' (van der Burg, 2009). These measures are required for the State to be assured of safe practice via an objective tangible means. This is seen in the following examples from the texts:

> *"Administers interventions, treatments and medications, (for example: intravenous therapy, calming and restraint), within legislation, codes and scope of practice; and*

according to authorised prescription, established policy and guidelines." (NCNZ, 2012a p. 14).

"Utilises a framework for ethical decision making and practises in accordance with legislation, policies and codes of conduct" (NZCMHN, p. 12).

The use of the words 'authorised' and 'established', alongside 'codes', 'prescription', 'policy', 'framework' and 'guidelines', reinforce the power that these documents have over the thinking and actions required by the nurse. Regulating practice in this way assumes that standardisation of practice will ensure consistent, accurate and effective outcomes. These outcomes can then be seen and measured and made legible. The benefit of universal standards is further reinforced by the academic text, which clearly connects the act of thinking to measurable outcomes.

"The use of universal standards of clarity, accuracy, precision and relevance means that the nurse has command of these standards." (Jones, p. 82, calling on Huckaby, 2009).

As Schon (1987) identifies, the need to apply standardised and universal principles to clinical situations is predicated on a focus on technical rational predictability. Rolfe (2014) maintains that a techno-rational approach may have a useful place in "simple and straightforward" situations (p. 1180). In situations where there is an ability to predict with relative certainty that a person needing care will respond successfully to treatment in a uniform manner, employing technical rationality can be of use.

Most healthcare encounters, however, are complex and indeterminate, and require sophisticated problem solving to achieve individualised person-centered responses. In the NCNZ example above, the call to use authorised prescriptions for calming and restraint discursively positions the nurse to demonstrate practice in ways that can be measured as meeting predetermined sanctioned outcomes. Following set criteria for predetermined outcomes in this way, places the emphasis on identifying skills and abilities that may meet the requirements of the policy, but may fall short of meeting the needs of the person in care.

This is illustrated in a recent report from an inspection of the Waikato District Health Board Mental Health and Addictions Service commissioned by the Director of Mental Health (Elliot, 2016). The report states that the service had developed defensive, risk-based protocols when applying the Mental Health Compulsory Assessment and Treatment Act (1992) in an attempt to manage risk "in response to recent serious incidents and subsequent external criticism and intense media attention" (p. 17). These protocols led to staff making decisions that complied with the protocols, but staff reported that they "… felt this limited the use of their professional judgement and experience and discouraged patient's self-management" (p. 18). The report stated that the changes were "perhaps understandable", but stated that they were "contrary to good clinical practice" and were "inconsistent with the intent of legislation that prioritises the least restrictive care (particularly when the Mental Health Act is read in conjunction with the New

Zealand Bill of Rights Act (1990)". The report further stated that "Defensive practice and attempts to control (rather than manage) risk work against the ability to minimise the risk of re-traumatisation" in the management of acute psychiatric illness (p. 18).

Critical thinking is at least compromised and at worst disabled when there are no, or limited, options to challenge the status quo. The above example demonstrates how the powerful interconnection of legal, managerial, safety and risk discourses negatively impacted on the critical thinking and professional actions of the staff. The difficulty in supporting professional judgement by thinking critically while adhering to the demands of legislation and the needs of a patient is clearly demonstrated in Elliot's report. A professional operating within all relevant legislation, amidst the contextual complexity that arises within unique patient circumstances, may well have arrived at different outcomes for people in care had a critical perspective been employed. Indeed, in his report, Elliot maintains that to effectively manage risk that occurs "on a daily basis" within mental health services, an inclusive approach is required. He states "… clinicians must positively manage risk in the context of the individual's life and their wider whanau context" (p. 18). Giving due consideration to the competing discourses of risk management and managing powerful hegemonic practices inherent in these, necessitates a critical thinking approach and contextual support.

Despite the apparent inflexibility of practice options while adhering to 'the rules', paradoxically the deliberate vagueness and ambiguity of the wording of the professional standards within the documents provide some space for the nurse to think critically. This flexibility enables inclusion of the 'wisdom of the profession' (van den Burg, 2009, p. 158) to be employed.

For example, the word "relevant" within the following indicator is open to interpretation by the nurse in selecting which legislation, code or policy is followed. Likewise, the term "in accord with", rather than 'following', implies flexibility. Furthermore, in order to uphold "health consumers' rights", the nurse has options in interpreting what the rights of the consumer are.

> *"Indicator: Practises nursing in accord with relevant legislation/codes/policies and upholds health consumers rights derived from that legislation."* (NCNZ, 2012a, p. 9).

Another example (below) which places ethical decision making with the requirement to follow legal processes also signals potential flexibility. By not specifying a particular framework, the nurse is enabled to select from a range of ethical decision making frameworks. They are also empowered by the use of the phrase 'in accordance with' to determine what legislation, polices and codes of conduct can be used and how best to use them while still adhering to the requirements of ethical decision making.

> *"Utilises a framework for ethical decision making and practises in accordance with legislation, policies and codes of conduct"* (NZCMHN, 2012, p. 12).

As well as the professional documents providing some flexibility for nursing practice while adhering to legislated requirements, they also extend this to require that a nurse applies critical thinking. This can be seen in the following examples:

> *"Indicator: Contributes to care planning, involving health consumers and demonstrating an understanding of health consumers' rights, to make informed decisions"* (NCNZ, 2012a, p. 14).

> *"Indicator: Makes appropriate professional judgement regarding the extent to which the health consumer is capable of participating in decisions related to his/her care."* (NCNZ, 2012a, p. 17).

> *"Ensures the health consumer has adequate explanation of the effects, consequences and alternatives of proposed treatment options"* (NCNZ, 2012a, p. 17).

> *"Nurses acknowledge a client's right to participate in an activity that may involve a degree of risk of which the client is fully informed, and take steps to minimise the risk."* (NZNO, 2012, p. 11).

Within all of these examples the need for the nurse to manage contextual complexity is clear. Compliance with legal requirements, alongside recognising and honouring the uniqueness of every individual healthcare encounter, demands a critical perspective. The need to critically engage with the underlying ideological assumptions inherent in concepts such as "self-responsibility", "acceptable risk", "individual rights", and "adequate explanation" is essential. This is reinforced by Jones (2012) within one of the academic texts:

> *Professional standards for critical thinking refer to ethical criteria for nursing judgements, criteria to be used for evaluation and criteria for professional responsibility. Application of professional, legal and ethical standards requires that nurses use critical thinking for the good of individuals or groups* (calling on Freegard, 2007, p. 82).

There are powerful forces at play for both the nurse and those in care which will position how these concepts are understood. Critical thinking is essential for recognition and management of such complexity. Understanding the dominant normalising ideologies enables nurses to do the 'right' thing for clients. The identification of the 'right' thing requires an engagement with possible competing worldviews and paradigms. Supporting individualised and context-specific decisions about informed consent as a professional in the manner depicted in the examples above can be fraught, because the consequences of not following the law can be dire.

> *Health professionals have legal obligations to obtain informed consent prior to a procedure and prior to data collection (eg, data collected for the National Immunisation Register). Unless there are specific legal exceptions to the need for consent, the health professional who acts without consent potentially faces the prospect of a civil claim for exemplary damages, criminal prosecution for assault (sections 190 and 196 of the Crimes Act 1961), complaints to the Health and Disability Commissioner, and professional disciplining* (MOH, 2016a).

Nurses are obliged to follow the laws governing their practice. Yet the push and pull of professional wisdom and the requirements of the law are challenging. Despite implying flexibility, there are clear expectations about their engagement and actions relating to informed consent. This may compromise agency because they are positioned to demonstrate that they have fulfilled the requirements of the law. It is also a requirement for demonstration of safe and competent practice.

The discourse of competence: Ensuring effective performance

Articulating with the legal regulatory discourse is the discourse of competence because it is through the provision of evidence of competence that a nurse is deemed safe to practice. As identified above, competency is also the means by which nursing practice is regulated. State control over a professional's field of practice is exercised via regulation and their performance by the measurement of competency. Meeting competency by adhering to established professional standards is a requirement, as illustrated in the following examples from the documents:

> *"Registered nurses are accountable for ensuring all health services they provide are consistent with their education and assessed competence, meet legislative requirements and are supported by appropriate standards"* (NCNZ, p. 3).

> *"Nurses demonstrate and maintain competence in clinical and technical skills and the application of knowledge"* (NZNO, p. 7).

> *"Professional accountability involves an obligation to recognise socially and professionally mandated policies and to maintain legal and ethical standards"* (NZCMHN, p. 12).

> *"As a nurse gains new knowledge and develops into a competent professional, the ability to think critically to make a sound clinical judgement expands"* (Jones p. 79).

In order to achieve this requirement, nurses need to provide evidence that the care they deliver is in keeping with credible professional norms. Benchmarking is an approach that enables practitioners to provide evidence of competent practice. Lindenberg (2009) states that "… the purposes of benchmarking and survey reports are to provide a quantifiable measure of performance and to quantify gaps between your practice and best practices" (p. 23). The use of benchmarking as an approach for capturing performance in a measurable way is particularly evident within the standards of practice set out in the NZNO and NZCMHN documents.

In the following examples, the need for a nurse to conduct their practice within the requirements of a prescribed field of practice, and meeting professional standards is clearly stated:

"Nurses enter into and maintain partnerships with colleagues; students, multi-disciplinary team members, and employers to ensure best practice standards are met and maintained" (NZNO, 2012, p. 9).

"Mental Health Nursing practice reflects accepted ethical standards and relevant codes of conduct and practice" (NZCMHN, 2012, p. 12).

"Indicator: Uses professional standards of practice" (NCNZ, 2012a, p. 9).

As identified in Chapter 2, these standards are usually predetermined by expert practitioners whose legitimacy to establish practice norms is authorised by their authoritative positions. However, the standards derived from these experts offer frameworks for thinking that normalise and legitimise particular practice decisions. As Reeves, Fox and Hodges (2009) identify, competency frameworks privilege techno-rational aspects of practice; aspects that focus on task acquisition and measurable outcomes. This normalising of professional behaviour has the potential to limit critical thinking and the development of new and innovative practices because nurses must shape their practice in ways that comply with these professional standards.

In the following example from Document 5, the author appears to be making the case that, by meeting standards, a nurse is demonstrating critical thinking. However, this would not fully meet the criteria for critical thinking as defined in Chapter 2 of this thesis. Predetermining the criteria by which the outcomes of thinking will be measured constrains the engagement with aspects of critical thinking such as the underpinning paradigmatic, prescriptive and causal assumptions (Brookfield, 2011).

> *Critical thinking includes intellectual and professional standards. These standards are the criteria for determining the soundness, justness and appropriateness of critical decisions and judgements. The use of intellectual standards involves a rigorous approach to clinical practice and cannot be done haphazardly. When a nurse considers a client problem, it is important to apply standards such as preciseness, accuracy and consistency to ensure clinical decisions are sound and valid* (Jones p. 82).

Furthermore, in addition to the expectation that nurses will meet professional standards is the expectation in the documents that nurses will think beyond established norms and generate new approaches that advance and ensure nursing is at the cutting edge of best practice.

> "*Nurses engage in creative and innovative approaches to ensure the needs of clients and best practice standards are met"* (NZNO, p. 8).

> *"Translates global and national mental health promotion policies into the local context"* (NZCMHN, p. 9).

Engaging creatively and developing innovative approaches requires a critical thinking disposition. Yet thinking, and acting, outside of established professional norms or applying

normative principles in an innovative way is challenging due to the constraining forces inherent within the powerful expectations of the professional standards. Developing innovative and creative approaches is a lofty ideal that potentially places a nurse in an untenable position due to the requirement that the thinking and action of the nurse meet predetermined parameters prescribed by professional 'best practice standards'. The agency to act creatively and innovatively is therefore limited by the need to follow these guidelines, calling into question evidence based practice protocols as an appropriate benchmark for innovation. In a similar way, adopting global and national initiatives as part of professional practice can only be achieved if sanctioned within professional standards alongside healthcare and organisational policies. The paradox for a nurse is the translation of policy expectations amidst the dominant and compelling demands of prescribed practice.

Professional discourse

This discourse was recognised across the documents when features of critical thinking were directly associated with the professional identity, roles and responsibilities of the nurse. In the literature review, a profession was defined as a discrete body of knowledge from which judgements, decisions and actions are derived. In the legal definition of nursing provided by the NCNZ, they state:

> *"Registered nurses utilise nursing knowledge and complex nursing judgment to assess health needs and provide care, and to advise and support people to manage their health."* (NCNZ, 2012a, p. 3).

The use of the terms 'nursing knowledge' and 'complex nursing judgement' in the opening sentence immediately signals the need for nurses to think amidst complexity, and therefore the need to critically think is clearly expected. This was echoed across all of the documents alongside the identification of the role of the professional nurse as being mandated and sanctioned to use professional disciplinary knowledge as experts to assess, plan, intervene, and evaluate a plan of care. Registered nurses are positioned to deliver nursing care, offer advice and support, and direct others within the nursing care team.

This mandate places nurses in a potentially powerful position, because they are socially sanctioned to support and manage the health of the population and as such have influence over those in their care. Van Dijk (1998) argues that "professional groups develop ideologies especially as a function of the interests tied to their activities and their special resources …" (p. 152). O'Byrne, Holmes and Roy (2015) call on Foucault (1977, 1991) to argue that the legitimate permission to act with social authority and pastoral power is both an extension of the law (sovereign power) and political technologies (disciplinary power). Holders of pastoral power use their expertise to engage those in care. This social mandate is further reinforced by the

level of "…trust, respect, empathy and understanding…" perceived by those in care about this legitimised "pastoral agent" (p. 136).

Nurses are depicted in the documents as 'pastoral agents'. The provision of such care is facilitated via the nursing process that has all the hallmarks of Foucault's (1977) notion of the "examination" (p. 184). The nurse, "examines" (assesses) a person in their care, "scrutinizes" the results of these assessments and evaluates ("engages in normalizing judgements") and then "intervenes" when the assessment and evaluation of the person falls short of a desired norm (p. 136). Pastoral power is enabled via both the nurse and the person receiving care recognising and accepting the socially sanctioned role of a registered nurse. "The examination combines the techniques of an observing hierarchy and those of a normalizing judgement. It is a normalizing gaze, a surveillance that makes it possible to qualify, to classify and to punish" (Foucault, 1977. p. 184).

Because the act of examining with a 'normalising gaze' enables the ability to make judgements on which corrective interventions can be justified, Foucault argues the examination is "…highly ritualized"(p. 184). The 'examination' will employ certain methods, have particular questions and answers, engage particular actors and enable the dictation of particular roles (Foucault, 1977. p. 185). The examination is a means of holding power and establishing the 'truth'. O'Byrne, Holmes and Roy (2015), in clarifying Foucault (1977), maintain that the ability to make such judgements is predicated on the recognition of the assessor's expertise. An assessor requires the "requisite competencies to make normalizing judgments..." (p. 137).

All of the documents call on the nursing process as an underpinning requirement for the delivery of care. Professional expertise is mobilised through the employment of a process, a framework, and plan which will demonstrate the outcomes of the knowledge, thinking, decision-making and actions of the nurse.

> *"They provide comprehensive assessments to develop, implement, and evaluate an integrated plan of health care, and provide interventions that require substantial scientific and professional knowledge, skills and clinical decision making"* (NCNZ, 2012a, p. 3).
>
> *"Nurses use a recognised nursing framework to assess and determine client health status and the outcomes of nursing intervention, and document appropriately."* (NZNO, 2012, p. 7).
>
> *"The mental health nurse makes appropriate clinical decisions based on comprehensive nursing assessments."* (NZCMHN, 2012, p. 7).

The need to think critically is also present, silently presented as 'substantial scientific and professional knowledge', 'comprehensive assessments', 'clinical judgement' and 'clinical decisions'. As identified in the literature review, process knowledge, (or knowing) how to perform as a professional, is only a part of what is required. As depicted in the above quotations, the agency to act with pastoral power is sanctioned through the nursing process.

Nurses are activated as social agents, 'using' knowledge and 'doing' things to people. The nursing process is a legitimate means of examining, making decisions, planning and then acting. Alongside this is the need to think critically to decide what information is most useful and appropriate in any nursing encounter. Critical thinking is also essential to ensure that what is being determined as appropriate is not predicated on a "normalizing gaze" and "normalizing judgements" that support just one 'truth'.

In the glossary of terms of the NCNZ competencies, 'appropriate' is defined as "Matching the circumstances of a situation or meeting the needs of the individual or group" (p. 32). In Fairclough's (1995) critique of 'the appropriacy of appropriateness' he identifies the ideological power of the concept 'appropriate'. His discussion navigates the complexities of language education but his arguments can be applied here. 'Appropriateness models', he claims, reflect the perspectives of dominant sections of particular social groups (p. 247). In this way the interests of these particular groups are normalised and become the way things are, and are assumed to be stable over time.

Within all of the documents analysed in this research, the nurse was called to make 'appropriate' decisions, actions, and judgements. Nurses were called to provide appropriate care, ensure appropriate boundaries, and use appropriate evidence. The scope afforded by being 'appropriate' fits nicely with the indeterminate aspects of the professional and calls very clearly for the need to demonstrate professional knowing that is in keeping with contextual complexity. Critical thinking would be essential in assisting to determine what would be appropriate. This gives agency through professional authority to the nurse, yet, as pointed out by Fairclough, the meaning of 'appropriate' may be determined by the power of the dominant discourse and ideological perspectives.

Powerful authorities, such as organisations via frameworks, and regulators via legal requirements, draw on and privilege dominant discourses to determine their definition of the concept of 'appropriateness'. This could be experienced as managerial discourse, which may privilege decision making in terms of efficiency and cost effectiveness, evidence based practice in terms of a hierarchy of evidence, and safety discourse in terms of generalisations. This is further explored in Chapter 7 through the example of a hospital management directive that nurses be vaccinated for influenza.

Safety and Risk discourse

The discourse of safety was also both explicitly and implicitly present in the documents. As identified earlier, this is an overarching discourse due to the requirement that the actions of a nurse pose no risk of harm to the public. At times the discourse of safety sits silently but always present in the discourses through its connection to legal discourse. This is seen in the following excerpts:

> *"Nurses provide documentation that meets legal requirements, is consistent, effective, timely, accurate and appropriate"* (NZNO, 2012, p. 6).

> *"…understanding of: The theories of therapeutic relationships and effective communication. The ethical and legal frameworks that support therapeutic relationships"* (NZCMHN, 2012, p. 4).

In both of these examples the demand for critical thinking is identified by the multifaceted expectations inherent in these nursing activities. In the first example the quantifiable aspects of safe practice can be seen; 'timely', 'accurate', 'effective', and consistent with the hallmarks of a technical-rational approach. 'Appropriate' however is a more nebulous construct which, as discussed in the previous section, leaves the door open for conflict between what may be deemed safe and how this should be managed by practitioners, organisations and the law.

In the second example the tension between developing a therapeutic relationship with a client, and keeping in step with ethical and legal frameworks can challenge culturally safe care. The expectations of professional boundaries within professional and legal discourse in therapeutic relationships can disrupt the ability of a nurse to gain the trust and connection necessary to work effectively with Māori. This will be further examined in Chapter 6.

The message that critical thinking is essential for the provision of safe care is clearly illustrated in the examples below from the texts. Safety in these examples is expressed explicitly. Both the professional and academic documents drew heavily on the discourse of safety and foregrounded this in their positioning of the link between critical thinking and safe practice. Connections to the discourse of care (as a professional) and competence were used to enhance the message of safety. The reader is left in no doubt that critical thinking is crucial to the provision of safe and competent care and is the hallmark of effective professional practice.

> *"Implements nursing care in a manner that facilitates the independence, self-esteem and safety of the health consumer and an understanding of therapeutic and partnership principles."* (NCNZ, 2012a, p. 26).

> *"Nurses appropriately challenge health care practice which could compromise client/ family/ whānau / hapū / iwi safety, privacy or dignity"* (NZNO, 2012, p. 11).

> *"Advocates for services that are free from discrimination and sensitive to an individual's cultural identity and wellbeing"* (NZCMHN, 2012, p. 3).

In the following professional examples, it is clear that knowledge and judgement, actions and decisions (attributes of critical thinking) are required for consumer safety. In the first example, the edict from NCNZ mandates that critical thinking be demonstrated in order to ensure the healthcare environment in which nursing practice occurs be safe. In positioning the nurse as accountable for maximising the safety of consumers in their care, NCNZ are foregrounding the responsibility of the thinking of the nurse. The discourse of safety is reinforced by the link to the discourse of care. Caring is a fundamental aspect of the role of the nurse and, while also

aligned with professional discourse in the following examples, directly supports the thinking required for safety.

> *"… being able to demonstrate knowledge and judgement and being accountable for own actions and decisions, while promoting an environment that maximises health consumer safety, independence, quality of life and health."* (NCNZ, 2012a, p. 4)

> *"Indicator: Takes action in situations that compromise health consumer safety and wellbeing"* (NCNZ, 2012a, p. 18).

> *"Nursing is concerned about critical thinking because it deals with "split-second decision making to keep people safe"* (Rubenfeld & Scheffer, 2015, p. 31).

> *"… all decisions must be accurate and made in a timely manner"* (Rubenfeld & Scheffer, 2015, p. 2).

The following series of particularly poignant statements from the texts is used to demonstrate the expectation of critical thinking to enable a nurse to fulfil the expectations of acting in a 'professional' manner. In the first two examples from the academic texts, "safe" care is placed first in the sentence, foregrounding its importance in the reader's mind. The use of the value laden words 'meaningless', 'good', 'great', 'essential', 'very dangerous', 'risks', 'hazards' and 'threats' leave no doubt of the consequences to care should critical thinking not be employed by the nurse. The first three examples also particularly emphasise the authors' strong opinions about the necessity of critical thinking for safe and effective care:

> *"Without CT, any attempts for safe, effective, efficient health care are meaningless"* (Jones, p. 23).

> *"…the delivery of safe, effective, and efficient care has always been the underlying goal of good nursing care. CT is essential to achieving these goals"* (Rubenfeld & Scheffer, 2015, p. 10).

> *"…great nursing requires thinking and doing. One without the other either does not work or can be very dangerous"* (Rubenfeld & Scheffer, 2015, p. 53).

> *"Indicator: Recognises and manages risks to provide care that best meets the needs and interests of health consumers and the public"* (NCNZ, 2012a, p. 12).

> *"Indicator: "Implements nursing responses, procedures and protocols for managing threats to safety within the practice environment"* (NCNZ, 2012a, p. 18).

Alongside the identification of safety is the discourse of risk. According to Godin (2006), risk has become a pervasive discourse within nursing and health. He argues that "risk assessment and risk management have become insistent imperatives, which shape a diverse range of healthcare and nursing practice" (p. 1). He maintains that the discourse of risk has given rise to individualising of the nurse's (and other healthcare professional's) responsibility for assessing and managing risk. Being charged with this duty of care has led to nurses feeling vulnerable, and as a consequence engaging in defensive practice. This is in keeping with the previously

discussed findings of Elliot (2016). The following examples from the texts highlight the nurse's individual responsibility for risk management:

> *"Nurses acknowledge a client's right to participate in an activity that may involve a degree of risk of which the client is fully informed, and take steps to minimise the risk"* (NZNO, 2012, p. 11).

> *"Indicator: Recognises and manages risks to provide care that best meets the needs and interests of health consumers and the public"* (NCNZ, 2012a, p. 12).

> *"Nurses identify hazards and risks to client safety and participate in developing and implementing a risk management plan through continuous quality improvement"* (NZNO, 2012, p. 7).

> *"Indicator: "Implements nursing responses, procedures and protocols for managing threats to safety within the practice environment"* (NCNZ, 2012a, p. 18).

The last two examples also link to managerial discourse via the use of the constructs of continuous quality improvement and organisational procedures and protocols. While the nurse is positioned as being individually responsible for complying with these, the expectations inherent within these constructs can compromise the engagement with critical thinking. Policies and protocols offer particular messages about what the organisation requires and in this way constrain or place boundaries around the possibilities that thinking critically could uncover. Hardy and Maguire (2013), in their review of literature, maintain that the concept of risk has become objectified as a construct that can be assessed and then managed if the assessment of risk is accurate:

> *Risk assessment – the process whereby risk is identified– on the one hand, is understood as "science" – that is, it is evidence and fact based, and also values free though the application of widely recognised and highly institutionalised procedures and techniques. Risk management on the other hand, is understood to be "policy" – that is, a decision about what to do to avoid or reduce identified risks, which is necessarily values based since it involves trade-offs between multiple objectives* (p. 84).

When risk is assessed within organisations using and privileging particular evidence, the ability of nurses to engage other means of assessment of evidence can be compromised. This is particularly influential for deciding how the risk will be managed. If policies and protocols for risk management are designed in light of risk assessment, the options for the nurse to employ critical thinking to inform judgements, decision and actions is compromised. The socio-cultural implications of this will be further discussed in Chapter 7.

Evidence-based practice discourse

Determining what evidence nurses should incorporate within their practice was a significant concern for this study. Within the literature review, attention was drawn to the dominance of evidence-based practice (EBP) within nursing practice and the link this had to critical thinking.

This discourse was identified across the documents when any reference was made to the call for evidence and/or research in relation to the provision of care.

Critical thinking is deemed essential alongside EBP for moderating and managing information across competing knowledge claims, and for questioning the taken-for-granted assumptions residing in these claims. DiCenso, Guyatt and Ciliska (2005) describe the actions required of a nurse when using EBP. Nurses need to:

> *…define a patient problem precisely and ascertain what information is required to resolve the problem, to conduct an efficient search of the literature, to select the best of the relevant studies, to apply the rule of evidence to determine their validity, to extract the clinical message, to determine how the patient's values affect the balance between advantages and disadvantages of the available management options, to involve the patient appropriately in the decision, and to implement and evaluate the management plan* (p. 6).

This is a challenging undertaking which requires a sophisticated and comprehensive engagement with information across a broad field of knowledge, experience and values. Such an endeavour has all the hallmarks of one requiring critical thinking in order to ensure excellent and appropriate patient care. Within EBP there are three equally important sources of evidence; evidence from research, clinical expertise and patient preferences (Mulhall, 1999). Within the literature review, the powerful position that research evidence, particularly from scientific research, held over the other two aspects was identified. This dominant position is of importance in understanding the enabling or disabling influence it may have on critical thinking.

Quantitative research, as seen in randomised controlled trials, is often in competition with other aspects of evidence, such as those of patient preference and practice knowledge. Rolfe (2014) illuminates this tension by arguing that "In a research-led or evidence-based discipline, the very idea and definition of practice is shaped and determined by the epistemological assumptions of the dominant research paradigm" (p. 146). Rolfe maintains that nursing has adopted a social scientific research paradigm that produces "general theories about the behaviour of large social groups… that will inevitably lead to the ideal of best practice as being based on the 'gold standard' of large-scale empirical studies whose findings can be applied to any patient in the population from which the research sample was drawn" (p. 146). He maintains that this will privilege "technical, generalizable knowledge and practice" (p. 146).

As identified in Chapter 4, the NCNZ (2012a) appeared to foreground scientific knowledge ahead of professional knowledge within the Registered Nurses scope of practice. The sentence states:

> *"They provide comprehensive assessments to develop, implement, and evaluate an integrated plan of health care, and provide interventions that require substantial scientific and professional knowledge, skills and clinical decision making"* (NCNZ, 2012a, p. 3).

This foregrounds scientific knowledge by placing it first in the sentence prior to professional knowledge. In keeping with Rolfe's argument, this potentially places quantifiable and measurable (techno- rationale aspects) of scientific and diagnostic discourse ahead of professional knowing. The dominance of research evidence that comes from quantifiable scientific methodology was highlighted as a dominant means by which EBP is used within the literature review. The privileging of random controlled trials as the gold standard in determining care is an example of this. In the face of statistics and 'objective' measures of success, professional knowing and client preferences can be silenced. In the following excerpts the dominance of the technical aspects of care, such as policies, procedures, and research are clearly depicted.

> *"Identifies examples of the use of evidence in planned nursing care"* (NCNZ, 2012a, p. 14).

> *"Indicator: Applies relevant research to underpin nursing assessment"* (NCNZ, 2012a, p. 15).

> *"Indicator: Reviews policies, processes, procedures based on relevant research"* (NZNO, 2012, p. 30).

The agency for a nurse to critically think and call on aspects of evidence other than the technical is silenced. Wisdom derived from professional practice, personal knowing and patient values and preferences is compromised. Critical thinking is not required in the face of technical rules and tasks. Of most concern, Rolfe (2014) would argue, is:

> *…the growing emphasis on practice based on 'best evidence' is de-emphasizing and detracting from the primary focus on what nursing is or should be, and is shifting the discipline towards a purely technical approach to practice. One of the possible effects of this shift is the tendency to regard patients instrumentally as sources of data and as passive bodies to be acted upon, as objects rather than subjects* (p. 147).

Ironically, the following examples require a nurse to employ critical thinking and use all three components of EBP in determining care.

> *"Evidence Based Practice: A process of integrating the best available evidence with professional expertise to guide professionals in decision-making regarding the care of individuals. It requires critical appraisal"* (NZCMHN, 2012, p. 14).

> *"The ability to think critically though the application of knowledge and experience, problem solving and decision making is central to professional nursing practice"* (Jones, 2012, p. 78).

> *"Nurses interpret, critique and use current evidence from research and other credible sources to make practice decisions* (NZNO, 2012, p. 7)

In this next example there is a clear edict that the management of care a nurse provides needs to be supported by nursing knowledge and evidence. This potentially limits the responsiveness of the nurse to the client's needs because there must be an alignment with professional knowledge and evidence. Critical thinking is required by a nurse to uncover the taken-for-granted assumptions privileged within nursing knowledge and evidence based practice that may limit the consumer's voice.

> "...assessment and managing health consumer care, which is responsive to the consumers' needs, and which is supported by nursing knowledge and evidence based research" (NCNZ, 2012a, p. 4).

In the following examples there is an expectation that any review and change in nursing activities will be supported and justified with research evidence. This potentially offers the nurse a credible position to have agency over nursing practice. This is evident in the following examples from NCNZ (2012a):

> "Participates in quality improvement activities to monitor and improve standards of nursing."

> "Indicator: Reviews policies, processes, procedures based on relevant research."

> "Indicator: Recognises and identifies researchable practice issues and refers them to appropriate people."

> "Indicator: Distributes research findings that indicate changes to practice to colleagues." (p. 30).

The ability for the nurse to participate in quality improvement, review polices and translate new understandings will potentially be hamstrung by the meaning of 'relevance', 'appropriate' and 'researchable'. These words have significant meaning when articulated within EBP discourse and other influential discourses. Critical thinking is potentially limited by EBP, professional, managerial and legal discourses when their normalising practices determine what is relevant, appropriate and researchable.

Managerial discourse

The principal aims of management are to control, predict, manage and maintain structures and processes within organisations with an intention to ensure organisational stability and productivity (DuBrin, 2013). Management discourse has been identified throughout the analysis above of the legal, professional, safety and risk, and evidence-based practice discourses. The powerful interconnection of management discourse alongside the other discourses was clearly depicted and discussed.

Management discourse is currently underpinned by policies of free-market efficiency, individualism and self-responsibility that are now seen in healthcare (see Gilbert, 2005). Rose and Miller (2010) maintain that market driven approaches allow the decision making within healthcare to be determined by those in management rather than healthcare professionals. Fiscal controls are then enabled that will shape healthcare in ways that reflect efficiency and cost effectiveness, and also the treatment of healthcare professionals as commodities in the workplace.

Managerial discourse was identified within the text when any fragment of managerial discourse was noticed within the documents. The managerial discourse connected to discourses of safety and risk, EBP, and the professional discourses of accountability, responsibility and care. Critical thinking is likely to be controlled in the face of managerial discourse.

> *In addition to safe care, CT is important for effective and efficient care. Effective care is individualised and accurate. It employs the correct interventions for the health situation at hand. Efficient care requires timely thinking so that resources are used appropriately* (Rubenfeld & Scheffer, 2015, p. 11).

Organisational policies and protocols, in the form of managerial directives, have the potential to dominate and limit the nurse's ability to think critically. Freshwater, Fisher and Walsh (2013) call attention to the impact on professional autonomy following the emergence of clinical governance initiatives within healthcare environments. Clinical governance is "… a set of initiatives designed to enhance care, and the promotion of a productive culture and climate within which care can thrive" (Braithwaite & Travaglia, 2008, p. 11). It arose as a response to serious concerns about quality and safety within healthcare. However, Freshwater, Fisher and Walsh (2013) argue that clinical governance has an agenda to standardise healthcare practices via systematic frameworks to support quality and standards. These clinical governance initiatives have in fact given rise to the "… external scrutiny of professional groups that are self-regulating" (p. 3). This scrutiny then translates to professional practice being measured in line with 'compliance to guidelines' of clinical governance frameworks (p. 3).

Managers, through employing clinical governance initiatives, reify managerial definitions and processes of safety and quality. Quality and safety initiatives are then understood and enacted in keeping with a management agenda (Mumby, 2001). The management agenda of cost effectiveness, efficiency, predictability and consistency can be seen in the following examples from the texts:

> *"…all decisions must be accurate and made in a timely manner* (Rubenfeld & Scheffer, 2015, p. 2)

> *"Implements nursing responses, procedures and protocols for managing threats to safety within the practice environment"* (NCNZ, 2012a, p. 18).

> *"Nurses negotiate to obtain the necessary resources to support nursing practice and make the best use of resources available in the provision of client care"* (NZNO, 2012, p. 13).

"Indicator: Demonstrates knowledge of, and accesses, policies and procedural guidelines that have implications for practice" (NCNZ, 2012a, p. 9).

Within the literature review it was noted that decision making was compromised amidst the pressure to manage resources and adhere to organisational structures. Furthermore, Litchfield and Jonsdottir (2008) signalled that the work of nurses is also viewed as a commodity to be managed as part of the organisations resources. This can be seen in the way the examples are worded to manage nursing actions.

Chapter Summary

This chapter completes the first two stages of this critical analysis. The analysis thus far has identified the methods by which the documents employ particular discourses to position critical thinking within nursing practice and has identified the possible impacts on the professional identity of the nurse.

In all of the five discourses that were identified as dominant there was clear evidence of how interconnected the discourses were and how influential this is in determining not only how critical thinking may be positioned but also how the nurse is discursively positioned within these complex, interconnected discourses. Thinking critically amidst the diverse articulations of what is expected from a nurse in providing care is challenging. The documents employ discursive strategies to obscure the meaning of critical thinking, and this makes its use in practice questionable. The links to rules and practice outcomes required by the State overshadow the autonomous practice required of a critically thinking nurse.

The legal discourse, identified as the most significant discourse, shapes the way the nurse engages with critical thinking. The power of the legal discourse is increased by other discourses. This was particularly noticeable when management, and safety and risk discourses converged. For example, as will be elaborated in the next two chapters, the nurse is affected by the legal obligations of an employer such as a DHB as it manages statutory obligations. A DHB can call on the following objective as determined by the NZ Health and Disability Act (2000); "to improve, promote, and protect the health of people and communities" (p. 23). This legal mandate enables an employer to develop policies such as that which requires nurses to wear masks if they have not had the flu vaccine.

In addition, nurses need to meet their obligations under the Health and Disability Act (2000) to "… reduce health disparities by improving the health outcomes of Maori and other population groups" (New Zealand Health and Disability Act, 2000, p. 7) which is also supported within the Code of Conduct (NCNZ, 2012b). Critical thinking is essential to meet this requirement and both of these examples will be further examined in Chapters 6 and 7.

Chapter 6: Critical thinking and the invisible dominant ideological perspective

"Most nurses are employed by Crown funded agencies and can, therefore, be considered agents of the Crown. As Crown agents, nurses have an obligation to honour the principles of the Treaty while undertaking nursing practice in the delivery of health services to, and with Maori consumers" (NCNZ, 2011, p. 16).

Introduction

The aim of the next two chapters is to complete the contextualised interpretation of this CDA where the interpretation and explanation of the research findings at a sociocultural level is presented. This stage of the research process involved looking outside the documents at the context in which the documents are operating. It is at this level that Fairclough maintains the ideological effects of the documents are evident. Fairclough (2003) and Huckin (1997) advocate an interdisciplinary approach to enable a contextualised understanding of how discourses within the texts operate within "particular areas of social life" (Fairclough, 2003, p. 15). The works of Deetz (1992) and Brookfield (1985), alongside the Social Constructionist work of Burr (1995, 2003), are used to answer the research questions and identify the way in which the dominant professional and organisational discourses identified within the research position critical thinking within nursing theory and clinical practice, and how these discourses position and influence nurses' professional identities. The discussion of the possible implications for practice will be presented and discussed further in the final chapter.

In the previous chapter, the discourses that had a major role in influencing critical thinking within nursing practice and theory were identified (legal, professional, safety & risk, management and evidence-based practice (EBP)). These discourses were also shown to connect to other influential discourses, adding to their reach and power over the way in which critical thinking is understood and can be achieved by the nurse.

These discourses all impact critical thinking by the way in which they represent nursing theory and practice within their particular discourse structure. These representations then frame the nurse's understanding of the need for critical thinking and this in turn prompts the nurse to employ (or not) critical thinking in particular ways. The next two chapters will offer two more detailed, contemporary examples to demonstrate the discursive positioning of the nurse and the resulting implications for practice.

Honouring the Treaty of Waitangi / Te Tiriti o Waitangi and providing culturally safe care

All of the professional documents require nurses to honour the principles of the Treaty of Waitangi. There is an expectation that nurses will understand and apply these principles when working with Māori as Tangata Whenua in Aotearoa/ New Zealand (NCNZ, 2012a). Because a nurse must think critically in order to meet this expectation, this topic offers a valuable argument for demonstrating the need and value of thinking critically within nursing practice.

Although it is beyond the scope of this study to offer a detailed account of the history of colonisation in New Zealand, some explanation around the Treaty of Waitangi is necessary to provide a frame of reference for the poorer health outcomes for Māori.

New Zealand was initially settled by Māori, who as Tangata Whenua are the first people of the land (Reid & Cram, 2005; Reid, Taylor-Moore & Varona, 2014). Following the arrival of British settlers in 1840 and the subsequent wars, a treaty between the British and Māori (the Treaty of Waitangi) was signed. It consisted of two versions, a Māori version and an English version (Duncan, 2007; Ramsden, 2015). The Treaty of Waitangi provided certain guarantees to the tangata whenua, within the Treaty articles. The Crown would protect "Māori taonga/treasures" and guaranteed that Māori would retain "control over Māori resources". In addition Māori were guaranteed equal "rights and privileges as British subjects enjoyed in 1840" (Ramsden, 2015, p. 7).

From its inception the Treaty of Waitangi did not result in good outcomes for Māori and the effects of colonisation became a focal point for political challenges by Māori during the 1970s and 1980s. Enactment of the 1975 Treaty of Waitangi Act and its 1985 amendment therefore required all Government bodies to "conduct their activities in a manner consistent with the Treaty of Waitangi" (Papps, 2002). Despite this obligation, the health outcomes for Māori as partners of the Treaty still lag behind those of other New Zealand citizens (Papps, 2002; Ramsden, 2015). In 2014 the MOH released its second version of He Korowai Oranga: Māori Health Strategy, with the overarching aim of "Pae ora- healthy futures" (MOH, 2014, p. 4). Within the document, the MOH acknowledges the continued health inequities experienced by Māori in New Zealand. These inequities exist across "almost all chronic and infectious diseases as well as injuries, including suicide "(p. 9).

In 1996, the Right Honourable Jenny Shipley affirmed via governmental policy guidelines that Māori, as tangata whenua, hold a unique place in our country, and that the Treaty of Waitangi is the nation's founding document. "To secure the Treaty's place within the health sector is fundamental to the improvement of Maori health" (cited by NCNZ, 2011). The NCNZ has acted upon the requirements within both versions of the Treaty of Waitangi to honour its duties and obligations to work in partnership with Māori, respond to their needs, work in ways that ensure equity and to measure and evaluate nursing responses to the Treaty of Waitangi. As identified

in Chapter 4, this is also a clear intention within both the NZNO Standards of Professional Practice and NZCMHN Standards of Practice for Mental Health Nursing.

The World Health Organisation defines equity as "the absence of avoidable or remediable differences among groups of people". The concept acknowledges that "not only are differences in health status unfair and unjust, but they are also the result of differential access to the resources necessary for people to lead healthy lives" (MOH, 2014, p. 9). Within He Korowai Oranga: Māori Health Strategy, the government signals its continued commitment to address Māori health inequities, improve health outcomes for Māori and guarantee Māori are "…involved in both decision-making and service delivery" (p. 7). Nurses as health practitioners clearly have an influential role in supporting Pae ora- healthy futures for Māori. According to the requirements of the profession they also have an obligation to do so.

Rules of engagement

NCNZ maintains that all registered nurses in New Zealand must "…have a commitment to be responsive to Maori interests, and to ensure that these are protected. This is particularly important in the health sector because Maori comprise a significant proportion of users of the health services and the health status of Maori is recognised as a health priority area. The participation of Maori in the services they receive from nurses is fundamental to increasing the effectiveness of interventions" (NCNZ, 2011, p. 12).

To this end NCNZ (2011) identified four principles that need to be upheld by registered nurses in NZ.

- Principle one: Tino rangatiratanga, which enables "Maori self-determination over health, recognises the right to manage Maori interests, and affirms the right to development" (p. 13).
- Principle two: Partnership which involves: "nurses working together with Maori with the mutual aim of improving health outcomes for Maori" (p. 13).
- Principle three: Nurses recognise that "health is a taonga and acts to protect it" (p. 14).
- Principle four: Nursing members "recognise the citizen rights of Maori and the rights to equitable access and participation in health services and delivery at all levels" (p. 14).

In order to support these principles, the NCNZ (2011) maintains that student nurses, as part of their nursing education, must … "critically analyse the Treaty of Waitangi and its relevance to the health of Maori in Aotearoa/New Zealand" and "critically analyse the underlying historical, social, economic and political processes that have contributed to the inequalities and disparities in the Maori health status" (pp. 14 & 18). NCNZ also identify four principles to guide registered nurses in their work with Māori. Most significant for this study is the direction to analyse and critique within Principle one:

"Maori health, and the inequalities and disparities in health status that exist, can be understood by; analysing the historical, social, economic and political processes to which Maori have been subjected; critiquing the relationship between Maori and the Crown based on the Treaty of Waitangi; analysing the power that nurses use when working with consumers who are Maori" (p. 17).

Critiquing and analysing the impact of colonisation, political, economic and social processes that contribute to these inequalities and disparities in health status for Māori requires critical thinking. Critical thinking enables nurses to identify and analyse the powerful ideological and hegemonic influences contributing to the continued negative impacts on the health status of Māori. It also enables nurses to determine approaches that will enable them to work in partnership and honour their obligations to the Treaty to provide culturally safe care.

NCNZ is clear in directing that nurses honour these Treaty principles and meet their responsibilities towards improving the health status of Māori. It positions nurses as agents of the Crown, to emphasise this responsibility:

"Most nurses are employed by Crown funded agencies and can, therefore, be considered agents of the Crown. As Crown agents, nurses have an obligation to honour the principles of the Treaty while undertaking nursing practice in the delivery of health services to, and with Maori consumers. To respond in an effective and efficient manner, nurses need to develop their knowledge, skills and practice to work effectively with Maori to achieve positive health outcomes and health gains. This involves the recognition, respect and acceptance that Maori are a diverse population, and have worldviews that differ from most nurses. It also requires nurses to deliver care in a culturally safe manner" (NCNZ, 2011, p. 16).

Professional, management, safety and legal discourses are evident in the above expectation from the NCNZ. These are illustrated as follows:

- "To respond in an effective and efficient manner", (professional and management).
- "… nurses need to develop their knowledge, skills and practice to work effectively with Māori to achieve positive health outcomes and health gains": (professional and management).
- "…to deliver care in a culturally safe manner" (professional and safety).
- Nurses are also identified as "Crown agents" (legal).

While not as overtly identified, the scientific discourse of EBP is also an expectation. This will be discussed further shortly.

NCNZ also directs that nurses be aware of the differing worldviews between Māori and "most nurses" in order to deliver culturally safe care. Recognising and valuing differing worldviews within the delivery of safe and effective care is therefore a requirement of all nursing encounters. The term 'worldview' refers to the deeply held values and beliefs that underpin assumptions about the world and those within it. Brookfield (2011) calls these "'paradigmatic' (how we see the world) assumptions that lead to, 'prescriptive' (how we think the world should

work and how people should behave) and 'causal' (assumptions we have about why things happen the way they do)" (p. 25). Most often invisible to us within these assumptions, Brookfield (2005) warns, are dominant ideological perspectives. A critically thinking nurse needs to uncover these assumptions in order to ensure they do not adversely impact their capacity to work in culturally safe ways.

Jackson (2015) reminds us that there is no one universally shared world view amongst Māori. She cites Marsden (2003); "the world view is the central systemisation of conceptions of reality to which members of its culture assent and from which stems their value system. The worldview lies at the very heart of the culture, touching, interacting with and strongly influencing every aspect of the culture" (p. 257). Panelli and Tipa, (2007), drawing on their understandings from the Ngai Tahu iwi, identify the significance of whakapapa (genealogical relationships) to Māori well-being. "For Ngai Tahu, the significance of whakapapa is demonstrated in their relationships with their territorial lands, their reverence for tupuna (ancestors), and their determination to exercise rangatiratanga (chiefly authority) and kaitiakitanga (the exercise of customary custodianship)" (p. 450). This is echoed by Durie (2004) who also identifies the link for indigenous people between the land and health and wellbeing. He also highlights whakapapa as forming the "substrate for indigenous knowledge" (p. 1139). Durie (1985) states that Māori understand health as:

> …a four sided concept, representing four basic tenets of life. There is a spiritual component, a psychic component, a bodily component and a family component. On the marae these are referred to as 'te taha wairua', 'te taha hinengaro', 'te taha tinana' and 'te taha whanau'. Together these components blend to form an integrated and comprehensive model for health (p. 483).

These tenets of health may stand in opposition or be minimised within a Western bio-medical paradigm (Durie, 2004; Wilson, 2008). Appropriately respecting diverse beliefs and health practices when working with Māori is essential. The recognition that there will be similarities as well as important differences is crucial to providing culturally appropriate care. This necessitates nurses being aware of the competing paradigms and critically reflecting on their positioning within them.

Within a Westernised world view, understandings of health are predicated on individualised factors and notions of an "ideal self" (Panelli & Tipa, 2007, p. 446). Understanding health in this way enables assumptions of individual self-responsibility and individualised notions of care to occur. This can be seen in the neo-liberal health policy, *Better, Sooner, More Convenient in the Community* (Ministry of Health, 2011). According to Duncan (2007), neo-liberalism is a political ideology that aims to limit the role of government, believing "different regions and nations can be developed using a one-size-fits-all set of policies, designed to enhance private enterprise and freedom of choice" (p. 191). The ideological assumptions are that through privatisation the values of efficiency, commercialisation and individualism will flourish and give rise to autonomous, self-responsible citizens, increased productivity and prosperity. The present

health care policies therefore demand that practitioners work in ways that engage people to maintain and improve their own health.

> *A major focus of current health policy is keeping people healthier in the community for longer. This approach supports people to stay healthy and identifies problems earlier, when they can most effectively be addressed. It also benefits the health service, which is working to address rapidly growing demand for services. People with a chronic illness like heart disease or diabetes and who receive good support and management of their illness in the community, are likely to stay healthier for longer and reduce unplanned hospitalisations. Reducing unplanned admissions to hospital will be of growing importance in the years ahead as the proportion of the population who are above retirement age increases. Demand for health services will significantly increase – there's no stopping that. But by spreading that demand across the whole health system, using the full skills of the talented clinicians in our communities, and supporting people to stay healthier in the community, it is demand which we will be able to manage* (Ministry of Health, 2011. p. 4).

This policy reads as one celebrating equality, accessibility and acceptability of health care for all New Zealanders. As an example of ideology within the policy, it reads as common sense that individuals would adopt healthcare practices that improve their health and that good citizens would do this in order to play their part to "benefit the health service, which is working to address rapidly growing demands for services". As Althusser maintains, we "live out the requirements of the prevailing ideologies while doing so under the illusion that we have freely chosen our way of life" (cited by Burr, 2003, p. 111).

Alongside this, by locating the patient at the centre of healthcare practices, the healthcare workforce is responsible for engaging patients in healthcare practices that achieve healthy outcomes. Registered nurses are expected to support health consumers to achieve this. As identified in Chapter 4, this is clearly signalled in the following competencies; "Nurses utilise nursing knowledge and complex nursing judgment to assess health needs and provide care, and to advise and support people to manage their health" (NCNZ, 2012a, p. 3). There is also the requirement of "…being able to demonstrate knowledge and judgement and being accountable for own actions and decisions, while promoting an environment that maximises health consumer safety, independence, quality of life and health." (NCNZ, 2012a, p. 4).

A different reality for the critically thinking nurse

While these rules of engagement are laudable, their implementation for a critically thinking nurse is far from straightforward. Firstly, some researchers challenge the philosophies behind the policies. Prussing and Newbury (2015) argue that the tenets of a neoliberal ideology undermine the essence of Māori world views and notions of collectivism valued within Māori culture. They maintain that "market driven" approaches "produce and sustain environmental, social and health inequities" (p. 58). With a focus on individualism and autonomy as central

tenets of our governing health policy, equity for Māori within our health system is difficult, if not impossible to achieve.

Furthermore, French (2010) claims that policy that focuses on individualism also has the potential to blame the system, or healthcare workers if they fail to deliver the services that individuals require for achieving healthy lives. This blame can extend further to patients who fail to take up healthcare support made available within the parameters of the current policy. Wilson (2008) attests to this. Her research identified the negative experience and outcomes for Māori women when healthcare approaches failed to recognise and value their cultural worldview. She identified that a "predominantly problem-based, biomedical focus" to the provision of care for Māori women led to a failure to address not only their specific needs but also "the socio-cultural dimensions that impact on health and well-being" (p. 180). She claims that this potentially leads to Māori women being "recipients of victim blaming or deficit explanations when healthcare providers determine healthcare outcomes that are not achieved, the responsibility being placed on individual Māori women and their whanau" (p. 180).

Another challenge for the implementation of the policy is that the depth of critical thinking and reflection required to meet the expectations is substantial. Engaging in critical thinking and reflection in a manner that will support those with whom one is working requires time and support. At the forefront of safe professional practice is the ability to engage with consumers. This requires the nurse to develop a therapeutic relationship with those in care. In terms of the Treaty, this demands that the nurse work in partnership, honouring the principles of the Treaty of Waitangi. This was clearly evident in all of the professional documents analysed. For example;

- "Practises nursing in a manner that the health consumer determines as being culturally safe" (NCNZ, p. 13).
- "Apply current nursing knowledge using a documented systematic approach to meet the stated and implied needs of clients / family / whānau / hapū / iwi"; (NZNO, p. 7).
- "Actively works towards reducing health disparities experienced by Māori" (NZCMHN, p. 3).
- Standard 3.2, states that the nurse must "work in partnership with Tangata Whenua to ensure mātauranga (Māori ways of knowing), beliefs and values are upheld within the practice context" (NZNO, p. 9).

Wilson (2008) reinforces the importance of this, calling attention to the negative impact on engagement should Māori women encounter "negative or judgmental attitudes" (p. 180). Recognising the impact of ones attitudes when working with others relies on the ability to reflect on the values, beliefs and taken-for-granted assumptions that influence each healthcare encounter.

The nurse is positioned by these powerful discourses, not in a singular way, but in complex and co-existing situations. As a professional, the nurse is expected, required and accountable to

develop relationships with consumers to support them in their healthcare encounters. They are accountable and responsible to ensure they do this in a safe and competent way, because they are regulated to ensure consumers are protected from harm. Nurses must also ensure that they follow the policies, guidelines and protocols of the organisations in which they work and that they do this in a manner that is safe for the consumer. Although all discourses are operating at the same time as the nurse determines a plan of care, certain discourses will dominate. The managerial discourse, for example, tends to dominate over the professional discourse in terms of defining safe care.

Wilson (2008) identified that the relational aspect of care was crucial for Māori women. The valuing and incorporating of their cultural worldview, personal circumstances and recognition of the effects of colonisation are essential in engaging and working with Māori. This has been reinforced by Janssen and Nelson (2014) who identified that the success of working with Māori was attributed to incorporating "Māori ways of being". They identified that in establishing and maintaining relationships there is a need to be "less formal than traditional professional relationships. The focus on whanaungatanga and reciprocity meant there was a need for personal disclosure and genuineness when dealing with clients" (p. 12). Working in this way requires a critically thinking nurse to reflect on how their worldview and interpretation of professionalism may impact their ability to provide care in a manner that is culturally safe for the health consumer.

Working in culturally safe ways demands a commitment of time as the process required to practice in a manner that honours Māori ways of being needs time, and for a non-Māori nurse, experience within the culture of Maoridom. Important cultural processes which may be required for culturally safe care, such as establishing kawa, waiata, karakia and sharing kai take time and commitment and may also need to be professionally informed.

One of the expectations of professionalism is the ability to develop and maintain professional boundaries. Nurses are expected to "use professional judgement in determining the appropriate boundaries of a therapeutic relationship with each client. The nurse – not the client – is responsible for establishing and maintaining boundaries" (NZNO, 2012, p. 9). The manner in which this is expected to be achieved can stand in conflict to what is appropriate from a Māori perspective. Indeed Janssen and Nelson (2014) identified this as a tension when working with Māori. "The focus on whanaungatanga and reciprocity meant there was a need for personal disclosure and genuineness" (p. 12). Whanaungatanga requires a commitment by those working together to share in a manner that establishes a personal connection and provides a sense of belonging for the consumer.

The time to attend to such processes also needs to be supported organisationally and requires that policies such as workload planning, patient allocation tools and healthcare targets are managed in such a way as to enable these significant cultural practices. The nurse's practice is likely to challenge the managerial discourse, predicated on the need for efficiency and

productivity because these can constrain professional, caring and culturally safe care options taken by the nurse. Huntington et al., (2010) identified this as a tension for nursing when highlighting the "competing imperatives" that are at play in healthcare contexts. The requirement by the organisation for safe and effective care is obfuscated by the managerial call for efficiency and the "…accountable use of resources … all in a climate of increasing fiscal restraint" (p. 1417). NZNO (2012) demand that nurses "are active in designing, implementing and evaluating workload measurement tools to ensure appropriate use of resources to meet client needs and ensure a safe working environment" (p. 13). Thus within the nursing texts, when both authors argue for safe, effective and efficient care, the managerial need for efficiency will dominate decisions about the resources available to the nurse.

The influence of market forces on the reduction of funding in health care is signalled in the Better, Sooner more Convenient Policy (MOH, 2011) with the requirement that this policy needs to be enacted within the existing health budget. Huntington et al., (2010) note the funding pressure for governments in many countries and highlight the impact this has on the quality and quantity of care provided. They identify that the increase in nursing workloads is due to high patient turnover and sustained patient acuity. Nurses need to respond to this pressure, they maintain, by employing strategies such as time management and they cite literature to support and assist with the management of this. The responsibility for keeping within budgetary constraints is devolved to nurses by the utilisation of workplace management schemes such as efficient time management. The nurse has no choice but to rationalise care in response to fiscal constraints. The ability to measure outputs and identify efficiencies will dominate as the nurse manages patient care in keeping with this neoliberal, market driven ideology.

Working with Māori in ways that honour the Treaty and increase health equity for Māori is a governmental priority and a requirement of individual nurses. Duncan, Thorne and Rodney (2015) support the view that health equity is "the "21st century social mandate for nursing" (p. 27). They argue that "nursing is poised as a knowledge-based human resource capable of effecting major advances toward the goal of health equity among populations" (p. 28). The professional discourse should be the most dominant for enabling such a mandate and as such critical thinking underpinning professional knowledge should prevail. This would enable nurses to utilise critical thinking to develop and implement culturally appropriate care, not based on time-management priorities, but on culturally determined practices. This is an essential aspect of ensuring Māori access to culturally relevant care and ensures the nurse "…actively works towards reducing health disparities experienced by Māori" (NZCMHN, 2012, p. 3).

This is compromised, however, by the dominance of neo-liberal ideology which has a focus on efficiencies that undermine "professional mandates that seek to advocate for social justice, public participation in healthcare decisions and action on social determinants of health" (Duncan, Thorne & Rodney, 2015). Policies such as the 'Better, Sooner, More Convenient' policy shift the responsibility for health to the individual and reinforce health inequities.

> *As a practice profession, nursing needs a knowledge base for action that can be evaluated to ensure that the mandate of the profession to provide equitable healthcare to reach toward the ideal of social justice is realized. So, while we are not advocating for the concretization of abstract concepts, such as the concept of social justice, we argue that we need to work toward the development of ways of determining the extent to which equitable actions, in context, are being implemented and to what effect*
> (Anderson et al., 2009, p. 288)

These authors maintain that critical reflection is required to achieve this level of abstraction. This resonates with the requirements of NCNZ, NZNO and NZCMHN that a critically thinking nurse would understand the broader social context within which healthcare operates. Nurses should be "analysing the historical, social, economic and political processes to which Maori have been subjected and critiquing the relationship between Maori and the Crown based on the Treaty of Waitangi alongside analysing the power that nurses use when working with consumers who are Maori" (NCNZ, 2011, p. 17) This requires them to be working reflexively in partnership, not only with consumers, but also with other healthcare workers. Critical thinking is essential for this reflexive approach so that nurses can challenge taken-for granted assumptions and more robustly address healthcare inequities.

Chapter summary

This chapter has highlighted the impossible position for nurses as they mediate competing demands within their practice. The push and pull of powerful discourses, which on the one hand require efficiencies, and on the other hand, calls for social action, necessitates a critical thinking disposition. It also requires a context that supports, not only the engagement with critical thinking, but also the outcomes of that thinking. The next chapter offers a specifically clinical practice example to identify the discursive positioning of nurses and how this impacts their agency.

Chapter 7: The constraints of managerial discourse

"Protecting our patients from getting the flu whilst in our care is not bullying. This is a widely consulted, well considered, scientifically informed policy that protects both patients and staff while in the services of the DHB. Because of this policy our wards and services are much safer to support the prevention of our vulnerable patients from catching the flu whilst in our care" (reported by: Kerr, 2015, p.3).

Introduction

In May, 2015 prior to the flu season, the Waikato DHB instigated a policy that required any staff member in direct patient contact to provide evidence that they had been vaccinated against the flu. Otherwise they were required to wear a mask when in contact with patients (Kerr, 2015).

> Masking Influenza: Waikato DHB's policy (2015).
>
> *Healthcare workers who are unable to establish that they have received the current seasonal influenza vaccination will be required to wear appropriate personal protective equipment such as surgical or procedural face masks during the declared influenza season while undertaking clinical duties or being present in a clinical area* (reported by: Morton, 2015b, p. A3).

This chapter provides a contextualised interpretation of how the dominant discourses that inform such a policy can constrain the ability of nurses to think critically and affect their professional agency.

The agency to critically think

One of the hallmarks of being a professional is the ability to make "autonomous decisions and have control over a field of work" (Traynor, Boland & Buus, 2010, p. 1584). Indeed the Nursing Council of New Zealand state, in their description of the registered nurse scope of practice, that registered nurses must "practise independently" (p. 3). Making autonomous decisions and practising independently requires appropriate professional knowledge and the agency to carry it out.

As identified in Chapter 2, nurses draw on a broad range of theoretical, philosophical, ethical and research knowledge to support their practice. Interpreting and determining the most appropriate knowledge claims from such a wide range of sources to make professional judgements is a complex and intellectually demanding endeavour. Critical thinking is required in order to determine the best evidence amidst this complexity. Acting on the outcomes of this thinking is influenced by both the professional knowledge of the nurse, and also their professional identity. Parker (1991) reminds us that our identity is determined by discourse,

because discourse will 'call' us in a particular way. The 'call' within discourse offers us subject positions. These positions, as described by Burr (2003), are "the process by which our identities are produced" (p. 111). Within the structure of the discourse we are provided with our identities as a nurse, woman or man, worker, patient or consumer. These identities then provide us with our understanding of what it means to be a 'nurse' and will determine how we interpret situations and how we are to act as that person in the world. Burr (2003) argues that we are not able to avoid subject positions; "we can only accept them or try and resist them" (p. 111). The ability to accept or resist positions within discourse is determined by the ability to claim authority within the discourse, to claim "…the right to speak and to be heard" (Davis, 1991, p. 51). Once immersed in the subject position we are then "locked into a system of rights, speaking rights and obligations that are carried out within that position" (p. 111).

Who pays the piper calls the tune…

In the face of dominant discourses, the ability for nurses to employ critical thinking can be challenging. Their capacity to achieve this is determined by how they are positioned within the discourse and their ability to claim 'speaking rights' within the available discourses. The DHB's vaccination policy offered no scope or invitation for a nurse to critically think about the best option for managing patient care during the flu season. The thinking has been done and conveyed within a managerial discourse. Nurses and the delivery of care by other health practitioners are controlled by this policy.

Identifying agency

A nurse can claim an agentic position within this dominant discourse when the control over their critical thinking and options for care are not recognised. Through the policy and the research evidence that informs the policy, the nurse has speaking rights using their professional authority. As health professionals, nurses play a significant role in advocating for the uptake of vaccinations in the community. They are required to provide information regarding vaccination, develop professional relationships in order to convey this information, support people with their decision-making processes surrounding vaccination and support them when being vaccinated (Lyons, 2014). Brownlie and Howson (2006) identified that most health professionals see vaccination as beneficial to public health and believe that "good citizens" get vaccinated. Calling on Foucault (1978) and his portrayal of 'governmentality' the notion of a good citizen emerges as a consequence of governmental agents and activities that "shape the conduct of populations" and "manage the human body" (p. 435). The ability to shape the behaviour of the population occurs through programmes such as vaccination schedules and campaigns promoting the benefits of vaccination to individuals and society. Good citizens, in response to such programmes, take up 'healthy' options such as these.

That vaccination is a wise and desirable health choice is promoted and marketed to the public in New Zealand via the Ministry of Health (MOH). This is evident on the front page of the MOH web site; "Influenza. Don't get it. Don't give it... Influenza – or the flu – is a virus that spreads quickly. Immunisation is your best defence against influenza, and is now available free for eligible people until 31 August" (MOH, 2016b). The Waikato DHB policy can be argued to be in keeping with the MOH position; don't get it (get immunised) don't give it (wear a mask). As a health organisation, the Waikato DHB's vision is: "Healthy People. Excellent Care" and their mission statement, to: "Enable us all to manage our health and wellbeing. Provide excellent care through smarter, innovative delivery" (Waikato DHB, 2016). These strongly suggest that good citizens manage their health and wellbeing and the focus of the care provided by the DHB is to facilitate this.

With this as a mandate, the establishment of policies, protocols and guidelines become a valuable means through which the Waikato DHB can fulfil this objective. Those with an agenda to increase vaccination uptake are able to reify organisational practices in order to serve this interest (Mumby, 2001). This is evident in the comment by the DHB chief executive: "As healthcare professionals we have an obligation to our patients and their safety. Influenza-associated deaths account for approximately 400 New Zealanders each year, according to a study published by the University of Otago" (reported by: Kerr, 2015, p.3)

The ability to universalise the belief that flu vaccination is in everybody's interest can be seen as a means of obtaining everyone's consensus and the creation of policies and protocols for patient procedures and mandatory standing are portrayed as, and usually experienced as, examples of evidence-based best practice, ensuring that patients receive, and healthcare practitioners deliver, good care.

For the nurse who endeavours to resist such a policy and disputes the evidence that informs it, the cost is high. Those who challenged the policy by refusing to wear a mask were suspended. "Three hospital nurses have been suspended for defying a controversial new policy forcing non-vaccinated workers to either get flu jabs or wear face masks" (reported by: Morton, 2015a, p. 1).Those that refused vaccination but wore a mask were identified by signs located within the workplace. "Signs had also been put up around Waikato Hospital stating workers wearing masks were not vaccinated" (Morton, 2015b, p. A3). The policy set up fear and intimidation within the staff at the DHB. Morton (2015b) quotes the following staff member; "...many staff at the DHB are scared and as such have either had the flu jab when they usually wouldn't get one or have been threatened with dismissal if they didn't wear a mask" (p. A3).

*A*nother employee stated that they had seen staff crying and "...consumed with rage and frustration.... Many have openly stated that they would not be getting vaccination if they felt they had a choice, but they strongly feel that if they don't have it they won't be able to do their

job" (Morton, 2015b, p. A3). Calls from staff that the enactment of the policy was a form of "bullying" were refuted with the following explanation by the CEO:

> *"Protecting our patients from getting the flu whilst in our care is not bullying. This is a widely consulted, well considered, scientifically informed policy that protects both patients and staff while in the services of the DHB" …"Because of this policy our wards and services are much safer to support the prevention of our vulnerable patients from catching the flu whilst in our care"* (reported by: Kerr, 2015, p. 3).

This policy discursively positions nurses working for the Waikato DHB who are not vaccinated as potentially unsafe. The use of the emotive value laden word "vulnerable" further positions the unvaccinated nurse as an infection risk to the public. Patients are potentially victims of the nurse because they are defenceless (vulnerable) and helpless in the face of the nurses non-compliance with well researched evidence. The minimising of the nurses' experience of "bullying" on the grounds that the policy is "protecting our patients from getting the flu" further positions the nurse as standing outside a collective by the use of the word "our".

There are two ways in which this policy limits critical thinking and the agency (the speaking rights) of the nurse. In the first instance, there is no opportunity for the nurse to decide on a case by case basis when they need to wear a mask. Nor is there any consideration of the effectiveness of wearing a mask. As a professional engaging with EBP, a nurse would employ critical thinking to assist them consider the research evidence that will contribute to a clinical decision. The research on the use of face masks to prevent the risk of infection from viruses is far from conclusive, but does offer some key points. According to the Centre for Disease Control and Prevention (CDC) (2009), there is no one "single action" but a "combination of actions" that need to be employed to limit the transmission of the virus. Frequent hand washing, covering the mouth and nose when sneezing or coughing, avoiding touching eyes, mouth or nose, staying home if sick and avoiding close contact are also recommended. They state that:

> *…infection control precautions, including respiratory protection, are imperfect" and that "Facemasks do not seal tightly to the face and are used to block large droplets from coming into contact with the wearer's mouth or nose. Most respirators (e.g. N95) are designed to seal tightly to the wearer's face and filter out very small particles that can be breathed in by the user. For both facemasks and respirators, however, limited data is available on their effectiveness in preventing transmission of H1N1 (or seasonal influenza) in various settings.*

Engaging only with the policy risks the possibility of not employing all of the strategies required to limit the spread of infection. Nursing has a long history of infection control practice. Florence Nightingale advocated the importance of aseptic techniques and nurses have been training as specialist infection control nurses for decades (Smith, 2005). In addition to drawing on research evidence nurses would engage their practical wisdom, clinical experience of mask use and potential impact on the patient.

One nurse was quoted in the NZ Herald as saying they believed that: "…the policy had a "detrimental effect" on relationships between patient and caregiver, which they said was built on trust, empathy and emotion. "Try it yourself sometime. Put on a mask and walk around your office or down the street or into a café. Observe the reactions of the people around you" (reported by Morton, 2015, p. A3).

Calling on professional knowing, and establishing therapeutic relationships is essential in order to engage with people and provide effective care. Nurses are positioned in this example by the powerful management discourse that offers no choice but to comply or risk losing their job. There is no professional mandate to counter this policy as all the professional documents demand the policy be followed by linking the professional discourse with the management discourse in the same discretion of practice.

> *"Accepts responsibility for ensuring that his/her nursing practice and conduct meet the standards of the professional, ethical and relevant legislated requirements"* (NCNZ, 2012a, p. 9).

> *"Work within their scope of practice, based on current nursing knowledge, professional judgement, experience and competence, within their area of practice and job description"* (NZNO, 2012, p. 6).

A second and possibly more significant constraint for the nurses' agency and their ability to critically think was that they had no opportunity to critically review or participate in the development of the policy. In keeping with the argument of Deetz (1992), the instigation of this policy illustrates the powerful place organisations have within society to influence the professional identities of its employees. Nurses were prevented from challenging the policy via discursive closure. The Waikato DHB introduced the policy and prevented staff autonomy by prohibiting their right to speak, preventing their access to the space to speak, and sanctioning those with particular expertise to speak. As reported by Morton (2015a), NZNO stated "…we believe the DHB has failed in its obligations to adequately consult with unions both in respect of the implementation of the policy and its impact on the workforce' (p. 1). Discursive closure was facilitated by privileging managerial and scientific discourses and marginalising professional and evidence from other professional, practice expertise and other scientific evidence.

The organisation did offer to "…seek staff and union feedback to consider any improvements on the policy moving forward" (Kerr, 2015b, p. A3) following the flu season. Positioning the input from staff and unions as 'feedback' is another example of discursive closure. By limiting the space to speak in this way, the agency of staff such as nurses to employ critical thinking in the development of policies that impact patient care is also limited. This occurs despite the professional mandate to engage in such endeavours as identified by NCNZ (2012a):

> *"Participates in quality improvement activities to monitor and improve standards of nursing"* (p. 30).

"Indicator: Reviews policies, processes, procedures based on relevant research" (p. 30).

"Indicator: Recognises and identifies researchable practice issues and refers them to appropriate people" (p. 30).

"Indicator: Distributes research findings that indicate changes to practice to colleagues" (p. 30).

Conclusion

Critical thinking is therefore hampered in a nursing world of enforced policies and protocols. Benner, Hughes and Sutphen (2008) draw attention to one such consequence of technical rationality; the "… tension and confusion that emerges when standing orders exists in practice traditions such as nursing and medicine" (p. 4). Practices such as standing orders are not questioned because they stem from examined knowledge based on sound research and evidence. And yet, as previously identified, in order to provide appropriate, individualised and context specific care, the questioning of policies may be required.

This vaccination policy offers an example of how risk management is dominating organisations and management. Hardy and Maguire (2016) identify two very important demarcations in the understandings of risk. Firstly, scientific, which they argue is the place where risk is assessed and identified using evidence that is "fact based, and also value free", having been determined with well-established protocols and scientific techniques. Secondly, management, which articulates risk as "policy" and determines how risk is to be managed (p. 84). Included in such policies are the ways in which risk is to be avoided or reduced. In the vaccination policy, this entails the need to ensure vaccination occurs, or in the absence of this, that a mask be worn.

From a sociological perspective, Godin (2006) maintains that managing risk is increasingly situated within the individual. He argues that people are "expected to be knowledgeable of the risks and manage them rationally" (p. 8). Citing Godin (2006) Beardwood and Kainer (2013) maintain that within this risk discourse, "self-reliance, autonomy, rationality, and self-regulation are socially valued and supported by neoliberal ideology" (p. 52). As a consequence of neoliberal ideology and the focus on individualism, self-responsibility and the reduction in government intervention there is the expectation that individuals will determine, evaluate and then manage risk. When the concern about risk is operationalised within organisations in the form of performance appraisals, clinical protocols, policies and clinical governance strategies, professional knowledge is devalued (Beardwood & Kainer, 2013). By inciting individuals to take up behaviours and technologies that claim to reduce risk for future disease, neoliberal practices of governance are seen to operate not through force, but rather as Petersen (1996) claims by "creating a sphere of freedom for subjects so that they are able to exercise a regulated autonomy" (as cited by Polzer, 2014, p. 48). Althusser's identifies this as the power of ideology, in its ability to 'manipulate' and 'control' people (cited by Burr, 1995, p. 83).

Individuals freely take on the ideas and practices inherent within dominant ideology without question, believing them to be right and normal.

For autonomous professionals, in this case nurses, thinking critically would at times involve challenging dominant organisational and professional discourses. As described by NCNZ , (2012a) competency 1.1:

> *"Accepts responsibility (discourse of responsibility) for ensuring that his/her nursing practice and conduct (professional discourse) meet the standards of the professional, (professional discourse), ethical (ethical discourse) and relevant legislated requirements (legal discourse of regulation)"* (p. 9).

In addition, as an indicator for this competency:

> *"Practises nursing in accord with relevant legislation/codes/policies and upholds health consumers rights derived from that legislation"* (p. 9).

In summary then, this example has highlighted the paradox that the critically thinking nurse experiences. Nurses are hamstrung by the interplay of powerful and dominant discourses that dictate their actions. Critical thinking is not necessarily desired or possible. Thinking about what the nurse should do is predicated on knowing what is expected within frameworks, policies, protocols and guidelines and doing ones best to please the pipers who play the tunes.

Chapter Summary

The two practice examples discussed in Chapters 6 & 7 clearly illustrate the position of paradox of a critically thinking nurse being pulled by discourses operating amidst powerful ideological perspectives. There is little doubt that the nursing profession on the one hand requires its members to engage in critical thinking so that it can fulfil the hallmarks of the profession it claims to be. On the other hand it calls into play powerful normalising functions to regulate and control its members to ensure patient safety. The next chapter discusses the findings of this research, practice recommendations, its limitations and possibilities for future research.

Chapter 8: The critically thinking professional nurse

Introduction

This final chapter intends to draw together the understandings about critical thinking within nursing practice that have been identified from this critical discourse analysis. Attention is focused on the continuing difficulties in defining critical thinking for nursing practice and some ideas are offered about managing the fraught landscape in which it occurs. Ideas for supporting the teaching and utilisation of critical thinking are also offered. The final section of the chapter provides recommendations for nursing practice and future research, and addresses the study's limitations.

This study set out to answer the following three research questions:

- How is language used to construct the meaning of critical thinking within nursing theory and clinical practice?
- How do professional, organisational and political discourses influence critical thinking within nursing theory and clinical practice?
- How do these discourses position and influence nurses professional identities and practice?

The motivation to answer these questions was fuelled by a desire to gain clarity about how critical thinking was defined within influential nursing documents. I presented the problematic definitional terrain that surrounds the construct of 'critical thinking' in the literature review. I also highlighted the overwhelming support there was for critical thinking within practice and academia and the links made to its pivotal role in the provision of safe and effective care. Understanding the influence professional, organisational and political discourses have on critical thinking is important. I have argued that discourses control and manipulate meanings via discursive closure. A perpetually conflicting paradox is experienced when, on the one hand critical thinking is encouraged or even mandated, and on the other is constrained within the profession and organisations for the benefit of political and organisational interests. I have shown how nurses are positioned and how their identities are constructed within these powerful discourses. In illuminating these concerns I have sought to bring clarity to this fraught landscape and identify potential supportive strategies for those teaching critical thinking and nurses trying to apply it.

Constructing critical thinking

Expecting nurses to think critically is challenging and warranted clarification. In addition, for those endeavouring to teach critical thinking, the terrain is equally problematic. Without doubt

the processes involved in critical thinking are widely debated, as is the manner in which critical thinking should be taught. When Rubenfeld and Scheffer (2015) make their comment that "all thinking is critical" (p. vii) to justify their use of the terms 'thinking' and 'critical thinking' interchangeably, there is potential for the nuances of critical thinking to be undermined. This could also explain why the term 'critical thinking' is used so ubiquitously within nursing practice. The naïve reader, or those new to thinking critically, may view all thinking as a form of critical thinking.

This research project has highlighted the tensions surrounding the construction of critical thinking and, most importantly, the challenges confronting a nurse endeavouring to use it. There was clear evidence within the study that critical thinking is expected and desirable within nursing practice. The ability for nurses to deliver care in the manner they are mandated, demands an awareness not only of what critical thinking is, but also when critical thinking is required, in what context, and then how best to use it.

Providing a definitive answer to the 'what is critical thinking?' question is difficult. The debates found within the literature were echoed within the documents studied in this project. The meaning of critical thinking within the documents was often obscure. However, it appears to take two forms. On one hand there is the requirement for nurses to use critical thinking in a linear, problem solving, and cause and effect way. On the other hand there is an expectation that nurses will engage with critical thinking in order to mitigate assumptions within practice that privilege certain perspectives and silence or constrain others.

The dominance of a linear problem solving approach within the documents was identified. This is enabled by constraining the engagement of philosophical approaches to critical thinking. The application of critical thinking as a legitimate problem solving approach was sanctioned by the major discourses in the documents. The legal, professional, evidence-based practice, safety and risk, and management discourses achieve this via discursive closure. The dominant discourses dictate the parameters in which nurses think through the use of rules, policies, procedures, protocols, processes, standards, codes and guidelines. These pre-determined and sanctioned directives demand that nurses accept the underlying assumptions from perspectives normalised within these powerful and authorised programmes rather than from differing ones. The thinking required of nurses demands that they employ disciplinary knowledge sanctioned from powerful and thus influential documents. Critical thinking when prescribed in such a way, takes on a "pseudo critical thinking" definition as described by Cody (2002, p. 185).

As identified in Chapter 7, when nurses position their practice within polices, protocols and frameworks that are supported by powerful discourses, their agency as a professional can be enhanced. This can, at times, be useful and work to the advantage of the profession and to those in care. As Rolfe (2015) identified, the technical approach that dominates evidence-based practice, policies and protocols can, in predictable, stable, patient encounters, be useful. Benner (1984) would also agree that these frameworks are of benefit to novice

practitioners learning the craft of the discipline. Indeed, Facione (1990) suggests that the findings from the Delphi report supported the notion that in order to employ critical thinking skills within "… certain contexts, domain specific knowledge" is required (p. 2). Arguably this is evident in nursing practice where nursing judgement depends on the knowledge of, and application within, practice of professional methods and techniques.

Robert and Peterson (2013) clearly articulate this in their model case example of critical thinking in nursing (Chapter 2). They offer an example that resonates with a pseudo critical thinking approach. The thinking that is described is a reasonable deduction from a patient situation that is arrived at by evaluating the presenting symptoms. The authors therefore maintain that this demonstrates all of the components of critical thinking. This was evidenced as the nurse employed knowledge of a patient case as a whole by considering signs and symptoms and providing safe care by accurate reasoning and intervention. The example provides a logical capture of the benefits of accurate problem solving within predetermined parameters. The example demonstrates the influence of both an EBP, professional and safety discourse on the thinking of the nurse. The nurse articulates his/her assessment, diagnosis, intervention and evaluation of care with the use of measurable, tangible and tacit criteria. However, whilst there is thinking and problem solving involved, the need to engage in a philosophical reflection is not demonstrated. While this example of thinking is to be encouraged and supported for safe and effective care, as an example of critical thinking it falls short. There is no requirement to engage with the underlying assumptions. If this model case was to more clearly illustrate all of the components of critical thinking, there would be a capture of underlying assumptions inherent in this situation. For example, the nurse may consider ways in which the health system would support the nursing action, whether there were financial constraints for healthcare options, what the potential impacts for the patient may be, who explains to the patient what has occurred and why.

The requirement to think critically about the assumptions impacting on nursing practice was also present within the diverse expectations of autonomous professional nurses. Delivering culturally appropriate, socially mandated and ethical nursing care requires the identification of ideological and hegemonic control within discourses that privilege certain perspectives and silence or constrain others.

The flexibility in the documents for a self-regulating professional to employ nursing expertise in ways that ensure nursing care is delivered as signalled above was identified. However, the research findings suggest this flexibility is constrained and controlled via the interconnection of the powerful discourses identified in the study. The professional discourse demands that the nurse use professionally sanctioned disciplinary knowledge, and navigate appropriately across a diverse range of theoretical perspectives before deciding what evidence will best serve the practice situation. The evidence based practice discourse demands that the nurse employ the 'best evidence' for the practice concern. Determining the 'best' evidence requires critical thinking because the nurse must apply this evidence in the face of indeterminate and

contextually complex practice. The safety and risk discourse demands that the nurse recognises and assesses all the possible risks to the safety of the person in care. Alongside this is the requirement that a plan of action to control or minimise the risk is developed. The management discourse demands that nurses perform within the mandate of the organisation by fulfilling their job descriptions and ensuring their practice enhances the position of the organisation. Overarching all of these is the requirement that they operate within the various legal and organisational regulations to ensure that they do no harm to the public. They are also responsible for ensuring they are competent to do this.

Determining the 'best' options amidst these requirements can only be achieved if the nurse is able to stand back and examine the ideological assumptions underpinning these discursive practices. This was highlighted by the example within the Mental Health and Addictions Service provided in Chapter 5 (p. 117). The example identified the negative impact on consumer care when managerial and legal discourse constrained professional autonomy. The manager's defensive use of the Mental Health Act to develop protocols that prescribed the options available for the delivery of care silenced the professionals. Practitioners were not enabled to engage with theoretical perspectives in determining what care could be 'best'. Amidst all of these discourses a nurse must also be able to act on the outcomes of critical thinking.

I support the claim by Tabak, Adi and Eherenfeld (2003) that nursing needs to employ a critical approach and engage with the philosophical assumptions that underpin nursing theory and practice. Of most importance is the ability to identify the "connection between power structures and knowledge, the recognition that the latter are mediated by language and practices, and the ability to ask questions that probe beyond the obvious" (p. 250). Thinking in this way requires an "examination of the social situatedness of knowledge claims, including underlying assumptions and values and the inclusiveness or exclusiveness of the discourses and practices that mediate that knowledge" (p. 250). Had this been the case in the above scenario, nurses would have been able to counter the dominance of management discourse and its interpretation of the law and, as Elliot (2016) suggested, use the Mental Health Act alongside the Human Rights Act to facilitate a better outcome for consumers.

I also agree with Ford and Profetto (1994) who argue for the need to shift the definition of critical thinking from a "problem solving approach" based on "facts and rules" applied within defined parameters to critical thinking as a process" where "knowledge and action are dialectically related through the mediation of critical reflection" (p.342). They argue that critical thinking then becomes a medium for supporting emancipatory knowledge by facilitating an understanding of the "larger socio-political, historical, and economic contexts" that is required in order to uncover and address powerful interest groups (Ford & Profetto, 1994, p. 343). Critical thinking in this definition enables the nurse to uncover and challenge taken-for granted assumptions and ideologically dominant positions. In Chapter 6 and 7 I offered examples of the possible constraints and enablers of critical thinking as described by Ford and Profetto.

The dominance of a linear problem solving approach is enabled by the invisibility of the engagement with a philosophical approach to critical thinking. This aspect is clearly hidden as part of the definition within the documents and even the word 'assumptions' can be seen as applied as a technical skill in judgement and decision making. The emphasis on judgement and decision making focuses attention on the outcomes of thinking, limiting the theoretical requirements for thinking critically.

Clinical Judgement and Reasoning

This research has identified the frequent use of other terms throughout the documents that refer to aspects of critical thinking. These include:

> nursing knowledge, complex nursing judgement, knowledge, judgement, self-awareness, clinical decision making, professional knowledge, scientific knowledge, clinical judgement, professional judgement, reflects, and evaluates.

These terms are employed due to the difficulty of measuring 'thinking'. The documents require evidence to determine whether practice is meeting expected standards. A quantitative measure of evidence can only be obtained by measuring the outputs of thinking in nursing actions. The foregrounding of measurable aspects and backgrounding of the philosophical complexity of critical thinking within these texts was presented in Chapter Four. Despite recognition by the authors that critical thinking requires the ability to identify assumptions and be aware of contextual considerations, the privileging of logical reasoning was evident. This is in keeping with the need to measure nurses' competence in order to determine their safety to practice. This focus on the measurable outcomes of critical thinking within the professional documents is not surprising.

The need to have concrete evidence of critical thinking was a constant theme within the documents. This supports literature claims that critical thinking is a challenging concept because there is no reliable way to measure it. In addition, the continuing positioning of critical thinking as a logical process and further, that clinical reasoning and judgement are more valuable constructs, warrants further investigation. This study has identified that the problem does not necessarily lie with the term 'critical thinking', but the way in which it is defined and its use enabled.

Critical thinking is discursively framed by influential nursing scholars as an inadequate concept for describing the thinking required for effective nursing. Benner, Sutphen, Leonard and Day (2010) call for an emphasis on clinical reasoning and judgement as separate constructs that may include critical thinking. Tanner (2005) argues that general critical thinking skills do not serve nursing well. However, her description of clinical judgement has many of the hallmarks of critical thinking:

Clinical judgment is tremendously complex. It is required in clinical situations that are, by definition, underdetermined, ambiguous, and often fraught with value conflicts among individuals with competing interests. Good clinical judgment requires a flexible and nuanced ability to recognize salient aspects of an undefined clinical situation, interpret their meanings, and respond appropriately. Good clinical judgments in nursing require an understanding of not only the pathophysiological and diagnostic aspects of a patient's clinical presentation and disease, but also the illness experience for both the patient and family and their physical, social, and emotional strengths and coping resources (Tanner, 2006, p. 205).

In addition to this definition, Tanner maintains that the nurse will incorporate contextual factors, such as prioritising across competing environmental demands and complex processes like "resolving conflicting family and care provider information, managing patient placement to appropriate levels of care, and coordinating complex discharges or admissions" (Tanner, 2006, p. 205). Her clinical judgement model, which relies heavily on reflection, resonates with that of critical thinking as defined by critical thinking scholars (Brookfield, 2011, Cody, 2002). However, it has less emphasis on identifying the assumptions and philosophical perspectives informing the thinking which may privilege one action over the other. The findings of this research highlight the inadequacy of a thinking process that does not take account of the powerful discursive assumptions that will enable some actions and suppress others. Traditional thinking programmes enable the normalisation of professional knowledge and care that fits with dominant ideologies. This may not be their intention but, as demonstrated in Chapters 5, 6 and 7, without a critical perspective, nursing loses its agency over its professional field of practice which is a requirement for autonomous practice and the responsive provision of care.

Teaching critical thinking

Regardless of the difficulties relating to its definition, there is no doubt that critical thinking is required of nurses. As identified in Chapter 2, all nurses practising in NZ must demonstrate critical thinking within the programme of study that leads to their registration as a nurse. It is therefore essential that critical thinking is taught as part of any nursing programme.

The difficulty for me, as an educator, is the belief on the one hand that critically thinking is desirable and necessary for professional nursing practice, and, on the other that it can be almost impossible to achieve. The outcomes of this critical discourse analysis have offered impetus for teaching students how to think critically and also how to support them to recognise the way they may be positioned by influential ideology and discourse that enables or constrains their thinking.

In keeping with Cody (2002) and Brookfield (2011), the findings of this research would suggest that critical thinking should be taught as a philosophical endeavour. Cody (2002) maintains that nurses must explore the assumptions that support their professional actions and critically

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analyse these in light of nursing theories and philosophies. Similarly, Brookfield (2011) argues that students must identify the paradigmatic assumptions, prescriptive assumptions and causal assumptions and their contextual appropriateness in any given situation (Brookfield, p. 2011).

I am arguing that to become critical thinkers, nurses must also be willing and able to challenge the taken-for-granted assumptions that inform the way they think. This takes time and honest reflection. Brookfield (2004) identifies that "critical thinking is learned incrementally, in fits and starts. It is not a smooth flowing voyage along a river of increasing self-knowledge and self-actualisation. It involves anger and anxiety as well as joyful moments of insight" (p. 343).

Asking nurses and nursing students to suspend their knowing and to critically reflect on what is informing them is not without its problems. Facilitating emotionally supportive conversations that allow nurses or students to uncover their assumptions also requires that they be willing to reflect and discuss these. Teaching critical thinking requires as Dewey (1933) claimed, an ability to encourage others to be sceptical of any one interpretation of truth and certainties, supporting the thinker to be doubtful long enough to have considered and analysed all possibilities (cited by Riddell, 2007).

The findings of this research would suggest that the teaching of the nursing process as a linear problem-solving method limits a nurse's ability to consider all possibilities. This finding is supported by Ford and Profetto (1994) who identified that a problem solving approach, privileges "…a cognitive technical interest" (p. 342). Furthermore, they argue that the nursing process fosters an emphasis on the "efficient and effective" outputs of the process. I claim this research has clearly illustrated how the interconnection of the dominant discourses construct critical thinking as a thinking process that leads to safe, effective and efficient healthcare by establishing the parameters for the thinking. Critical thinking is still being identified as a problem-solving process that occurs within predetermined parameters with the aim of efficient (managerial discourse underpinned by neo-liberal policies) and effective practice (measurable and tangible outcomes that meet outcomes supported by powerful interest groups). As Rolfe (2015) reminds us, due to the multifaceted nature of nursing practice, most nursing encounters are not well supported by such an approach. Prescribing practice via policies and protocols has the potential to render the nurse powerless in the face of indeterminate, contextually complex and conflicting consumer needs. Teaching critical thinking must involve supporting learners to discover what knowledge is required to best suit each healthcare situation. It also requires the ability to critically reflect on the wider socio-cultural context in which healthcare is situated.

Reflective practice is heralded as essential for supporting the development of critical thinking and the recognition of assumptions. Identifying assumptions, particularly those stemming from ideology and hegemony is difficult without a collaborative reflexive approach. A collaborative approach supports critical thinking because sharing conversations assists to "integrate ideas, apply critical thinking to new contexts and take critical action" (Wass, Harland and Mercer,

2011. p. 326). Critical thinking cannot be achieved without reflection. It is not a matter of deduction and consideration of a just and reasonable outcome, but rather as Kincheloe (2000) argues, critical thinking is really "the ability of individuals to disengage themselves from the tacit assumptions of discursive practices and power relations in order to exert more conscious control over their everyday lives" (cited by Brookfield 2005, p. 12). Ford and Profetto (1994) claim critical reflection involves two "moments". Firstly it involves the critical review of an individual's own practice and secondly the "critical understanding of the situation and of the way the system works to maintain the status quo" (p. 343).

Once again, neither can be achieved without noticing how the inherent discourses offer positions that affect the agency of a nurse. A crucial part of teaching students to critically think is the obligation to identify the potential impact of the thinking. As identified in Chapters 5, 6, and 7, powerful discourses demand that nurses 'be a certain nurse'. For example, to be a 'vaccinator', to uphold the Treaty (and advocate for health equity) and to restrain people in care (to keep them safe). Recognising these position calls and the nurse's agency within these positions is essential. The nurse may have no ability to effect change or to resist the call, yet being aware of the impact of discourses is, in itself, agency. Agency is also about recognising the positioning. It is not freedom from discourse but the ability to see its effects and to "resist, subvert, and change the discourses themselves through which one is being constituted" (Davies, 1991, p. 51).

Study limitations

This critical discourse analysis comprised the analysis of five documents influential in NZ, both in defining critical thinking and in prescribing its use. As the researcher, I have had a long standing interaction with these documents. All of them have in some form impacted on my nursing and educational practice and, as a consequence, the manner in which I have read and analysed them is not value free. I am mindful that this thesis represents a partial view; my own. As Toolan (1997) reminds us, "… you cannot analyse or write about power, hegemony and dominance without yourself potentially being implicated and compromised by the powerful and hegemonising turns of your own discourse" (p. 87). The meanings generated from my readings of the documents will be partial and incomplete. Other researchers may have focused on different pieces of text and as such developed different understandings. My intention is not to maintain that I have determined the correct or only interpretation, just that it is a plausible interpretation. It is also not intended that this work will offer generalisations that can be transferable across other documents. The intention here was to uncover the paradoxical positioning of a critically thinking nurse within NZ nursing practice and theory as portrayed in the five documents analysed in this study.

Conclusion and Recommendations

This study has shed light on the perpetual paradox that confronts a critically thinking nurse within the New Zealand context. The findings have highlighted the dominant definition of critical thinking as a cognitive problem solving approach. That approach was identified as aligning with measurable outcomes and techno-rationality that kept in step with rules and regulations. Paradoxically, there was also the call in the documents for critical thinking to encompass an engagement with underpinning assumptions and values in order to ensure contextually appropriate care. However, critically thinking in this way and acting on the outcomes of the thinking was problematic and possibly perilous for the nurse.

Critical thinking, and reflection, should be a philosophical endeavour that allows an engagement with underpinning assumptions, not only within individual practice, but also within the wider socio-cultural practice arena. Thinking in this way becomes a medium for supporting emancipatory knowledge. Emancipatory knowledge allows a nurse to uncover, and challenge, taken-for granted assumptions and ideologically dominant positions. Such knowledge is a requirement if nurses are to meet their socially mandated responsibility of supporting the diverse health needs of all citizens. This study has identified that critical thinking supports emancipatory action, and is necessary for an autonomous professional nurse. However, alongside this, is the need for nurses to be aware of the way powerful discourses will position them; on the one hand, offering them agency, and on the other, constraining it.

The continuing difficulty in defining critical thinking and the powerful discourses that both enable or constrain its use requires the profession's attention. Given the continued call for its use, and the identification of its significance for nursing practice, the profession is obligated to clarify what exactly is needed.

This research has identified that critical thinking within nursing practice is predominantly articulated as that described as 'pseudo-critical thinking' by Cody (2002). In keeping with Atkinson (1997) who argued critical thinking is a social practice, I argue that, as a social practice, critical thinking in nursing adopts a pseudo-critical thinking approach and is learnt and performed as the 'thinking norm' sanctioned by the culture of the profession.

This is of significance in undergraduate education, on-going professional development and postgraduate education of nurses because thinking critically is a social practice required in the development of a nurse's professional identity. The hallmark of critical thinking needs to be with the engagement of the theoretical paradigm that is informing the idea under scrutiny. This will not occur in all nursing decision making situations and indeed would be made impossible by the dominant discourses present in the analysed documents.

The way forward

Teaching and learning about critical thinking in both undergraduate and postgraduate education is essential, as is the continued application of critical thinking to nursing practice. This requires on-going engagement with critically reflective practice in both nursing education and practice.

I support the view of Barnett (1997) and Cody (2002) that a collaborative approach is essential for supporting critical thinking. Sharing and reflecting on nursing within a professional community is required and I argue that this is best enabled within a clinical supervision relationship. Clinical supervision offers a supportive place wherein nurses are able to critically reflect both on their practice and also on the socio-political influences on nursing practice.

According to Bond and Holland (2010) clinical supervision is:

> *…regular, protected time for facilitated, in-depth reflection on complex issues influencing clinical practice. It aims to enable the supervisee to achieve, sustain and creatively develop a high quality of practice through the means of focused support and development* (p. 15).

The authors maintain that clinical supervision is the best way to support nurses to truly work in partnership with clients and to recognise and address inequalities (Bond & Holland, 2010). This is of particular importance to the inequities that exist within NZ healthcare, particularly because Māori feature significantly in poor health outcomes, as discussed in Chapter 6. The literature reviewed by Butterworth, Bell, Jackson and Pajnkihar (2007) also demonstrates that clinical supervision is effective in supporting nurses to embrace new practice developments and manage the "increased autonomy, responsibility and independent working" they are encountering within changing healthcare (p. 265). Alleyne and Mansour (2007) found conclusive evidence from their study with district nurses that group clinical supervision with an executive co-coaching approach assisted the nurses to identify how "making sense of patterns from the past, planning for the future and facilitating the clinical nursing leadership processes today" significantly enhances the quality of patient care and outcomes for the future (p. 230). Furthermore, the district nurses' ability to take the lead and manage change was demonstrated within multidisciplinary teams. Of particular interest was their ability to question the "attitudes about the dominance of general practitioners" (Alleyne & Mansour, 2007, p. 231).

Future research

The research I have undertaken focused attention on influential nursing documents and their impact on the meaning and use of critical thinking in nursing theory and practice. It also identified the way in which dominant discourses positioned nurses' professional identities. Further research could investigate how nurses themselves define and use critical thinking and

what meaning it holds in terms of their professional identity. It could add value to this work to hear personal accounts of how nurses negotiate the demands from the profession that they think critically amidst the day to day realities of clinical practice.

Another area for future research lies in the teaching and learning of critical thinking. This research has identified the lack of a consistent definition and the emphasis on a pseudo-thinking approach has implications for educational practice. How this is being managed and mitigated warrants attention. I have recommended that clinical supervision is a valuable method for developing and supporting critical thinking in nursing theory and practice. Future research could investigate the effectiveness of this method in teaching critical thinking within a NZ context.

Finally, this was a textual analysis and impact of the emotional work involved in thinking did not form part of this study. Given the identification of the emotion involved in critical thinking (Brookfield, 2011), this also warrants attention.

In Closing

In the spirit of the self-confessed reflexive critical thinker that I think I am, I offer the following beliefs and convictions I hold about the topic and which have inhabited and informed this important CDA project. The fact that critical thinking has many definitions does not detract in any way from its importance as a vital dimension of nursing practice. Critical thinking is a courageous endeavour because it requires serious reflection on, and acceptance of, deeply held personal and professional beliefs, values and assumptions. Excellent nursing can only occur when individual nurses are willing to think critically about their practice, the nature of health care delivery, and the complex contexts in which it is located.

Appendix

Table 1: Critical thinking examples from professional documents

This table lists statements from the professional documents that draw on various discourses to define and impact critical thinking in nursing theory and practice. The discourses are also identified. Statements under "Denoted" include words that are recognised as being part of the definition of critical thinking as determined from the literature in Chapter 2. Where wording does not explicitly define critical thinking, but critical thinking is required to complete the described activity, the statement is put under "Implied".

Critical thinking examples from document 1: NCNZ (2012a)

Denoted: Examples of excerpts from the text: Characteristic of Critical thinking linked by use of knowledge, judgement, evaluation, research, decision making, reflects, understanding, evidence, take action, critique.	Discourse
"Registered nurses utilise nursing knowledge and complex nursing judgment to assess health needs and provide care, and to advise and support people to manage their health" (NCNZ, p. 3).	Professional Care
"They provide comprehensive assessments to develop, implement, and evaluate an integrated plan of health care, and provide interventions that require substantial scientific and professional knowledge, skills and clinical decision making" (NCNZ, p. 3).	Scientific Professional Care EBP
"Registered nurses may also use this expertise to manage, teach, evaluate and research nursing practice" (NCNZ, p. 3).	Professional Educational Management EBP
"…being able to demonstrate knowledge and judgement and being accountable for own actions and decisions, while promoting an environment that maximises health consumer safety, independence, quality of life and health" (NCNZ, p. 4).	Professional Accountability Care Safety Ethical

"…. assessment and managing health consumer care, which is responsive to the consumers' needs, and which is supported by nursing knowledge and evidence based research" (NCNZ, p. 4).	Professional Care EBP
"…as a member of the health care team, the nurse evaluates the effectiveness of care and promotes a nursing perspective within the interprofessional activities of the team" (NCNZ, p. 5).	Care Professional
"Indicator: Accepts responsibility for actions and decision making within scope of practice" (NCNZ. p. 9). "Indicator: Demonstrates knowledge of, and accesses, policies and procedural guidelines that have implications for practice" (NCNZ. p. 9). "Indicator: Uses professional standards of practice" (NCNZ. p. 9).	Professional Responsibility Accountability Legislation Management Safety
"Indicator: Demonstrates knowledge of differing health and socio-economic status of Maori and non-Maori" (NCNZ, p. 10).	Professional Care Safety (Cultural) Legal (Treaty)
"Indicator: Understands accountability for directing, monitoring and evaluating nursing care provided by enrolled nurses and others" (NCNZ, p. 11). "Indicator: Makes appropriate decisions when assigning care, delegating activities and providing direction for enrolled nurses and others" (NCNZ, p. 11).	Accountability Care Professional Legal
"Indicator: Reflects on his/her own practice and values that impact on nursing care in relation to the health consumer's age, ethnicity, culture, beliefs, gender, sexual orientation and/or disability" (NCNZ, p. 13).	Professional Safety (Cultural) Legal Care Ethical
"Indicator: Contributes to care planning, involving health consumers and demonstrating an understanding of health consumers' rights, to make informed decisions" (NCNZ, p. 14). "Indicator: Demonstrates understanding of the processes and environments that support recovery" (NCNZ, p. 14). "Indicator: Identifies examples of the use of evidence in planned nursing care" (NCNZ, p. 14).	Professional Responsibility Care Safety (Cultural) EBP Legal
"Indicator: Applies relevant research to underpin nursing assessment" (NCNZ, p. 15).	Professional Care EBP
"Indicator: Makes appropriate professional judgement regarding the extent to which the health consumer is capable of participating in decisions related to his/her care" (NCNZ, p. 17).	Professional Legal Ethical Care Safety

"Indicator: "Understands emergency procedures and plans and lines of communication to maximise effectiveness in a crisis situation" (NCNZ, p. 18). "Indicator: Takes action in situations that compromise health consumer safety and wellbeing" (NCNZ, p. 18).	Safety Care Professional Managerial
"Evaluates health consumer's progress toward expected outcomes in partnership with health consumers" (NCNZ, p. 19). "Indicator: Evaluates the effectiveness of the health consumer's response to prescribed treatments, interventions and health education in collaboration with the health consumer and other health care team members. (Beginning registered nurses would seek guidance and advice from experienced registered nurses)" (NCNZ, p. 19). "Indicator: Reflects on health consumer feedback on the evaluation of nursing care and health service delivery" (NCNZ, p. 19).	Professional Care Safety (Cultural) Management
"Reflects upon, and evaluates with peers and experienced nurses, the effectiveness of nursing care" (NCNZ, p. 21). "Indicator: Accesses advice, assistance, debriefing and direction as necessary" (NCNZ, p. 21).	Professional Care Safety Legal
"Maintains professional development" (NCNZ, p. 22). "Indicator: Updates knowledge related to administration of interventions, treatments, medications and best practice guidelines within area of practice" (NCNZ, p. 22). "Indicator: Takes responsibility for one's own professional development and for sharing knowledge with others" (NCNZ, p. 22).	Professional Care Safety Legal EBP Management
"Integrates evidence-based theory and best practice into education activities" (NCNZ, p. 23). "Promotes a practice environment that encourages learning and evidence-based practice" (NCNZ, p. 23).	EPB Professional Care
"Participates in quality improvement activities to monitor and improve standards of nursing" (NCNZ, p. 30). "Indicator: Reviews policies, processes, procedures based on relevant research" (NCNZ, p. 30). "Indicator: Recognises and identifies researchable practice issues and refers them to appropriate people" (NCNZ, p. 30). "Indicator: Distributes research findings that indicate changes to practice to colleagues" (NCNZ, p. 30).	Professional EBP Management Safety

Implied: Examples of excerpts from the text: Characteristic of Critical thinking silent but present within described activities.	Discourse
"Registered nurses are accountable for ensuring all health services they provide are consistent with their education and assessed competence, meet legislative requirements and are supported by appropriate standards. (NCNZ, p. 3)	Accountability (Professional) Competence Legal Safety
"Accepts responsibility for ensuring that his/her nursing practice and conduct meet the standards of the professional, ethical and relevant legislated requirements" (NCNZ, p. 9). "Indicator: Practises nursing in accord with relevant legislation/codes/policies and upholds health consumers rights derived from that legislation" (NCNZ, p. 9).	Professional Responsibility Accountability Legislation Ethical Management *Safety*
"Demonstrates the ability to apply the principles of the Treaty of Waitangi Te Tiriti o Waitangi to nursing practice" (NCNZ, p. 10). "Indicator: Understands the Treaty of Waitangi/Te Tiriti o Waitangi and its relevance to the health of Maori in Aotearoa/New Zealand" (NCNZ, p. 10).	Professional Legal Care Ethical Safety (Cultural)
"Promotes an environment that enables health consumer safety, independence, quality of life, and health" (NCNZ, p. 12). "Indicator: Identifies and reports situations that affect health consumers or staff members' health or safety" (NCNZ, p. 12). "Indicator: Recognises and manages risks to provide care that best meets the needs and interests of health consumers and the public" (NCNZ, p. 12).	Safety Responsibility Professional care Safety
"Practises nursing in a manner that the health consumer determines as being culturally safe" (NCNZ, p. 13). "Indicator: "Recognises the impact of the culture of nursing on health consumers' care and endeavours to protect the health consumer's wellbeing within this culture" (NCNZ, p. 13). "Indicator: Practises in a way that respects each health consumer's identity and right to hold personal beliefs, values and goals" (NCNZ, p. 13). "Indicator: Avoids imposing prejudice on others and provides advocacy when prejudice is apparent" (NCNZ, p. 13).	Safety (Cultural) Legal Care Professional
"Indicator: Undertakes practice procedures and skills in a competent and safe way" (NCNZ, p. 14). "Indicator: Administers interventions, treatments and medications, (for example: intravenous therapy, calming and restraint), within legislation, codes and scope of practice; and according to authorised prescription, established policy and guidelines" (NCNZ, p. 14).	Professional Safety Competency Legal Care Management Ethics EBP

"Indicator: Uses suitable assessment tools and methods to assist the collection of data" (NCNZ, p. 15).	Professional Care EBP
"Ensures the health consumer has adequate explanation of the effects, consequences and alternatives of proposed treatment options" (NCNZ, p. 17). "Indicator: Provides appropriate information to health consumers to protect their rights and to allow informed decisions" (NCNZ, p. 17). "Indicator: Assesses the readiness of the health consumers to participate in health education" (NCNZ, p. 17). "Indicator: Discusses ethical issues related to health care/nursing practice, (for example: informed consent, privacy, refusal of treatment and rights of formal and informal health consumers" (NCNZ, p. 17). "Indicator: Takes the health consumer's preferences into consideration when providing care" (NCNZ, p. 17).	Professional Responsibility Safety (Cultural) Care Legal Ethical
"Acts appropriately to protect oneself and others when faced with unexpected health consumer responses, confrontation, personal threat or other crisis situations" (NCNZ, p. 18). "Indicator: "Implements nursing responses, procedures and protocols for managing threats to safety within the practice environment" (NCNZ, p. 18).	Safety Professional Responsibility Accountability Managerial
"Provides health education appropriate to the needs of the health consumer within a nursing framework" (NCNZ, p. 20).	Professional Care
"Establishes, maintains and concludes therapeutic interpersonal relationships with health consumers" (NCNZ, p. 25). "In dicator: Initiates, maintains and concludes therapeutic interpersonal interactions with health consumers" (NCNZ, p. 25). "Indicator: Incorporates therapeutic use of self and psychotherapeutic communication skills as the basis for nursing care for health consumers with mental health needs" (NCNZ, p. 25). "Indicator: Utilises effective interviewing and counselling skills in interactions with health consumers" (NCNZ, p. 25).	Professional Care Safety (Cultural) Counselling Psychodynamic Management
"Implements nursing care in a manner that facilitates the independence, self-esteem and safety of the health consumer and an understanding of therapeutic and partnership principles" (NCNZ, p. 26).	Professional Care Safety Responsibility
"Communicates effectively with health consumers and members of the health care team" (NCNZ, p. 27). "Indicator: Uses a variety of effective communication techniques" "Indicator: Employs appropriate language to context" (NCNZ, p. 27).	Safety Care Responsibility Professional
"Indicator: Makes appropriate formal referrals to other health care team members and other health related sectors for health consumers who require consultation" (NCNZ, p. 29).	Professional Responsibility Care Safety Management

Critical thinking examples from document 2: NZNO (2012)

Denoted: Examples of excerpts from the text: Characteristic of Critical thinking linked by use of knowledge, judgement, evaluation, research, decision making, reflects, understanding, evidence, take action, critique.	Discourse
"Nurses work within their scope of practice, based on current nursing knowledge, professional judgement, experience and competence, within their area of practice and job description" (NZNO, p. 6).	Competency Safety Legal Professional Care Management
"Nurses use competent clinical judgement to implement all aspects of the nursing process, ensuring appropriate and effective care" (NZNO, p. 6).	Care Professional Safety Competency Legal Management
"Nurses demonstrate evidence of application of evidence-based research in practice" (NZNO, p. 6).	EBP Professional Care Safety
"Nurses take action (taking action includes advocacy) to promote the provision of safe, appropriate and ethical care to clients" (NZNO, p. 6).	Safety Professional Care Responsibility Legal Ethical
"Nurses know how and where to find information to support the provision of safe, appropriate and ethical client care" (NZNO, p 7).	Safety Professional Care Managerial Ethical
"Nurses interpret, critique and use current evidence from research and other credible sources to make practice decisions" (NZNO, p. 7).	EPB Professional Care
"Nurses demonstrate and maintain competence in clinical and technical skills and the application of knowledge" (NZNO, p. 7).	Legal Professional Care

"Nurses apply current nursing knowledge using a documented systematic approach to meet the stated and implied needs of clients / family / whānau / hapū / iwi" (NZNO, p. 7).	Professional Care Management
"Nurses use a recognised nursing framework to assess and determine client health status and the outcomes of nursing intervention, and document appropriately" (NZNO, p. 7).	Care Professional Accountability Management
"Nurses demonstrate knowledge and appropriate utilisation of evidence-based policies" (NZNO, p. 7).	EBP Professional Care
"Nurses critique and apply research in their practice" (NZNO, p. 8).	EBP Care Professional
"Nurses engage in creative and innovative approaches to ensure the needs of clients and best practice standards are met" (NZNO, p. 8).	EBP Care Professional
"Nurses use professional judgement in determining the appropriate boundaries of a therapeutic relationship with each client. The nurse – not the client – is responsible for establishing and maintaining boundaries" (NZNO, p. 9).	Professional Accountability Care Safety Legal Ethical
"Nurses enter into and maintain partnerships with colleagues, students, multi-disciplinary team members, and employers to ensure best practice standards are met and maintained" (NZNO, p. 9).	EBP Professional Managerial
"Nurses evaluate the effectiveness of relationships/partnerships and make appropriate interventions as required" (NZNO, p .9).	Care Professional Accountability Safety
"Nurses use reflection to critically analyse their practice, identify any gaps in knowledge and take steps to address these (NZNO, p. 10).	Professional Care EBP
"Nurses lead and participate in the regular evaluation of nursing practice" (NZNO, p. 0).	Professional Care

"Nurses take action to resolve conflict" (NZNO, p. 12).	Professional Safety Legal Responsibility
"Nurses develop innovative solutions to practice issues" (NZNO, p. 12).	Professional Care

Implied: Examples of excerpts from the text: Characteristic of Critical thinking silent but present within described activities.	Discourse
"Nurses function within relevant legislation, meeting statutory requirements" (NZNO, p. 6). "Nurses provide documentation that meets legal requirements, is consistent, effective, timely, accurate and appropriate" (NZNO, p .6). "Nurses identify, respond to and document adverse events" (NZNO, p. 6).	Legal Professional Responsibility Safety Care Management
"Nurses participate in continuous quality improvement. " (NZNO, p. 6).	EBP Professional Management
"Nurses work in partnership with Tangata Whenua in the development and implementation of nursing practice standards and quality improvement activities" (NZNO, p. 7).	Safety Professional Responsibility Managerial EBP
"Nurses identify hazards and risks to client safety and participate in developing and implementing a risk management plan through continuous quality improvement" (NZNO, p. 7).	Safety Care Professional Accountability Management
"Nurses work in partnership with Tangata Whenua to ensure mātauranga (Māori ways of knowing), beliefs and values are upheld within the practice context" (NZNO, p. 9).	Safety (Cultural) Professional Care Legal (Treaty)
"Nurses use expertise and attend to the differing ways in which people experience health, well-being, illness, disability, the environment, health care systems, and other people in all interactions from initiation to termination of the relationship / partnership" (NZNO, p. 9).	Care Professional Responsibility

"Nurses invest time, effort and other resources into maintaining and expanding knowledge and skills required for competent practice and ongoing professional development" (NZNO, p. 10).	Professional Legal Competence
"Nurses demonstrate ongoing commitment to culturally safe practice" (NZNO, p. 10).	Professional Safety (Cultural) Care
"Nurses engage in peer review as part of ongoing professional development of self and colleagues" (NZNO, p. 10).	Professional Responsibility
"Nurses ensure that education pertaining to Māori health and well-being is delivered appropriately in consultation with Tangata Whenua" (NZNO, p. 10).	Professional Safety (Cultural) Legal (Treaty)
"Nurses participate in the development and implementation of standards of nursing education and practice through ongoing improvemen.t" (NZNO, p. 10).	Professional Responsibility Educational
"Nurses address ethical issues using an identifiable nursing ethical framework – for example the NZNO document *A process to manage challenging professional/ethical issues* (NZNO, 2010b)" (NZNO, p. 10).	professional Ethical Responsibility
"Nurses appropriately challenge health care practice which could compromise client / family / whānau / hapū / iwi safety, privacy or dignity" (NZNO, p. 11).	Professional Responsibility Safety (Cultural) Care Legal Ethical
"Nurses acknowledge a client's right to participate in an activity that may involve a degree of risk of which the client is fully informed, and take steps to minimise the risk" (NZNO, p. 11).	Professional Safety Legal Care Ethical Accountability
"Nurses respect a client's right to live and die in dignity" (NZNO, p. 11).	Professional Care Ethical Legal
"Nurses demonstrate respect for clients / family / whānau / hapū / iwi / community spiritual and cultural beliefs and values" (NZNO, p. 11).	Professional Care Responsibility Ethical

"Nurses advocate for clients, the workplace and the profession" (NZNO, p.12).	Safety Professional Accountability Responsibility Management Ethical
"Nurses provide direction to and delegate where appropriate, collaborate with, support, and share knowledge and expertise with novices, students and other unregulated care providers including health care assistants" (NZNO, p. 12).	Professional Legal Management Responsibility Accountability
"Nurses support colleagues to manage inappropriate workplace behaviour" (NZNO, p. 12).	Professional Safety Management
"Nurses are active in designing, implementing and evaluating workload measurement tools to ensure appropriate use of resources to meet client needs and ensure a safe working environment" (NZNO, p. 13).	Professional Management Safety Care
"Nurses manage resources efficiently and effectively to meet health needs" (NZNO, p. 13). "Nurses participate in decision making processes that affect health needs/resources…" (NZNO, p. 13). "Nurses negotiate to obtain the necessary resources to support nursing practice and make the best use of resources available in the provision of client care…" (NZNO, p. 13). "Nurses are active in designing, implementing and evaluating workload measurement tools to ensure appropriate use of resources to meet client needs and ensure a safe working environment…" (NZNO, p. 13). "Nurses actively identify nursing workforce needs and respond in order to maintain appropriate skills and mix of staff to enable client care and ensure safe practice…" (NZNO, p. 13). Nurses identify, appropriately document and report inadequate or unsafe resources and act to improve these" (NZNO, p. 13).	Professional Management Safety Care
"Nurses work in partnership with client / family / whānau / hapū / iwi / community to define health needs and to manage resources effectively to meet these needs ensuring positive health outcomes" (NZNO, p. 13).	Professional Care Legal Management Safety (Cultural)

Critical thinking examples from document 3: NZCMHN (2012)

Denoted: Examples of excerpts from the text: Characteristic of Critical thinking linked by use of knowledge, judgement, evaluation, research, decision making, reflects, understanding, evidence, take action, critique.	Discourse
"…understanding of: The influence of their own values, beliefs and attitudes in their interactions with others" (NZCMHN, p. 2).	Professional Safety
"Integrates theoretical knowledge and principles into therapeutic relationships" (NZCMHN, p. 5).	Professional Care Legal Ethical
"Mental health nursing practice reflects contemporary health care standards, theories, models and philosophies of care" (NZCMHN, p. 6).	Care Accountability Professional Competency (standards)
"…understanding of: Contemporary theories of mental health nursing" "Contemporary models of assessment and clinical decision making" (NZCMHN, p. 6).	Professional Care
"Makes appropriate clinical decisions based on comprehensive nursing assessments" (NZCMHN, p. 7).	Safety Care Professional
"Evaluates the plan of care in collaboration with people with mental health issues, families/ whānau and other relevant providers" (NZCMHN, p. 7).	Professional Care Safety (Cultural)
"…understanding of: Current evidence underpinning professional practice" (NZCMHN, p. 10).	Professional EBP Care
"…understanding of: A range of psychological, behavioural, social, biological, spiritual, cultural and complementary treatments and interventions utilised in mental health care" (NZCMHN, p. 6).	Professional Care Psychological, behavioural, social, biological, spiritual, cultural

"Utilises a range of interventions underpinned by appropriate evidence" (NZCMHN, p. 7).	EBP Care Professional
"Evaluates their own practice with regard to the reduction of stigma and discrimination" (NZCMHN, p. 9).	Professional Ethical Care Legal
"Evaluates the evidence base for professional practice" (NZCMHN, p. 10).	EBP Professional Care Safety
"Evaluates their own professional practice and offers feedback to colleagues" (NZCMHN, p. 10).	Professional Safety Care
"Engages in professional supervision and reflective practice" (NZCMHN, p. 10).	Professional Care
"Recognises the role of research and evidence in informing professional practice. " (NZCMHN, p. 11).	Professional EBP
"Utilises a framework for ethical decision making and practises in accordance with legislation, policies and codes of conduct" (NZCMHN, p. 12).	Professional Legal Ethical
"Values ethical reflection and review of professional practice" (NZCMHN, p. 13).	Professional Ethical
Glossary: "Evidence Based Practice: A process of integrating the best available evidence with professional expertise to guide professionals in decision-making regarding the care of individuals. It requires critical appraisal" (NZCMHN, p. 14).	Professional Care EBP

Implied: Examples of excerpts from the text: Characteristic of Critical thinking silent but present within described activities.	Discourse
"…understanding of: Te Tiriti o Waitangi articles and associated principles" (NZCMHN, p.2). " Respects the place of Te Tiriti o Waitangi in Aotearoa New Zealand and its place in Mental Health Nursing practice" (NZCMHN, p. 3).	Professional Legal (Treaty) Safety (Cultural)
"…understanding of: The association of language, communication styles, spiritual beliefs and practices to mental health, wellbeing and cultural identity" (NZCMHN, p. 2)	Care Professional Safety (Cultural) Ethical
"Actively works towards reducing health disparities experienced by Māori" (NZCMHN, p. 3).	Legal (Treaty) Safety (Cultural) Professional Care
"Advocates for services that are free from discrimination and sensitive to an individual's cultural identity and wellbeing" (NZCMHN, p. 3).	Safety (Cultural) Professional Care Legal Ethical
"Facilitates access to culturally appropriate models of care" (NZCMHN, p. 3).	Safety (Cultural) Care Professional
"…understanding of: The theories of therapeutic relationships and effective communication. The ethical and legal frameworks that support therapeutic relationships" (NZCMHN, p. 4).	Professional Care Legal Ethical
"…understanding of: The boundaries of therapeutic relationships with people experiencing mental health issues" (NZCMHN, p. 4).	Professional Care Safety (Cultural) Ethical Legal
"…understanding of: The philosophy and principles of recovery and wellbeing (NZCMHN, p. 4). "Applies principles of recovery and wellbeing in relationships with all people affected by mental health issues" (NZCMHN, p. 5).	Professional Care Safety (Cultural) Ethical
"Identifies and works to resolve ethical and legal issues arising in therapeutic relationships" (NZCMHN, p. 5). "Values experiences of people with mental health issues as the basis for therapeutic relationships" (NZCMHN, p. 5).	Professional Care Legal Ethical

"Mental Health Nursing practice reflects a person/family/whānau centred, strengths- based approach that addresses physical, psychological, cultural, social, educational, employment, family and spiritual needs" (NZCMHN, p. 6).	Professional Care Safety (Cultural) Responsibility
"…understanding of: Theories and models of mental health promotion" (NZCMHN, p. 8)	Professional Care
"Mental health promotion strategies are developed in partnership with people with mental health issues and families/whanau" (NZCMHN, p. 8).	Professional Safety (Cultural) Care Ethical
"Translates global and national mental health promotion policies into the local context" (NZCMHN, p. 9). "Assists people with mental health issues to make lifestyle decisions that promote health and wellbeing" (NZCMHN, p. 9).	Professional Management (Neoliberal?)
"Articulates their individual philosophy of practice" (NZCMHN, p. 10).	Professional Care
"Professional accountability involves an obligation to recognise socially and professionally mandated policies and to maintain legal and ethical standards" (NZCMHN, p. 12). "Mental Health Nursing practice is congruent with relevant policies and legislation" (NZCMHN, p. 12). "Mental Health Nursing practice reflects accepted ethical standards and relevant codes of conduct and practice" (NZCMHN, p. 12).	Professional Legal Management
"Practises in accordance with legislation relevant to the mental health practice setting" (NZCMHN, p. 12). "Identifies the relevance of health policies to practice" (NZCMHN, p. 12).	Professional Legal Ethical Management
"Participates in reviews of clinical practice and service delivery" (NZCMHN, p. 12).	Professional Management

Table 2:   Critical thinking examples from texts

This table lists statements from the two textbooks:

1. **Critical thinking tactics for nurses: Achieving the IOM competencies: Rubenfeld, M. G., & Scheffer, B. K. (2015, 3rd ed.)**

| Examples of excerpts from the text	Discourse
"Without CT, any attempts for safe, effective, efficient health care are meaningless" (Rubenfeld & Scheffer, p. 23). "…the delivery of safe, effective, and efficient care has always been the underlying goal of good nursing care. CT is essential to achieving these goals" (Rubenfeld & Scheffer, p. 10).	Care Safety Professional Management
"Another way CT benefits clinicians is by helping them move from novice to advanced beginner to competent to proficient and ultimately to expert" (Rubenfeld & Scheffer, p. 13).	Competency Professional
"…all decisions must be accurate and made in a timely manner (Rubenfeld & Scheffer, p. 2) "In addition to safe care, CT is important for effective and efficient care. Effective care is individualised and accurate. It employs the correct interventions for the health situation at hand. Efficient care requires timely thinking so that resources are used appropriately" (Rubenfeld & Scheffer, p. 11). "One of the jobs is the everyday reality of CT within the context of nursing process, that is, what nurses do every day in patient encounters" (Rubenfeld & Scheffer, p .47) "patient + You (nurse) + Thinking skills + knowledge + Nursing process = great nursing" (Rubenfeld & Scheffer, p. 47)	Care Professional Safety Accountability Management
"…good clinicians rely on professional ethics and intellectual integrity to reinforce their thinking" (Rubenfeld & Scheffer, p. 12)	Professional Care Ethical

"Clinicians who think critically have more confidence in their reasoning." "Confidence empowers…" "CT is important to job satisfaction because it helps the clinician attain and maintain a professional nursing self-image" (Rubenfeld & Scheffer , p. 11). "CT leads to empowered decision making, job satisfaction, and expertise in practice for clinicians" (Rubenfeld & Scheffer p. 23).	Professional Management EBP Care
"Polarity management is one strategy for using CT to analyse commonalities and then find creative ways to deal with other issues" (Rubenfeld & Scheffer , p. 18; calling on, Yoder-Wise, 1995).	Management Professional
"… administrators must have "advanced abilities to think critically… to improve clinical systems, decrease errors and sentinel events, and engage staff involvement to refine patient systems" (Rubenfeld & Scheffer, p. 18. Quoting Hansten & washburn, 1999, p. 39).	Management Safety Professional
"…great nursing requires thinking and doing. One without the other either does not work or can be very dangerous" (Rubenfeld & Scheffer p. 53). "CT bridges the gap between knowledge and action." (Rubenfeld & Scheffer, p. 53).	Competency Care Safety
"…healthcare professionals also rely on all 17 CT dimensions to meet the criteria for their professional status". "…the basics of any profession include a code of ethics, a body of knowledge, higher education, and self-regulation" (Rubenfeld & Scheffer, p. 19) using (Haynes, Boese, & Butcher, 2004).	Care Professional Safety Competency Legal Ethics
Nursing is concerned about critical thinking because it deals with "split-second decision making to keep people safe" (Rubenfeld & Scheffer, p. 31).	Professional Accountability Safety
"Studying CT by itself is a wonderful philosophical activity, but as nurses we must look at CT in action. CT is a tool to be used in the muddy world of healthcare" (Rubenfeld & Scheffer, p. 8).	Professional Care Management Safety
"Without the necessary CT, diagnoses may be inaccurate and therefore affect the quality of health care as the nurse heads down the wrong path in patient care" (Rubenfeld & Scheffer, p. 8).	Professional Safety Care

2. Critical thinking and nursing judgement: Bronwyn Jones. In J. Crisp, C. Taylor, C. Douglas, & G. Rebeiro (Eds.), Potter & Perry's fundamentals of nursing (4th ed.).

Examples of excerpts from the text	Discourse
"In clinical situations, it is important for the nurse to think critically so that the client ultimately receives the very best nursing care." (Jones, p. 75).	Professional Care Safety Ethical
"Although the responsibility of making clinical decisions may seem frightening to a new student, it is a rewarding and challenging profession." (Jones, p. 75).	Professional Care Safety Responsibility
"Through critical thinking, a person confronts problems, considers choices and chooses an appropriate course of action." (Jones p. 75).	Professional Care Safety
"The development of the critical thinking skills of challenging assumptions, reflecting on experience and questioning one's usual way of thinking while promoting patient safety through the process of clinical judgement and decision making is crucial to the delivery of high-quality patient care." (Jones, p. 77). (Referring to Ashcraft, 2010).	Professional Care Safety
"…the nursing process…provides a systematic framework for the use of logical thought processes or critical thinking to collect, analyse and synthesise client data crucial to clinical decision making in the best interests of the client." (Jones, p. 75).	Care Professional Safety Ethical
"Nurses have the important responsibility of making accurate and appropriate clinical decisions." (Jones, p. 77).	Professional Care Safety Responsibility
"An essential component of critical thinking and clinical decision making is the nurse's specific knowledge base." (Jones, p. 77).	Professional Care
"Critical thinking model demonstrates how nursing process and critical thinking combine to assist in providing the best care for patients." (Jones, p.xxvii).	Professional Care EBP
"The ability to think critically though the application of knowledge and experience, problem solving and decision making is central to professional nursing practice." (Jones, p. 78).	Professional Care EBP

Quote	Categories
"As a nurse gains new knowledge and develops into a competent professional, the ability to think critically to make a sound clinical judgement expands." (Jones, p. 79).	Professional Care
Specific critical thinking competencies in clinical situations include diagnostic reasoning, clinical inferences and clinical decision making." (Jones, p. 79).	Professional Care EBP
"Learning to become a critical thinker is a requirement for graduates of all nursing undergraduate programs and for entry to practice as a beginning registered nurse (RN). Critical thinking as expressed though clinical judgement and decision making is assessed continuously throughout your nursing program in order that you will be able to accurately identify client problems, safely manage these problems and justify the actions you take with relevant rationales or logic." (Jones, p. 77).	Professional Care Education
"The specific critical thinking competency in nursing is the nursing process." (Jones, p. 79).	Professional Care
"Critical thinking includes intellectual and professional standards. These standards are the criteria for determining the soundness, justness and appropriateness of critical decisions and judgements. The use of intellectual standards involves a rigorous approach to clinical practice and cannot be done haphazardly. When a nurse considers a client problem, it is important to apply standards such as preciseness, accuracy and consistency to ensure clinical decisions are sound and valid." (Jones, p. 82).	Professional Care Safety Evidence
"The use of universal standards of clarity, accuracy, precision and relevance means that the nurse has command of these standards." (Jones, p. 82). (calling on Huckaby, 2009)	Professional Care
"Professional standards for critical thinking refer to ethical criteria for nursing judgements, criteria to be used for evaluation and criteria for professional responsibility. Application of professional legal and ethical standards requires that nurses use critical thinking for the good of individuals or groups." (Jones, p. 82). (calling on Freegard, 2007).	Professional Care Safety Legal Ethical
"Standards also ensure that the highest level of nursing care is promoted" (Jones, p. 82).	Professional Care Safety
"Decision making is the end point of critical thinking and leads to problem resolution" (Jones, p. 80).	Professional Care Safety
Evidence-based practice requires that decisions about client care are made based on the best available evidence" (Jones, p. 80).	Professional Care EBP

Te Ao Māramatanga - New Zealand College of Mental Health Nurses
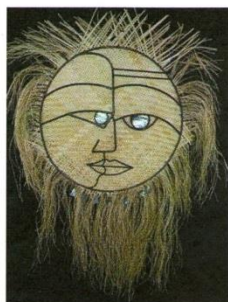
About The College logo - Rangi & Papa

The Logo represents Ranginui - Sky Father (left profile) and Papatuanuku - Earth Mother. In this representation they depict our humanity laying against a bed of Harakeke.

' from the separation of Ranginui and Papatuanuku, first light burst into the world and from it came a wellspring of knowledge and understanding.'

'Te Whei Ao
Te Ao Mārama'

The logo was first developed by a local artist for the Australian and New Zealand College of Mental Health Nurses International Conference, *Earth, Sky & Number 8 Wire,* held in Rotorua in 2003. This conference celebrated 10 years of New Zealand's association with the ANZCMHNs and was also a watershed year where in New Zealand nurses agreed to form the new New Zealand College of Mental Health Nurses, Te Ao Māramatanga.

In 2004 Rangi and Papa was formally adopted as the logo to represent the new Te Ao Māramatanga - New Zealand Collage of Mental Health Nurses.

Figure 3: NZCMHN College logo

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