Nursing Best Practice Guidelines: reflecting on the obscene rise of the void

DAVE HOLMES PhD, RN[1], STUART J. MURRAY PhD[2], AMÉLIE PERRON PhD (C), RN[3] and JANET McCABE PhD (C), RN[4]

[1]Associate Professor, *School of Nursing, Faculty of Health Sciences, University of Ottawa, Ottawa, ON,* [2]*Assistant Professor, Department of English, Faculty of Arts, Ryerson University, Toronto, ON* [3]*Lecturer and* [4]*Research Assistant, School of Nursing, Faculty, of Health Sciences, University of Ottawa, Ottawa, ON, Canada*

Correspondence
Dave Holmes
School of Nursing
Faculty of Health Sciences
University of Ottawa
451 Smyth Road
Ottawa K1H 8M5
ON
Canada
E-mail: dholmes@uottawa.ca

HOLMES D., MURRAY S.J., PERRON A. & McCABE J. (2008) *Journal of Nursing Management* **16**, 394–403

Nursing Best Practice Guidelines: reflecting on the obscene rise of the void

Aim(s) Drawing on the work of Jean Baudrillard and Michel Foucault, the purpose of this article is to critique the evidence-based movement [and its derivatives – Nursing Best Practice Guidelines (NBPGs)] in vogue in all spheres of nursing.

Background NBPGs and their correlate institutions, such as the Registered Nurses' Association of Ontario (RNAO) and 'spotlight' hospitals, impede critical thinking on the part of nurses, and ultimately evacuate the social, political and ethical responsibilities that ought to distinguish the nursing profession.

Evaluation We contend that the entire NBPG movement is based on the illusion of scientific truth and a promise of ethical care that cannot be delivered in reality. We took as a case study the Registered Nurses' Association of Ontario (RNAO), in the province of Ontario, Canada.

Key issues NBPGs, along with the evidence-based movement upon which they are based, are a dangerous technology by which healthcare organizations seek to discipline, govern and regulate nursing work.

Conclusion(s) Despite the remarkable institutional promotion of 'ready-made' and 'ready-to-use' guidelines, we demonstrate how the RNAO deploys BPGs as part of an ideological agenda that is scientifically, socially, politically and ethically unsound.

Implications for nursing management Collaborations between health care organizations and professional organizations can become problematic when the latter dictate nursing conduct in such a way that critical thinking is impeded. We believe that nurse managers need to understand that the evidence-based movement is the target of well-deserved critiques. These critiques should also be considered before implementing so-called 'Nursing Best Practice Guidelines' in health care milieux.

Keywords: baudrillard, best-practice guidelines, critique, evidence-based movement, Foucault, nursing

Accepted for publication: 8 January 2008

'Obscenity – that is to say, the total visibility of things – is unbearable to the point that we have to apply an ironic strategy to survive. Otherwise this particular transparency would be totally lethal (Baudrillard 2003, p. 29)'.

Introduction

French sociologist Jean Baudrillard (2002) makes the following provocative claim: 'Today we do not think the virtual, the virtual thinks us' (2002, p. 107). Baudrillard suggests that human reason and agency are illusions, best described as effects of the fantastic and the unreal. In his famous essay, 'Dust Breeding' (2001), he explains how a virtual nothingness or void can give the illusion of plenitude and reality. As an example, he turns to the phenomenon of reality television. In the English-speaking world, most readers would be familiar with **Big Brother**, **The Real World**, **Survivor** and others of this genre. For Baudrillard (2001), these shows radically call into question the meaning of the word 'real' at the same time as they challenge our unreflective experience of 'reality'. Reality no longer anchors us (if it ever did); rather, these shows teach us that man is an endless experimentation of himself (2001), an exhibition without destiny or density. When exhibitionism is taken to its limits and everything is meant to be seen, then there is no longer anything to see, no voyeurism. The scene at once becomes **obscene**, the unbearable mass-mediatised visibility of all things; reality becomes supplanted by the viral seductions of illusion (2002). Baudrillard concludes:

> 'This means it is useless searching for a politics **of** the virtual, an ethics **of** the virtual, etc., since it is politics itself which is becoming virtual, ethics itself which has become virtual, in the sense that both politics and ethics are losing the principles governing their action, losing their force of reality (2002, p. 111)'.

This article deploys Baudrillard's provocative insight to argue that Nursing Best Practice Guidelines (NBPGs) must be understood as dangerously illusory, virtual and devoid of substance. We limit our particular analysis to the Canadian context and to a discussion of the Registered Nurses' Association of Ontario (RNAO), set in Canada's most populous province, with a population of approximately 13 million (Statistics Canada 2006). In more general terms, this essay claims that NBPGs and their correlate, evidence-based movement, threaten to supplant the reality of patient healthcare with a grand and insubstantial illusion. The BPG movement is ideologically driven, giving us 'ready-made tools', 'rules' and 'guidelines' that ultimately impede nurses' critical thinking and serve as disciplinary technologies to govern nursing work. In this way, our political and ethical responsibilities are evacuated, surrendered to the 'ready-to-use' machinery of BPGs. The nursing profession in Ontario increasingly is mobilized by the rise of this BPG void – a discourse that seduces at that same time as it paralyses, a discourse that controls in part by obscuring its very own regulatory mechanisms and systems of domination, a discourse that promotes and rewards action without (critical) thought. Nursing is losing the principles governing its action, losing the force of its reality.

Recently, we have joined other scholars in the debate surrounding evidence-based practice (e.g. Freshwater & Rolfe 2004). Our critical perspective develops some of the five shortcomings of the evidence-based movement admirably outlined by Cohen *et al.* (2004), namely, (1) that evidence-based practices rely too heavily on empiricism, (2) rely on too narrow a definition of 'evidence', (3) ironically, lack any 'evidence' of their own efficacy, (4) are of limited use for individual patients, and (5) threaten the autonomy of the clinician/patient relationship. In addition, however, our work has drawn attention to the hidden social and political dimensions of 'evidence' and 'best practices', working to spark more substantial epistemological debates within the fields of nursing and medicine (see Holmes *et al.* 2006a,b, 2007, Murray *et al.* 2007). The critical reflection that follows focuses on the evidence-based movement and BPGs as they are being implemented by so-called 'spotlight organisations' and 'champion' stakeholders. Inspired by the work of Jean Baudrillard and Michel Foucault, we chart the rise of this obscene banality in Ontario nursing, arguing that the Registered Nurses' Association of Ontario (RNAO) is part of an institutional network (including nurse managers) that ideologically disciplines, controls and regulates nurses' work in healthcare settings. We argue that despite its success, this institutional nexus impedes critical thinking and evacuates those social, political and ethical responsibilities that ought to distinguish the profession of nursing.

Episteme, Discourse, and Ideology

According to Foucault (1980), an 'episteme' (from the Greek for 'knowledge' or 'science') is the accepted or dominant manner of gaining and organizing knowledge in a given historical period. An 'episteme' is a 'strategic

apparatus' (1980, p. 197) that informs our ways of seeing, our **Weltanschauung** or 'worldview'; it operates covertly and underwrites understanding of the world. Put another way, an 'episteme' is the implicit ground of our knowledge, the condition of possibility for something to appear to us as true or false, good or bad. Dominating 'epistemes' or worldviews are expressed in part through institutions, such as healthcare settings and through specific scientific disciplines, such as nursing, psychiatry or accounting. It is difficult, if not impossible, to **see** the 'episteme' that frames that way that one sees, so we must understand 'epistemes' by virtue of their effects, that which the 'episteme' mobilizes or enables. One example would be the early 20th century eugenic discourse on building a 'healthy nation': this discourse effect was in part based on a complex racist 'episteme' that informed a 'science' of race, purity, intelligence, disease and so on. This discourse was played out through the segregation of the races in US schools, through laws prohibiting miscegenation, through widespread tolerance of white supremacist groups, through myriad national, state and civic public policies, and so on. Thus, the discursive effects of an 'episteme' are intricate and far reaching. These instituted ways of seeing drive specific actions, allow for 'knowledge' development in certain areas, and foster the development and implementation of regulatory mechanisms which, in turn, are supported by myriad interconnected institutions and scientific disciplines (the perceived 'scientificity' or 'truth' of which is often measured by the extent of their 'epistemic' compliance).

We content that the evidence-based movement constitutes a contemporary illustration of this phenomenon. Indeed, its 'epistemic' agenda is obvious in the very language of its own self-description. An early editorial in the **British Medical Journal** offered the following definition of what constituted the best evidence in evidence-based medicine (EBM): 'identifying the best evidence means using epidemiological and biostatistical ways of thinking' (Davidoff *et al.* 1995). Thus, we are not merely thinking **of** epidemiology or thinking of biostatistics; we are not even using epidemiology or biostatistics – 'thought itself' becomes epidemiological and biostatistical; 'thought itself' becomes regulated by these disciplines. We do not think the virtual – the virtual thinks us.

While the term 'discourse' traditionally refers to a dialogue or a form of communication between two or more persons or groups, in Foucault, we find that a discourse is more broadly a textual form of expression. Discourses are institutionalized manners of speaking; they can shore up or even challenge the dominant 'episteme', depending on their context and reception.

The current dominance of the evidence-based movement stems largely from the very discursive structures it creates to disseminate its message and ensure its 'scientificity' and 'truth'. Again, its language is imporant because it becomes not just a way of speaking, rhetorically, but a way of thinking, 'epistemically' – and ultimately, a way of being in the world, ontologically. Significantly, then, within the 'best practice' lexicon, model institutions are called 'spotlight organizations'; key players are dubbed 'champions'; and there has been a proliferation of specialized jargon, conferences, university curricula, journals, and so on. We shall return to some of these below. This movement has led to the massive mobilization of resources and the implementation of interventions, which, in turn, further supports the hegemony of the evidence-based movement and consolidates its hold on attitudes and behaviours. With the evidence-based movement, we are witnessing a self-maintaining and self-fulfilling phenomenon that ruthlessly denigrates alternate modes of thinking while promoting its own through the spectacle of transparent accountability, efficiency and 'gold standard' excellence.

Foucault offers a more critical view. His genealogical methodology seeks to expose the workings of dominant 'epistemes', bringing to light the implicit strategic apparatuses by which something appears to be true or false, good or bad. In other words, Foucault makes explicit the conditions of possibility that underwrite our ways of knowing and even our ways of being in the world. We believe that his analysis can be extended to the discourse surrounding the evidence-based movement and its postulates, helping to parse for us the complex interactions between organizational, institutional and ethico-political structures and concerns. Discourses are institutionalized ways of knowing; they are tied to discplinary power. This is doubly complex because, on the one hand, disciplines operate as a form of power/knowledge through specific scientific disciplines (such as nursing); on the other hand, they often designate a specific disciplinary institution that is mandated with a mission of social control and regulation (such as hospitals and prisons). We return to this in greater detail below.

At this juncture, however, we can begin to see how the complex nexus of institutions – from governmental policies all the way down to individual ways of seeing – emerges almost as something virtual, in Baudrillard's sense. These systems manufacture consent because they are seductive and manipulative. There is great pressure to comply with the dominant 'episteme'. For Baudrillard as for Foucault, our historical 'truths' emerge from this nexus; we are not rational agents who think the virtual,

but rather, the virtual thinks us. Moreover, the virtual thinks us in such a way that we continue to 'think' that we can think the virtual, as if we were in control. For those who are sceptical of this insight, consider for a moment what happens when researchers refuse to conform to – or actually epistemologically challenge – the reigning discursive norms: They are treated as heretics; they are ridiculed; their research is deemed 'unscientific', etc. On the other hand, those who piously comply are rewarded with prestige and opportunity – they have purchased indulgences from the gatekeepers of Science and Truth. In short, the whole apparatus swings into motion to maintain the status quo. For this reason, Foucault has argued that scientific discourse conceals a quest for power through the appropriation of a supposedly absolute and objective truth – in our words, a virtual theocracy. The dogmatic exclusion of alternate modes of thought is a feature of what Foucault calls a 'regime of truth', a dominant way of seeing that seeks recourse in scientific discourse, maintains the effects of hegemony and consolidates the myriad institutional structures from which these arise. Indeed, there are multiple discursive regimes, each of which can be traced to particular settings and institutions (hospitals being one of them). Nevertheless, each replicates the same process: ideologically valorizing one discourse and excluding or marginalizing all others. This invariably leads to the establishment of binding norms because such discursive regimes target specific objects of knowledge as surfaces upon which social policies are inscribed. These policies result in normalizing trends that homogenize thought, discourse and behaviour in the name of a particular ideology. And finally, in spite of their reputation as fertile ground for new ideas, academic institutions are no exception to this exclusionary phenomenon and, in fact, often constitute its source.

Best Practice Guidelines in the Canadian Context

The institutional genealogy of BPGs
In order to understand the current situation and the growing support of BPGs in the Canadian context, specifically within Ontario, one must have at least a superficial understanding of the complex relations between various governmental bodies since the early 1990s. This includes the needs put forth by nursing as a professional body. Here, we might pursue a Foucauldian genealogy, analysing the historical relationships that exist between power, knowledge and truth; specifically, this involves the production of knowledge and truth occurring both between and within concrete institutions and disciplines (Danaher *et al.* 2000). The

production of knowledge and truth, in the context of nursing and healthcare in Ontario, increasingly has revolved around the ideology of BPGs, and the underlying economic and governmental contexts must be understood alongside the associated moves of the Registered Nurses' Association of Ontario (RNAO), as well as the needs of the nursing profession, expressed through the Canadian Nurses Association (CNA). In 2002, the Canadian Nurses Association (2002a) forecast a shortage of 113 000 nurses by the year 2016, and the state of nursing was yet again complicated by policies put in place in the late 1990s that aimed to reduce costs, resulting in a decrease in the number of nursing positions as hospitals faced shrinking budgets (Canadian Nurses Association 2002a).

Genealogically, the RNAO's best practice guidelines gained a prominent position in Ontario's healthcare system in part because nursing as a profession was forced to question its position within a healthcare system that was in financial turmoil and during a change in the political parties in government. In 1999, when BPGs were brought into the spotlight, it was through funding made available by the Conservative-led Ministry of Health and Long Term Care. In 2003, the BPG movement found staying power with continued cycles of funding through the Liberal government (Grinspun 2005). Since their inception the RNAO guidelines have been celebrated as a means for nurses to provide the highest levels of patient care. Ironically, however, there is little evidence to suggest that these guidelines actually result in improved patient 'outcomes'. In addition to patient care, these guidelines provide health care organizations with recommendations to ensure optimal nursing care. BPGs are presented as a way for nursing to safeguard its place within a changing and ever-more costly healthcare system in Ontario. Within Ontario, then, BPGs are supported by government because they appear to reduce costs, standardize patient care and offer public accountability; within healthcare settings, however, and within disciplinary nursing formations, BPGs are promoted as eternal and true, the highest standard of nursing excellence. In this regard, BPGs dominate the RNAO agenda and, by extension, mutually come to reinforce the ideologies that govern the state, professional bodies, educational systems (colleges, universities) and health care organizations.

The nursing (state) apparatus
To further understand the context of nursing in Ontario, it will be useful to turn to Louis Althusser (1971), who suggests the existence of an 'ideological state apparatus' (ISA). In a nutshell, ISAs are realities that

'present themselves to the immediate observer in the form of distinct and specialized institutions' (p. 143). ISAs function primarily through ideology and on a secondary level through the means of repression appropriate to the ISA in question. Ideology is described by Althusser as a 'system of ideas and representations which dominate the mind of a man or a social group' (p. 158). From this, we would say that nursing in Ontario is governed through institutional mechanisms that operate ideologically, that is, which dominate the mind of a social group through institutions that promote particular ways of seeing, thinking, and being. The apparatus is a system of social beliefs that have a bearing on social values, public policy, the economy and other factors that are closely linked. For our purposes here, we would contend that the RNAO, the CNA, the institutes that support nursing education and the entire nexus of institutions that employ nurses – all of these ought to be classified as ISAs in Althusser's sense. These institutions or ISAs share the same ideology: the truth of the evidence-based movement and a belief in the efficaciousness of BPGs or clinical guidelines that emerge from 'evidences'. The propagation of the BPG ideology via ISAs is clear both through nursing literature supporting BPGs and through the actions of the RNAO, which implements and evaluates the use of BPGs across 47 health care organizations in Ontario.

To provide some additional context, one commentator argues that the evidence-based movement – and by extension, BPGs – has been presented as the possible answer to:

> 'The crisis of authority and **legitimation** healthcare practitioners find themselves confronting in our postmodern times. The evidence-based movement is predicated on an internally consistent ideology that ''hard'' science (via empiricism, positivism, economic rationalism and pragmatism) is the best and only way to further our understandings and the practices which flow from those understandings (Walker 2003, p. 152)'.

If this crisis of authority and legitimacy is true, it would explain why nursing has felt the need to enhance the legitimacy and accountability of the profession. In an age that demands cost effectiveness and the efficient use of (dwindling) resources, nursing has had to struggle to safeguard its position and professional contribution within the healthcare system. The evidence-based movement and the institution of BPGs arrive 'ready-made' and 'ready-to-use': they provide the illusion of legitimacy and accountability because they tend to standardize and quantify nursing work. On a superficial level, the use of guidelines is seen as a mechanism to 'reduce uncertainties associated with clinical decisions, diminish variation around usual practices, demystify unfamiliar terminology and decrease the need to search for journals and articles' (Canadian Nurses Association 2002b). Along with Freshwater and Rolfe (2004), we believe and recognize that:

> 'Many practitioners are extremely busy people who are perhaps so immersed in their day-to-day practice that they have little time to think, let alone to read. However, we also believe that to practice is not merely a case of doing, even if it is ''evidence-based doing.'' We believe that practice entails reading about doing, thinking about doing, writing about doing.... And until health care workers and their managers recognize, accept and facilitate this expanded concept of practice, they will find it difficult to make the leap from workers to practitioners and from a job to a profession (p. 3)'.

The Price of Obscene Visibility

A visit to the website (http://www.rnao.org) of the RNAO is a lesson in obscene (after Baudrillard) spectacle. The evidence-based movement and BPGs have achieved a hyper-visibility in what one theorist, in the context of pornography, has called 'the frenzy of the visible' (Williams 1989). Indeed, the RNAO website boasts a plenitude of virtual information, a spectacle of BPG ideology that promotes one and only one way to be a good nurse. The website not only solicits the viewer, it situates him or her within the banal scene of BPG discourse, promoting BPGs as desirable through the celebration of 'best practice spotlight organisations' (BPSOs) and 'best practice champions' (BPCs).

BPSOs are healthcare organizations selected by the RNAO through a 'Request for Proposals'. These specially chosen organizations implement, evaluate and share lessons learned from their guideline experiences and research findings. The partnership is dynamic and long term, focusing on making a so-called 'positive' impact on patient care in the province. The role of the partnership between the RNAO and the BPSOs will be to: 'demonstrate creative strategies for successfully implementing nursing best practice guidelines; evaluate implementation and outcome measures through on-going audits and/or formal research studies; and, share broadly the lessons learned and results of the implementation' ('Spotlight Organizations', RNAO website). To support this scheme, the RNAO commits financial and expert resources based on funding support

received from the Ontario government. In turn, BPSO candidates are expected to commit finances and expertise from their own resources. It is almost as if BPSOs have been granted membership in an elite club.

BPCs, on the other hand, are nurses 'who are passionate about improving nursing practice and client care in their organization' ('Champions', RNAO website). But clearly, passion is not enough – champions must be involved, and the RNAO website promotes its 'Champions' Workshops' and 'Champions Newsletter'. There are even web links for aspiring champions (presumably everyone) to 'Get Involved' and to answer their burning questions – 'How do I become a Best Practice Champion?' and 'What are the benefits of getting involved?' One-day Initiation Workshops include an orientation the topics of which include: 'issues and trends in evidence-based practice', 'information on the Best Practice Guideline project (development and dissemination)', 'identifying the core competencies of a Champion', among others ('Get Involved', RNAO website). Presumably, nurses who are made of **The Right Stuff** will be successful in their application to become Champions and will soon enjoy organizational and/or unit/programme-level influence. These Champions will assume multiple roles – essentially championing their championship – such as 'bringing awareness of best practices to their organisation, influencing groups and committees to consider these best practices, mobilizing, coordinating, and facilitating the training and development of professional staff in best practice guideline implementation, etc'. ('Champions', RNAO website). This frenzied enthusiasm is meant to be infectious. The RNAO has even developed a promotional graphic that exhorts: 'I'm a best practice champion – **ask me!**' This kind of evangelism is certainly not the way we envision the role of healthcare professionals.

While individual nurses are expected to assess their shortcomings in practice, nurse managers and leaders are called upon to play a key role in ensuring excellence in clinical practice and to convey dominant discourses in nursing. As BPGs are introduced into nursing units, many interventions are put in place by managers in order to maximize their uptake. This may include the designation of an implementation team, a 'champion', information sessions, workshops, or posting the clinical guidelines in strategic areas on the unit (RNAO 2002). These strategies constitute various forms through which nurses are trained to understand, integrate and accept practice guidelines. As uptake occurs, nurses comply with new recommendations and modify their practice accordingly. Role modelling is a key strategy to ensure the uptake and retention of new practices. Nurses who

do not endorse these guidelines will therefore be faced with peers who do; their (standard) practice will constantly be compared to and measured against others' (best) practice.

As BPGs become ingrained in the policies and in the normal everyday procedures that make up nursing work in health care settings, the knowledge that nurses utilize within their practises becomes regulated and increasingly automatic. The price of this purported efficiency is very steep indeed: thoughts and actions are governed by guidelines, which impedes critical thinking. The BPG ideology has also infected Ontario's educational apparatuses, with nursing students being 'indoctrinated into evidence-based practice' through the promotion and use of BPGs. Through an initiative proposed by the RNAO, with financial support from the Ontario Ministry of Health and Long Term Care, in 2004, BPGs were encouraged to be integrated into nursing education. Although the education system is charged with the production of nursing graduates who are both critical thinkers and capable of providing evidence-based nursing (Canadian Nurses Association 2002b), it does not seem necessary to indoctrinate students in the current BPGs, as the hope should be that new graduates will have the ability to find, assess and apply relevant research to their practice. How would indoctrination in the current BPGs encourage the critical thinking skills so valued by the profession? Forcing nurses to follow BPGs and the actions being taken to implement them at the institutional level is to remove critical thinking from nursing practice, which will not only impact the profession's autonomy but also its scope of practice.

BPGs as the New Nursing Ethos

To be sure, the RNAO along with its BPSOs will maintain that the implementation of BPGs is based on ethics or on a sense of professional duty. This message is clear from the language used to support BPGs and evidence-based practice: quality, accountability and best care. However, this immediately results in an ethical and professional conflict for those nurses who do not utilize BPGs to underpin their nursing philosophy or to structure their day-to-day practice. These nurses maybe be seen – and may soon come to see themselves – as failing to provide the best possible care, or as working against cost-effective measures implemented by healthcare agencies (such as the Ontario Ministry of Health and Long Term Care), the ostensible purpose of which is utilitarian – to provide the greatest good to the greatest number of patient/clients. Certainly policy-makers and nurses alike should be accountable for their

actions, which mean that they should be able to account for the evidence upon which their decisions are based, rather than blindly following BPGs. As Grinspun *et al.* (2001/2002) state, 'it behoves practitioners to deliver their care based on the strongest current evidence' (p. 59). However, while the 'strongest evidence' is supposedly embodied in convenient ready-made and ready-to-use BPGs, to date there have been few studies (if any) that fairly evaluate the implementation of guidelines vis-à-vis patient 'outcomes'.

Notwithstanding the lack of evidence to support its 'best evidence' claims, statements like these nonetheless appeal strongly to nurses' sense of duty to their patients in terms of accountability and providing competent care. We contend that 'real' accountability and 'real' competency involves a thorough and wide-ranging evaluation of the 'best' evidence that underlies the BPG 'best' practices, as we explain below. Here it is important to point out that the 'best evidence' of BPGs is dangerously virtual, that is, it provides the illusion of rigour and scientificity, the illusion of meeting ethical responsibility and professional duty, but like the RNAO website, there is a great deal of smoke and mirrors. The illusion is additionally dangerous because it is programmatic, it has an agenda: when BPGs are embedded as healthcare policy and encouraged at educational and organizational levels, they will tend to capture and to direct ways of thinking and ways of doing. Those nurses who choose not to utilize the BPGs must reconcile themselves with powerful statements from the RNAO president such as the following: 'without implementation (of BPGs), patients will not get the quality care they deserve, and nurses will not practice to their fullest potential' (Grinspun 2005, p. 7). BPGs seem to be the easy answer to the question of how to change practitioner behaviour 'in light of research evidence' (Ciliska 2006, p. 38); however, as we have argued, BPGs soon come to guide not only practice but the very thought processes – the ways of thinking – that provide the 'epistemic' underpinnings of day-to-day nursing practice. The next section addresses this concern in greater theoretical detail.

BPGs and Disciplinary Power in Nursing

At this juncture, we return briefly to Foucault in order to further demonstrate how the BPG ideology becomes internalized and, almost as a moral injunction, is taken up and lived by individual practitioners. In his work in the 1970s, Foucault famously gave us a new conceptualisation of power – not as an object to be wielded by one individual or group over another, nor as a repres-

sive or dominating force that would keep an individual or group in check. Instead, for Foucault power is not here or there, it is no thing, but it is relational, it is in flux, a process. From the French, 'pouvoir', power means 'to be able'. It does not limit but it **'produces'** the kinds of relations we can have. Thus, power permeates the social fabric and it serves to regulate social interaction by encouraging some relations and discouraging others. Speaking specifically of 'disciplinary' power, we can point to the multiple training techniques, the ways an individual is indoctrinated and the ways that bodies are coerced and controlled. In this sense, BPGs operate as one form of disciplinary power today.

Disciplinary power refers to the various techniques aimed at regulating individual bodies in order to make them operate a certain way for a given purpose (Foucault 1995). A discipline is also a process by which received knowledge and sets of skills are instilled into individual persons, e.g. I say that I understand the nursing discipline because I have been 'disciplined' or trained in a particular way. According to Foucault, these 'disciplines' were 'methods which made possible the meticulous control of the operations of the body, which assured the constant subjection of its forces and imposed upon them a relation of docility-utility' (1995, p. 137). In other words, disciplines create submissive, yet skilful, docile bodies through the concerted actions of multiple disciplinary technologies. Schools and universities are prime examples of this process, as students are taught, trained and shaped into competent practitioners (such as nurses). Discipline is thus understood as the various processes by which students are trained to relinquish certain behaviours and embrace others (through punishment and reward), in order to ready them for the workplace, where another set of disciplinary technologies undoubtedly holds sway.

Most significantly perhaps, through discipline, the individual 'internalises' certain practices, discourses, and types of knowledge that are deemed necessary, valuable, and desirable. The disciplined individual will then embody and reproduce these practices and discourses, which fit within and maintain the particular epistemic, socio-political, and economic (etc.) power matrixes within which the individual navigates and operates. One important, but sometimes overlooked, feature of discipline is that as a result 'disciplined individuals' are accorded a certain rank or position within a given social system (Danaher *et al.* 2000), one that is often attractive and bestows certain advantages upon these individuals, including expert status, prestige, financial rewards, political 'immunity,' etc. As we mentioned above, the consecration of a healthcare setting turned into a BPSO

or of a nurse turned into a BPG Champion are salient examples of such advantages.

The success of disciplinary power in shaping bodies into an organized, productive and useful workforce points to an important feature that sets disciplinary power apart further from other modes of power. Specifically, discipline uses surveillance as a way to ensure the gradual transformation of both mind and body. This means that structures are in place to monitor and assess the progress of the individual as he or she acquires the desired knowledge and skills. The rigid order and accountability mechanisms of BPGs in hospital settings provide one example. While this may seem obvious, it may be less clear how the individual 'internalizes' the surveillance, how he or she comes to take an active role in this surveillance to self-police and to self-regulate. Having deeply internalized the surveillance structure, the individual experiences this self-regulation as a moral duty, coming from deep within the soul, rather than from some exteriority (remember: power is diffuse, it obscures itself, and, like an 'episteme', it is impossible to point to directly). In this regard, Foucault writes: 'the soul is an effect and instrument of a political anatomy; the soul is the prison of the body' (1995, p. 30). Self-regulation is at the heart of disciplinary power and it underlines further the internalization of discipline. One is more likely to comply with such training if it is deemed necessary and valuable. In the workplace, disciplined bodies (such as nurses) operate as their own supervisors (such as nurse managers and so-called champions) in monitoring their practices and keeping them in check. Surveillance also occurs through consultation with peers and through the technology of administrative tools (e.g. forms, statistics) that provide feedback about one's performance. For example, the structure and expectations categorically outlined on performance reports become internalized and soon invisibly regulate behaviour. Discipline is thus part of a system in which knowledge and power feed off and maintain one another.

To offer another example, nurses may be asked to complete questionnaires in order to assess their level of knowledge in a certain area (e.g. pain management). This is meant to provide them with feedback about the kind of care they provide. We must bear in mind that such questionnaires are themselves disciplinary mechanisms; they create a discrete body of knowledge for nurses' use, one that may be designed to make BPG uptake all the more desirable. Nurses who identify gaps in their knowledge through comparison with the skill sets offered by BPGs may feel compelled to adopt the BPG approach. In this sense, while the guidelines will readily identify gaps, we must beware of those strategic 'gaps' that are framed in such a way as to recommend BPGs as the immediate – and sometimes only – remedy. The BPGs are self-referring and self-promoting. Other, possibly better, solutions will be ignored. Additional strategies to facilitate guidelines uptake may include one-on-one consulting between a BPG resource person (usually a so-called 'Champion') and staff nurses; consultation with BPG peers; or joining support groups (RNAO 2002). Here there is a strong social dimension, where each nurse will interact with others. Strategically, the situation is designed to effect maximal peer conformity, where behaviour is disciplined and the social dimension adds to the surveillance – and ultimately, self-surveillance – of nursing practices.

As seen above, BPGs have been put forth as the 'modus operandi' in many settings with the explicit aim of both improving clinical outcomes and reducing costs. The persuasive language that surrounds the systematic production and utilization of BPGs casts them in the utmost positive light. Expressions such as 'best practice', 'best outcomes', 'champions', 'excellence in practice', 'gold standard', 'spotlight organizations' and the like are meant to leave no doubt, rhetorically, about the professional desirability of BPGs or the 'epistemic' certitude that underwrites them. Furthermore, when the RNAO or other organizations suggest even in passing that patients might be denied the best possible care by those practitioners who do not implement BPGs, it is easy to see how the BPG ideology takes on moral overtones. Powerful statements, such as 'we become out of date and our patients pay the price for our obsolescence' (Sackett 1997, p. 10), infuse BPGs with a moral injunction that is difficult to critique from within the limited terms that the evidence-based movement accepts as valid (Murray *et al.* 2007). The BPG ideology casts nurses who endorse BPGs as ethical beings who look out for their patients' best interests. While these are noble ends, the means do not support them in this case. Further, the BPG ideology implies that those who do not integrate BPGs into their practice dismiss one of nursing's fundamental principles: safe, competent care. As such, nurses are under pressure to internalize the moral discourse that surrounds BPGs because they wish to perform as ethical practitioners – and BPGs are presented as the only way to do so. Again, such internalization is a cornerstone of disciplinary power.

Resisting the Trend: An Intellectual Duty

Clinical practice guidelines (or BPGs in nursing's Orwellian 'Newspeak') are undoubtedly a useful vehicle

to implement changes in clinical practice and service provision (Miles *et al.* 2006). But we would immediately caution that certain conditions must be met: the social, political, economic and ethical aspects of BPG implementation must be fully brought to light. BPGs are supposed to be based on the 'best evidence' available, 'synthesized' through the technical processes of systemic reviews; the problem, however, is that this 'evidence' and the process of its acquisition and synthesis is at times based on a highly politicized and 'epistemically' biased process (Holmes *et al.* 2006a,b, 2007, Murray *et al.* 2007). The Cochrane Collaboration Group has, for example, been accused of methodological fetishism or even a lack of intellectual rigour because the Group fails to address the wider socio-political dimensions of its 'epistemic' commitments. Given that systematic reviews form the basis of BPGs, we agree with MacLure (2005), who argues that the systematic review:

> 'assumes that evidence can be extracted intact from the texts [articles] in which it is embedded, and "synthesized" in a form that is impervious to ambiguities of context, readers' interpretations of writers' arguments (i.e. [epistemological, theoretical, and methodological] bias). Most significantly of all, systematic review systematically degrades the central acts of reviewing: namely **reading** and **writing**, and the unreliable intellectual acts that these support, such as interpretation, argument and analysis. By replacing reading and writing with an alternate lexicon ["Newspeak"] of scanning, screening, mapping, data-extraction and synthesis, systematic review tries to transform reading and writing into accountable acts. It tries to force their clandestine operations – the bits that happen inside people's heads, or the incorporeal gaps between decoding and comprehension, thought and expression – up into plain view, where they can be observed, quality-controlled and stripped of interpretation or rhetoric (p. 394; **authors' additions**)'.

With this critique in mind, we can see that much of the library of current Ontario Nursing BPGs is of highly limited value in everyday clinical practice. Of course, it stands to reason that the reductive limitations of BPGs, along with the systematic reviews from which they are derived, are what make them so easy and ready to use: 'in many ways the limitations of practice guidelines are their defining characteristics' (Miles *et al.* 2006, p. 243). Sadly, in Ontario, debate regarding BPGs is nearly non-existent because evidence-based

nursing and the entire ideological state apparatus of nursing best-practice guidelines have successfully defined nursing practice today – so much so, in fact, that BPGs are considered the 'only' best way of practicing nursing in a professional and responsible manner. Resistance seems futile.

Yet, anyone who believes in the possibility of intellectual progress agrees that a prerequisite for such progress is frank and open debate (Freshwater & Rolfe 2004). In the realm of nursing academia (at least in the Canadian context we have been discussing), critique is effectively silenced and divergent points of view are labelled as unscholarly or scientifically unsound. Nevertheless, it is an intellectual duty to expose the virtual for what it is. While Althusser postulated an 'epistemological break' between ideology and science, for him it was a critical process, rather than a sudden revolutionary upheaval. Consequently, we must be prepared to fight the quasi-totalitarian BPG ideology over the long tem.

Final Remarks

Without a doubt, the RNAO is clearly aligned with government imperatives, which in turn are supported by a powerful power/knowledge apparatus in which many researchers play a definite role in pushing for this new BPG nursing agenda. However, a careful reading of the many systematic reviews, best practice guidelines and so forth calls for prudence as well as critique. We have argued that, in the Ontario context, BPGs obey political and economic imperatives, rather than scientific and clinical ones. Thus, BPGs, along with the evidence synthesis and systematic reviews upon which they are based, must be understood foremost as rhetorical and political enterprises. The Cochrane Collaboration was founded on a myth (Greenhalgh & Russell 2005), a false belief that the judgements required for evidence synthesis are achieved through the skilled application of tools (data-extraction sheets, etc.) and evidence hierarchies, where 'methodologically inferior studies' are ignored or rejected. This false belief has been exalted into an ideological truth of the highest order.

Why is it that nurses have so uncritically embraced the evidence-based movement and its associated correlates? Why is it that a discipline, such as nursing, finds it difficult to accept nuances and debates? Why is it that members of a discipline – particularly scholars – refuse to engage in philosophical, political and theoretical debates? How has evidence-based nursing come to constitute the 'modus operandi' of the profession and

the discipline of nursing? Some answers to these questions can be found in the almost magic words 'evidence based', where the highly rhetorical force seduces many of us. However, some scholars from well-regarded institutions worldwide have begun to address strong critiques with regards to the evidence-based movement and its correlates, highlighting among other things the conflict of interest between peer-reviewed journals and evidence-based incorporated products (see Upshur *et al.* 2006).

In Ontario, the RNAO's ideological programme is adopted blindly by hospitals and other healthcare settings which in turn become vassals of the RNAO monopoly. Collaborations between health care organisations and professional ones can become problematic when the latter dictate nursing conduct in such a way that critical thinking is impeded. Indeed, we have argued that the ideological structure of BPGs ultimately evacuates individual practitioners of their social, political, and ethical responsibilities. If that is not enough, because BPGs are based on systematic reviews and 'best evidence', which itself lacks evidence of improved outcomes, scientifically speaking BPGs are virtual science, spectacle, and illusion. Certainly, BPGs virtually answer nursing's quest for social and scientific legitimacy. But practicing nursing is not only a way of doing – as written in procedures or guidelines; nursing practice must rely on critical reflection, a task that demands reading and debate. Ready-to-use guidelines are much like ready-to-eat TV dinners: the appealing packaging hides what is in fact an unhealthy product. The only way forward is critical debate in which the BPG way of thinking is challenged 'epistemically', once again with sensitivity to those social, political and ethical responsibilities that ought to distinguish the profession of nursing.

References

Althusser L. (1971) *Lenin and Philosophy and Other Essays (B. Brewster, Trans.).* Monthly Review Press, New York, NY.

Baudrillard J. (2001) *Dust Breeding (F. Debrix, Trans.). CTheory (8 October 2001).* Available at: http://www.ctheory.net/articles.aspx?id=293, accessed on 22 May 2007 [originally published as: L'élevage de la poussière, Libération (29 May 2001)].

Baudrillard J. (2002) *Screened Out (Trans. C. Turner).* Verso, London.

Baudrillard J. (2003) *Passwords (Trans. C. Turner).* Verso, London.

Canadian Nurses Association (2002a) *Planning for the Future: Nursing Human Resource Projections.* CAN, Ottawa.

Canadian Nurses Association (2002b) *Position Statement: Evidence-based Decision-making and Nursing Practice.* CAN, Ottawa.

Ciliska D. (2006) Evidence-based nursing: how far have we come? What's next? *Evidence-Based Nursing* **9**, 38–40.

Cohen A.M., Stavri P.Z. & Hersh W.R. (2004) A categorization and analysis of the criticisms of evidence-based medicine. *International Journal of Medical Informatics* **73**, 35–43.

Danaher G., Schirato T. & Webb J. (2000) . *Understanding Foucault*, Sage, Thousand Oaks, CA.

Davidoff B., Haynes B., Sackett D. & Smith R. (1995) Evidence-based medicine. *British Medical Journal* **310** (6987), 1085–1086.

Foucault M. (1980) *Power/knowledge: Selected Interviews and Other Writings, 1972-1977.* Pantheon, New York, NY.

Foucault M. (1995) *Discipline and Punish: The Birth of the Prison.* Random House, New York, NY.

Freshwater D. & Rolfe G. (2004) *Deconstructing Evidence-based Practice.* Routledge, London.

Greenhalgh T. & Russell J. (2005) Reframing evidence synthesis as rhetorical action in the policy making drama. *Healthcare Policy* **1** (1), 31–39.

Grinspun D. (2005) BPGs improving care, advancing evidence-based practice. *Registered Nurse Journal* **17** (4), 7.

Grinspun D., Virani T. & Bajnok I. (2001/2002) Nursing best practice guidelines: the RNAO project. *Hospital Quarterly* **5** (2), 56–60.

Holmes D., Murray S.J., Perron A. & Rail G. (2006a) Deconstructing the evidence-based discourse in health sciences: truth, power, and fascism. *International Journal of Evidence-Based Healthcare* **4** (3), 180–186.

Holmes D., Perron A. & O'Byrne P. (2006b) Evidence, virulence, and the disappearance of nursing knowledge: a critique of the evidence-based dogma. *Worldviews on Evidence-Based Nursing* **3** (3), 95–102.

Holmes D., Gastaldo D. & Perron A. (2007) Paranoid investments in nursing: a schizoanalysis of the evidence-based discourse. *Nursing Philosophy* **8**, 85–91.

MacLure M. (2005) 'Clarity bordering on stupidity': where's the quality in systematic review? *Journal of Education Policy* **20** (4), 393–416.

Miles A., Polychronis A. & Grey J.E. (2006) The evidence-based health care debate – where are we now? *Journal of Evaluation in Clinical Practice* **12** (3), 239–247.

Murray S.J., Holmes D., Perron A. & Rail G. (2007) No exit? Intellectual integrity under the regime of 'evidence' and 'best-practices'. *Journal of Evaluation in Clinical Practice* **13** (4), 512–516.

RNAO (2002) *Toolkit: Implementation of Clinical Practice Guidelines.* RNAO, Toronto.

Sackett D.L. (1997) *Evidence-based Medicine: How to Practice and Teach EBM.* Churchill Livingstone, New York, NY.

Statistics Canada (2006) *Population by Year, by Province and by Territory. 26 October 2006.* Statistics Canada. Available at: http://www40.statcan.ca/cgi-bin/getcans/sorth.cgi?lan=eng&dtype=fina&filename=demo02a.htm&sortact=2&sortf=6, accessed on 30 May 2007.

Upshur R., Buetow S., Loughlin M. & Miles A. (2006) Can academic journals be in financial conflict of interest situations? The case of evidence-based incorporated. *Journal of Evaluation in Clinical Practice* **12** (4), 405–409.

Walker K. (2003) Why evidence-based practice now? A polemic. *Nursing Inquiry* **10** (3), 145–155.

Williams L. (1989) *Hard Core: Power, Pleasure, and the 'Frenzy of the Visible'.* University of California Press, Berkeley, CA.