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SOCIAL REGULATION, MEDICALISATION, AND THE NURSE'S ROLE: INSIGHTS FROM AN ANALYSIS OF NURSING DOCUMENTATION

Abstract

Background: Medicine is recognized as a dominant source of governmentality and social regulation, and although nursing has been implicated in the same process, analytical work in this area has been sparse. *Objectives:* The article aims to present an analysis of nursing records in order to understand the structural and social processes that mediate the texts. *Methods:* 45 sets of nursing records drawn from four clinical sites in Ireland were subjected to a discourse analysis. *Results:* This article focuses on two main themes that were derived from data: (i) the manner in which nurses controlled, regulated and invigilated patients' activities of daily living; and (ii) the way in which activities of daily living were mediated by a biomedical worldview in the clinical settings. Through the organizing framework of Activities of Daily Living (ADLs), normative social practices relating to hygiene, eating and drinking, sleeping and so forth were surveyed and monitored within clinical settings. We construct qualitative categories around a range of ways that nurses assessed and judged patients' capacities at ADLs. Furthermore, it is argued that the framework of ADLs epitomises the medicalisation of normative social practices, whereupon the most mundane of normal functions becomes redefined as an actual or potential clinical pathology, legitimating nursing interventions. According to the nursing documentation, biochemical interventions in the form of various medications were the most dominant means through which nurses attempted to restore or improve the functional capacity of an ADL. *Conclusion:* We conclude by proposing that nurses' invigilation of patients' ADLs is not necessarily a repressive feature of nursing practice, but rather has the potential to be used to advocate on patients' behalf in certain circumstances.

Key words: Activities of Daily Living; medicalisation; nursing documentation; social regulation.

Medical sociologists have, for a number of decades, presented sociological analyses of the manner in which medical discourses operate to maintain, reproduce and even construct societal norms by medicalising everyday social activities or categories of subjects (Zola, 1984; Illich, 1984; Lupton, 2003; Fitzpatrick, 2001). Moreover, the charge has been made that aspects of life (having previously been constructed as normative social practices) become surveyed and regulated under medicine's clinical gaze (Foucault, 1973). A small subset of these analyses have considered how nursing, particularly with the advent of 'new nursing,' has played its part in this regulating progress (Armstrong, 1983; May, 1992; Porter, 1997). The central argument in this body of work is that the construction of a therapeutic role for nurses in relation to a patient's psychological care has signaled a new identity for the patient with the potential for new opportunities for social surveillance and social control by nurses over patients. In this article, we attempt to extend this scholarship by unpacking aspects of nurses' socially regulating role through an analysis of nursing records.

The paper begins with a brief outline of the medicalisation thesis in relation to medicine's incorporation of normative social activities into its remit, as contextual knowledge against which to position the directions that nursing has taken in this regard. Since, in our study, nursing work (and records) were officially organised around Activities of Daily Living (ADLs) (constituent of the Roper-Logan-Tierney (RLT) model of nursing) at the hospitals where data for our study were gathered, we present a brief account of this model. The methodology for the study is then outlined, followed by the study's findings. In presenting the data analysis and discussion, we explore the regulating and invigilating role of nurses in relation to activities of daily living as suggested in the textual accounts they produced in clinical contexts. We go on to consider how this role reflects, maintains and reproduces the normative social expectations of contemporary culture. In particular, we elucidate how the RLT model gives formal recognition to the medicalisation of ordinary daily activities, and creates a framework for nurses through which the process of medicalisation is facilitated.

The medicalisation of everyday life

The manner in which everyday aspects of life such as death, birth, ageing, sleeping and so forth have been redefined as medical problems that fall within the jurisdiction of biomedicine has been a concern among sociologists since the 1970s. The charge is that medicine has become a powerful institution of social control, influencing societal norms that had hitherto been dictated by religion (Freidson, 1970; Zola, 1972, 1984; Illich, 1984). Zola proposed (1972, 1984) that medicine's increasing power has emerged, not because of an increase in physicians' political power, but rather through the medicalisation of everyday life, whereby more and more realms of daily life have come to be related to 'health' or 'illness.' The medical profession then positions itself to identify what is deemed to be good and evil for individuals and for society as a whole.

Zola (1984) argues that if something can be demonstrated to impact upon the operations of the body or mind, it can be redefined as a medical problem, and fall within the boundaries of biomedicine. As examples, he refers to the previously constructed natural processes of ageing and pregnancy that have been transformed into medical matters. Zola draws attention to the inclusion of comprehensive medicine and psychosomatics, that require patients to divulge symptoms not merely of the body, but also of their daily living habits and anxieties. Medicine, he argues, is intervening in attempting to moderate a person's life with regard to working, sleeping, playing and eating at an ever increasing pace. Moreover, the focus on prevention means intervening before a disease even begins. Illich (1984) similarly argues that modern medicine has transformed pain, illness, and death from a personal challenge to a technical problem, and impedes human beings' ability to adapt autonomously to their environment.

The Roper-Logan-Tierney model of nursing

As in Britain, the Roper-Logan-Tierney (RLT) model of nursing has become the dominant model used in Irish hospitals, including the four hospitals from where the documents for this study were sourced. Since we refer to ADLs at various points throughout the article, a brief outline of the RLT model is presented here.

This model of nursing was developed in Edinburgh by three nursing leaders, Nancy Roper, Winifred Logan and Alison Tierney and first published in 1980 as *The Elements of Nursing*. Since then, an updated account of the model has been published at regular intervals, culminating in the authors' final book and critique of the model published in 2000. The objective of the model, according to its progenitors, was to provide a conceptual framework that identified 'the theoretical base that underpins nursing practice across healthcare settings' (Roper et al, 2000:1). The model is comprised of 12 ADLs that encompass everyday social activities (see Figure 1) and these are related to the stages of the lifecourse, the levels of

dependence/independence associated with each, and wider factors that influence the ADLs (Roper et al, 2000: 15-16). Much is made of the notion of each person's 'individuality in living' (p.77). Thus the aspiration is 'to identify the individual's pattern of living (and actual or potential problems with any of the ALs) so that the nurse can individualise the nursing of that person taking account of that individual's lifestyle - and where appropriate, taking account of family and/or significant others' (2000: 77-78). This individualizing is to be achieved through the nursing process, encompassing the stages of assessing, planning, implementing care, and evaluation. Later in this article, we will consider ADL in relation to our data and the wider sociological debates about the medicalisation of everyday activities.

Methodology

Data upon which this paper is based was obtained as part of a wider five-year study, the aim of which is to inductively develop a Nursing Minimum Data Set (NMDS)¹ for Irish clinical settings and to further the knowledge base on how nurses make clinical decisions. Two collaborative research teams are involved in this wider study, one focusing on general nursing (Treacy et al, 2003) and the other on psychiatric nursing (Scott et al 2003; see also Mac Neela et al, in press). The focus of this paper is on one of the data sets, namely documentation data, gathered as a basis for constructing the NMDS. (Two further papers focusing on different aspects of discourses embedded in documentation have been published separately (Hyde et al, 2005; Irving et al in press).) The documentation used in this analysis is confined to data gathered in a general nursing setting. The specific purpose of the analysis that follows is to offer theoretical insights into nurses' text based records of patient care.

Access to nursing records was granted by the ethics committees at four hospitals in Ireland, and approval was also obtain from the ethics committee at the university where the research team is based. Three of the hospitals were in a city (identified in exerts as A, B and C) and the fourth (D) in a rural area. Across the four hospitals, a range of specialisms was represented, namely, cardiac nursing, oncology nursing, general medical nursing and general surgical nursing. With the help of nurse managers, records were selected on the basis of patients who were typical for the specific unit in terms of diagnosis and length of stay. In total, the complete set of nursing documentation for 45 patients comprised the data; a complete set of nursing records included all parts of documentation written by nurses for each patient. At the time that data were collected, the length of stay for each patient whose records formed the data ranged from between 3 and 21 days. Records were handwritten verbatim on the wards so that a completely accurate data set would be obtained. However, in order to protect the anonymity of the patients, staff and other parties, all identifying information and names, including the ward name were omitted. Records were carefully stored so that only those on the research team could access them.

Data were analysed using discourse analysis, whereupon written communication in the specific clinical context was studied. Since the objects of study were the texts alone, engendering examples of language-use, this type of discourse analysis is distinguished from discourse conceived of as a set of ideas or a way of thinking and talking about things through a culturally and socially defined system of knowledge. Yates (2004) distinguishes the former type of discourse analysis as small 'd' and the latter as big 'D'. However, as Yates notes, discourse analyses tend to reveal something about both small 'd' and big 'D', though the emphasis may be greater on one or the other. Our data are based on small 'd' discourses since we are relying solely on what the nurses wrote about their practice rather than on what they either thought about or did in practice. However, a feature of discourse analysis is an appreciation that language carries symbolic meaning and that knowledge and power lie behind the language. As Yates (2004: 242) notes in relation to discourses of culture and social relations:

¹ A Nursing Minimum Data Set is a tool validated in the clinical realm that is used to classify patient problems and nursing phenomena, nursing activities and interventions, and related patient outcomes, with the objective of identifying what nurses do and to what effect.

. . . language practices and texts form part of systems of knowledge; in particular the ways in which such big 'D' discourses form the basis of ideological positions and are linked to, formed by and support systems of power in societies.

In the course of the analysis of the nursing records, texts were carefully read in order to explore meaning in the language. An important point to bear in mind is that while texts present particular constructions of reality, they contemporaneously exclude others. Through an engagement with data, an understanding of the structural and social processes that mediated the texts were sought, and there was an openness to identifying evidence of dominance and the exercise of power (Lupton 1992).

Findings

For conceptual purposes, data are presented around two main themes: (i) the manner in which nurses monitored, regulated and invigilated, or kept a regulatory watch over (Walter et al 1995), patients' activities of daily living; and (ii) the way in which activities of daily living were mediated by a biomedical worldview in the clinical settings.

Monitoring, regulating and invigilating daily activities

Documentation suggested that nurses determined 'appropriate' standards associated with the fulfillment of activities of daily living, and the tone and content of the written entries, relating ostensibly to nursing practice, indicated that certain patient behaviours were constructed as deviations from acceptable standards. Marsh et al 2000: 656-7) define deviance as follows:

' . . . any behaviour that differs from the normal . . . [and] could be uncommonly good or brave behaviour as well as unacceptable behaviour. . . However, deviance generally refers to behaviour that is disapproved of and leads to a hostile and critical response from 'conventional society.'

It was suggested in data that that nurses invigilated patients' capacities at performing ADLs. There were two dimensions to the invigilating role. One was to do with normative expectations about the ADLs in terms of acceptable practices such as having a daily all-over wash, maintaining a level of mobility and so forth, while the second dimension related to nurses' clinical judgments about where patients were located on the dependence/independence continuum. As we will go on to reveal, these two dimensions mediated one another as part of the regulating role of nurses.

Records suggested that nurses constructed moral categories in relation to patients in subtle ways according to the extent to which patients were deemed to be willing to fulfill an ADL. We use the term 'moral' here in the sociological sense advanced by Hepworth (1995: 176), who developed Goffman's (1968a, 1968b) notion of how societies establish mechanisms of categorizing people according to normative expectations. Hepworth's theoretical development of Goffman's work was empirically exemplified in how styles of ageing are assigned value judgments according to 'socially constructed moral categories' (Hepworth, 1995: 177). Hepworth noted the socially produced meaning associated with the category of 'positive' ageing placed a higher value on independent lifestyles while denigrating self-indulgent lifestyles associated with social dependency.

In the following analysis, we detail the extent to which nurses, with varying degrees of subtlety, depicted such aberrations, and more importantly, how nurses interpreted these. For conceptual purposes, we present nurses' text based constructions of these transgressions along a continuum, starting with what we coin as 'genuine incapacity' and moving on to more negative moral categorising of patients' behaviours.

Genuine incapacity

There was some evidence in the nursing records, albeit very modest in empirical scope, that the nursing evaluation of patients' ADLs could be used in ways that canvassed for the patient's position in the face of regulation from other occupational groups. This occurred where nurses judged that a patient was genuinely unable to meet the standard of an ADL expected by another health worker. While there were just two examples of this in the entire data set, nonetheless, they are important, since patient advocacy is a notion that nursing elites have been encouraging in recent years. In the example that follows, the nurse clearly indicates that his or her clinical judgment about an older person's ability to undergo a physical exercise treatment is at variance with that of the physiotherapist.

B12: Pt very poor on feet. Unable to weight bare + needs 2 nurses to transfer from chair to bed. Seen by physio ? To go to gym mané. I feel Pt would be unable for same (severe RT weakness).

What is absent from this entry is whether the nurse in question attempted to negotiate with the physiotherapist the most appropriate course of action regarding the patient's mobility, and if so, how that process was resolved. In a second example, although the sense of advocacy is much weaker, nonetheless, the nurse attempts to justify the patient's difficulty with mobility in terms of his dyspnea [difficulty in breathing] that tacitly suggests that the nurse judges the physiotherapist's intervention strategy regarding the patient's mobility to be inappropriate.

C1 S/B physio who spoke with nursing staff and feels a more strict approach needs to be used when trying to get Pt to do things for himself.

C1 . . . Pt sat out in chair for an hour this pm with use of Zimmer frame. Encouraged to mobilise more but with little effect.

C1 Pt requires much encouragement to do things for himself. However was dyspnoeic on minimal exertion overnight.

Again, in the case of the second example, there is no information as to whether or not the nurse challenged the physiotherapist's clinical judgment with reference to the nurse's own situational knowledge gained from exposure to the patient over an extended period. Nonetheless, at least in terms of how it is documented, the extract describes a sense of empathetic advocacy, however weak. Thus, there is some suggestion in nursing records that nurses' monitoring and invigilating patients' ADLs can facilitate an advocacy role and work in the patient's favour. The examples here also indicate that evaluations about mobility, for example, are far from objective but rather are socially produced and subjectively determined to some extent at least.

Needing encouragement

There were a number of entries in nurses' notes, presented in mild and temperate terms, suggesting that nurses gently propelled patients towards the fulfillment of certain ADLs. The word 'encouraged' was frequently used here, indicating that patients were gently directed towards a particular action relating to an ADL such as eating and drinking or personal cleansing.

C2 Tolerating poor dietary intake. Encouraged with nutritional drinks.

C1 Diet and fluids to be encouraged in supplementary drinks.

C2 24/1/03 . . . Encouraged to reposition self + be more independent with feeding and hygiene. Assistance given as needed with ADLs.

These entries did not tend to include evaluative statements about the extent to which the patient responded to the nurse's encouragement. They represent subtle attempts to regulate aberrations in expected standards of performing ADLs.

Excusable deviance

Within this category, excusable deviance is used to depict documented episodes where patients did not meet the recognized standard of performing an ADL, but where it was insinuated or stated in nursing documentation that the aberration was exonerated. This arose primarily in those circumstances where patients were deemed to fall short of expected standards for an ADL for various reasons beyond their control. Biological impairment or impediments were sometimes cited, and implicitly exonerated the patients' shortcomings in restoring bodily functioning.

A7 Mobility restricted at present due to L arm weakness and tiredness.

Notice in the following example that the patient is judged to be 'unable' (rather than unwilling) to eat or drink.

A5 Chemo withheld. Pt dehydrated. Unable to eat/drink x 48 hrs. C/O [complaining of] abdominal pain. S/B Dr hold tx [treatment] review in 1/52.

B1 Presenting features- unwell 2/7, nausea ++, vomiting ++, unable to eat/drink, anorexia; previously admitted 30/12/03 for cycle 2 chemo.

Although the word 'refused' in the following extract suggests a sense of deviance, this is written with the clear qualification that such deviance is owing to the person's nausea, and is therefore vindicated.

B1 Care as per care plan, admitted to ward at ... admitted for hydration, pt refusing to eat and drink due to nausea, Zofran IV given @

At other times in nursing documentation, psychosocial reasons were given for patients behaving in ways that were at variance with normative expectations. The status of these data is less clear, insofar as the extent to which patients' behaviour is deemed to be legitimate or deviant is difficult to interpret. The defensive use of 'refused' in some of these entries suggests the later to be the case. However, in the extract below, the patient's deviance is linked to his/her 'low mood', which in the records becomes medicalised as a clinical pathology requiring biomedical intervention, and therefore reads as an exemplar of excusable deviance.

B1. 10/1/03 pt uncooperative this am, refusing to shower or wash, remaining in bed most of day, quiet man, mood seems low,

B1 mood very low, remained in bed, refused to sit out . . . seen by team, for psychosocial referral, commenced on oromorph, IV dose first. . . seen by psych team to commence citalopram mane.

Inexcusable deviance

Inexcusable deviance refers to those situations where patients were reported as having acted contrary to nurses' requests, but with no record of a valid biomedical or psychomedical impediment to support the patient's transgressions. 'Non-compliant' and 'refused' were terms used in these circumstances.

C1 17:30 Pt nursed on PRO 2000 mattress this am. Pt refused to get out of bed.

A1 04:30 continues to smoke. Non-compliant with O2 therapy.

B1 Seen by team for reinsertion of NG tube. . . . Dr returned to reinsert NG tube, pt refused same.

D8: Patient outside for long periods of time against nurse's advice. Smoking re-education re post op complications and advised to rest in bed or sit out on chair for short time.

A daily wash, a relatively new norm in historical terms (Shove, 2003), was clearly a normative expectation of nursing staff.

B1 . . refused to have wash.

13/1 day – comfortable morning, remained in bed, refused to sit out, refused to wash.

In some cases, nurses' interpretation of the patient's stance was unclear, such as in the following example where the patient is recorded as having refused to wash (a normative expectation) because he/she wanted to sleep.

C1: Refused wash this am. Wanted to sleep for the morning . . .

While in situations that we have categorized to be *excusable deviance* (above), the records suggested that patients had a good biological reason for not performing an ADL, by contrast, in the following example of *inexcusable deviance*, the nurse specifically refers to the absence of a biological impediment to the performance of an ADL.

A2 nil episode of vomiting or nausea but refused evening tablets.

This category of excusable deviance also extends to references to situations where nurses had diagnosed a functional deficit in the patient, yet where patients were resisting attempts by nurses to be assisted in carrying out particular ADLs.

A2 (Pt.) has been very drowsy this morning. Refusing assistance with hygiene. . . (Pt.) remains very pale, sleeping for much of morning . . .

D4. Assisted wash & skin areas intact. Frail on his feet refusing assistance of 1 to 2.

In the example that follows, in the nursing records, the patient's 'poor compliance' was linked to delayed progress towards a restoration of his/her functional abilities.

S/B physio however progress limited due to poor compliance using frame when transferring.

Some patients, it was reported, required additional surveillance and monitoring to ensure compliance.

B1 pt needs supervision in taking PO medications, very poor compliance.

Alterations in 'co-operation' levels by patients also came to be recorded, so the same patient could shift in and out of the diverse socially produced categories at various junctures during hospitalisation.

A2 Pt. v co-operative this am. Appears better form. Stood up well with frame for balance.

Activities of daily living mediated by a biomedical worldview

A striking aspect of data was the extent to which efforts were made to restore the functional capacity of patients by biomedical interventions, particularly through the use of pharmacological remedies. Data suggest that every deviation from the expected level at which an activity of daily living ought to be performed tended to be moderated through biomedical means. (Elsewhere, we have linked the biocentrism in nursing documentation with the technocratic hegemony associated with late modernity

(Hyde et al, 2005.) In the clinical setting, the maintenance of normative standards of ADLs was mediated by a heavily medicalised worldview, with a 'pill for every ill', or rather, a pill for every deviation in an ADL, such as in sleeping patterns, in eliminating, for anxiety and so on. Consider the following example of a patient whose ADL of sleeping was thrown out of kilter by excessive noise levels in the environment. The problem was apparently addressed by attempting to regulate the individual's biochemical processes through pharmacological means rather than by manipulating the offending environment.

C11. Pt slept very little overnight due to noise in ward → query to increase Normacin [drug].

The manner in which some nurses documented issues, with words such as 'refused' strongly suggested that there was an expectation that patients ought to accept pharmacological products to restore any aberrations in ADLs.

B 10 Pt complained of dizziness, feeling sick and headache with tingling sensation, obs BP=119/71, PR=92, O2 Sat on O2 @ 3l PM/NC 96%, T=36.4°C, BSL=4.4mmols. Patient refused any medications both PO and IM (Pt charted for Stemetil).

A3: Pt slept for short period only, was being disturbed by X (Pt) [another patient]. Refused night tablet.

Consider the following example of a patient whose eating and drinking capacity was affected by vomiting. The entry records the patients as having 'refused' antiemetics (anti-vomiting medication).

A4. C/O abdominal cramps and vomited x 2. Small amounts, refused antiemetics.

The following is a similar example in the case of a patient with diarrhoea.

C10 . . . Remains apyrexial patient requesting to wear pad, same supplied. Refused immodium for diarrhoea overnight.

As a matter of interest, non-compliance with medication features among the 'Risks associated with medication' (Roper et al 1999: 97) as part of the ADL of maintaining a safe environment, reflecting the normative imperative that medication ought to be taken if prescribed.

It must be noted that amidst the plethora of references to biomedical products being used to regulate ADLs, there were a few exceptional entries documenting alternative means towards ADL achievement. For example, one entry stated that a nurse 'talked at length' to a patient who was distressed about her diagnosis, with no reference to biochemical means being used to regulate her emotions (as occurred in many other instances of psychological distress). Another entry referred to a patient being given prune juice rather than pharmacological laxatives for constipation, while yet another referred to a patient being repositioned in an attempt to alleviate insomnia. Deep breathing exercises were encouraged to facilitate relaxation in another record.

Discussion

Findings from this documentation study suggest that nurses invigilated, monitored and regulated patients' capacity at performing ADLs, and created moral categories relating to such capacity. In addition, nursing records indicated that, in the clinical realm, ADLs were heavily cross-cut with a biomedical worldview about functional restoration. Since findings are based solely on the written records of nurses, they are therefore limited to what nurses write about their practices and patient care rather than on what they actually do in practice.

The moral categories that nurses created are socially produced around normative societal and nursing cultural expectations. In these records, how nurses interpreted standards and boundaries of activities of

daily living tended to reflect dominant assumptions about appropriate behaviour valued in Western culture. In spite of the theoretical basis of the RLT model promoting individualized care, data suggested that nurses measured patients' standards relative to those that were normative within the nursing culture, and deviations were variously constructed in terms of inability, 'refusing', being non-compliant and so forth. In this way biopower was exercised in regulating bodies (see Foucault, 1973). There was little evidence of an unproblematic acceptance of patients' self-identified normative practices. Data suggested that daily all-over washing is valued over and above remaining unwashed, mobilising is valued over and above remaining immobilised, independence is valued over dependence, non-smoking is valued over smoking and so forth. These are the standards of the culture in which the nurses live and work, where dirt, sloth, and smoke are normative vices, where physical independence and self-care are espoused and where there is a collective cultural obsession with health and associated normalisation of behaviour. In addition, the nursing culture and context itself is rich in norms and routines that become superimposed on wider normative standards. Thus, while sleeping for the morning and skipping an all-over wash may be acceptable occasionally in one's own home, in the normative culture of the ward, such exceptions did not have a place.

Other studies have also noted that nurses make moral judgments about patients (Stockwell, 1972; Jeffery, 1979; Johnson & Webb, 1995). Yet our data also demonstrates that this invigilating capacity of nurses to evaluate and categorise can have a positive impact for patients, as exemplified especially by the category *genuine incapacity*. The potential for an advocacy role here was noted, although in the case of documentation data used in this study, it is not clear whether nurses actually negotiated with others in the health care team on the basis of their (nurses') judgment. That nurses' exercise of power could work in the patient's favour is consistent with a Foucauldian conceptualisation of power, where the exercise of power may be productive and not just repressive (Lindgren, 2000).

As we have argued both here and elsewhere (Hyde et al, 2005; Irving et al in press), nursing documentation in this study was heavily dominated by a biomedical perspective whereupon documented aspects of nurses' management of ADLs were mediated by a pharmacological response to almost every functional deficit. This suggests that nurses are struggling to express the psychosocial aspect of their role in nursing records. (In Hyde et al (2005) we raised the question as to whether documenting complex psychosocial aspects is even feasible.) This heavily medicalised worldview of functional restoration is interesting, given the increasing attention to Complementary and Alternative Therapies (CAM) in nursing (Tovey and Adams, 2003). Tovey's and Adams's (2003) analysis of texts on CAM within nursing noted that such texts draw attention to the preponderance of medicalised techniques in treatments to the detriment of human contact. Yet our data suggest that in the busy atmosphere of the hospital ward, recourse to biomedical remedies to address functional problems in patients may be the quickest and easiest option for nurses in their efforts to rehabilitate patients and maintain social order.

Let us unpack aspects of nurses' social control potential by considering the manner in which the ADL framework facilitates medicalisation and serves to extend normal activities as legitimately nurses' business. It should be noted at this point that Roper, Logan and Tierney acknowledge that because of the complexity of each ADL, it would be impossible for them to cover all aspects relating to ADLs in their exposition of the model. Also, the model was developed for educational and practical purposes for nursing students and nurses rather than for theoretical purposes. Given that student nurses and nurses need to be prepared to engage in clinical practice with usable practical guidelines, our account here is not intended as a critique of the model's usefulness for practice, but rather to locate its tenets within wider sociological debates.

As indicated earlier, the medicalisation of life has usually referred to whole (formerly) social categories, such as pregnancy, ageing or dying that have come under the jurisdiction of medicine. In the case of ADLs, these represent a more fine grain process of medicalisation where human activities are broken down into their constituent parts and even the most basic of human activities, such as defecating, is translated into a potential clinical pathology requiring assessment, monitoring and so forth. The construction of ADLs for

the official gaze of the nurse perhaps represents the epitome of the medicalisation of everyday life, where formal recognition is given to the nurse's role in assessing, monitoring and regulating matters associated with, for example, dressing, expressing sexuality and indeed dying. While arguably nurses have long been regulating aspects of patients' lives, the RLT model has facilitated the reconstruction of everyday living into a medio-scientific discourse requiring technical and psychological interventions.

Take, for example, the everyday activity of moving about. In the RLT model, mobilizing becomes redefined into the language of ergonomics and the workings of the musculoskeletal system. 'Good walking, standing and sitting positions should be cultivated' we are told, because in addition to 'being aesthetically pleasing to the onlooker, they conserve energy' in the execution of everyday activities (Roper et al: 2000: 39). Personal cleansing and dressing become associated with the language of both physiology and psychology. It is stated that '[a]ppropriate selection of clothes can reduce strain on the body's heat regulating . . . (Roper et al, 2000: 33)', and the contemporary significance afforded to clothing is linked to the psychosocial realm (legitimizing it further as a nursing matter) as indicated in the following quotation:

. . .The activity of dressing offers the opportunity for making decisions that help to develop a feeling of self-direction, an important part of self-fulfilment, and a fascinating feature of the AL of expressing sexuality. So, clothes are a powerful vehicle of communication (Roper et al, 2000: 34).'

Invoking psychosocial discourses in relation to the therapeutic benefits of dressing in this way feeds into the contemporary interest in personal 'body projects' through which individual self-identity may be fostered by individuals in developing a purposeful relationship to their own body (Shilling, 1994: 5). This historically new relationship between dressing and self-identity is socially produced, and through the ADL texts, reproduced and reinforced. Perhaps the overall objective of the RLT model - promoting independence in ADLs - represents the most poignant manifestation of contemporary cultural values, where a high regard is placed on efforts to minimize dependency.

Although the RLT model reflects contemporary values about 'normal' living and tends to mirror these rather than problematise them, it is, nonetheless underpinned by assumptions of democratic principles. Individual diversity across the category of 'normal' is one of the model's theoretical underpinnings, as is autonomy in decision-making. Yet, at the same time, this emphasis on patient involvement also feeds into the ideology of healthism – the collective concern with and pursuit of health - insofar as patients are invited on a journey of self-reflection on how they feel about their ADLs, thereby reinforcing a cultural obsession with health.

This dimension of the RLT model that promotes patient diversity and individuality of patient preferences was not a strong feature of our data. We could glean little from the records, for example, about the usual cleansing habits of those reluctant to wash, or whether or not they usually took medications for their ills. It may well be the case that for older people, the contemporary norms of hygiene have overtaken their preferences in a climate of rapidly increasing sanitization (see Shove, 2003).

While the formal framework through which nursing work was organized at the study sites were ADLs, our study did not establish the extent to which nurses consciously invoked the RLT model in their nursing practice. We do know that the term 'ADL' was written in the freehand of nurses in 40 extracts of 16 different documents (Irving et al, 2004). However, an important consideration is that, although the RLT model was the official means by which nursing work was organised, it is quite plausible that nurses largely ignored the tenets of the model, and simply got on with their nursing practice according to the cultural norms into which they were socialised. Since the documentation templates were (to varying degrees) already organized (by management) around the ADLs, it is quite possible that nurses were carrying out their nursing work in much the same way as their predecessors did (in the days before the introduction of this model of nursing) while inserting occasional references to ADLs for impression management. In his study at a Belfast ICU, Porter (1995) noted that the RLT model and the nursing process were not an

inherent aspect of how nurses organized their practice; rather nursing process documentation was used for formal, legal reasons relating to patient care but actually used very little otherwise.

Notions about what constitutes good nursing practice are steeped in values about what comprises 'good' and 'bad', and these values are socially produced within society. To elucidate the regulatory role of nurses is not to suggest that their practice is necessarily wanting or poor. After all, social regulation has long been recognised by social theorists as essential for justice in society, for example, to alleviate poverty, protect vulnerable groups, dismantle patriarchy and so forth. The challenge for nurses is to appraise the meaning and ethics of their role over time, so that their regulating function is underpinned by the most morally defensible courses of action.

Figure 1

Activities of Living
Maintaining a safe environment Communicating Breathing Eating & drinking Eliminating Personal cleansing and dressing Controlling body temperature Mobilizing Working & playing Expressing sexuality Sleeping Dying

From Roper, Logan, & Tierney (2000) *The Roper-Logan-Tierney Model of Nursing Based on Activities of Daily Living*. Edinburgh: Churchill Livingstone.

What is already known about this topic?

- That medicine is a traditional source of social regulation and surveillance
- That nursing can act as a disciplinary mechanism, although knowledge about how this is represented in text is very limited to date

What the paper adds

- A nursing-sociological analysis based on a discourse analysis of written records, revealing nursing's role in the surveying and normalizing processes
- A challenge to dominant interpretations of an established organizing framework within nursing

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