Reflective practice and daily ward reality: a covert power game

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Background. The concept of reflection is propounded in the literature as an epistemology for practice that enables practitioners to solve their daily problematic situations through conscious thought processes which eventually leads to practice-based knowledge. Hence, reflection became a central tenet of both theory development and educational provision in nursing. Furthermore, this centrality of reflection was reinforced by statutory nursing bodies and service providers by adopting it as the means for carrying out adequate professional practice. Although this may be the case, issues of implementation of reflection within the daily reality of practitioners are frequently overlooked within the literature. Moreover, little consideration appears to be given on the impact that the organizational culture and the politics of power may exert on the implementation of reflective practices within daily ward reality.

Aims. This paper explores how reflection is viewed by nurses within their daily reality in the medical wards, examines the relationships between the organizational culture of these wards and the practitioners and investigates whether reflective methods of practice were being implemented when the study was conducted.

Methods. An interpretative ethnographical methodology was implemented and the data collecting methods used were observation, interviews and qualitative content analysis with a group of 16 practising nurses from four medical wards of one NHS Trust in England. Two interviews were conducted with each nurse within 3-week intervals. The content of these interviews evolved from the analysis of episodes of practice observed when the nurses were giving nursing care. These data were supplemented by narratives from the nurses’ in the form of written reflective accounts that were analysed via qualitative content analysis techniques.

Findings. Four themes were generated: (i) relationships between nurses and doctors; (ii) relationships between nurses and managers; (iii) nursing practice; and (iv) nurses’ input in the outcome of a clinical situation.

Conclusions. The concept of reflection appears to be invalidated by the organizational hierarchy of the wards on the basis of a power struggle game. The ward structure portrays reflection as an abnormal method of practice and knowledge development. This belittlement of reflection does not mirror the practitioners’ reality. Instead, it is an intelligent and intentional act on behalf of the dominant professional groups in the wards to create an illusionary picture of ward reality to allow them to survey and define nursing practice and thus maintain and remain in...
power. This is explicated by using Foucault's analysis and critical social theory framework. Hence, reflective processes are constrained by this covert power game; reflection, where used, is confined to nurses' personal time and space.

**Relevance to clinical practice.** The realization of this covert power game by individual clinical nurses can become the incipient point for formally using reflective methods in the practice setting.

**Key words:** interpretative ethnography, power games, reflection, reflective practice, ward reality

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**Introduction**

Reflecting upon feelings located in the subconscious or upon behavioural patterns stimulated by past experiences has been one of the core therapeutic approaches of both Freudian psychoanalysis and the behaviourist school (Watson, 1913; Watson & Rayner, 1920; Freud, 1940; Clark, 1996). However, reflection, as an experiential learning process rather than a therapeutic one, was propounded by the pragmatist philosopher Dewey (1933, 1938). Subsequently, this notion of experiential learning using reflective modes of thinking was transferred to the domain of professional practice by the work of Schon (1983, 1987) and Kolb (1984). Both consider that professional practitioners need to include the reflective schema within their practice repertoire to solve daily practice problems. Therefore, reflection is seen as a technique for developing knowledge and enhancing practice.

Consequently, reflection acquired a bulk of theoretical writings suggesting it, at least in theory, as the hallmark of professional practice. As such, it was embraced by nursing without much contemplation on issues of implementation within daily ward reality. The phrase ‘reflective practice’ makes its appearance in British nursing documentation with the introduction of Project 2000 (UKCC, 1986), a new strategy for pre-registration education; and more than 350 articles associated with the phrase ‘reflective practice’ were published during the 1990s (Hannigan, 2001). Conclusions were drawn that, despite any disadvantages that reflection may have, it is nonetheless the best tool that nursing has to date for advancing its practice and therefore should become an integral part of nursing (Jarvis, 1992; Newell, 1992; Kim, 1993).

This study explores the reality of nurses using reflective practice within the medical units of one NHS hospital trust in England. The intention of the study was to explore whether nurses were able to practice reflectively within the organizational and social structures existing in their clinical environment.

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**Literature review**

Writers have attempted to promote reflection as a practical tool for nursing by developing models of structured reflection, models of critical incident analysis and reflective cycles and spirals (Gibbs, 1988; Holm & Stephenson, 1994; Johns, 1996; Rolfe, 1996). All these represent heuristic tools intending to tune the practitioner into the reflective situation through formal discussions, mentoring and portfolio writing, thus enabling verbalization of professional judgement and clinical decisions through conscious and rational thought processes. Therefore, such practitioners become researchers of their own practice and develop both knowledge and practice at once (Jasper, 1996; Durgahee, 1998; Freshwater & Rolfe, 2001; Rolfe et al., 2001).

The wealth of theoretical writing within the literature resulted in nursing’s statutory and educational bodies accepting reflection as an essential component for the development of the autonomous, critical and advanced practitioner. Therefore, a set of criteria and strategies were developed by educationalists to include reflection as a core skill to be acquired in pre- and post-graduate programmes (Jasper & Rolfe, 1996; Glaze, 2001; Liimatainen et al., 2001; Jasper, 2003). At the same time statutory bodies worldwide adopted the concept of reflective practice as an essential component for nursing practice (Boychuk Duchscher, 1999; UKCC, 1999; Kuokkanen & Leino-Kilpi, 2000; Wong & Lee, 2000).

In consequence, reflection is considered not only useful for providing adequate levels of care, but also as a prerequisite for the provision of professional nursing (Hargreaves, 1997; DoH, 1999; UKCC, 1999; Malin, 2000; The Sainsbury Centre, 2000). However, few have considered the challenges and feasibility of implementing reflective methods of practice in the context of ward reality, where nurses are socialized into a practice culture developed over many years and which changes slowly despite educational and political imperatives. Furthermore, and despite the fact that developments such as clinical supervision, mentorship and preceptorship are
promoted as generic tools for the fostering of reflection in practice, it is more than often an issue of willingness of the organization to embrace such concepts sincerely, to mobilize the necessary resources and to implement strategies to deal with power relationships, control and excessive direction in ward reality (Hawkins & Thibodeau, 1989; Morton-Cooper & Palmer, 1995; Gillings, 2000). Many studies suggest that cultural and organizational factors often lead to misinterpretation, misuse and misconstruction of the reflective process. This may eventually undermine reflective procedures, and practitioners' confidence and competence in their own practice (Greenwood, 1993; Hargreaves, 1997; Platzer et al., 2000; Hannigan, 2001). Furthermore, it is cautioned that reflection runs the risk of being accommodated to fit existing cultural and organizational strategies in monitoring practitioners, rather than changing these to facilitate the enhancement of knowledge and practice (Latimer, 1995; Gilbert, 2001).

Overall, the literature acknowledges that the relationship between reflection and practice is becoming an increasingly prominent, frequently referred to but inadequately defined concept (Paterson, 1995; Baker, 1996; Gallichan, 1997; Lyons, 1999). Moreover, reflection is seen to have acquired a disproportionate body of theoretical writing in relation to the evidence of implementation and merit that it currently holds within practice reality (Pierson, 1998; Brown & Gillis, 1999; Kim, 1999; FitzGerald & Chapman, 2000).

Furthermore, if the organizational culture ignores or deliberately neglects the nature of learning through reflection or does not facilitate and support its use, it is unlikely to become evident in daily practice. A critical social theory and Foucauldian perspective would suggest that dominant groups within hospital organizations determine what counts as valid and worthy knowledge for practice, and may reject learning and practice strategies that threaten their own powerful position. This is more a result of a political or ideological enterprise that reflects the organization's dominant values, attitudes and social relationships, rather than mirroring reality (Hazelton, 1990; Seidman, 1994; Kuokkanen & Leino-Kilpi, 2000; Bjornsdottir, 2001). Therefore, if reflection does not sustain or add to the power of the powerful in ward reality it may be subtly excluded from nurses' daily practice.

Whilst the literature identifies reflective strategies as the means by which nurses can learn and develop their practice, supported by evidence presented from studies viewed via an educational perspective, few are able to illustrate the materialization of reflection within the daily reality of clinical practice. This ethnographic study aims to illuminate these relationships between organizational reality and reflection by exploring whether the ward reality in one NHS Trust promotes reflection as a method of practice.

The study

Methodology

Interpretative ethnography was implemented to explore whether nurses in four medical wards used reflective techniques as part of their everyday practice. This involved the deconstruction, co-construction and eventual reconstruction of the ward reality. In exploring the taken-for-granted notions, and going behind the phenomena themselves, we provide alternative explanations that broaden our knowledge about the relationship between reflection and practice reality. Both Lincoln and Denzin (1998) and Marcus (1998) suggest that the result of the findings in interpretive ethnography are inter-subjectively construed and are constructed by both researchers and participants, building upon the delicate interplay of the emic (insider's) and etic (outsider's) perspective. This enabled us to capture the everyday, rather than ideal reality of the use of reflection within these wards.

Research methods

Purposive sampling was used to select participants of maximum variation to secure a wide range of experience (Polit & Hungler, 1999; Bowling, 2000). Participants were recruited initially through the clinical nurse manager and an informal approach by the principal researcher (SM). Four staff nurses (n = 16) D or E grade, from four wards, were recruited at two different hospital sites. The study had approval from the local ethics committee. All participants provided informed consent and were assured that all data provided would remain confidential and anonymous.

Data collection

Data collection commenced with observing each nurse provide nursing care to two different patients. These data
were recorded in the form of field notes. Following the observations, a 45-minute, tape-recorded interview was conducted which explored the nurse’s decision-making processes and how they perceived their use of reflection in practice. Consequently, the participants completed a written reflection of a practice situation. A second interview ensued, after approximately 3 weeks, that allowed us to follow up issues raised in the first interview; ask the nurses about their written reflections and concentrate on any changed perspectives that may have occurred. It also enabled us to clarify issues that had arisen from all data sources and begin to test the data’s emerging structures.

Findings

The main theme that emerged from the data was termed ‘nursing practice within the ward context.’ This theme was constituted by four categories (Fig. 1) identifying the relationships between reflection and everyday ward practice. These four categories are: relationships between nurses and doctors; relationships between nurses and managers; nursing practice; and nurses’ input in the outcome of a clinical situation.

Relationships between nurses and doctors

Despite the changing climate in the relationship between doctors and nurses in recent years, it still remains an unequal one. What has changed, however, is the way that nurses are monitored. No longer do doctors in these wards overtly limit nursing activities by dictating practice; nor do they punitively confront inadequate practice. However, a subtle influence remained as doctors imposed a ward culture, which obliged nurses to ask the doctor’s consent for their actions. In the following quotations the nurses felt the necessity to advise and comply with the doctor’s decision-making plans to conduct her nursing activities:

She (observed nurse) explained to me, going over the notes, that the patient was a chronic COPD patient and that due to his exacerbation of that situation he was admitted. When I asked if there is a care plan developed for patients, she replied that there is and the doctors are the ones that make out that care plan. Yeah, very much on this ward; I do not know about other areas like midwifery, but here you are very much, you have to do exactly what the doctors say.

As I said, the doctors are above the nurse. You know that is the way you got it and that is the way I have been bought up, lets face it. I think it is going to be very hard refusing doctor’s opinion.

The next extract also demonstrates nurses’ lack of power to promote their critical thinking and reflective knowledge on the basis that such a thought process and knowledge formation does not suffice for the articulation of a valid argument or rebuttal of the dominant society scientific knowledge. On the contrary, such knowledge becomes valid only if supported by evidence emerging from scientific thought and if accepted by doctors:

Observing the nurse undressing, cleaning and redressing a patient’s legs, the nurse commented that her leg ulcers are not getting any better and that her previous experience with patients with diabetes and leg ulcers require more aggressive treatment, rather than cleansing with normal saline, as was the prescribed regime. When I asked if she was ready to put that forward to the doctors, she replied that, ‘Um well I cannot change the regime, I will maybe review the patient condition in 4–5 days time and probably read a bit on leg ulcers and perhaps then I will refer to the doctor if he can change the regime.’

The nurses also considered medical practitioners as more knowledgeable than themselves. This notion emerged from the fact that the multi-varied types of knowledge that nurses exhibited were considered to be insignificant, invalid and abnormal. In the ward reality, valid knowledge was equated to ‘hard’ scientific knowledge that doctors possessed:

But if I don’t agree with a drug hopefully they would listen to me. But then they have more scientific knowledge than I do, they know drug interaction, etc., etc. slightly more than I do. It is 60–40%, 60 them 40 us.
Domination by doctors led the nurses to consider the utility of reflection for practice. Despite reflection being viewed as a way of enhancing professional practice knowledge, it was considered of limited value because of nurses’ limited power to implement any kind of change. The next quotation demonstrates this scepticism:

It is a big circle and then I think if you can actually instigate change amongst nurses and doctors, it is going to be an occasion of nurses getting together with the doctors and saying ‘Look you’ve got problems with this, we’ve got problems with it, how can we actually sort this out between us.’ But who is going to have the power to do that?

This category acknowledges that the power relationship between doctors and nurses adversely affected the use of the reflective processes. Although no longer controlled by doctors, the nurses are still perceived to maintain an unequal power relationship. This notion of inferiority is related to the value attributed to specific types of knowledge that imbue the beholder with power. Thus, much of nursing knowledge goes unrecognized and under-valued as it does not emerge from the dominant scientific paradigm. Hence, although nurses may have knowledge of alternative actions to be more effective in specific cases than those prescribed by the dominant paradigm, rather than implementing this knowledge, nurses are subjugated to the dominant power structure. This being a direct result of the nurses’ perception that the types of knowledge they possess are not as valid as the scientific knowledge possessed by doctors.

Relationships between nurses and managers

The relationship between nurses and management at all levels was considered an authoritarian one, where decisions flowed from top to bottom. The nurses considered themselves to be situated on the bottom rung by simply implementing managerial strategies whereas management appeared to define nurses’ aims and objectives without any consultation about their feasibility or utility. This organizational structure is projected in the following quotations:

I know you can effect change from the top, but it seems to me that every nurse that makes it to the top forgets that they are a nurse and they become more managerial.

Like, I don’t know, hospital administrators, I am not saying they don’t know; they know their job, but what they sometimes say does not work on the ward, because they have not been down on the ward for a long time – or that is how it seems, anyway.

Furthermore, management, in a covert fashion imposed what was appropriate or inappropriate behaviour and what kind of knowledge was valued by placing emphasis and eminence on scientific and theoretical knowledge and at the same time degrading the importance of other types of knowledge, such as that emanating from reflection, as not normal and therefore invalid for practice. The nurse in the following extract, whilst reflectively examining her practice and identifying inadequacies imposed by scientific and theoretical knowledge, was left by management unsupported in transforming her reflective knowledge into clinical practice and in effect discouraged:

... with a cardiac arrest, we had a patient and we felt, I mean the doctor felt that they had done enough but I just felt we could have done a bit more and I also felt they could have done more. When I brought that up as a subject the particular person higher up, he said that he would speak to the doctor but they never did and it left me feeling quite dissatisfied, I felt I could not do anything about it.

Furthermore, this lack of facilitation was viewed in relevance to the fact that nurse managers became estranged to the ward reality, as their knowledge repertoire varied significantly from that of practising nurses. Once a nurse is no longer confronted with individual patients, s/he misses out on the direct, contemporary and specific knowledge of those patients:

I am happy at the grade I am now. I am an E grade. I don’t particularly want to go on. If I go on to an F grade then that is management and I am not really interested, I like nursing care, I like being with patients you know. I think once you get up higher you are more involved in management staff and I don’t like management.

Yeah, I prefer the nursing work to the managerial.

These nurses stress the fact that nurse managers exclusively based their decisions, judgements and actions on objectified and generalized knowledge acquired from sources far removed from the ward reality. This was considered as a compartmentalization of knowledge that failed to mirror and/or understand the specific reality of the wards. Moreover, the fact that this type of knowledge was valued as scientific knowledge transformed managers into people with power and became the legitimating authority of practitioners’ decisions, judgements and practice methods. Therefore, specific and subjective types of knowledge developed through informal reflective processes appear to be defined by managers as invalid and abnormal for practice. This then provided managers with the potential to validate their own knowledge whilst on the contrary considering the practitioners’ knowledge that emanated from the reflective processes as invalid.
Nursing practice

The nurses considered their learning as a continual, ongoing process and while they were practising at the same time, observed colleagues, compared knowledge and learned from each other. This included using reflection-on-action to analyse practice after the event, as well as reflection-in-action as to alter practice at the time it was taking place:

…but if you are saying to somebody, ‘Can you show me how to do this because I have not done it before’ and they are quite experienced you can say, ‘Why are you doing that?’ and get the reasoning behind it and if you do not think that the reasoning sounds correct then you can go away. You can also not just ask one person but two or three people, because everybody has their own way of doing something and just because it is different, it does not mean it is incorrect each time. That is the way I do, I ask reasons behind what they are doing.

However, nurses’ inclinations to use reflection foundered on assumptions of knowledge validity and normal practice. Together, the nursing hierarchy and the medical establishment demonstrated their power by preventing the use of reflective techniques and requiring specific and predictable methods of conducting practice. The nurses were aware that these people were assessing and defining their practice competence and therefore abandoned any sincere use of reflection and the disposition to learn from practice. Instead, the nurses conformed to others’ demands, carrying out their practice in a routine and ritualistic manner:

…Yeah, definitely, there are rituals and routines. There is this Sister on the ward and she is the night Sister and she wants things done in a certain way and cannot say why this is a good thing. For instance, post-operative patients have observations checked hourly through the night regardless of what time they came back from theatre the day before. So you can have somebody come back to the ward at nine in the morning, for example, and still have their observations recorded every hour at night and I think that that is wrong because you have to wake up that patient each time and still have their observations recorded before. So you can have somebody come back to the ward at nine in the morning, for example, and still have their observations recorded every hour at night.

Thus, most nurses practised in a routine manner as a result of their own perceived powerlessness, whether in the presence of the person who demanded such practice or not:

It is all drugs, dressings, washing, beds, lunch, dressing, teas, observations, and back in bed. That is a ritual isn’t it? Everyday you have this list of jobs you have to do and you go on doing them.

This imposition of routine practice was not derived from one specific person. Instead, it was incorporated into a ward culture nominated as ‘normal’ practice and was very quickly learned and adopted by the nurses:

I mean, no one would actually say you cannot do that. But, especially in this ward there is a thing about the patient having to wake up at half past six. Whether they are asleep or not they have to get up and sit in a chair ready for when the day staff come on for breakfast. And this is an elderly care ward and most people would not get up at half past six even if they were well, let alone if they weren’t well.

Whilst practising nurses acknowledged this, they did not proceed to subverting the status quo, but instead became resigned to the safety of routine practice. Their unwillingness to change the dominant reality was rooted in the fact that they considered themselves as the wrong people to do so:

I tend to keep my mouth shut. It is probably defeating but as I found over the years that loads can be said and loads of nurses can be saying it, unless the right nurse says it very little gets changed so I just go for the option of not saying anything just get on doing my work.

Thus, an inhospitable clinical culture was created for any formal reflective activity. Any kind of reflective practice was limited to personal time and personal space:

No, there is not any formal reflection, not on the ward. It will have to be on my own time. If I wanted to look something up yeah, they would not give it to you.

Practitioners considered themselves powerless to formally and overtly use reflective processes to conduct their daily practice. Both types of reflection were viewed negatively by ward culture, thus forcing nurses to either abandon reflection or use it covertly. This resulted in the suppression of reflective modes of practice on the basis of a power game rather than on the basis of the utility and validity of reflection.

Nurses’ input in the outcome of a clinical situation

Nurses’ input in the wards was judged continuously by themselves and others, against the criteria of scientific knowledge, despite them drawing on several sources of knowledge rather than just scientific knowledge. However, the fact that the ward culture invalidated alternatives to scientific knowledge resulted in nurses justifying their actions, knowledge and input against only empirical criteria. Hence, whilst nursing input was viewed as lacking a robust knowledge base, it actually was that the criteria against which it was judged did not acknowledge the totality of professional nursing knowledge. This use of incomplete criteria was not coincidental. It provided the mechanism for the dominant groups to maintain their authority over nurses and the potential to impose their decisions on clinical situations:
When I asked how patient plans are created and evaluated, the nurse answered that doctors do care plans and that doctors are the ones to evaluate them. Nurses did not set out a patient plan, at least in his ward.

But within the ward the doctors do medically dominate. When it comes to patient care on the basic scale then I have the rules, I set the standards, but medically wise, drug wise and making decisions on a larger scale they (doctors) tend to set the rules.

The objectification of practice and the imposition of measurable criteria for various clinical situations did not explain the complexities of nursing practice. Under these criteria, nursing input was not made visible to non-nurses and thus there was only partial understanding of it. The following quotation shows that alternative criteria, such as the use of paradigm cases that acknowledges the learning achieved from previous experiences, may indeed need to supplement the scientific paradigm:

Well we have got a patient on the ward at the moment. A year ago, she was in the same situation she is now and this particular lady, when she was at home and she couldn’t breathe, then she came to the stage that she became really ill and she cannot move because, she is so big. I am talking about thirty stones and when she came to us a year ago she was not walking, she was lying in bed. We got her up to her feet, we got her home, but unfortunately the same thing happened again and she has come in with exactly the same symptoms. But we are going through all the channels again and hopefully this time they will really look into her eating habits and the social side of the problem and give more help from that point of view, which the doctors had dismissed. So I do not think it is the fact that it is the eating disorder that needs more attention, I have pointed that out and hopefully they will address that this time.

The nurse recognized that previous strategies had failed to address this patient’s problems, and expanded her assessment framework to look beyond the physical and consider psychological and social factors as contributing to the condition. Reflectively learning from previous situations resulted in developing valuable suggestions for a future course of action. However, the language she uses to express this suggests that she perceives herself as peripheral to the decision-making processes, rather than being considered as an equal member of the team.

Summing the findings of this study, it appears that the dominant culture within practice reality attributes validity to scientific knowledge while at the same time ignores the multifarious types of knowledge implemented by practising nurses. Thus, reinforcing a hierarchy of power structure where professionals that base their decisions and patient input on scientific knowledge to be considered as normal practice and dominant figures and those that do not to be marginalized as abnormal and ones that need to be supervised by these dominant figures. Hence, although practising nurses used reflective techniques to develop their knowledge, these did not constitute overt and formal processes and moreover, they were not considered as valid and valuable methods of knowledge development and practice provision.

Discussion

The findings demonstrate that the ward culture considered reflective practice as an invalid method of knowledge acquisition and therefore did not overtly promote it as a way of delivering or developing practice. This did not arise from the fact that reflection actually was invalid and not normal for practice. The nurses used, and indeed acknowledged, that reflection was both powerful for developing practice and was also a tool for revealing the totality of their professional knowledge and input in patient outcomes. This demarcation was imposed by powerful groups, ostensibly in the name of evidence-based practice, and reflected the basis of the struggle between groups with differing power.

The concept of a technically constructed or illusory reality that is based on language, representation and institutionalization with the intent to produce or reproduce difference, inequality and oppression, has been the key concept of critical and postmodern thinkers (Derrida, 1967; Lyotard, 1983; Gough & Mcfadden, 2001; Abma, 2002). Within this postmodern framework the powerful agents in the ward reality, namely doctors, senior nurses and (nurse) managers have constructed reality and knowledge on the basis that can differentiate them from others and by doing so are able to establish a relationship that allows them the dominant position. The routines and rituals, the language used and the input in the outcome of a patient situation were all means that differentiated practitioners from these groups, attributing power to the latter and depriving it from the former.

Reflective practice was understood by the nurses not only as a tool for advancing practice and knowledge, but also as a consciousness-raising activity that could renegotiate issues of knowledge, practice and eventually roles and power within the hospital setting. However, such a renegotiation will introduce an unavoidable threat to the current equilibrium of control and power within the dominant groups. Hence, they did not view the introduction of reflection as positive and used their power to block its implementation. The process adopted to marginalize the use of reflective
activities was its devaluation in scientific terms, suggesting that it is not normal for practice and not valid for knowledge development. Hence, nurses were once again faced with the situation of having learnt potentially liberating strategies within an educational context, yet having them belittled and devalued by those in power. Whilst these strategies were quite subtle, they had behind them the authority of contemporary notions of evidence-based practice and the historical validity attributed to positivist scientific methodologies and processes in knowledge generation. Thus, whilst nurses were not prohibited from practicing reflectively as such, neither were they encouraged. Rather, they were made to feel that they were outside the norm by doing so, and as a result could be potentially labelled as ‘not one of us.’ This has a socializing effect of bringing the deviant back in line and reimposing the dominant cultural practices.

Foucault has termed this ‘disciplinary technology,’ which is achieved by using a normalization process. In this process the dominated population is classified as normal or not normal according to the criteria of the dominant group. Hence, individuals who are delinquent or exhibit anomalies according to this classification are identified and, consequently, treated and reformed. This method of normalization becomes a technique of power because the dominant group defines abnormalities. Once someone is nominated as abnormal, then it is totally justifiable to intervene, to supervise and to discipline the abnormal individual (Dreyfus & Rabinow, 1983; Rouse, 1996; Schaap, 2000). This was seen throughout the study, where nurses avoided the overt use of reflective processes, as these processes were labelled as abnormal for adequate practice provision, but rather they reluctantly aligned to what was defined as normal by being aware of the existing and yet covert power game.

Conclusion

In conclusion, the study’s outcomes raise challenges for implementing reflective methods of practice within the current organizational culture in the medical wards investigated. Such liberating and consciousness-raising strategies are potentially subversive for the sovereign of the powerful groups. The results of this study, framed within critical social theory and Foucauldian analysis, suggest that reflection is nominated by the ward culture as abnormal for practice. Thus, a reality is created where reflection is considered as invalid, not because it actually is so, but because this construction allows the powerful groups to sustain and extend their power.

Contributions

Study design: SM; data collection and analysis: SM; manuscript preparation: SM, MJ.

References


