2010

Bringing about behaviour change: nursing practice and cardiac rehabilitation

Lucia Apolloni

University of Wollongong
NOTE

This online version of the thesis may have different page formatting and pagination from the paper copy held in the University of Wollongong Library.

UNIVERSITY OF WOLLONGONG

COPYRIGHT WARNING

You may print or download ONE copy of this document for the purpose of your own research or study. The University does not authorise you to copy, communicate or otherwise make available electronically to any other person any copyright material contained on this site. You are reminded of the following:

Copyright owners are entitled to take legal action against persons who infringe their copyright. A reproduction of material that is protected by copyright may be a copyright infringement. A court may impose penalties and award damages in relation to offences and infringements relating to copyright material. Higher penalties may apply, and higher damages may be awarded, for offences and infringements involving the conversion of material into digital or electronic form.
BRINGING ABOUT BEHAVIOUR CHANGE: NURSING PRACTICE AND CARDIAC REHABILITATION

A thesis submitted in partial fulfilment of the requirement for the award of the degree

DOCTOR OF PUBLIC HEALTH

From

UNIVERSITY OF WOLLONGONG

By

LUCIA APOLLONI, B.A. (Psych) Hons

SCHOOL OF HEALTH SCIENCES

2010
DECLARATION

I, Lucia Apolloni, declare that this thesis, submitted in partial fulfilment of the requirements for the award of Doctor of Public Health, in the School of Health Sciences, Faculty of Health and Behavioural Sciences, University of Wollongong, is wholly my own work unless otherwise referenced or acknowledged. The document has not been submitted for qualifications at any other academic institution.

Lucia Apolloni

2010
ACKNOWLEDGEMENTS

I dedicate this thesis to my husband, Garry Gow, who died on March 30th 2009.

I have been fortunate to have the support of many people throughout the period of my candidature and for that I am truly grateful. First, I would like to thank my supervisor, Dr Lindsey Harrison, for her patience, encouragement and direction, without which I would never have completed this task. Her professionalism, thoughtfulness and friendship, during a difficult time in my life, renewed my belief that I could accomplish this venture. I would also like to thank Professor Patrick Crookes and Dr Rohan Jayasuria for their supervision and support during the initial stages of this undertaking when I was clarifying my thoughts and direction. I wish to acknowledge and thank the participants in this study who were kind enough to share their time and their experiences; without their generous contribution this thesis would never have been completed. I would also like to thank their managers for recognising the value of this research and for facilitating its progress. To my colleagues and dear friends who supported me through the highs and lows of this journey, thank you. Finally, I want to acknowledge a debt of gratitude to my family for their ongoing patience and encouragement. In particular, I want to acknowledge the love and support of my late husband Garry Gow and my two wonderful daughters Alexandra and Olivia; without them I could not have reached my goal.
ABSTRACT

The concern that underpins this research is that the impetus for assimilating behavioural models and frameworks into community nursing work is divorced from an informed understanding of how this work is currently being undertaken and what constitutes its elements. While there is considerable evidence that many nurses deliver behavioural interventions for the prevention and amelioration of disease, the literature provides little and generally superficial detail about the way in which this work is actually carried out.

This qualitative research investigates nurses’ behaviour change practice within the context of community based cardiac rehabilitation. The methods of research were designed to explore multiple dimensions of this area of nursing work; namely the theory that informs it, the practice itself and the factors that serve to facilitate and constrain it.

The sample was drawn from four area health services across New South Wales, Australia. Maximum variation sampling was chosen as the sampling method to enable a view that is wide-ranging and inclusive of varied practices. The twenty-seven participants included both specialist and generalist nurses who were responsible for the delivery of Phase II cardiac rehabilitation services conducted in outpatient or community-based settings. The data were obtained from a process of semi-structured interviewing and were subjected to thematic analysis and an exploration of discourse.

The research found that generalist and specialist nurses carry out their behavioural interventions in completely different ways, which rules out any distinct theory or explanation for the way this work is carried out. This diversity of practice is
underpinned by nurses’ varied and at times conflicting understandings about what this work entails and how it should be performed. It stems not only from differences in nurses’ knowledge and skills, but also from the organisational context that serves to either facilitate or constrain practice for behaviour change. Indeed, organisational practices, including those instigated by nurses themselves, are instrumental in determining whether certain knowledge and skills for delivering behavioural interventions are gained in the first place, as well as whether nurses are enabled to translate these into practice and develop appropriate skills for this area of work.

The findings expose the power relations between the different groups of nurses, which serve to support dominant medical and organisational interests. While the specialist nurses exercised their autonomy to gain new knowledge and develop their expertise, they also employed it to shape and control the work of their generalist colleagues in standardised medically focused ways. Generalist nurses are required to follow clinical pathways or standardised processes whereas the autonomy specialist nurses are accorded in their practice enables innovation and allows the development of expertise in this non-clinical area of nursing work.

An important finding is that behavioural theory plays little part in informing practice. Few generalist nurses demonstrated any knowledge or understanding of behavioural theory. In developing this area of practice, they attempt to mould it into routine patterns of clinically focused practice, which sees the behavioural elements of their work limited to instructional or educative exercises.
Specialist nurses acknowledge that theory grants them an understanding of behaviour change processes yet they adopt an eclectic approach informed by trial and error learning rather than a specific behavioural model or framework. This type of learning is informed by the nurses’ subjective understanding of individual patients and the way those patients make sense of their reality. It provides nurses with a repertoire of possible strategies, allowing them the flexibility to work with the patterns and nuances that present in practice situations.

The findings have implications for nurse education, which aims to teach how behavioural interventions can be incorporated into everyday nursing work. They also raise issues as to how health care organisations can best facilitate and support knowledge and skill development for this area of practice.
# TABLE OF CONTENTS

DECLARATION .......................................................................................................................... II

ACKNOWLEDGEMENTS ........................................................................................................ III

ABSTRACT ................................................................................................................................ IV

TABLE OF CONTENTS ........................................................................................................... VII

LIST OF TABLES, FIGURES, ILLUSTRATIONS ................................................................. XII

CHAPTER ONE: INTRODUCTION TO RESEARCH ........................................................... - 1 -

1.1 Introduction ........................................................................................................ - 1 -
1.2 Aims and Objectives of Research ...................................................................... - 5 -
1.3 Significance of this Research ............................................................................. - 6 -
1.4 Approach to Research ........................................................................................ - 8 -

1.4.1 Process of Research .................................................................................... - 8 -
1.5 Summary of the Findings ................................................................................. - 10 -
1.6 Thesis Structure ................................................................................................ - 12 -
1.7 Background to the Study .................................................................................. - 14 -

1.7.1 Changing Face of Nursing Work in the Community Sector ..................... - 15 -

CHAPTER TWO: BRINGING ABOUT BEHAVIOUR CHANGE: THE LITERATURE .. - 21 -

2.1 Introduction ...................................................................................................... - 21 -
2.2 Health Care Delivery: Shifting Directions of Nursing Work....................... - 22 -

2.2.1 Evolution of Nursing Models in Community Health ......................... - 27 -
2.3 Behavioural Interventions In The Primary Health Care Context ............. - 30 -
2.4 Nurse-Delivered Behavioural Interventions: The Literature ................. - 33 -

2.4.1 Theoretical Approaches to Behavioural Interventions ...................... - 36 -
2.5 Conclusion ........................................................................................................ - 38 -

CHAPTER THREE: CARDIAC REHABILITATION AND THEORIES OF BEHAVIOUR CHANGE ......................................................................................................................... - 40 -

3.1 Introduction ........................................................................................................ - 40 -
3.2 Cardiac Rehabilitation: Background .............................................................. - 41 -
  3.2.1 Contemporary Cardiac Rehabilitation .................................................. - 44 -
3.3 Theories and Behavioural Models In The Context Of Healthcare ............... - 50 -
  3.3.1 The Health Belief Model ......................................................................... - 52 -
  3.3.2 The Theory of Reasoned Action .............................................................. - 54 -
  3.3.3 Social Learning Theory .......................................................................... - 57 -
  3.3.4 Transtheoretical Model of Behaviour Change ........................................ - 59 -
  3.3.5 Motivational Interviewing ..................................................................... - 62 -
3.4. Behavioural Theories and Nursing Work: Issues and Concerns ............... - 64 -
3.5 Conclusion .................................................................................................. - 67 -

CHAPTER FOUR: APPROACH AND METHODS OF RESEARCH .............................. - 68 -
  4.1 Introduction ................................................................................................ - 68 -
  4.2 Nature of Research .................................................................................... - 70 -
  4.3 Sampling .................................................................................................... - 73 -
  4.4 Gaining Access to Research Sites .............................................................. - 75 -
  4.5 Process for Obtaining the Sample .............................................................. - 76 -
    4.5.1 Patient Involvement ............................................................................ - 78 -
    4.5.2 Sampling Procedures .......................................................................... - 79 -
  4.6 Data Collection .......................................................................................... - 80 -
  4.7. Profile of the Nurse Participants ............................................................... - 83 -
    4.7.1 Work Location of Participants ............................................................. - 85 -
  4.8. Data Management .................................................................................... - 86 -
  4.9 Analytical Approach .................................................................................. - 86 -
  4.10 Thematic Analysis .................................................................................... - 88 -
    4.10.1 Phase One: Becoming Familiar With The Data .................................. - 89 -
    4.10.2. Phase Two: Generating Initial Codes ............................................. - 90 -
    4.10.3 Phase Three: Searching For Themes ............................................... - 91 -
    4.10.4 Phase Four: Reviewing Themes ....................................................... - 91 -
    4.10.5 Phase Five: Defining and Naming Themes ....................................... - 92 -
  4.11 Examining Discourse ............................................................................... - 93 -
  4.11.1 Perspective On Discourse .................................................................. - 94 -
  4.12 Dependability and Adequacy of Research .............................................. - 99 -
    4.12.1 Conveying Participants’ Perspectives ............................................... - 100 -
    4.12.2 Discourse Analysis and Theoretical Perspective ............................. - 102 -
LIST OF TABLES, FIGURES, ILLUSTRATIONS

TABLE 3.1: RECOMMENDED MANAGEMENT FOR PREVENTING CARDIOVASCULAR EVENTS .............................................................. - 47 -

TABLE 3.2: MAIN ELEMENTS OF PHASE II CARDIAC REHABILITATION ................. - 49 -

FIGURE 3.1: MAJOR ELEMENTS OF THE HEALTH BELIEF MODEL ......................... - 53 -

FIGURE 3.2: MAJOR ELEMENTS OF THE THEORY OF PLANNED BEHAVIOUR .... - 56 -

FIGURE 4.1: THEME “DISCURSIVE FLEXIBILITY” ..................................................... - 93 -

TABLE 5.1: NUMBER OF NURSES WHO CONVEYED AWARENESS AND/OR APPLICATION OF BEHAVIOURAL THEORIES AND/OR MODELS (N=27)........... - 110 -
CHAPTER ONE: INTRODUCTION TO RESEARCH

1.1 Introduction

This qualitative research explores nursing practice for bringing about patient behaviour change; that is, the practice itself and the factors that shape it. This aspect of nursing work has been chosen as the focus for research because, unlike medically or treatment focused nursing work, it remains relatively unexplored and poorly understood. This is particularly the case in the community health sector where it is generally accepted that behavioural interventions are part of a broader generalist-nursing role. Also unclear is the role of theory in informing this area of nursing work. To date, very little is known about whether, and to what extent community health nurses draw on behavioural theory, models and frameworks to guide their behaviour change practice and if so, how these are applied in practice.

Traditionally, the scope of community nursing has revolved around medically driven or treatment focused work, and has included caring and enabling practices. Following the inception of the primary health care approach (World Health Organisation [WHO] 1978) however, the role of many community-based nurses expanded to include areas of work along the entire health care continuum, which spans from health promotion and illness prevention to rehabilitation and palliative care. The nurses with a generalist community-nursing role also worked across a range of settings, population groups and health areas.
Common to areas of nursing work such as health promotion and the various levels of illness prevention, is practice that aims to change or modify health related behaviours that potentially place people at risk for developing chronic diseases and other preventable conditions. Despite this focus however, there has been no parallel development of nursing theory and models to guide and support this area of work. Instead, nurses have been left to draw on whatever knowledge they have available to them and/or to borrow, interpret and adapt theory from other disciplines.

In the main, the literature conveys the behavioural components of nursing work in a superficial way in that it draws on language with the assumption that it communicates common meaning. Typical examples of this are the terms “patient education”, “counselling”, “empowerment”, “illness prevention” and “health promotion” and “health protection”. What remains unclear however, is how nurses implement the various elements of these processes in their practice.

Although there is an expansive body of research that deals with behavioural interventions in the health care context, it is mostly concerned with demonstrating the effectiveness of interventions, rather than providing in-depth or comprehensive descriptions of the process elements that comprise them. This can also be said of research focusing specifically on theory-based behavioural interventions. There are however, numerous studies addressing theories’ predictive and explanatory abilities. The proliferation of studies of “effectiveness” can be partly attributed to the health care system’s increasing emphasis on evidence-based practice; a movement that holds the scientific paradigm and randomised control trials as the ‘gold standard’ for assessing therapeutic effectiveness.
In response to the increasing emphasis on evidence-based practice, several health disciplines have shifted away from intuitive and experience-based practice models to a position that advocates the use of evidence based-practice (Muenchenberger 2007). Increasingly, health care organisations are requiring that interventions undergo evaluative trials before they are deemed suitable interventions (Barlow 2004; Levant 2005; Molloy et al. 2007). While the value of this evaluative approach is not being discounted, the scientific paradigm that underpins it is limited in its potential to explore the complex, dynamic and often context specific processes that come together in individually tailored behavioural interventions. Paradoxically, the increased emphasis on objective “evidence”, and more so the traditional standpoint about research that informs it, has actually contributed to the gap in knowledge about the complex and often unpredictable phenomena involved in many approaches to individually focused behavioural interventions.

This study sets out to address this gap in nursing knowledge by exploring the elements of this practice and the knowledge that underpins it. It argues that a qualitative methodology is best suited to providing an in-depth description of these phenomena and, given the complex and shifting nature of the health care environment, it is also suited to explaining the influences that shape, facilitate and delimit this area of nursing work.

The service setting chosen for this research is Phase II cardiac rehabilitation (also known as community-based cardiac rehabilitation), which incorporates both specialist and generalist community health nurses delivering multi-faceted interventions, where bringing about patient behaviour change is a goal of practice. The rational for this
choice is that this goal remains constant, unlike some other community health services that alter their focus according to shifting organisational demands.

The behaviours that are the focus of intervention in Phase II cardiac rehabilitation are smoking, alcohol misuse, obesity and lack of physical activity (Australian Institute of Health and Welfare [AIHW] 2006; National Heart Foundation [NHF] 1998, 2004). Bringing about changes in these health-related behaviours is also a focus in other areas of health care, which makes this research relevant to a wider professional audience.

The remainder of this chapter is structured in the following way. The aims and objectives of research are presented overleaf. These are followed by the section “Significance of the Research” which outlines the study’s potential contributions in terms of knowledge building about the nature of nursing work for bringing about patient behaviour change.

The next section “Approach to Research” introduces the service setting chosen for this research. It also provides a synopsis of how the study was undertaken including information about the processes utilised for data gathering and analysis.

This is followed by the sections “Summary of the Findings”, which presents an overview of the research findings and an outline of the “Thesis Structure”.
The chapter concludes with “Background to the Study”. This section sets the scene for the study by examining how the adoption of the primary health care philosophy (WHO 1978) has impacted on the nursing role in the community health sector.

1.2 Aims and Objectives of Research

The aim of this study is to explore the ways that nurses seek to bring about patient behaviour change in the health service context of community based or Phase II cardiac rehabilitation. There are two main related areas in this study: first what this practice involves and secondly the understandings and influences that shape this practice. The objectives of the study are:

To explore and identify:

- The nurses’ expectations and understanding of their cardiac rehabilitation role;
- The nurses’ perceptions and understanding of the processes, theories and models of behaviour change;
- What the nurses actually do to bring about behaviour change;
- The facilitators, limitations and constraints on the nurses’ behaviour change practice.
1.3 Significance of this Research

The design of this study will enable the discovery of findings that can potentially extend both practical and theoretical knowledge relating to nursing practice for bringing about behaviour change. The need for this research is determined firstly by the lack of literature that explicates this area of work and secondly by the lack of nursing specific theoretical frameworks to guide it. As with most other nursing work, bringing about behaviour change constitutes a social process, which is determined not only by the practitioners but also by the context in which it evolves and takes place. As well as presenting findings that are previously unpublished, the present study also claims significance in the areas of the overall research approach and contextual sensitivity.

Qualitative studies exploring how the elements of nurse delivered behavioural interventions are carried out are relatively rare. In the main, research that focuses on nurses’ behaviour change practice is limited to discrete service contexts, programs or projects. A major concern is that there is a dearth of literature examining whether, and if so how, generalist nurses carry out their behavioural interventions when they lack an understanding of behavioural theories and related approaches.

The lack of in-depth research exploring this area of nursing work is surprising, given bringing about patient behaviour change has been deemed an integral component of primary health care nursing since the 1970’s (WHO 1978, 1996, 1997). Unlike the standardised approaches to treatment focused practice that are guided by policy, protocols and pathways, in the community sector, behaviour change practice has become a largely hidden and taken for granted aspect of the nursing role. The exception
to this is their educative practice (Burke & Fair 2003; Whitehead 2001), an approach that lends itself to the bio-medical model.

The timeliness of this research is supported by evidence of the increasing prevalence of preventable behaviourally related illnesses (AIHW 2008) and the Australian Government’s pressing focus on the secondary prevention of chronic disease (National Health and Hospitals Reform Commission 2009). In light of this, it is extremely important that the clinicians who deliver behavioural interventions for the prevention of chronic diseases, including cardiovascular disease are proficient in their approach. For this to occur it is likely that nurses require a practical as well as theoretical understanding of what this area of practice entails.

The findings of this study make an original contribution to the body of knowledge that relates to the areas of health promotion, illness prevention, rehabilitative services and nursing practice in general. By providing clinicians with new and additional knowledge with which they can compare their current practice, they will be able to reflect on ways that can improve the services they deliver.

The present study is also significant in that it does not ignore or attempt to marginalise contextual issues. Instead it brings them to the fore, by emphasising ways they can serve to facilitate, constrain or prevent this area of work in the community-nursing context.
1.4 Approach to Research

This section is fundamental to developing an understanding of the logic that underpins this research. The exploratory nature of this study called for an openness to the discovery of data that provide additional dimensions to the phenomenon that is the focus of this research; that is the ways that nurses seek to bring about patient behaviour change. Akin to research conducted by Seibold (2006) and Simons and Squire (2008), this study involves the sequential or progressive use of different analytical methods to the same data set.

1.4.1 Process of Research

Nurses from within four Area Health Services located within the State of New South Wales, Australia participated in this study. A non-probability sampling method was used to obtain the twenty-seven study participants who were nurses responsible for the delivery of Phase II cardiac rehabilitation services. The twenty-seven nurse clinicians that took part in this research were either employed solely in the area of Phase II or community-based cardiac rehabilitation (n=11) or performed this work as part of a broader generalist community-nursing role (n=16).

Semi-structured interviews were used to collect the data. The research questions were concerned with identifying and describing nursing processes for bringing about patient behaviour change and the knowledge that shapes them. These were analysed by adopting a progressive analytical approach where each successive stage was informed by the previous findings. Given the exploratory nature of this research this approach
was considered appropriate as it enables a multidimensional approach to analysis (Savage 2000).

The process of analysing the data commenced with thematic analysis and was data-driven as opposed to theory driven. This method is suitable for exploratory research because of its flexibility and applicability to many different qualitative approaches; those governed by a particular theoretical position as well as those independent of theory (Braun & Clarke 2006; Crabtree & Miller 1992; Holloway & Todras 2003).

Regarded as the “foundational method for qualitative analysis”, thematic analysis is also considered a method in its own right (Braun & Clarke 2006: 78). The framework adopted for this phase of analysis is similar to that developed by Braun and Clarke (2006). This method was applied to obtain a descriptive account of nursing work and the factors that influence it, which reflects the perspectives of the participants. During this initial phase of analysis it became evident that issues of power and control permeated the nurses’ accounts. On the basis of this finding, the discourses that shaped their accounts were then sought and examined.

The theoretical perspective that informed this analysis was post-structuralism, which is underpinned by the premise that meaning is not inherent in objects or language but rather is constructed through discourse. All forms of discourse analysis are underpinned by constructionism (White 2004). In discussing constuctionism Crotty explains:
“There is “no objective truth waiting for us to discover it. Truth, or meaning, comes into existence in and out of our engagement with the realities in our world. There is no meaning without a mind. Meaning is not discovered but constructed”

(Crotty 1998: 8-9)

1.5 Summary of the Findings

The findings obtained from the data analyses are summarised below:

1. Nursing practice for bringing about behaviour change is diverse. This is evident in the nurses’ descriptions of practice but also in the discourses they draw on to describe it. Their approach to practice rests, not only with their individual knowledge and skills, but is also influenced by the organisational context and related practices that serve to either facilitate or constrain this area of their work.

2. Theory provides expert nurses with some understanding of the behaviour change process but their practice is not driven by it. Theory sits in the background while their own personal understanding of what does and what doesn’t work in similar circumstances guides their individualised approach.

3. Expert nurses adopt an eclectic approach to bringing about behaviour change; one that brings together individually focused processes and strategies informed by the nurses’ subjective understanding of individual patients and the way patients make sense of their reality. The way they develop expertise for this practice does not fit the same patterns as contemporary models of skill
acquisition in nursing; it is about the art of persuasion rather than practice
guided by a correct or “best” way of doing things.

4. Nurse autonomy determines the nature of their behaviour change practice. The
nurses who experience greater autonomy exercise their agency to explore and
incorporate alternative approaches into their practice. In contrast, the nurses
who are directed in their work, practice in ways that are shaped primarily by
dominant organisational discourses.

5. Nurses are controlled and seek to control other nurses in all sorts of ways.
Nurses who are granted the most power and autonomy in the organisation
apply it in ways that see them become extensions of the organisation in that
they exercise this power to reinforce the dominant medical and managerial
influences. Nurses also exercise their agency to either conform to the dominant
influences or resist and at times undermine them.

The above findings are explored and discussed to provide an in-depth description of this
area of nursing work and the influences that shape it. It will be explained that nurses’
practice cannot be divorced from the context in which it occurs. The context, which
includes organisational practices, influences nurses’ professional identities, their
understanding of what their work entails, the ways they carry out this work and how it
develops over time.
1.6 Thesis Structure

The thesis comprises three major parts. The first includes the introductory chapters. This is followed by three data chapters. The third and final part of this thesis draws together and discusses the major findings; it also recognises the limitations of this study and provides recommendations for nurse education and further research.

As previously explained, chapter one introduces the issues of analytical concern and outlines the research objectives that are addressed in the thesis. The significance of the study is also discussed and a summary of the methodological and analytic approach adopted to conduct the research is presented. This is followed by an overview of the findings. The chapter concludes with background information, which introduces factors that have contributed to behavioural interventions becoming an integral part of nursing work.

Chapter two, the second introductory chapter expands on the background by exploring and critiquing the literature, specifically what is and isn’t known about nurse delivered behavioural interventions in the community health setting. Despite this area of work being an integral component of many nurses’ roles, the way it is carried out in everyday practice remains virtually unexamined. The role of behavioural theory in informing this area of nursing work is also obscure.

The third introductory chapter comprises two sections. The first describes the service context of Phase II cardiac rehabilitation and includes information about the aims of the service and the models of service delivery encountered in this research. The second
section is aimed at enabling an informed appraisal of the findings about the nurses’
application of theory in practice and provides a theoretical perspective of the
behavioural models and frameworks that are commonly applied in health care settings.

Chapter four is the final introductory chapter and describes the approach and methods of
research. It commences with a discussion about the nature of this research, which is
followed by justification for the selection of participants and the study sites, the data
collection processes used and the associated methods of inquiry. The chapter concludes
with discussion about the dependability and adequacy of the research. Ethical
considerations relating to the conduct of the study and issues relating to entry into the
field are discussed in the context of the corresponding methods.

The second part of this thesis comprises chapters five, six and seven where the results of
the research are presented. Chapter five is concerned with the theory underpinning
nurses’ behaviour change practice, chapter six describes what this practice entails and
chapter seven explores the impact of organisational practices on the nurses’ work. Each
chapter follows a format that includes illustrative narrative from the interviews.

The third part of this thesis comprises chapter eight and concludes this dissertation with
a summary and discussion of each of the major findings in light of the extant literature.
It also examines the significance of the social milieu in the workplace and the ways that
interrelated issues of power and control impact on nursing work. Conclusions,
limitations of the study, and suggestions for further research are presented in the final
section of the chapter.
In addition to this the thesis has eight appendices. These are:

- Appendix 1: A copy of the Ethics Approval from the University of Wollongong
- Appendix 2: Participant Information Sheets
- Appendix 3: Participant Consent Forms
- Appendix 4: The initial and revised interview schedules that guided data collection
- Appendix 5: The aims of contemporary cardiac rehabilitation
- Appendix 6: Risk factors for cardiovascular disease
- Appendix 7: The processes of change (Prochaska & Velicer 1997)
- Appendix 8: Principles of motivational interviewing

1.7 Background to the Study

There are many interrelated factors that have led to nursing work expanding into areas of health service provision that focus on health promotion, illness prevention and early intervention. All of these are areas of health service delivery that require a focus on health related behaviours. This section provides background information that describes some of the main factors that contributed to the development of the nursing role to these relatively untraditional areas of practice.
1.7.1 Changing Face of Nursing Work in the Community Sector

The founding of community health services across Australia in the mid 1970’s and the subsequent Declaration of Alma Ata Primary Health Care (WHO 1978) brought new dimensions to the nursing role. These impacted mainly on nurses working in the community sector and to a lesser degree nurses working in the public hospital system. The social view of health that underpinned the philosophy of primary health care saw traditional models of nursing as being limited in that they focused primarily on the treatment of medical conditions and were generally based on prescriptive medical orders (O’Connell 2002). While most traditional nursing approaches also included dimensions of patient “care” the focus of nursing work, in both hospital and community-based contexts, was predominantly treatment focused care (Kelly & Symonds 2003).

From an organisational perspective, the primary health care approach was deemed to be more efficient and cost-effective for improving health and wellbeing than a focus on treatment alone (Smith 2000). This shift in focus was immense and quite problematic. The Australian health care system faced the challenge of smoothing the progress of services to promote healthy lifestyles, healthy environments and healthy public policies in an arena dominated by medical and economic influences (Kickbush 1987; WHO 1986, 1997).

The enormity of this challenge was, and continues to be, the assimilation of the primary health care philosophy into nursing roles that have historically been dominated by medical influences (Armstrong 2005; Robinson & Hill 1998; Whitehead 2003).
Essentially this meant that the role evolved to one underpinned by disparate paradigms, which implies that nurses can hold different interpretations of the concept of community health, community nursing and how their work should be carried out.

Community nursing goals were embodied in the concept of prevention and the adage “prevention is better than cure” became the rhetoric not only in the community health setting but also in other areas of health care. The prevention of illness and disability was customarily defined in terms of primary, secondary and tertiary prevention (Ewles & Simnet 1992). While various definitions of these levels of “prevention” exist, due to the lack of boundaries between them, there is general consensus that each level refers to the following:

- Primary Prevention - Measures that prevent the occurrence of an illness or disability;
- Secondary Prevention - Measures aimed at early detection and early intervention;
- Tertiary prevention is aimed at minimising suffering due to poor health, reducing or eliminating long-term impairments and disabilities and, promoting peoples’ adjustment to irrevocable conditions.

Community nurses were considered to be uniquely placed to undertake the varied activities along the primary health care continuum because of their closeness with patients, their families and communities with whom they work (Aitken 1994; Clark 1999; Dines 1994; WHO 2000). As a result, they were expected to embrace the new primary health care philosophy and translate it into their practice.
This line of reasoning lacked consideration of the differences between medical and primary health care models of service delivery. It assumed that the knowledge and skill base required for more traditional medically focused nursing work was also appropriate for meeting the goals of the alternative practices advocated by this all-encompassing philosophy of health care.

The focus on “prevention” was accommodated into the community-nursing role by an increased emphasis on health education at the individual, family, group and community level. While “health education” has been defined in varied ways, the understanding that prevails in the nursing literature is that it has the potential to bring about change; a supposition that is particularly evident in the following passage:

“(Health education is) any activity which promotes health related learning, ie. some relatively permanent change in an individuals’ competence or disposition. Effective health education may thus produce change in understanding or ways of thinking; it may bring about some shift in belief or attitude; it may influence or clarify values; it may facilitate the acquisition of skills; it may even affect changes in behaviour or lifestyle” 

(Tonnes et al. 1990: 6)

The primary health care movement also required the community nurse’s role as health educator to expand to the broader role of health promoter (Kickbush 1987; Robinson & Hill 1995, 1998; Whitehead 2003, 2004). Fundamentally health promotion is an attempt to improve the health status and wellbeing of individuals, communities or populations by means of prevention of disease. The definition also includes the concepts of
empowerment, equity, collaboration and participation provide the means or methods for achieving health promotion goals.

The broader strategies for promoting health are clearly defined in the Ottawa Charter (WHO 1986). These reflect an approach that extended beyond the medical to the social, economic and political milieus and that commands radical changes to the way health services are organized and delivered. The strategies for promoting health advocated by the World Health Organisation (1986) are:

- Building Healthy Public Policy
- Creating Supportive Environments
- Strengthening Community Action
- Developing Personal Skills
- Reorienting Health Services

The way these health-promoting strategies have been realised in Australia varies considerably across different health services, particularly in relation to how they have been translated and incorporated into the community-nursing role. A review by Maben and Clark (1995) suggests that nurses' understandings of the concept are firmly embedded in the more traditional medical approach rather than the new paradigm approach to health promotion. This is reinforced in much of the literature that focuses on nurses’ health promotion work, which suggests that nurses realise these aspects of their role in terms of illness risk factor reduction through individual behaviour and lifestyle changes (Maben & Clark, 1995).
There is considerable argument however, that approaches which focus on ‘individuals’ as opposed to communities and populations are limited in the overall scheme of health promotion. Firstly, it is argued that these approaches are interventions rather than activities aimed at the prevention of illness and disease. Secondly, they are considered limited as they reflect medical forms of care rather than a focus on the broader contextual factors that impact on health (Lindsey & Hartrick 1996; Robinson & Hill 1995, 1998).

While the literature provides numerous examples of nurses undertaking a broad range of health promotion activities in the context of generalist community nursing work, the focus of their overall practice continues to be at the level of individuals, their immediate families and carers (Eagar et al. 2008). This pattern of practice has accommodated the increasing clinical component of this work due to increasing treatment focused health care demands over the past two decades (Kemp et al. 2005).

Regardless of the criticisms surrounding nurses’ health promotion work, practice for bringing about individual patient health-related behaviour change is integral to the role of nurses and other health professionals working in primary health care. Increased attention to this area of health care is warranted not only because of the increasing evidence linking behaviour with the increased risk and occurrence of preventable diseases (Liebson & Amsterdam 2000; Orth-Gomer 1996; Rozanski et al. 2005) but also because related practice is poorly understood and largely taken for granted in many general areas of health care.
One such area is Phase II or community-based cardiac rehabilitation, which provides the service context for this study. Given that the study is seeking to explore nursing processes aimed at bringing about behaviour change, it was considered necessary for the study participants to have considerable experience in this area of practice. Cardiac rehabilitation guidelines stipulate that these services need to be provided by a multidisciplinary team (NHF 2004); however, there is wide acknowledgement that the behavioural aspects of this work are generally carried out within the cardiac rehabilitation nurses’ role (for example: Dafoe & Huston 1997; Harris & Burgess 2003; Jolliffe & Taylor 1998; Nolan & Nolan 1998; Stokes 2000).

The next chapter reviews the literature that focuses on the way nurses seek to bring about behaviour change. Firstly, it examines the shifting direction of nursing work and the way community nursing has evolved in recent years. It then presents an overview of the relevance of behavioural interventions in the primary health care context and discusses the literature that specifically addresses nurse-delivered behavioural interventions.
CHAPTER TWO: BRINGING ABOUT BEHAVIOUR CHANGE: THE LITERATURE

2.1 Introduction

This chapter explores and critiques the literature as it relates to nurses’ behaviour change practice in the community health setting and the objectives of this research. Despite this area of work being an integral component of many nurses’ roles, the way it is carried out in everyday practice remains virtually unexamined. The role of behavioural theory in informing this area of nursing work is also obscure.

To set the scene, this chapter commences with a review of the changing landscape of health care delivery, highlighting some of the major influences that have impacted on the nature of contemporary community nursing work. The relevance of this chapter is that it provides explanation for the way individually focused behavioural interventions are situated in the community health-nursing context. For the purpose of this research, the term community health nurse refers to publicly funded generalist and specialist nurses working from community health centres.

The focus then shifts to the evidence that supports the inclusion of behavioural interventions in health care delivery. Methodological issues associated with intervention research are also discussed as they contribute to the rationale for the current study. The final section of the chapter focuses specifically on nurse delivered behavioural interventions. It emphasises the gaps in knowledge surrounding this area of nursing work and presents the reasoning that underpins the selection of the research context and the participants for the study.
2.2 Health Care Delivery: Shifting Directions of Nursing Work

It is essential that any description of context in studies makes explicit its focus either as a presentation of the complexity of factors that enable effective practice or the way in which organizational systems and structures interact with each other. (McCormack et al. 2002: 97)

In considering the literature relating to nurse-delivered behavioural interventions, it is useful to understand how health care reforms in Australia have developed and impacted on nursing work in recent years, particularly in the community health sector. These reforms have brought about changes that have resulted in a cyclical shift in the focus of community nursing from the broader functions of primary health care, which include health promotion and illness prevention, back to the more specific areas of acute and chronic care. Despite these changes however, the expectation that community health nurses working in primary health care carry out behavioural interventions has remained constant (Kralik & van Loon 2008).

The World Health Organisation’s declaration of Alma Ata (1978) saw the initial focus of primary health care reforms in Australia create a shift in the balance of care from institutional or hospital-based care to community-based services. The aim was to enhance community access to appropriate, accessible and affordable levels of health care (Venturato, Kellet et al. 2005). The Declaration of Alma Ata (WHO 1978) and the subsequent Ottawa Charter (WHO 1986) and Jakarta Declaration (WHO 1997) also advocated that the primary health care health strategy address the underlying social, political and economic causes of ill health.
This direction was translated into the community health sector through a focus on health promotion, preventive health care and early intervention to complement the more traditional approaches to treatment and rehabilitative care (Nesbitt & Hanna 2008; Patterson 2008). The way these functions have been incorporated into community nursing work has varied dramatically however, and has also altered considerably over time in response to the changing priorities for health service delivery (Annells 2008).

Health care reforms and the resultant changes in the organisation of health care, including those to the community nursing role, have been fuelled by escalating health care costs and the influences of economic rationalism (Harris et al. 2008; McDonald & Smith 2001; Orchard 1998; Pusey 2003;), developing technology (Eggert 2005) and an aging population which has resulted in increases in consumer health needs (AIHW 2008). Exacerbating the implementation of these reforms are the increasing shortages in the Australian healthcare workforce, particularly in nursing, medicine and allied health (AIHW 2001, 2004, 2008). The factors above have contributed to ongoing changes in the composition of primary health care teams and the nature of the work carried out by the professionals within these teams (Duckett 2005; Laurant et al. 2007; Zwar et al. 2007). Consequently, these factors have resulted in a more complex community nursing role characterised by a strong emphasis on treatment and at the expense of the broader primary health care functions (Brookes et al. 2004; Ellefson 2001; Kemp, Harris & Comino 2005; Smith 2000;).
The negative impact of shortages in the nursing workforce and the increasing demand for acute and chronic nursing care is well recognised. The accompanying increases in nursing workloads have not only contributed to professional dissatisfaction but have also served to erode aspects of nurses’ health promoting and preventive work (Brookes et al. 2004; Duffield & O’Brian-Pallas, 2003; Kemp et al. 2005).

Although nursing services in primary and community health have advocated a focus on health promotion and prevention in recent years (Keleher et al. 2007), they have succumbed to a more conservative, selective primary health care approach dominated by the medical model. This has resulted in a community-nursing role characterised by the strong emphasis on acute and chronic care (Brookes et al. 2004; Ellefson 2001; Kemp et al. 2005).

This shift in focus has created an anomaly in the way community health nurses are expected to practice. While they aspire to a humanistic ideology and holistic approach, they now find themselves in a health care service context where goals are outcomes-oriented and the emphasis is on efficiency and rationalisation coupled with a strong focus on the technical and scientific (Brookes et al. 2004; Duffield & O’Brian; Pallas 2003; Smith 2000). In other words, changes to the community-nursing role have created a contradiction between a ‘market driven’ health care environment and the values of person-centred practice that nurses espouse (McCormack et al. 2002).
Despite what is professed, market forces have served to reinforce and perpetuate the dominance of the medical establishment which has continued to remain a structural feature of health care systems in Australia and the majority of English speaking countries (Keleher et al. 2007). Acute hospital funding has priority over other health services (Taylor 2008). Additionally, given public sector community nursing falls between state and federal funding it is subject to in multiple funding programs and service agreements, which have resulted in the models of community health nursing varying widely within and across Australian States and Territories (Taylor 2008).

The dominance of the medical model is also evidenced in the educational preparation of nurses (Clark 2005; Gordon 2005) despite the considerable recent changes that have occurred in nursing education throughout Australia, the United Kingdom and the United States of America (Allen et al. 2006; Linsley et al. 2008; Wigens & Westwood 2000). In Australia, educational preparation for community based and primary health care nursing is underdeveloped. Unlike nursing preparation for the acute care sector, there are no guidelines for the minimum educational requirements that are currently “mostly informal and unaccredited” at the registered nurse level (Keleher et al. 2007: 2).

Although many of the recent changes to nurse education reflect the values of humanistic care and “partnerships” between patients and health care providers, they are based on what Clark (2005) classifies as a “dominator” system. This system is characterised by rigid hierarchies that perpetuate a scientific rationale approach to care planning that relies on positivist or logic-based approaches as the only valid models for facilitating professional practice (Clark 2005: 7). Watson (2000: 39) alleges that despite what is professed, nurse education teaches mostly “rules and procedures, rights and wrongs,
specialised terminology, symptom and problem identification, basic disease processes and technical interventions”.

One of the most relevant changes to nurse education has been the shift from hospital-based apprenticeship style training to the preparation of nurses in the tertiary sector (Stein-Parbury 2000); a shift that has resulted in more complex requirements being placed on nurses generally (Gordon 2005; Kralik & van Loon 2008). Given that the current Australian nursing workforce comprises nurses trained in the hospital and tertiary sectors (Ashworth et al. 1999; Stein-Parbury 2000), this change to nurse education has led to differences in nurses’ perceptions of what constitutes the nursing role and how nursing work should be approached and carried out (Brookes et al. 2004). This is particularly relevant to the current study given that some participants were trained in the hospital setting while others were university trained. Irrespective of how nurses are trained however, their education has continued to focus primarily on acute care delivered in the hospital environment, particularly at the undergraduate level (Clark 2005).

Also of concern is recent research that highlights a general dissatisfaction amongst nurses; a situation that is fuelled by multiple, complex and interrelated factors including increasing workload demands and deteriorating work conditions (Duffield & O’Brien-Pallas 2003; Eggert 2005; Forsyth 2006; Goodin 2003; Oulton 2006). Less tangible factors, such as nurses’ expectations about their role and work conditions also contribute to this situation. For example Eggert (2005: 3) argues that a fundamental causative factor for the nursing shortage in Australia is that employers within the public health care sector “do not meet the legitimate workplace expectations of contemporary
nurses. This can be attributed to the hierarchical structure of nursing, which is incongruent with the self-image of professional autonomy and responsibility taught in universities”.

The factors discussed thus far bring to light some of the contextual influences that have impacted on the evolution of contemporary primary health care nursing and the way functions such as health promotion and prevention are currently realised in day-to-day practice. Given “context” is not stable but continually changing, influencing those within it and being influenced by them, the broader and immediate context in which nursing practice occurs is fundamental to the research process and to the interpretation of findings (Crowe 2005).

2.2.1 Evolution of Nursing Models in Community Health

Community health, under the guidance of the Australian 1973 National Community Health Program put forward seven goals for health service provision. These were prevention, participation, self-help, integrated services, area responsibility, teamwork and accountability (Division of Health Services Research 1975). The new community health models evolved differently in each of the Australian states and territories. However, their inception was distinct from hospital oriented planning, as they espoused a population rather than patient focused approach (Owen et al. 2008).
The way these models have developed has been economically as well as politically determined. They have been contingent on the:

“key debates around managing the tensions between the efficiency efforts to reduce utilisation of high cost acute services on the one hand and the need for equity, especially for disadvantaged populations, and access to generalist and basic level care as well as preventive interventions on the other”

(Owen et al. 2008: 33)

The inception of community health services resulted in the scope of nursing work expanding dramatically in that it incorporated work that spanned the health care continuum (see Kralik & van Loon 2008; Stanthorpe & Lancaster 2004). In some area health services, broad generalist models were instigated; these saw community health nurses provide services across the life span, from maternal and child health to chronic aged and palliative care. In others, generalist nurses had a narrower scope of practice, working alongside nurses in specialty areas such as child and family and mental health. Variations of these models were also introduced. As with other aspects of nursing work they have continued to change over time in response to the major influences shaping the Australian health care system (Kralik & van Loon 2008).

Community health nurses have however, continued to espouse common goals. These are to “help a community protect and preserve the health of its members” and to “promote self-care among individuals and families” (Zotti et al. 1996: 212). These goals are broader than those of “community-based nursing” or “district nursing” which was the prevailing model prior to the adoption of the primary health care approach and the
inception of community health services. “Community-based nursing” services differed in that they did not focus on communities per se but on providing treatment and/or personal care in patients’ homes (Keleher 2000; St John & Keleher 2007).

The Australian government has continued to emphasise the importance of health promotion and illness prevention as well as a more balanced approach to funding across the health care continuum (Keleher et al. 2007; Lin & Faukes 2007). Despite this, the dominant contemporary influences in the planning of health services have steered the generalist community nursing role to one that is reminiscent of community-based treatment focused nursing, which were known as “district nursing services” before the introduction of community health centres and generalist community nursing in the early 1970s (Grehan 2008).

Accompanying the narrowing focus of community nursing work in recent years has been an increase in the number of specialist nurses and associated changes in the role delineation of community health nurses. Although there are many variations in the way their roles have been incorporated in the community health sector, they can be aligned with the two main approaches encountered in this research. The first involves generalist nurses working in specialty areas under the guidance of a specialised nurse (clinical nurse consultant or clinical nurse specialist). The second requires specialised nurses to be responsible for the actual delivery of care in their specialty area.
The array of community health nursing service delivery models across Australia and the diversity in the community-nursing role across and within area health services were major considerations when deciding on the service context and the participants for this study. Cardiac rehabilitation was chosen as the service context for study as bringing about patient behaviour change, for the amelioration of cardiovascular risk factors, is a consistent goal in this area of practice (National Heart Foundation 2004).

2.3 Behavioural Interventions In The Primary Health Care Context

In Australia, as in other western countries, the incidence and prevalence of chronic diseases is increasing rapidly and it is predicted that by the year 2020 chronic diseases will account for approximately seventy five percent of all deaths (National Health Priorities Action Council 2006). In response to this growing burden of disease, the present Australian Government has made the goal of effective prevention and management of chronic diseases a key policy objective (National Health and Hospitals Reform Commission 2009).

Underpinning this objective is evidence that one third of the chronic disease burden can be attributed to seven largely preventable risk factors, which are: tobacco smoking, poor diet and nutrition, unsafe alcohol use, excess weight, high blood pressure and high blood cholesterol (AIHW 2006). This evidence also informs the key principles of the Australian National Disease Strategy, which advocates that health promotion and the prevention of chronic illness become national priorities (National Health Priorities Action Council 2006: 9)
Research over the years has left little doubt that the adoption of behavioural and lifestyle changes can prevent, allay or modify chronic disease and/or related risk factors (Armstrong, Bauman & Davies 2000; Ebrahim et al. 2006). The efficacy of various behaviour change interventions has been demonstrated for behaviours including smoking (Lancaster & Stead 2005; Priest et al. 2008; Rice & Stead 2004; Stead & Lancaster 2005; Secker-Walker et al. 2002), alcohol use (Finfgeld, 1999; Foxcroft et al. 2002; Kaner et al. 2007; Wilk et al. 1997), dietary habits (Brunner et al. 2007; Thompson et al. 2003) and physical activity (Ashworth et al. 2005; Foster et al. 2005; Joliffe et al. 2007).

The literature focusing on behavioural interventions for the prevention, reduction, and modification of health related risk factors, is expansive. However, while the effectiveness of various interventions has been demonstrated, a range of methodological issues has been identified and considerable debate remains as to the applicability of these in naturalistic settings (Hulscher et al. 2006; Molloy et al. 2007). Examination of meta-analyses and systematic reviews on trials of behavioural interventions in the Cochrane Data Base reveals issues relating to the heterogeneity in the type of interventions, study populations, duration of the interventions follow-up time and outcome measures. While randomised controlled trials are regarded as “gold standard” for assessing therapeutic effectiveness of behaviour change interventions and determining best practice approaches (see Molloy et al. 2007), the issues raised by meta-analyses and systematic reviews bring into question the extent to which “evidence-based” interventions are implemented in practice, or for that matter their level of appropriateness in naturalistic settings.
Aside from individual case research and a few population-based trials and quasi-experimental research, health behavioural intervention studies have been largely restricted to narrow contexts or controlled settings removed and/or isolated from the broader natural health care setting. The containment of intervention research can be partly attributed to the existing rules of “scientific” evidence which are underpinned by the premise that ‘science’ is best served by studies that examine interventions with relatively uncomplicated and demonstrable chains of causation (McQueen 2000).

In contrast, behavioural interventions carried out in the community health context are generally complex and frequently involve multidisciplinary and multifaceted approaches in dynamic settings (Hulsher et al. 2001; McDonald & Hare 2004). By their very nature, the multidisciplinary and integrated models of care currently mandated by the Australian government (Davies et al. 2009) beg the development of innovative research designs to determine the effectiveness of their varying components.

Given the nature of these interventions, the main shortfall of traditional studies of effectiveness is the difficulty in isolating the contribution of professionals involved and elements of intervention most responsible for benefits. This is compounded when multiple behaviours are the focus for intervention. Examples include chronic disease self-management programs (Chodosh et al. 2005), secondary prevention programs for coronary artery disease (Alexander et al. 2005; Eshah & Bond 2009; Linden et al. 2009;), obesity programs (Galani & Schneider 2008; Summerbell et al. 2009; Wilfley et al. 2007), and lifestyle programs aimed at reducing hypertension (Dickinson et al. 2006).
Overriding these concerns however, is the issue that is at the heart of this study. That is, there is a lack of explanation and in-depth description as to how the various elements of behavioural interventions are actually carried out. In the majority of studies “the intervention process” is described briefly, if at all. The same applies to the many contemporary practice guidelines that call for the use of behavioural counselling and yet fail to explicate what this type of counselling involves (Kaplan 2009).

Having said this, detailed descriptions of intervention processes may not be required to evaluate effect. Interventions that involve little personal interaction, such as providing or exposing patients to educational material or other stimulus, provide such an example. When interventions call for considerable interaction between the patient and service provider, they are likely to be more complex and convoluted and their elements are more difficult to isolate while at the same time being potentially relevant to the outcome.

2.4 Nurse-Delivered Behavioural Interventions: The Literature

Research focusing on nurse-delivered behavioural interventions has grown steadily over the years. However, a review of the literature for this research has proved complex. Firstly, nurse-delivered behavioural interventions address a vast array of health related behaviours in numerous health care settings. There are also wide variations in the way these interventions are organised and carried out, as well as the content of these interventions.
Multidisciplinary interventions present further complications due to the difficulty in isolating nurses’ contribution to the overall interventions as their effectiveness is attributed to combined efforts. The small but increasing body of research focusing on the effectiveness of “nurse-led clinics” provides further example of difficulty in isolating nurses’ contribution to multidisciplinary approaches. In this type of setting nurses play a co-ordinating or key facilitative role and provide services alongside other health professionals (Wong & Chung 2006). The settings for these clinics include general practice, community health centres and hospitals and focus on health areas such as the secondary prevention in coronary heart disease (Campbell et al. 1998; Murchie et al. 2003, 2005; Page et al. 2005;), diabetes (New et al. 2003; Carey 2007) and asthma (Smith et al. 2005).

It has been widely claimed that nurse delivered behavioural interventions are potentially efficient, effective and practical ways of addressing the growing burden of chronic disease in communities (Ades 2002; Allen 2000; Campbell 1998; Cobb et al. 2006; Hartley 2002; Miller et al. 1996; Schenk & Hartley 2002). They have been shown to be successful, ranging from those devoted solely to changing single behaviours such as smoking (see Krainuwat 2005; Lai et al. 2009; Rice 2006), alcohol consumption (Holloway et al. 2006; Lock et al. 2006), and diet (Jaireth et al. 2002) to those that focus on multiple health behaviours (for example: Koelewijn-van Loon et al. 2008; McKee et al. 2007; Sharma 2007).
There are also several studies where nurses’ practice for bringing about behaviour change is part of a broader intervention involving multiple nursing processes. For example: screening programs such as the Oxcheck and British Family Heart studies (Wonderling 1996), risk factor trials such as the SPLINT program which focused on the reduction of hypertension and hyperlipidemia in diabetes (New et al. 2009), trials addressing the general risk factors for coronary heart disease (Campbell 1998; Halcom et al. 2007) programs addressing the management of various chronic diseases (see Kreindler 2009) and various rehabilitation programs including cardiac rehabilitation (Eshah & Bond 2009; Taylor et al. 2009).

Further complicating this review of literature are the numerous approaches applied to behavioural interventions and the language used to describe them. While some interventions are simply referred to as “behavioural” (for example: Jairath et al. 2002), others are classified as “risk factor modification”, “prevention”, “lifestyle modification” “health promotion”, “educational” or “counselling” activities. These different approaches and associated discourses reflect the many influences that have contributed to the evolution of this area of nursing work. However, they also create different and at times conflicting perspectives of what behavioural interventions entail. This makes it difficult to establish best practice approaches.

Although this may seem non-problematic, there is considerable confusion and often a lack of understanding as to the meaning of these terms and their theoretical underpinnings. As Whitehead (1999, 2001, 2003) explains, this is evidenced in the literature where some of these terms are used interchangeably. Adding to the lack of consistency in naming nursing behavioural interventions for bringing about behaviour
change is the lack of detailed description of the various elements the intervention processes entail. Overarching and somewhat taken-for-granted terms including “counselling”, “education”, “motivating”, “guiding” and “supporting” are commonly used to categorise or describe the elements of behavioural interventions. However, little or no attention is given to the potential variance associated with the way individual nurses understand and carry out these aspects of practice.

2.4.1 Theoretical Approaches to Behavioural Interventions

There is also an increasing body of literature focusing on nursing interventions guided by behavioural theory. Generally, these are described in more detail than non-theoretical approaches. However, it is more common for the various elements of the theoretical model or framework to be described rather than how they are actually applied as methods in the intervention process. As explained previously, by ignoring individual differences in the way these processes are applied, it is assumed that they are delivered in a consistent way.

The most commonly applied behavioural theory in nursing intervention research is Bandura’s (1977) Social Cognitive Theory, more specifically applications of his “self-efficacy” construct (Bandura 1977; 1997). Various models and frameworks that include aspects of Bandura’s theory are more commonly adopted; these include Prochaska and Di Clemente’s (1983, 1984) Stages of Change Model also known as the Transtheoretical Model of behaviour change and in more recent years Miller and Rollnick’s (1991, 2002) Motivational Interviewing counselling method. These models are described in more detail in the next chapter.
Nursing interventions adopting the Stages of Change model address health related behaviours including: smoking cessation (Rice 2006) the promotion of physical activity and exercise (Adams & White 2003; Marshall & Biddle 2001), dietary change (Salmela et al. 2009) and substance use (Riesma et al. 2002) as well as multiple health behaviours (Deveraux et al. 2005) including those addressed in specific health care settings such as cardiac rehabilitation (see McKee et al. 2007).

There have been a number of systematic reviews that have examined the efficacy of motivational interviewing (Britt et al. 2003, 2004; Burke et al. 2003; Dunn et al. 2001; Lai et al. 2009; Rubak et al. 2005). Its success in several trials aimed at changing behaviours associated with increased risk of cardiovascular disease, have contributed to its being recommended as a potentially useful approach for facilitating behaviour change in cardiac rehabilitation (Everett et al. 2008; Hancock et al. 2005; Webber 2003). However, while this approach is gaining popularity in various areas of health care, to date its application outside the areas of substance abuse and addictive behaviours is limited.

A recent study by Everett et al. (2008) provides a comprehensive outline of the intervention methods involved in motivational interviewing, which is uncommon in nursing intervention research. The general pattern in the nursing literature focusing on theory-based interventions is that of describing the theory or model rather than the application of its elements.
This lack of detail limits the extent to which behavioural interventions can be replicated and poses a challenge as to how behavioural interventions can be incorporated into daily nursing practice in areas such as chronic disease management and cardiac rehabilitation.

In recent years, the issue of nurse competency for carrying out behavioural interventions has received particular attention. The reasons frequently cited for nurses not delivering this type of health promotion and disease prevention oriented care is a lack of training and skills and associated lack of confidence (Burke & Fair 2003; Frantz 1999; Pelletier et al. 2000; Stokes 2000). However, there is little research that addresses nurse competencies in this area of work; that is, their knowledge, skills and confidence levels. The relatively negligible attention that has been paid to the nature of knowledge nurses need to effectively carry out individually focused behavioural interventions is concerning.

2.5 Conclusion

In summary, various health care reforms have impacted on the nature of nursing work within a primary health care framework. The assimilation of the broader functions of primary health care into everyday community nursing practice has been gradual and in some cases cyclical due to competing organisational influences. The reasoning that underpins the need for behavioural interventions in health care settings has also been explored.
The evidence relating to nurses’ involvement in the behavioural aspects of health service delivery has highlighted a considerable knowledge gap. While the value of theoretical approaches to individual behaviour change is also recognised their application within the community-nursing context has been sporadic and inconsistent.

Although various nursing approaches to individually focused behavioural interventions have been shown to be effective, very little is actually known about how nurses carry out the elements of practice that make this so. The nature of intervention research and the methodological issues associated with it, present difficulties in identifying nurses’ contribution to positive behavioural outcomes. They also bring into question the applicability and appropriateness of various interventions in naturalistic health care settings.
CHAPTER THREE: CARDIAC REHABILITATION AND THEORIES OF BEHAVIOUR CHANGE

3.1 Introduction

The first section of this chapter focuses on Phase II cardiac rehabilitation. It aims to enable the reader to situate the findings in the service context where the participants’ behaviour change practice takes place. Sometimes referred to as community-based or outpatient cardiac rehabilitation, Phase II cardiac rehabilitation is part of a comprehensive three or four stage rehabilitation program that aims to maximise the physical, psychological and social functioning of patients with various forms of cardiovascular disease.

Nurses play a key role in the delivery of cardiac rehabilitation (Eshah & Bond 2009). Defining the role of the cardiac rehabilitation nurse is complex however, as there is an overlap between the clinical, psychological and educational components of this work. More importantly, while the clinical aspects of this work are well defined the psychological components are more or less taken for granted aspects of this nursing role.

The second part of this chapter introduces and describes the most commonly applied theoretical approaches for behavioural interventions in health care settings. This overview is not restricted to behavioural models that are known to be applied by nurses. An understanding of these models prior to delving into the findings of this research provides a theoretical perspective of the different approaches nurses may be adopting in practice. Given the objectives of this research, it is also considered important for the
reader to have some understanding of current theories that explain the phenomenon of individual behaviour change.

3.2 Cardiac Rehabilitation: Background

The World Health Organization Expert Committee defines cardiac rehabilitation as:

….the sum of activities required to influence favourably the underlying cause of the disease, as well as the best possible physical, mental and social conditions, so that they (patients) may, by their own efforts preserve or resume when lost, as normal a place as possible in the community.

(WHO Expert Committee 1993: 5)

Cardiac rehabilitation is a rapidly developing area of health care designed to address the management of patients with various forms of cardiovascular disease and/or related events including myocardial infarction. The goals of cardiac rehabilitation are to decrease disability, as well as prevent and decrease recurrent coronary events, associated hospitalisations and death (WHO 2009).

Coronary heart disease (CHD), also called ischaemic heart disease, is the most common cause of sudden death in Australia and affects 1 in 6 Australians or 3.2 million people. This figure is predicted to rise to 1 in 4 or 6.4 million by the year 2051 (NHF 2005). Coronary heart disease encompasses several conditions, including angina and myocardial infarction, which are manifestations of the underlying condition known as
coronary artery disease which results from fatty plaque building up inside the arteries; this in turn can cause blockages or obstructions to the flow of blood in the coronary arteries (Smith & Ruiz, 2002).

There is considerable evidence that specific risk factors increase the likelihood of coronary heart disease and related events (Heslop et al. 2001; Kannell 2002; Liebson & Amsterdam 2000; Lindsay & Gaw 2004; Newby et al. 2006) and that a combination of risk factors may have an interactive and cumulative effect on the total risk (NHF 2005). Some risk factors such as age, genetics, family history and being male, are non-modifiable, however others, such as the traditional behavioural and bio-medical risks and various psychosocial risk factors, are considered amenable to intervention (See Appendix 6).

Cardiac rehabilitation has progressed from the early 1900s when heart attack patients were confined to two months bed rest, for fear that physical activity would lead to the development of complications such as ventricular aneurisms, cardiac rupture and even death (Froelicher 1988), to the current day where comprehensive programs commence soon after patients are admitted to hospital (Eshah & Bond 2009).

The evolution of cardiac rehabilitation corresponds with the advances in medicine and medical technology over the past century. The most significant breakthroughs are considered to be continuous electro-cardiographic monitoring (ECG) and the introduction of pharmaceuticals including beta antihypertensives and various lipid-lowering drugs (American Association of Cardiovascular and Pulmonary Rehabilitation...
Other advances contributing to contemporary approaches to cardiac rehabilitation relate to the growing recognition of the role of behavioural, psychological and social factors in the development of coronary heart disease (Aroney et al. 2006; Burg & Berkman 2002; Hemmingway & Marmot 1999; King et al. 2001; MacLeod & Davey Smith, 2003; Orth-Gomer & Schneiderman 1996; Smith & Ruiz 2002; Thompson 2007).

As well as the established links between psychological factors such as depression, anxiety and hostility, factors associated with the social environment such as social isolation are also known to contribute to negative emotions and behaviours known to precipitate manifestations of coronary heart disease (Aroney et al. 2006; Bunker et al. 2003; Carroll et al. 2001; NHF 2003; Smith & Ruiz 2002). Negative emotions such as excessive stress confer a definite risk in that they can contribute to biomedical risk through behavioural pathways such as smoking and inactivity (Smith & Ruiz 2002). The link between psychosocial risk factors and coronary heart disease is further complicated when factors such as individual beliefs, attitudes and emotions are considered (Paquet et al. 2005; Sobel 1995).

Given that the majority of risk factors for coronary heart disease are related to behavioural, psychosocial factors and bio-medical risks, cardiac rehabilitation care has moved from more traditional medical, pharmacological and exercise only approaches to interventions that consider the management of the broader range of risk factors (Balady et al. 2000; NHF 2003, 2004; Smith et al. 2001; Wenger et al. 1995).
These advances have led to cardiac rehabilitation being a cost effective strategy for the secondary prevention of recurrent coronary events in people with pre-existing cardiovascular disease (National Health Priority Action Council [NHPAC] 2006). In countries with a high prevalence of coronary heart disease, cardiac rehabilitation is considered to be a priority and essential aspect of care (Balady et al. 2007; Graham et al., 2007; Camm et al. 2006).

### 3.2.1 Contemporary Cardiac Rehabilitation

In Australia cardiac rehabilitation is an important and integral component of the treatment and care offered to people who suffer from angina, have suffered a heart attack and/or who have undergone cardiac surgery and procedures including coronary by-pass and coronary angioplasty. Some programs also cater for patients with stable angina or chronic heart failure (AIHW 2004). The broad and specific aims of contemporary cardiac rehabilitation in Australia are outlined in Appendix 5.

Cardiac rehabilitation has evolved into a multifaceted and multidisciplinary process that offers patients a long-term programme of medical and pharmacological treatment and cardiac risk factor modification through strategies including exercise prescription, education and counselling (AACVPR 2004, ACRA 2008).

There is considerable evidence that suggests a multifactorial approach to cardiac rehabilitation, which includes exercise and psychosocial interventions, is associated with lower morbidity and mortality rates in that it can reduce the incidence of cardiac events (Joliffe et al. 2007; Murchie et al. 2003; Rozanski et al. 2005; Taylor et al. 2004).
Cardiac rehabilitation is also known to contribute to fewer readmissions to hospital and shorter length of hospital stay (Sinclair et al. 2005). Physical and psychosocial benefits resulting from cardiac rehabilitation have also been demonstrated; these include significant improvements in self-esteem and health related quality of life, dietary behaviour and weight loss, increasing physical activity and smoking cessation (see Wachtell et al. 2008).

The National Heart Foundation of Australia (2004) and the Australian Cardiovascular Health and Rehabilitation Association (2008) advocate an integrated multidisciplinary approach to the delivery of cardiac rehabilitation services. While nurses are the majority of professionals who co-ordinate and deliver these services, doctors, physiotherapists, occupational therapists, nutritionists and psychologists also form part of the multidisciplinary team.

It is important to note however, that the professional mix, the differences in expertise between professionals and the extent of multidisciplinary involvement vary considerably across, and at times within, Area Health Services. These differences relate to factors including the service delivery model/s within a particular area, resource constraints, geography, population and the availability of health professionals. Irrespective of the service delivery model, the modification of the patient’s risk factor profile is fundamental to all cardiac rehabilitation interventions (ACRA 2005, 2008; Donker, 2000; NHF 1998, 2004).
The recommended management for preventing cardiovascular events highlights the multifaceted and complex nature of the work for preventing and/or reducing behavioural and psychosocial risk factors. It also provides an indication of the need for input from a variety of health professionals (see Table 3.1).

Contemporary Australian cardiac rehabilitation programs include three distinct and sequential phases. Phase I commences soon after a patient is admitted to hospital and focuses primarily on medical and pharmacological management. Phase II is implemented post discharge and involves patient follow-up by specialist teams and Phase III, commonly referred to as maintenance, describes measures that aim to assist patients continue to practice and maintain behaviours introduced in the earlier phases of the program (NHF & ACRA, 2004).

Phase II cardiac rehabilitation, also described as community-based or outpatient cardiac rehabilitation, provides the service delivery context for this study. It has been defined as any cardiac rehabilitation that is delivered entirely or in part outside the traditional hospital setting (Harris & Record 2003). While this phase of rehabilitation generally follows a period of hospitalisation, it also includes services such as group and exercise programs conducted in the hospital setting. This phase of the rehabilitation process includes and complements individual medical care delivered by medical specialists and general practitioners (NHA & ACRA 2004).
Table 3.1: Recommended management for preventing cardiovascular events

<table>
<thead>
<tr>
<th>Intervention Focus</th>
<th>Core Components</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lifestyle and Behavioural Risk-Factor Management</td>
<td>Smoking Cessation</td>
</tr>
<tr>
<td></td>
<td>Nutritional Counselling</td>
</tr>
<tr>
<td></td>
<td>Alcohol Counselling</td>
</tr>
<tr>
<td></td>
<td>Physical Activity Training</td>
</tr>
<tr>
<td></td>
<td>Weight Management</td>
</tr>
<tr>
<td>Bio-medical Risk Factors/Medical Management</td>
<td>Lipid Management</td>
</tr>
<tr>
<td></td>
<td>Hypertension Management</td>
</tr>
<tr>
<td></td>
<td>Diabetes Management</td>
</tr>
<tr>
<td>Pharmacological Management</td>
<td>Anti-platelet Agents</td>
</tr>
<tr>
<td></td>
<td>ACE Inhibitors</td>
</tr>
<tr>
<td></td>
<td>Statins</td>
</tr>
<tr>
<td></td>
<td>Anti-coagulants</td>
</tr>
<tr>
<td></td>
<td>Other</td>
</tr>
<tr>
<td>Non Pharmacological Management</td>
<td>Implantable Cardiac Defibrillators</td>
</tr>
<tr>
<td></td>
<td>Secondary Prevention/Cardiac Rehab. Programs</td>
</tr>
<tr>
<td></td>
<td>Management of Chest Pain and Discomfort</td>
</tr>
<tr>
<td>Psychosocial Factors and Assessment</td>
<td>Psychological Management</td>
</tr>
<tr>
<td></td>
<td>Social Management</td>
</tr>
</tbody>
</table>

Adapted from: National Heart Foundation of Australia (2004b)

There are various program models in Phase II cardiac rehabilitation and these largely determine the role nurses play in the overall rehabilitative process. These include the traditional group model where supervised exercise graduation is the primary focus and alternative programs such as individually focused home-based programs, case management models and interventional or managed care programs (Stone et al. 2005). Irrespective of the program model, the main elements of Phase II cardiac rehabilitation outlined in current Australian guidelines (National Heart Foundation 2004) inform this area of health care overall (See Table 3.2).

The elements of Phase II cardiac rehabilitation that relate to nurses’ behaviour change practice are “education, discussion and counselling”. However, while the terms reflect
aspects of generalist community nursing work (Bramadat et al. 1996) and competencies for cardiac rehabilitation nursing (AIHW 2004; Stokes 2000), describing behaviour change practice in this way lacks clarity as there are many understandings of the terms and variations as to how these aspects of practice are actually carried out.

The need for comprehensive guidelines and protocols for nurse practice for delivering psychosocial interventions was highlighted over a decade ago (Crookes et al. 1997). However, there is still a question as to whether nurses working in areas such as cardiac rehabilitation possess the relevant knowledge and skills to carry out this work. This can be expected given the paucity of research concerned with describing how nurses actually deliver the various elements of their behaviour change practice.

The requirements for bringing about successful behaviour change are vastly different from those required for treatment focused work. Unlike the specific protocols that guide treatment interventions, there are several theoretical approaches, models and frameworks that inform processes for bringing about behaviour change.
Table 3.2: Main Elements of Phase II Cardiac Rehabilitation

**Assessment, Review and Follow-up**
- Individual assessment and regular review, which includes attention to physical, psychological and social parameters.
- Referral to appropriate health professionals and services as required.
- Discharge or summary letters sent to the GP, cardiologist and other primary care provider as nominated by the patient.

**Low or Moderate Intensity Physical Activity**
- Can include a supervised group or individual program, including a warm-up and cool-down period, and catering for the individual needs and capacities of each patient.
- Resistance training as appropriate
- Written guidelines for resumption of daily activities, including a home walking program, and aiming to accumulate a minimum of 30 minutes of light to moderate intensity physical activity on most, or all, days of the week.
- Individual review of a physical activity program on a regular basis (at least three times during participation in the program).
- Instruction in self-monitoring during physical activity

**Education, Discussion and Counselling**
- Basic anatomy and physiology of the heart.
- Effects of heart disease, the healing process, recovery and prognosis.
- Risk factors for heart disease and their modification for ongoing prevention (e.g. smoking cessation, physical activity, healthy eating, control of blood lipids, weight, blood pressure and diabetes).
- Supporting skill development to enable behaviour change and maintenance.
- Resumption of physical, sexual and daily living activities including driving and return to work and/or full activities.
- Psychological issues e.g. mood (depression), emotions, sleep disturbance.
- Social factors e.g. family and personal relationships, social support/isolation.
- Management of symptoms e.g. chest pain, breathlessness, palpitations.
- Development of an action plan by patient and carer to ensure early response to symptoms of a possible heart attack.
- Medications e.g. indications, side effects, importance of concordance.
- Investigations and procedures.
- Cardiac health beliefs and misconceptions.
- The importance of follow-up by specialist, GP or other primary care provider

Adapted from: Australian Institute of Health and Welfare (AIHW) 2004
“Best Practice” guidelines recommend a ‘stage’ approach for the behavioural aspects of Phase II cardiac rehabilitation (Australian Cardiac Rehabilitation Association, 1999; Goble & Worchester, 1999; NHF 1998, 2004). However, it is not within the scope of these guidelines to provide explanation of how to go about the processes that make up this approach. Given nurses are not given practical instruction in the application of this or other theoretical approaches in their general training, gaining knowledge and developing skills in this area of work is largely a matter of exposure to these models in the course of their work and/or ongoing education and personal choice.

3.3 Theories and Behavioural Models In The Context Of Healthcare

The recognition that living a healthy lifestyle can prevent heart disease and other chronic illnesses has been met with a search for interventions that can potentially facilitate behaviour change and health management skills (Elder et al. 1999). The need to bring about such changes has led to many health professionals drawing on the social and behavioural sciences for theories and models to guide their practice. Given that the focus of this research is nursing practice for bringing about patient behaviour change, this section will briefly overview some of the main theories and models that aim to explain, predict and influence individuals’ health behaviours, specifically those the literature suggests are most frequently applied in the health care sector.

Theories of health behaviour range from those adopting an ecological or social view of health, which considers the diverse factors impacting on health, such as policy, environment and social context, to those that focus primarily on individuals. The
majority of contemporary behavioural models applied in the health care sector however, have stemmed from Social Learning Theory (Bandura, 1977, 1986, 1997) and fit into the broad category of cognitive behavioural theories. The main assumption underlying cognitive approaches is that behaviour is mediated through cognition and that while knowledge is generally necessary to produce behaviour change it is not sufficient given that behaviour is influenced by other factors.

Reviews conducted by Noar et al. (2007), Noar & Zimmerman (2005) and Glanz et al. (1997) found four influential and commonly used cognitive models of behaviour change:

- **The Health Belief Model** (Becker 1974, Janz and Becker, 1984)
- **The Theory of Reasoned Action/Theory of Planned Behavior** (Ajzen 1985)
- **The Transtheoretical Model of Behavior Change** also known as the **Stages of Change Model** (Prochaska & Di Clemente 1983)
- **Social Cognitive Theory** (Bandura, 1986, 1997).

Additionally, **Motivational Interviewing (MI)**, a counselling method introduced by William Miller (1983) has increased in popularity and application in the health care sector over the past decade. Miller and Rose (2009: 527) have proposed an emergent theory of MI which emphasises two active components: “a relational component focused on empathy and the interpersonal spirit of MI, and a technical component involving the differential evocation and reinforcement of client change talk.”
The behavioural models outlined thus far are described in detail in the following sections.

### 3.3.1 The Health Belief Model

The Health Belief Model (Becker 1974; Janz & Becker 1984) is one of the longer established of the theoretical models designed to explain and predict health behaviour. Originally developed to explain individual participation in preventive public health programs such as health checks and immunization, the model has been applied to a variety of health behaviours over the past thirty years. The core assumption underpinning the Health Belief Model is that the likelihood of an individual taking health related action related to a given health problem depends on the interaction between four different types of health belief (Figure 3.1).
The four different types of health beliefs are the extent to which individuals:

- Perceive themselves to be susceptible to a particular condition or problem.
- Believe it will have potentially serious consequences for them or others.
- Believe a course of action is available which will reduce their susceptibility, or minimise the consequences.
- Believe that the benefits of taking action will outweigh the costs or barriers.

(adapted from: Nutbeam & Harris 1998)
Interventions based on the Health Belief Model generally involve predicting if individuals will engage in positive health behaviours by determining their perception of their condition, identification of modifying factors, and the likelihood of their taking desired action (Becker 1974). Becker considers the most influential determinants of individual behaviour change are their perceived barriers and whether or not they consider achieving an improved health status as a valuable outcome.

Guidelines for applying the Health Belief Model generally include three major components (Elder, Ayala & Harris 1999). The first involves assessing the patient’s perceived susceptibility to a particular illness and its severity, which assists health messages to be structured according to these perceptions. The second component involves eliciting the patient’s perceived barriers to changing certain health behaviours and then discussing ways to overcome these barriers. The third strategy requires assessing the perceived benefits of changing behaviour and incorporating these into the intervention process as positive reinforcement for change.

3.3.2 The Theory of Reasoned Action

The Theory of Reasoned Action is a widely used behavioural prediction theory, which represents a social-psychological approach to understanding and predicting the determinants of health behaviour (Redding et al. 2000). Like the Health Belief Model it focuses on identifying individual characteristics, beliefs and values that are associated with health behaviours. Initially developed by Ajzen and Fishbein in 1974 the Theory of Reasoned Action is based on the assumptions that individuals are rational beings, their
behaviour is under their voluntary control and that their intention to act is the most immediate determinant of behaviour (Redding et al. 2000)

Ajzen and Fishbein (1980) further developed their Theory of Reasoned Action by adding *perceived behavioural control* as an additional influence on actual behavioural control and renamed it the Theory of Planned Behaviour. The main elements of the theory are outlined in Figure 3.2.

Theory of Reasoned Action proposes that a person’s intention to act is influenced by three theoretically independent constructs: attitudes, subjective norms and perceived behavioural control. Ajzen and Fishbein defined the three independent constructs as follows (1980):

- **Attitudes** refer to a person’s evaluation of the behaviour in question. That is the degree to which performance of the behaviour is positively or negatively valued and their belief that a desired outcome will occur if that particular behaviour is carried out (behavioural beliefs).

- **Subjective norm** relates to perceived social pressure to perform a particular behaviour, that is, a person’s beliefs about what other people think he or she should do (normative beliefs), and the extent to which the individual desires to comply with other people's wishes.

- **Perceived behavioural control** refers to a person’s perception of the difficulty involved in performing the behaviour. The greater the sense of control, the greater the intention to perform the behaviour. Behavioural control is determined by a
person’s beliefs about the presence of factors that may facilitate or hinder performance of the behaviour.

Figure 3.2: Major Elements of the Theory of Planned Behaviour

According to Ajzen and Fishbein’s theory (1980), attitudes, subjective norms and perceived behavioural control, combine to determine a person’s intention to perform a particular behaviour. Intention is considered to be the immediate antecedent of behaviour, which is the visible response in a given situation. Successful performance of a particular behaviour however, depends not only on favourable intention but also on actual behavioural control, which is the extent to which a person has the skills, resources and other prerequisites to perform the behaviour.
Guidelines for applying the Theory of Reasoned Action include four major components (Elder, Ayala & Harris 1999). The first is to determine whether the patient’s significant others, for example family and friends, endorse the behaviour and then, if endorsed, the second component involves highlighting the social pressure to engage in the desired behaviour. The process is supported by providing examples of others who engage in the desired behaviour. A fourth component is to use specific examples of desired behaviours when assessing behavioural intentions.

Over years the Theory of Reasoned Action has been applied to several diverse health-related behaviours including weight loss, smoking, alcohol abuse, HIV risk behaviours, and mammography screening. Applications of the theory however, have focused primarily on behavioural intention and the prediction of behaviour change rather than on the behaviour change itself (Redding et al. 2000).

3.3.3 Social Learning Theory

Bandura’s (1977, 1986, 1996) Social Learning Theory, also known as Social Cognitive Theory has been described as the most comprehensive theory of human behaviour change (Redding et al. 2000). It proposes that behaviour can be explained in terms of continuous interchange between three key factors which operate as determinants of each other: the individual, the environment and behaviour. A change in one of these factors impacts on the other two (Bandura 1997). This concept, known as reciprocal determinism, forms the basic organising principle of Bandura’s theory.
According to Social Learning Theory, the behaviour change process is a function of setting personal goals that are based on the outcome a person expects from changing behaviour (outcome expectations), the tasks required to achieve these goals and self-efficacy expectations for performing those tasks (Bandura 1977, 1986, 1989, 1997; Bandura, Adams & Bayer 1977). Self-efficacy is a core concept of Bandura’s theory and is described as an individual’s belief of their ability to perform certain behaviours. The theory proposes that self-efficacy is the most important prerequisite for behaviour change, as it underpins how much effort a person puts into a task and what the outcome of that task will be.

Bandura’s concepts of ‘observational learning’, and ‘participatory learning’ (i.e. learning by supervised practice and repetition) are also considered important as they potentially lead to the development of the knowledge and skills necessary for behaviour change (behavioural capability) and are considered powerful tools in building self-confidence and self-efficacy (Nutbeam & Harris 1998). A person’s self-efficacy is understood to play a crucial role in determining a person’s persistence and effort for changing behaviour (McDermott 1995).

Self-efficacy can be developed through a variety of means such as past performance accomplishments, vicarious experiences, social and verbal persuasion, and physical or emotional arousal (Bandura, 1977, 1986, 1997). The importance of this construct in the context of behaviour change has been widely recognised and as a result it has been incorporated into other major theories and models of behaviour change including the Health Belief Model and the Transtheoretical Model of Behaviour Change (Redding et al. 2000).
Bandura’s work provided the foundation for the social cognitive perspective in psychology, which can be described as a synthesis of behavioural, cognitive and social elements. Acknowledgment of the dynamic and reciprocal relationship between an individual, their behaviour, and the environment highlights the complexity of health problems and the limitations of interventions that focus on behaviour in isolation from the social and physical environments. Understanding the way in which the physical and social environments provide incentives and/or disincentives for different behaviours indicates ways of constructing interventions that can modify these environments to further support healthy behaviours and provide opportunities to change (Nutbeam & Harris 1998).

3.3.4 Transtheoretical Model of Behaviour Change

Available research suggests that the intervention model that is the best known and widely adopted in recent years for facilitating behaviour change is Prochaska and Di Clemente’s (1983, 1985) Transtheoretical Model of Behaviour Change (TTM). The model integrates constructs from other major theories and combines them to develop a framework and guidelines for intervention.

The model has two principal components: stages of change, and the processes of change including the levels of change (Proachaska et al. 1992). The model is based on the premise that there is a temporal and experiential dimension to behaviour change and that the processes involved and influencing variables differ throughout the change process (Proachaska et al. 1992).
The central organising construct of the model is *Stages of Change*. These stages are not linear as individuals can move backwards and forwards between the stages or discontinue the change process at any time. The five stages of the behaviour change process proposed by the model are as follows (Prochaska & DiClemente 1983; Di Clemente et al. 1991):

- **Pre-contemplation** – no intention to change behaviour
- **Contemplation** – considering making a change in behaviour
- **Preparation** – commenced making small changes
- **Action** – actively engaging in new behaviour
- **Maintenance** – sustaining behaviour change over time

Additional stages named ‘relapse’ and ‘termination’ have also been identified (Prochaska et al. 1992). Relapse refers to the individual reverting to a stage before maintenance. Termination is a stage that relates to some specific behaviour such as addictions and it signifies when individuals have a new self-image and no temptation to revert to previous behaviour.

The second principle component of the Transtheoretical Model is called the *processes of change*, which includes ten experiential strategies and techniques that individuals and/or change agents use to modify problem behaviours (Prochaska & DiClemente 1983, 1984). The *processes of change* provide some explanation as to how shifts in behaviour occur (Prochaska et al. 1992).
They are described as including cognitive, emotional, behavioural and interpersonal processes. Intervention research adopting the Transtheoretical Model has demonstrated that successful behaviour change depends upon the use of specific processes at specific stages (Prochaska et al. 1993). The ten processes of change are summarised in Appendix 7.

One of the key constructs of the Transtheoretical Model is “decisional balance” which can be explained as the comparison of potential gains and losses or “pros and cons” of the behaviour change process. Decisional balance varies according to the individual’s current stage of change (Janis & Mann 1977). Another key construct that is fundamental to the change process is self-efficacy (Bandura, 1986, 1997) in that progression through the stages of change are associated with a corresponding increase in self efficacy, with the lowest level being in the pre-contemplation stage (Prochaska & Di Clement 1992).

The utility of this model has been described as its usefulness for designing interventions that facilitate movement from one stage to the next (Velicer et al. 1999). The model also provides a framework for determining which psychosocial and perceptual factors are most critical for moving an individual through the stages of change and when these factors are important (Prochaska & Velicer 1997).

A counselling method closely associated with the Transtheoretical Model of behaviour change is Motivational Interviewing (Miller 1983, Miller & Rollnick 1991, 2002). The strength of this method is its usefulness for facilitating a person’s movement through the various stages of change (Schinfeld & Kub 2001).
3.3.5 Motivational Interviewing

Motivational interviewing is a directive client centred counselling method for bringing about behaviour change (Miller & Rollnick 2002). The method was first described as a brief intervention for problem drinking (Miller 1983). Since then it has been applied extensively as an intervention in a wide range of other health areas where patient motivation poses a common challenge (Miller & Rose 2009; Rollnick et al. 2007).

Underpinning this approach is the premise “As I hear myself talk, I learn what I believe” in other words, “we can literally talk ourselves into (or out of) things” (Miller and Rollnick 2002: 21). The foremost means by which motivational interviewing works is by activating a person’s own motivation for change (Rollnick et al. 2007: 5).

The conceptual approach of motivational interviewing has been linked to prior psychological theory. Miller (1983) credited the change promoting value of hearing oneself argue for change to Festinger’s (1957) formulation of cognitive dissonance and to Bem’s (1967) reformulation of self-perception theory. Also important was Carl Roger’s (1959) theory of “necessary and sufficient” interpersonal conditions for fostering change (Miller & Rose 2009).

In addressing the question “what is motivational interviewing?” Miller and Rollnick (1991, 2002) described four basic principles; these are: express empathy, develop discrepancy, roll with resistance and support self-efficacy. Miller and Rollnick (1991, 2002) go into considerable detail to explain how these principles should be applied in
practice; their elements are outlined in Appendix 8. A brief description is provided hereafter.

Expressing empathy differs from expressing sympathy. It is contingent on the clinician understanding and accepting the patient’s experiences and way of seeing the world, including their ambivalence about change. To do this the clinician must attempt to see and understand the patient’s perspective, “listen rather than tell, build up rather than tear down and compliment rather than denigrate” (Walsh 2004).

To develop discrepancy, the clinician needs to enhance clients’ awareness of the inconsistencies between their unhealthy or undesirable behaviours and their personal goals and/or values. This realisation is considered a powerful motivator. However, it is important that the clinician refrain from identifying these discrepancies but instead help the client identify them.

Resistance is a defence that often presents when a person finds it too difficult or painful to face some aspect of their problem (Malan 1982). To roll with resistance, the clinician needs to firstly recognise this is what is happening and to avoid opposing this resistance by argumentation or direct persuasion as this is likely to strengthen the resistance and mobilise additional defences. The aim of this process is to allow the client to be the primary source of answers and solutions rather than them being imposed by the clinician.
A person’s belief in the possibility of change acts as an important motivator (Rollnick et al. 2007). Supporting self-efficacy requires the clinician to express to the client a belief in the possibility of positive change, emphasising the client’s own ability to choose and carry out a plan to change her or his behaviour.

The four basic therapeutic skills or methods that enable a clinician to carry out the four principles described above are reflective listening, asking open-ended questions, affirming and supporting the client through the interaction, and summarising what has been said to link and reinforce material that has been discussed. Miller and Rollnick (2002) emphasise that motivational interviewing is collaborative and not a prescriptive approach in which the counsellor evokes the person’s own intrinsic motivation and resources for change. They explain that underpinning this process is the clinician’s ability to gain the client’s trust and create an environment where the client is willing to openly discuss issues relating to risk behaviours.

3.4. Behavioural Theories and Nursing Work: Issues and Concerns

An important distinction needs to be made between behavioural theory and the models, frameworks and approaches that draw on or have links to one or more of these theories. The behavioural theories and models discussed in this section thus far, since their inception, have contributed substantially to an overall understanding individual behaviour.
An important consideration however, is that these theories are limited to predictions, explanations and descriptions of how a process might work, rather than how it does work and therefore they should not be considered as solutions to problem behaviours (Curtis 2000; Whitehead 2001). Behavioural theory also stands in isolation from the broader context in which individuals live and does not take into account the many factors influencing health and well being (Nutbeam & Harris 1998). It stands to reason then, that the application of this type of theory in community nursing work is fraught with concerns and raises numerous issues.

Behavioural theory is associated with the discipline of psychology and has been “borrowed” so to speak by health professionals other than clinically trained psychologists. Villaruell et al. (2001) raise an important issue when they highlight that very little attention has been given to determining whether these theories provide empirically adequate descriptions, explanations, or predictions of nursing phenomena. Little attention has also been given to whether existing behavioural, theories, models and frameworks can be incorporated into everyday nursing work rather than being stand-alone interventions.

The complexity of theoretically based behavioural interventions and the skills required to carry them out are factors that have received little attention in the literature, particularly in intervention trials where nurses deliver the interventions. In these situations, nurses generally received relatively minimal training in the intervention process, and it was assumed they could deliver interventions with similar proficiency as clinicians trained for this area of work.
The assumption that nurses are equipped with the necessary skills and qualities to undertake theory based behavioural interventions raises the issue of education and training in the practical application of these approaches in the nursing context. Stephen Rollnick (2002) brings this issue to the fore when he explains that the counselling method of motivational interviewing as a skilful clinical method and not just a set of techniques that can be easily learnt. In terms of evidence, on exploring the numerous trials into the counselling method of motivational interviewing, Miller and Rose (2009) established a causal chain model linking therapist training, therapist and client responses during treatment sessions, and post counselling outcomes.

Given the current emphasis on the prevention of chronic disease through behavioural means, a pressing issue is how to integrate theoretical-based behavioural interventions into nursing work. In order to answer this question however, one needs to take a step back. Rather than answering the question “what theory or theories best lend themselves to nursing work?” we need to look at what nurses are currently doing to bring about behaviour change; not only to determine the approaches and methods they adopt and how they are applied in practice but also the factors that facilitate and delimit this practice.

It may be argued that nursing theories should be used to explain and guide all nursing practice. Nursing theories, such as those of self-care and rehabilitation, have built established knowledge amassed in the mind/body sciences. However, behavioural theory was chosen as the focus of this study because nursing theories are more wide ranging, encompassing various areas of nursing care. Behavioural theory, on the other hand, explains the phenomenon of individual behaviour change and has been used in
this study, and in the literature, to provide a theoretical perspective to investigate the different approaches nurses may be adopting in practice.

3.5 Conclusion

This chapter introduced two relevant areas to this research. Firstly it provided a brief background by introducing the rationale underpinning cardiac rehabilitation. It then went on to describe contemporary cardiac rehabilitation, which provides the service context for this research. Given bringing about behaviour change is a primary goal in this area of health care, the most frequently applied behavioural theory, models and approaches in the health care context were then introduced, some of which are known to have been applied in the context of community based cardiac rehabilitation. The information provided herein enables an informed appraisal of the findings of this research. It also highlights some of the issues that are central to the rationale for this study. Although two distinct topics, the nurses’ behaviour change practice and the service context in which they work are intrinsically linked. Contextual influences determine the overall requirements for nursing practice as well as influencing the nursing requirements, that is knowledge and skills that shape the nature of this practice.
CHAPTER FOUR: APPROACH AND METHODS OF RESEARCH

Developing methodology for certain types of qualitative research is an ongoing process. The nature of the problem to be investigated is fluid, incompletely determined at the beginning of the study, and subject to change as the study progresses. The design cannot therefore be fully specified in advance, but rather emerges over time. (Seibold 2001: 147)

4.1 Introduction

The research method adopted for this qualitative study fits within a non-positivist paradigm and focuses on the way that cardiac rehabilitation nurses seek to bring about behaviour change in their patients. Rather than searching for an objective reality to define this practice and how it is carried out, this research describes and explores the participants’ subjective views. The findings provide an explanation of nursing practice that is based not only on the signified content of speech but also its significance in the social context; those aspects considered to be constitutive of meaning (Derrida 1978).

Contrary to positivist approaches that are based on the assumption that reality is singular, objective and can be separated from the observer, qualitative methods adopt the premise that multiple realities can exist in any given situation and that these realities are subjective (Strauss & Corbin 1998). The subjectivity reflected in the findings of this
research however, lies not only with the participants who provided the data but also with the researcher who interprets it (Creswell 1994).

A qualitative methodology was suited to the exploratory nature of this research as it called for a flexible approach that was open to discovering previously unpublished dimensions of practice. In other words it needed an open approach that would allow methods that were consistent and coherent with the epistemology of this research to be introduced as the study progressed.

In-depth interviewing using a semi-structured format was chosen as the primary data collection method. While the research posed certain questions, the aim was to keep the interviews as open as possible to allow the participants to speak freely about their practice. This approach was also likely to lessen the extent to which the researchers’ personal conceptual framework would be imposed on the participants (Gilgun & Abrams 2002).

The progressive approach adopted in this research is similar to that described by Seibold (2001) in that it is an ongoing process that draws on various analytical techniques. Although specific questions were to be addressed, the nature of the phenomenon being investigated was incompletely determined at the beginning of the study. This meant that the theoretical framework was dependent on data analysis and not vice versa. As Seibold (2002: 6) explains, the study was “guided by theory at various levels and stages of the process”. The processes of analysis commenced inductively with thematic analysis and progressed to the exploration of discourses shaping the nurses’ accounts.
The methods of analysis are described in detail later in this chapter, which is structured in the following way.

Firstly, it provides an explanation about the nature of this research. This is followed by a detailed explanation and justification of the methods adopted during this research; including obtaining the study sample and the processes of data collection, data processing and analysis. The chapter concludes with discussion about the dependability and adequacy of the research.

Ethical considerations relating to the conduct of the study and issues relating to entry into the field are discussed in the context of the corresponding methods. The ethical conduct of this multi-site research was an important consideration throughout this study and extended beyond the protection of human subjects to the potential impact the experience may have on participants’ future involvement in research.

4.2 Nature of Research

The relativist thinking upon which this research is based emphasises subjectivity and varying perspectives and maintains that reality exists only as multiple mental constructions. As Crotty (1998: 64) explains, “the way things are” are really just “the sense we make of them”. The implication of adopting this ontological stance is that the findings of this study represent a version of reality that is always interpreted and is therefore subjective and socially constructed.
Constructionism provides the epistemology underpinning this research. The basic premise of constructionism is that all knowledge is derived from and maintained by social interactions (Berger & Luckman 1967). Research underpinned by this epistemology enables an understanding of the nurses’ reality from their perspective, as it is “internally experienced, socially constructed and interpreted” (Sarantakos 1998: 36).

That meaning is not “discovered but constructed”, is far removed from the notion of objectivism that is fundamental to the positivist stance (Crotty 1998: 42). While inquiry into subjective realities is likely to give rise to different interpretations, it is maintained that a level of understanding can be achieved through the researcher eliciting and refining or interpreting individual constructions of reality (Lincoln & Guba 1985).

Interpreting others’ realities however, is a process that is unavoidably informed by the researcher’s own way of seeing the world. Although subjective interpretation in qualitative research is inevitable, rigour can be enhanced through an ongoing process of reflexivity, which involves continual and critical evaluation of how the researcher’s methods, viewpoints and ideas influence the analysis (Alvesson 2003; Alvesson & Skoldberg 2000).

Given the progressive approach adopted by this research the need for epistemological reflexivity was considered paramount; particularly because the process of analysis was not linear but cyclical. Epistemological reflexivity, as it is understood in this research, refers to the process of reflecting on the assumptions that we have made during the
course of the research and the implication of these assumptions for the research and its findings (Breuer & Roth 2003; Cutcliff 2003; Koch & Harrington 1998; Willig 2001).

The constructionist epistemology enables the researcher to bring significance to the nurses’ perspectives through exploration and interpretation of the social meanings conveyed in their communication (D’Andrea 2000; Holloway 1999). As epistemology, it does not shape research methodology per se (Brueer & Roth 2003) but it is embodied in the theoretical perspectives that inform methodology, for example: postmodernism, poststructuralism and symbolic interactionism (Crotty 1998).

The analytical methods adopted in this research are tied by the same non-positivist epistemology. Poststructuralist perspectives on discourse and meaning underpin the researcher’s understanding of the nature of the data obtained and the way some of the findings have been interpreted. From this stance, what we know is always a result of the discourses or ways of thinking that are available to us. As such, the social processes that are the focus of this research are constituted in and through discourse (Edwards & Potter 1992; Potter & Wetherell 1987).

Although this perspective considers language to be an “unstable system of referents” thus making it “impossible to ever capture completely the meaning of an action, text or intention” (Denzin & Lincoln 1994: 15), the nurses’ subjective understandings and views of the world are seen to be as legitimate as any other (Crotty 1998). The analysis of discourse from the poststructuralist perspectives allows the researcher to explore the
way the nurses construct their practice and bring particular meaning to these constructions. This is discussed in more detail later in the chapter.

4.3 Sampling

To obtain a comprehensive understanding of the way cardiac rehabilitation nurses try to bring about behaviour change, the similarities as well as the differences, a sufficient variation and breadth of sampling across the study context was required. Maximum variation sampling was chosen as the sampling method as it would enable a view that was wide-ranging and inclusive of diverse practices. Lincoln & Guba (1985) described this method as the most appropriate technique for naturalistic inquiry. Another reason for selecting this sampling method is that it would enable the researcher to capture and describe the central themes that cut across participant and program variation (Patton 1990). It was decided therefore, to recruit cardiac rehabilitation nurses working across a range of geographical areas and service delivery models.

Initially it was anticipated that the nurses recruited to the study would be designated ‘cardiac rehabilitation nurses’ however, in two of the participating area health services, community health nurses delivered home-based cardiac rehabilitation services as part of a broader generalist role. Given the aim of the sampling method was to obtain data that was inclusive of diverse practices it was decided to include this group of nurses in the study sample.
The sample size was another consideration. An adequate sample size in qualitative research is a matter of the researcher’s judgement when evaluating the data that has been collected in relation to the research method, the sampling strategy, the intended output and the uses to which it will be put (Sandelowski 1995). The question that guided the sampling process in this research was: “Is there anything new in the data that can add to what has already been discovered?” This meant that the sample size would be decided when no original themes were identified in newly obtained data. The process for arriving at this point, called “saturation”, entails adopting a process of comparing and coding the data throughout the data collection period. Ideally, this would have entailed a simultaneous process of data collection and analysis (Glaser & Strauss 1967). However, for logistical reasons, in two of the four Area Health Services, the data were analysed as a set following the data collection period.

At this point it is important to note that there is a fundamental difference between the sampling method adopted in this research and “theoretical sampling” which is the method integral to the grounded theory approach (Glaser & Strauss 1967). The purpose of this study was not to develop a theory as is the case with grounded theory methodology, but to obtain a comprehensive understanding of the phenomenon being explored.
4.4 Gaining Access to Research Sites

The initial step for gaining access to the research sites was to gain approval from the Ethics Committee overseeing research in the initial study site. Once this approval was obtained, five other Area Health Services in New South Wales were approached and asked to take part in the study.

The offices of the Chief Executive Officer were contacted to obtain information about their usual research processes and protocols and the relevant contact people. The nominated contact people, all senior nurse managers working in community health and/or cardiac rehabilitation services, were then sent a summary of the research proposal together with a letter of invitation to take part in the study. Of the five additional areas approached, three agreed to participate. In all, four Area Health Services participated in the study. The reason for one area’s refusal was that the focus of research was not congruent with its research priorities. In the other area, the senior nurse manager did not agree due to concerns that the nurses would be overextended due to existing research commitments.

The nominated person in each of the participating areas was contacted by telephone with an offer to meet personally to discuss the research proposal. Due to the long distances required to travel, the senior nurse managers from three of the four areas decided to forego the meeting and to discuss preparatory matters by telephone and e-mail.
4.5 Process for Obtaining the Sample

The process for approaching potential nurse participants differed according to the Ethics requirements and protocols existing within each of the Area Health Services. In one area I was asked to contact potential participants directly whereas in others information about the project and letters of invitation were to be sent to the nurse manager who then distributed these to nurses delivering Phase II cardiac rehabilitation services.

Ensuring that nurses did not feel coerced into participating, either by the researcher or by the nurse managers, who in some areas were responsible for recruiting nurse participants, was an important consideration for obtaining the sample. Potential participants were sent copies of the project summary, the participant information sheet and the consent form prior to being asked for their written consent (see Appendices 2 and 3). The nurses, who were interested in taking part in the research, were asked to either contact the researcher directly or to forward their names and contact details to their nurse manager who in turn forwarded them to the researcher via e-mail.

Once a list of potential participants was completed, they were contacted by telephone to clarify their intention to participate and to arrange a suitable time for interview. In areas where data collection would involve considerable travelling, interviews were scheduled in a geographically ordered sequence. Written informed consent was obtained from all participants before the commencement of each interview. The participants were also informed of their right to withdraw from the project at any time without consequence and without others being notified.
The process of obtaining consent also included obtaining permission to audio-tape the interviews. In addition, participants were offered a copy of their transcript should they wish to check for accuracy, a process described as member checking (Lincoln & Guba 1985). None of the nurse participants took up this offer; however, several requested a summary of the findings following the completion of the project.

One participant did not wish to be audio-taped, in this case brief notes were taken during the interview. At the completion of the interview these were read to the participant to check for accuracy. Comprehensive field notes were made immediately after the interview session.

Participants’ rights of confidentiality were maintained by the use of codes to label audio taped data, transcripts and electronic data. All electronic data were password protected. Participants were also assured that no identifiable information regarding their participation would be revealed or discussed with other persons.

A master list of participants’ names, together with their respective codes and contact details were kept in a secure locked place together with a file containing participants’ signed consent forms. These were kept separate from coded audio-taped data and coded interview transcripts. Pseudonyms, nursing designation and geographical descriptors (city, urban, rural and semi-rural) were used to label excerpts from participants’ transcripts in the research report. Due to the small number of males in the sample (n=2), to maintain anonymity, all participants were allocated pseudonyms associated with the female gender.
4.5.1 Patient Involvement

The research process also involved observing some nurse participants in the course of their work. This meant that patients were involved in part of the research process. Some data relating to the observation of nursing processes in patients’ homes were recorded as field notes and used to augment the researcher’s understanding of the interview data collected later. The purpose for including an observational strategy in the study was to familiarise the researcher with the service delivery context and the processes involved. Notes were recorded from memory soon after the completion of home visits. They focused on aspects of the nurse patient interaction relating to the research objectives and that were considered to be of interest to the research. The observations and field notes fostered self reflection and allowed the researcher to understand the intervention context and, later, to ascertain meaning in the interview data.

The observational components of the study were limited to the primary research site and entailed observing nursing processes during home-based interventions. While patient details and information were not collected during these sessions, it was considered important that patients’ rights of informed consent, privacy and confidentiality were maintained.

Patients were provided with written and verbal information regarding the project and their attending nurse obtained verbal consent prior to the research visit. At the commencement of each observational home visit, the patient information sheet and the patient consent form were reviewed with the patient and written informed consent was obtained (see Appendices 2[a] and 3[b]). As with nurse participants, all patients
involved in the observation process were assured that participation was voluntary and that refusal to participate would not affect service delivery in any way.

### 4.5.2 Sampling Procedures

A purposive or non-probability sampling technique was used in this study. Purposeful sampling is considered to be the dominant strategy in qualitative research and involves seeking information-rich cases, which can be studied in depth (Patton 1990). In this study, the sample comprised nurses working in the area of community-based cardiac rehabilitation. Given that some nurses specialised in this area of work while others incorporated it into a broader generalist community-nursing role, it was anticipated that the nurses would have a level of expertise in behaviour change practice.

Four clinical nurse consultants who were working in the area of heart failure, and who were nominated by their senior nurse managers, were also included in the sample. Two of these clinical nurse consultants had extensive experience in cardiac rehabilitation (over 7 years) and the remaining two incorporated cardiac rehabilitation services as part of their current role. While including the nurses impacted on the homogeneity of the study sample, their work experience and goals of practice were congruent with the aims of this research.

Sampling took place over a twelve-month period. It commenced in the primary research site where four participants were interviewed over a period of two weeks. The remaining interviews were spaced throughout the data collection period so that analysis could be carried out before proceeding to the next interview or, as was the case in two
of the research sites, before the next set of interviews. A total of twenty-six interviews and six observation sessions were conducted.

An additional measure incorporated into the research process was the provision of a presentation about the study for interested staff in each of the participating Area Health Services. These were not intended as a recruitment strategy but rather as a means to contribute to the culture of nursing research by providing input to those who were not directly involved in the research process. Presentations were held in each of the four participating Area Health Services and were attended by nurse participants and several of their colleagues.

4.6 Data Collection

The primary method of data collection was in-depth interviewing. As previously mentioned, field notes were also obtained following the observation of nurses delivering services in the home setting. Demographic data relating to the nurse participants were also recorded at the beginning of each interview.

Prior to each interview, efforts were made to put participants at ease, this included: adopting a casual approach when they entered the room, ensuring participants were comfortable and so on. Participants were also asked if they had any questions about the interview process or the research generally; the ensuing conversation was taken as an opportunity to engage them and set a casual tone for the interview process.
As previously mentioned, some data were also obtained by observing nurses at their work. These data were recorded as brief notes during the session and then as comprehensive field notes soon afterwards. On each occasion, matters relating to the nurses work were clarified following the completion of the observation session and documented accordingly. These notes were treated as other data in that they were coded, transcribed and underwent some analysis.

The in-depth interviewing technique adopted for this study involved face-to-face encounters that were aimed at obtaining “informants’ perspectives on their lives, experiences or situations as expressed in their own words” (Taylor & Bogdan 1984, p.77). These perspectives generally cannot be observed by the researcher and would otherwise remain concealed (Rees 2000). Chenail explains:

The rationale for conducting in-depth interviews is that people involved in a phenomenon may have insights that would not otherwise be available to the researcher, and it is the quality of the insight that is important, rather than the number of respondents that share it. (Chenail 1992: 1)

A semi-structured interview guide was developed so that areas of interest were likely to be addressed (See Appendix 4). This format involved asking participants a series of open-ended questions relating to the research objectives. While it enabled the researcher to obtain rich data in the primary research site where the researcher was known to the participants, it proved suboptimal in the second site, as participants’ responses seemed to be “textbook” in nature in that they did not freely disclose their perceptions and experiences.
The concern about the quality of the data led to altering the interviewing method. Subsequent interviews commenced with the open-ended question “Can you tell me about your role in cardiac rehabilitation; what you typically do?” Participants were allowed to talk freely until they felt they had provided a sufficient response. The interview questions relating to the research objectives were then only asked if nurses had briefly discussed or not mentioned one or more of these areas of interest. When this was the case, prompts such as “can you tell me about” or “can you tell me more about……” were used to encourage them to expand on what had been said.

As the focus for cardiac rehabilitation is broader than bringing about behaviour change, this line of questioning enabled participants to discuss their role and practice from their own perspective. Given they were aware of the purpose of the research, it also enabled them to include the aspects of their role that they considered relevant. This approach also lessened the likelihood of the researcher’s understandings being imposed on participants, which was desirable given the exploratory nature of the study.

The 26 interviews that were carried out ranged from 30 minutes to 110 minutes in duration. The average interview lasted approximately 70 minutes. The interview sample consisted of 27 nurses. On one occasion two nurses requested a joint interview due to pressing work demands. The interviews were conducted at locations that were mutually convenient. The majority of nurse participants (n=21) were interviewed at their main place of work and the remainder at a local community health centre or hospitals. One nurse requested the interview be conducted at her home as she was on annual leave and the venue was on route to one of the provincial study sites.
4.7. Profile of the Nurse Participants

This section of the chapter is concerned with providing a description of nurses who participated in the study. The participant characteristics that are described in this section demonstrate that the sample is not homogeneous. The different service delivery models in which participants work, their designated roles, their previous experience and knowledge base, all contribute to this diversity.

The majority of nurse participants had the designated title of Generalist Community Nurse. The remainder are classified as either Clinical Nurse Consultants or Clinical Nurse Specialists. To avoid confusion, the two latter nursing designations are referred to as “specialist nurses” except when discussing one or other specific designation, in which case their designated title is used. The number and proportion of participants in each nursing category is as follows:

- Cardiac Rehabilitation Clinical Nurse Consultants (n=5, 18%)
- Heart Failure Clinical Nurse Consultants (n=4; 15%)
- Cardiac Rehabilitation Clinical Nurse Specialists (n=4; 15%)
- Generalist Community Nurses (n=14, 52%)

Of the 27 nurses participating in the study, 25 were female and 2 were male. Participant ages ranged between 28 and 65 years. Data relating to participants experience in the field of nursing were also obtained. Participants’ overall nursing experience ranged between 10 years and 38 years, with a mean of 22 years\(^1\).

\(^1\) “Years of experience” does not include experience during participants’ nurse training.
“Years of nursing experience” for the two nursing categories participating in the study were also examined and there was little difference. The nature of the nurses’ experience was also examined. The relevance of this information is questionable however, given the diverse nursing backgrounds of both the specialist and generalist nursing groups. The prominent difference between the two nursing groups is that, while the average years of experience is similar (specialists=22years; generalists=21years), the greater part of specialist nurses’ experience was gained in the hospital setting.

The type of work the participants undertook in the different settings also varied. The specialist nurses had spent considerable time in the area of cardiology and/or other areas of critical care such as intensive care and accident and emergency. All clinical nurse consultants and two of the four clinical nurse specialists had also attained formal qualifications in cardiology and/or cardiac rehabilitation.

Generalist nurses on the other hand while having varied work experience, were less experienced in the area of cardiology than specialists nurses. Only three had formal qualifications in cardiac rehabilitation at the time of the research. The majority of generalist nurses however, had been given some education in this area of work and were able to access support from clinical nurse consultants and/or experienced nurse managers. In summary, the sample is best described as ‘mixed’. The nurses’ qualifications and years of experience encompassed non-specialist nursing work in hospital and/or community settings and included specialty areas including cardiac rehabilitation, cardiology, intensive care, heart failure, diabetes, oncology, palliative care, paediatrics and midwifery. In addition, some participants had worked in management, supervisory, co-ordinating and educational roles.
4.7.1 Work Location of Participants

The participants’ cardiac rehabilitation work was also influenced by the geography of the areas in which they worked. Given the majority of the nurses worked in the community setting “work location” refers to the areas in which participants work rather than their office base. The majority of nurses within each participating area health service worked across at least two different types of geographical areas listed below:

- Area Health Service 1 – City, Urban, Semi-Rural and Rural
- Area Health Service 2 – Inner City and Urban
- Area Health Service 3 – Semi-Rural and Rural
- Area Health Service 4 - Semi-Rural, Rural and Remote

The geographical areas in which the nurses worked was an important factor associated with scope of the nurses role in delivering cardiac rehabilitation services. In city and urban areas the availability of allied health professionals facilitated a multidisciplinary approach to service delivery. In rural and remote areas however, access to these professionals was limited which meant that nurses delivering these services carried out extended roles.

2 Patients from other Area Health Services were regularly treated in city hospitals where they were assessed for referral and follow-up by community based nurses in their respective geographical areas.
4.8. Data Management

In qualitative research, data analysis is the process of systematically arranging and presenting the data in order to search for ideas and find meaning in the data collected (Curtis 2002). The progressive analytical approach adopted for this research included two methods; these were qualitative thematic analysis (Braun & Clark 2006; Miles & Huberman 1994) and discourse analysis guided by the poststructuralist perspective. Although the extent of data analysis was not predetermined, the volume of textual data that would be generated from the in-depth interviews called for electronic data storage, management and processing.

The data gathered during this research were managed with the QSR NVivo 2 program. This program enables data to be easily entered, stored and processed and supports coding, memoing and retrieval processes (Richards 2002). The program also enabled the generation of reports containing details of the source text, codes and memos thereby assisting in establishing trustworthiness through the provision of a visible audit trail.

4.9 Analytical Approach

This study adopted a progressive approach to analysis, which was similar to the process described by Seibold (2001). This means that the methodology and techniques were developed as part of a reflexive process that sought interaction with the data and literature in the study of how nurses seek to bring about behaviour change. The term ‘approach’ has been used as, contrary to the term “methods”, it indicates an epistemological viewpoint about the nature of enquiry and the type of knowledge that is
produced; it also requires the kinds of methodological strategies that are consistent with this viewpoint (Holloway & Todras 2003; Giorgi 1970).

As Seibold (2001) explains, the methodology for some types of qualitative research is an ongoing process and emerges over time. Therefore, the research design cannot be fully specified in advance. Although this study began with certain research questions, the nature of the phenomenon being investigated was incompletely determined at the beginning of the study. This called for flexibility within the approach so that new methods of analysis may need to be introduced as the study progressed.

The constructionist epistemology underpinning this research, discussed in section 4.2, allows this fusion of theoretical and methodological approaches that are suited to the research interest as it unfolds during the process of analysis. While the approach draws on the work of a mixture of qualitative methodologists, the processes of analysis are compatible in that they are not guided by contrasting or conflicting philosophies and methodologies.

As previously discussed in section 4.2, the formal process of analysis commenced inductively with thematic analysis, which is compatible with constructivist epistemology (Braun & Clark 2006). This method was selected because of its flexibility and applicability to many different qualitative approaches (Holloway & Todras 2003). The purpose of this phase of analysis was to address the research objectives by obtaining foundational data grounded in the perspectives of the participants. The
As thematic analysis progressed, the diversity in the nurses’ accounts raised questions as to the nature of these differences. This in turn led to the exploration of the discourses that shaped the nurses’ accounts and further questioning about the findings, which included the power play that became evident during the analysis. Discourse analysis adopts a philosophical perspective grounded in post-structuralism; a perspective that does not denote a single theory per se but a set of theoretical positions that share basic common tenets. Poststructuralist perspectives on discourse, which were introduced in section 4.2, are discussed in more detail in section 4.11.

4.10 Thematic Analysis

Thematic analysis is regarded as the “foundational method for qualitative analysis” and was the method chosen to formally commence the analytical process given its suitability to the exploratory nature of the research. The rationale for this choice is that thematic analysis allows for flexibility and is applicable across many different qualitative approaches, those governed by a particular theoretical position as well as those independent of theory (Boyatzis 1998; Holloway & Todras 2003;). Considered a “foundational method for qualitative analysis” thematic analysis is also regarded as a “method in its own right” and is compatible with constructionist epistemology underpinning this research (Braun & Clark 2006).
The aim for applying this method was to obtain a descriptive account of nursing work and the factors that influence it, which reflected the perspectives of the participants. Thematic analysis can be defined as a process of systematically identifying, analysing and reporting patterns, referred to as ‘themes’ that are evident in the data. The process begins when the analyst looks for areas of interest in the data; it ends with the reporting of the content and meanings in the data.

The process of thematic analysis progressed in the stages described below and involved a synthesis of inductive methods based on the framework developed by Braun and Clark (2006), and the work of Strass and Corbin, (1990) and Miles and Huberman (1994). It should be noted, that, while specific stages have been described, the process was not linear. It is more precise to describe the process as “recursive” as there was movement back and forth to compare and review the way data were coded and interpreted throughout its various phases (Braun & Clark 2006).

4.10.1 Phase One: Becoming Familiar With The Data

The process of analysis commenced soon after the interviews when the researcher reflected on what was said and took notes about impressions, ideas and areas of interest. Each of the audio taped interviews was personally transcribed and then the transcript read once completed. This process also included making notes on thoughts, ideas and points of interest; this allowed the researcher to consider each interview in its entirety before formally commencing the process of analysis. The value in the processes just described is that they helped the researcher to gain a ‘feel’ for the data and its intended meaning. The process also aided critical reflection on the conduct of the interview.
This process of reading each transcript was repeated before the commencement of formal analysis. Braun and Clarke (2006: 87) describe the initial stage of thematic analysis as “immersion”, where the researcher reads each transcript in an “active” way and attempts to recognise the overall meanings participants are trying to convey before shifting focus to line-by-line analysis. The rationale for this strategy is to gain a “feel” for the text and to bring attention to the expressive content of participants’ talk. Some researchers may consider this process as inviting subjectivity. However, it is defended by the constructionist philosophy that informs this study, which supports the argument that words out of context convey limited meaning (Crotty 1998).

The electronic data management system allowed notes to be made on each transcript in the form of “memos” which is similar to the processes of making “marginal remarks” which is writing ideas directly onto the transcripts (Miles & Huberman 1994: 66). At this stage these remarks were broad in focus and included comments, ideas and questions that would signal my attention during the subsequent analysis.

4.10.2. Phase Two: Generating Initial Codes

This phase involves the production of initial codes from the data and focused on capturing the scope of the nurses’ accounts. Basically, coding is a process whereby data are defined and categorised (Charmaz 2000; Morse 1994; Silverman 1993). This process is referred to as “open” coding and commences with “line-by-line analysis” of the data to identify as many codes as possible (Strass & Corbin 1990: 63). This step is also known as “in-vivo” coding and refers to when the researcher uses the participants’ own words to title the code (or node) that holds the relevant text (Richards 2002).
The next step was to shorten the in-vivo codes into terms that captured the essence of what the participant was saying. For example, the process underlying the following statements was given the code title of “normalising”. In the next phase of analysis this code was later linked as a subcategory for the theme “allaying fear/anxiety”:

“I think it helps for them to know that it’s quite normal to feel anxious about their condition” (Julie Generalist Nurse: Semi-Rural)

“To address their concern, I usually say things like ‘I’ve heard that so many times before’, that’s a common thing I use, ‘I wish I had a dollar for every time I’ve heard that” (Deidre Clinical Nurse Consultant: City and Urban)

4.10.3 Phase Three: Searching For Themes

This phase refocuses the analysis at the broader level of themes and involves sorting codes into potential themes (Braun & Clarke 2006). These themes do not reside in the data waiting to emerge or be discovered, but are produced through the researcher’s interests and sense making of the coded data and its respective categories. Themes are abstract and, as described by Ryan and Bernard (2000: 769), “often fuzzy”. This is because themes can develop and be redefined throughout the process of analysis.

4.10.4 Phase Four: Reviewing Themes

Once the themes were determined the researcher had a sense of the significance of the themes in relation to the research objectives. However, it became clear that while some of the themes were focused, others required further review. This review phase of the
analysis involved drawing conclusions about the data and then verifying these by comparing data within and across themes (Miles & Huberman 1994). The aim of this process was to refine the themes so that the data within them came together in a consistent and meaningful way while ensuring the themes were broad enough to encapsulate the set of ideas contained in the data segments that they comprised (Attride-Stirling 2001; Braun & Clark 2006).

4.10.5 Phase Five: Defining and Naming Themes

This phase of the analysis is about identifying the ‘essence’ of what each theme is about (Braun & Clarke 2006). It entails describing the themes in ways that, when combined, tell this research story. The main phenomenon of interest that was the focus for this research was nursing practice for bringing about behaviour change; the essence of this practice for specialised nurses is the art of persuasion. The themes that describe and explain this practice are the focus for the data chapters. Reaching this point calls for a detailed written analysis of each theme including how they contribute to the overall purpose of the research (Braun & Clark 2006: 92) and requires the identification of sub-themes and related data. Sub-themes are themes within a theme and can be useful for illustrating the components of a large or complex theme. When presented as part of a thematic map, they can be particularly useful in demonstrating the “hierarchy” of meaning within the data. This can be seen in Figure 4.1 which portrays the components of “discursive flexibility”, a construct specific to the expert nurses’ communication.
4.11 Examining Discourse

The decision to identify and examine the discourses shaping the nurses’ texts was directly influenced by the thematic analysis. During the early stages of analysis it became clear that the participants’ did not share common understandings of this area of nursing work even though many adopted similar terms to label what they do; for example “counselling”, “education” and “empowerment”. The nurses’ talk about the elements of these processes revealed an area of nursing work shaped by diverse understandings and practices. This raised question as to the nature of these differences
and motivated the researcher to explore the discourses that shaped this area of nursing work. At this stage the aim was not to explore their inherent social meanings as such but rather to piece together an understanding of the various influences that shape this area of practice.

At times the language associated with particular discourses served as rhetoric in that it was incongruent with nurses’ descriptions of actual practice. At other times, nurses entered into particular discourses in ways that saw these discourses serve as tools for maintaining power and control and for achieving particular ends. The complex interplay of power relations that the nurses created through discourse in essence created the social context in which practice occurs. The way the nurses described their professional identities, their roles and their practice revealed a milieu where organisational practices largely determined the nature of their work. Much of the nurses’ talk also focused on ways they either conformed to or resisted organisational practices, which resulted in some of the diversity evident in their work. Examining discourse then, was seen as an appropriate and alternative means for exploring the contextual influences that shape this area of nursing work.

4.11.1 Perspective On Discourse

The term “discourse” has numerous and varied definitions. Therefore, before describing the process of discourse analysis it is important to clarify the way “discourse” is understood in this research. This requires not only a definition but also some discussion about the theoretical perspective that underpins it.
Discourses are "practices that systematically form the objects of which they speak" and it is through discourse that the social production of meaning occurs and is maintained (Foucault 1972: 49). The concern of discourse analysis is not with the content of language but rather with the meanings it may convey. While there is no specific method to guide the process of discourse analysis (Parker 1992), the interpretation of discourse needs to be informed by a particular theory or perspective. As van Dijk (1997: 1) explains, simply making “common sense” comments about talk or a section of text “will seldom suffice”.

This section builds on earlier discussion about the “nature of research”, which describes this study as being informed by the poststructuralist perspective. Essentially, poststructuralism is a perspective on knowledge and language (Cheek 2000). It is important to note however, that the term “poststructural” does not denote a single theory per se, but a set of theoretical positions including amongst others, those conveyed in the works of Roland Barthes (1950–1980), Jacques Derrida (1930-), Michel Foucault (1926-1984), Jacques Lacan and feminist writers including Julia Kristeva (1941-), Helene Cixous (1937-) and Luce Irigaray (1932-). While the work of these theorists brings nuances to the way texts are understood, they do share common tenets that challenge conventional understandings of language and meaning.

Poststructuralists contend that meaning is not stable and that any single correct approach to knowledge, research or interpretation is untenable given that the meanings assigned to language are bound to the time and context in which they unfold (Parker & Burman 1993). While language is a means by which people make sense of their world it does not convey objective truths or a common reality. Instead, language has a stabilising
influence in that it acts as a vehicle for conveying socially constructed truths and taken for granted meanings (Doering 1992).

Individuals do not create their own language but instead adopt language and enter into discourses that are culturally, historically and ideologically available (Billig 1997). This means that there are no ‘knowing’ subjects that can exist independently of language (Morawski 2001: 148). In this sense, words operate as a predetermined system for allocating meaning; “they are not reflections of an external reality but expressions of group convention” (Crowe 1998: 339).

‘Subjectivity’ is another fundamental construct in poststructural thinking in that individuals construct and gain their identity and status by taking a position within a pre-existing form of language (Gergen 1991: 104; Crowe 1998: 339). This means that subjectivity is not mediated by individual motivations and intentions but instead through social discourses and cultural practices (Arslannian-Engoren 2001). This has major implications for understanding the construct of subjectivity and what constitutes a person’s notion of their personal and professional “self”.

In describing the construct “subjectivity” Nicola Gavey writes:

“(Subjectivity is)….a process that is fluid and complex, and which is determining (or agentic), even if always in a way that is constrained and limited. Thus as subjects we are able to pull at the same time as we are pulled – never capable of truly free choice, but still able to exist in a form that feels like our own unique identity and to act in ways that feel like choice.” (Gavey 2002: 435)
Discourses are considered to be regulated systems of meaning yet they are contradictory rather than being unified, coherent and rational. Subjectivity then is not stable but rather fragmentary and inconsistent (Gavey 2002). That subjectivity itself is defined by discourse, and that it cannot exist independently of discourse, has implications for how individuals both situate themselves, and are situated, in their social world, which has implications for this research.

Poststructuralists assert that individual thinking and how they situate themselves in relation to others are shaped by influences or power that is manifested in discourse. The way the concept of ‘power’ is understood varies according to the theoretical position taken from within this school of thought. There are however, shared perspectives, one being that knowledge is a socially constructed phenomenon that is closely associated with power. ‘Power’ does not equate with ‘knowledge’ however. Instead, the two exist interdependently; power generating knowledge, which in turn acts as a tool for initiating and maintaining power (Foucault 1982).

Knowledge grants institutions and individuals power and the ability to maintain the status quo by controlling and regulating what constitutes meaning and therefore, individual experience. When different meanings are recognised and attempts are made to adopt them power becomes challenged, disrupted and at times displaced as new forms of power come into being (Gavey 1997).
Some poststructuralists challenge the notion of power emanating from the top and suppressing individuals below. They profess that power emanates in a far more insidious way and operates through “discipline” which implies both surveillance and conformity (Foucault 1972). This type of disciplinary power exists on multiple levels, is focused on individuals and is inherent throughout all of society. As Foucault (1972) explains, the world as we know it, is selected, controlled and organized by a number of social and institutional forces. Power “limits what is acceptable to be known, and knowledge develops in response to and sometimes in resistance to the limits set by power” (Doering 1992: 25).

In light of the discussion so far, it should be clear that poststructural approaches are not research methods in themselves but instead are ways of thinking about reality. They determine “the type of research that is done and the types of analyses that are carried out” (Cheek 2000: 4). A poststructuralist perspective underpins this research because it is congruent with the researcher’s own beliefs about “truth” and “reality”. In this sense it provides the lens through which the participants’ perspectives and hence the findings have been interpreted. Discourse analysis offers a way to examine the way individuals account for and make sense of themselves and their social context (Shotter 1993).

Discourses are not impartial or transparent means for creating reality but are constitutive of meaning; they create and recreate identities, understandings and happenings over time. The process of discourse analysis then, not only seeks to identify the discourses individuals draw on to construct their world and to examine the meanings they create, but also to examine their consequences.
The process of discourse analysis in this research was somewhat constrained in that it focused primarily on providing an in-depth descriptive account of the way nurses’ approach their behaviour change practice, which is in keeping with the aim and objectives of this research. Examining the power play inherent in the context of practice through a discursive lens has also added depth to this study. It has highlighted the way that organisational practices serve to delimit and constrain this area of nursing work and the unexpected consequences that they have brought about. The findings from this analysis are detailed and woven through the data chapters and discussed in the final chapter of this dissertation.

4.12 Dependability and Adequacy of Research

“Qualitative” research does not denote a singular approach. Although there are numerous criteria for assessing rigor in qualitative research, their appropriateness for particular study is limited to the extent to which they conform to the methodological assumptions underpinning the paradigm of inquiry (Denzin & Lincoln 1994; Koch 1994, Koch & Harrington 1998; Rolfe 2006).

The evaluation criteria adopted for this research are: “adequacy”, which relates to the extent that research findings are well grounded, relevant and meaningful (Hall and Stevens 1991) and “dependability”, which refers to the methodological and analytical decision trails established by the researcher (Sebold et al. 1994: 399). This choice of criteria does not conform to the application of set “rules” but instead values flexibility
and reflexivity, which enable the researcher to respond to “the challenges presented by the messy reality of the research project” Rolfe (2006: 13).

4.12.1 Conveying Participants’ Perspectives

The initial concern of this research was to explore the way nurses seek to bring about patient behaviour change by obtaining and conveying descriptions of practice that reflected the perspectives and experiences of the nurse participants. This research considers the participants’ perspectives as being as valid as any other. If this were not the case they could not provide the foundation for the analysis of discourse, irrespective of the theoretical perspective that informs it. To convey their perspectives in a dependable and adequate way called for an understanding of their subjective reality, the meanings they assign to objects and events, and how their behaviour is adapted in relation to this (Locke 2001; Rubin & Rubin 1995).

Seeing and conveying the world according to others is not as straightforward as it may seem. If the participants’ reality is subjective then so too is that of the researcher. Several strategies have been advocated in an attempt to overcome the issue of researcher subjectivity, including “bracketing” (Janesick 2000), putting one’s own perspectives and values aside (Glaser 1978, 1992) and rejecting any preconceived theoretical frameworks (Miles & Huberman 1994). However, this research rejects the notion that subjectivity can be eliminated or put aside. Instead, it adopts the belief that researchers cannot capture participants’ meanings unless they are equipped with the ability or “perceptual apparatus” that allows them to do so (Locke 2001).
The levels of analysis undertaken in this research call for both theoretical and social sensitivity as well as the ability to draw on theoretical and experiential knowledge to interpret the data (Barnes 1996). This ability relies largely on whether researchers share a common language and culture with the participants and whether the researcher possesses and/or develops theoretical sensitivity during the course of the research (Holloway 1997; Holloway & Wheeler 2002; Strauss & Corbin 1990). The extensive experience of the researcher as a community health nurse, with tertiary qualifications in the field of psychology, provided the knowledge and experience to “understand events and actions seen and heard” during this research (Strauss & Corbin 1990:42).

In addition to this, the researcher actively sought to become familiar with the environment in which Phase II cardiac rehabilitation was delivered (see Ashworth 1997; Cutcliffe & McKenna 1999). This was achieved through informal discussion with participants and observing community-based cardiac rehabilitation nurses in the course of their work. Aside from gaining an understanding of context and culture by “understanding the meanings that participants create to communicate their experiences”, these processes are also considered instrumental in establishing rapport (Morrow 2005: 253).

Tape recording and personally transcribing interviews also served as a means for enhancing rigour as it enabled the researcher to critically reflect on the conduct and process of each interview. Participants were also offered a copy of the transcript from their tape-recorded interview. This process, referred to as “member checking” (Lincoln & Guba 1985), enables the accuracy of the data to be confirmed or disputed.
The research report provides further testimony of the “accuracy” of the researchers’ interpretations. Beck explains:

(Credibility relates to) “how vivid and faithful the description of the phenomenon is ……..informatics and readers who have had the human experience [of the phenomena]……..recognize the researcher’s described experiences as their own”

(Beck 1993: 264)

The notion of accuracy however, can only be assigned to “what” was said, as the meaning the words conveyed are always interpreted and therefore can always be contested. The researcher can bring alternative personal and theoretical understandings to the research process. In the words of Charmaz:

“Data do not provide a window on reality. Rather the ‘discovered’ reality arises from the interactive process and its temporal, cultural and structural contexts. Researcher and subjects frame that interaction and confer meaning upon it. The viewer then is part of what is viewed rather than separate from it”

(Charmaz 2000: 523-524)

4.12.2 Discourse Analysis and Theoretical Perspective

The second concern of this research became evident during the process of thematic analysis. This was to examine the social construction of nurses’ talk through the exploration of discourse. That there is no specific method to guide this (Parker 1992) makes demonstrating reliability and validity, in the traditional sense, unworkable (Potter 1996).
The view that qualitative studies need to be judged against criteria that are congruent with the qualitative paradigm is expressed by many qualitative researchers including Tobin and Begley (2004), Morse (1999), Strauss and Corbin (1998) and Sandelowski (1993). In pluralistic research, demonstrating consistency between the research paradigm, the theoretical viewpoint informing the research and methods is particularly important for demonstrating rigor (Baker et al. 1992; Bradbury-Jones 2007; Holloway & Todras 2005;).

The dependability and adequacy of findings from the analysis of discourse was maintained through processes of personal and epistemological reflexivity; an exercise that was facilitated by the academic supervisor’s efforts to keep the researcher on track. Willig defines two types of reflexivity in the following way:

Personal reflexivity’ involves reflecting upon the ways in which our own values, experiences, interest, beliefs, political commitments, wider aims in life and social identities have shaped the research……..‘epistemological reflexivity’ encourages us to reflect upon assumptions (about the world, about knowledge) that we have made in the course of the research, and it helps us to think about the implications of such assumptions for the research and the research findings

(Willig 2001:10)

In scholarly research reflexive processes are not limited to one analytical method or phase of research and need to be reconsidered on an ongoing basis throughout the research process. As explained by Breuer and Roth (2003) a reflexive research methodology is one where reflexivity plays a role in choosing and cultivating the topic
and research questions, refining the approach, positioning and acting in the field, analysing and interpreting the data and documenting the research. Reflexivity can be viewed as a means for achieving consistency, which can be evidenced in the documentation of research.

At this point it is important to state that the process of personal and epistemological reflexivity involves critical reflection. Although these two concepts are closely aligned, in that they both adopt a critical stance, they are distinct concepts. In his seminal work Schon (1983), explained that reflexivity involves reflecting in action whereas critical reflection involves reflecting on action. Both concepts have been explored for several decades particularly in the feminist research literature (Ryan and Golden 2006) and while there is often a blurring of the two concepts they involve situating the research process in culture, place and time. The purpose of researcher reflexivity and critical reflection is in essence to identify and respond to power relations and structures that exist and that are brought about by the research process (Daley 2010).

4.12.3 Situatedness of the Inquiry

Discourse is not produced without context and cannot be understood without taking context into consideration ……. Discourses are always connected to other discourses which were produced earlier, as well as those which are produced synchronically and subsequently. (Fairclough & Wodak 1997: 277)

Guba and Lincoln (1989) contend that because perceived realities are constructed within particular contexts they should be identified and examined in light of that context.
Denzin and Lincoln (1994: 114) suggest rigor can be evaluated by making known the “historical situatedness of the inquiry, the extent to which the inquiry acts to erode ignorance and misapprehensions and the extent to which it provides stimulus to action”. The notion of “context” is fundamental to this research in relation to both the situation in which nursing work occurs and the way it impacts on this work.

4.12. Strengthening Adequacy and Dependability: Other Means

The recording of research activities and the researcher’s thoughts about these activities as field notes created an audit trail, which as Lincoln and Guba (1985) suggest, is one approach for establishing trustworthiness of the research findings. This audit trail served to facilitate transparency of the analytical process in that it provided a comprehensive description of the methods adopted during the course of the study including the difficulties and inconsistencies that occurred. This was also facilitated by the use of the data management package (NVivo Version 2: QSR International) for data processing as it enabled ongoing review of the coding and the development of themes.

It is believed that one of the most robust means of assuring the dependability of qualitative research is to involve the research participants by seeking their views on the findings (Ashworth, 1993; Lincoln & Guba, 1985). The ultimate test of credibility therefore, rests with the extent to which the findings reflect the participants’ experiences and the researcher’s ability to bring added meaning to participants’ and others’ understandings of the nurses’ behaviour change practice (Guba & Lincoln 1981).
Rolfe explains:

…….trustworthiness is concerned not with whether the data have been rigorously collected, but with their interpretation and presentation. Paradoxically, any attempt to present the findings as objective or ‘truthful’ (that is, as the best or only representation of reality) will be seen as untrustworthy. (Rolfe 2006: 13)

4.13 Conclusion

This chapter has provided a detailed description of the methodological considerations and methods applied in this research which explores the ways in which nurses working in Phase II cardiac rehabilitation seek to bring about patient behaviour change. Also explained was the sampling process and a detailed profile of the participants. Methods of data collection and data management were also described as was the approach to and methods of analyses. Data analysis commenced with a method of thematic analysis that provided a rigorous and systematic process. A discourse analysis informed by a poststructuralist perspective was also undertaken. The chapter provided justification for the qualitative approach as the method of enquiry and the techniques employed to ensure the dependability and adequacy of the research.
CHAPTER FIVE: THEORY CONSTRUCTING PRACTICE

5.1 Introduction

This chapter is about the theory that underpins cardiac rehabilitation nurses’ behaviour change practice. The findings explain how some nurses have adapted to the behavioural aspect of their cardiac rehabilitation work by continuing to practice within the parameters of their “usual” clinically focused role. Others however, have pushed aside the dominant influences of medicine and organisation to incorporate alternative understandings and approaches.

The first section of the chapter explores the nurses’ knowledge and understanding of existing behavioural theories and frameworks and how they are applied in practice. The data reveal how, when it comes to individually focused interventions, nurses who are familiar with theoretical approaches to behaviour change do not adhere to any specific theory, model or framework. Instead, they keep theory “in the background” to gain an understanding of their patients and to inform some of their decision making in relation to the behaviour change process.

The findings also reveal how some nurses practise in ways that incorporate understandings and processes that resemble existing theoretical approaches even though they claim not to have any knowledge or understanding of behavioural theory or related approaches. While it is not possible to tell whether these nurses have had some prior exposure to these concepts, the majority of participants attribute their understanding of behavioural interventions to experiential learning.
The second section of the chapter explores the role of experience in shaping the nurses’ behavioural interventions. The findings reveal the multifaceted nature of their practice in that it brings together what the nurses refer to as “common sense” understandings and learning they have gained from professional experience. Of particular importance is that the nurses attribute much of this knowledge to understandings that have evolved from the “trial and error” learning associated with their repeated attempts at bringing about behaviour change.

The data reveal how several nurses have developed their own behavioural theory from practice and that it is this theory which provides them with their understanding of “what works and what doesn’t work” in particular circumstances. These personal theories are not stable however, but continue to evolve according to the patterns and nuances that the nurses encounter in each individual practice situation.

5.2 Theory in the Background

5.2.1 Models That Are Used

This section of the chapter presents findings that relate to the extent of the participants’ knowledge and understanding of behavioural theories, models and frameworks and how they are applied in practice. They reveal a wide scope of understanding that ranges from a lack of knowledge about existing behavioural theories and related models to well developed understandings that enable some of the nurses to apply theory in flexible and individually tailored ways.
The nurses’ talk about theoretical models and frameworks was considerably varied, which made it difficult to ascertain the extent that theory-based knowledge informed their behaviour change practice. This was mainly due to this talk being couched in the practice or processes they were discussing at the time rather than in a rendition of what they did or didn’t know about such models and frameworks.

Also contributing to this difficulty is that some of the nurses conveyed their understanding of behavioural theory in common everyday talk, whereas others entered into psychological speak to label or describe related processes. Irrespective of this, the nurses’ talk enabled a comparison between the knowledge they professed to have and how they applied it in practice.

The data do provide considerable indication of the nurses’ theoretical knowledge in relation to bringing about behaviour change, the models that they apply and, to some extent, ‘how’ the nurses apply these in practice. The next table (see Table 5.1) outlines the behavioural theories/models that nurses either mentioned or discussed during the course of their interview.

It is important to note, that these data are not restricted to revelations that the nurses made by chance. Those who did mention one or more behavioural theories and/or related approaches were prompted to expand on these. When nurses did not mention any theory or theoretical approach in describing their practice, they were asked if they were aware of any and if so, whether and how they applied them in their cardiac rehabilitation work.
Table 5.1: Number of nurses who conveyed awareness and/or application of behavioural theories and/or models (N=27)

<table>
<thead>
<tr>
<th>Theory/ Model or Approach</th>
<th>Stages of Change (TTM)</th>
<th>Social Cognitive Theory/Self Efficacy</th>
<th>Health Belief Model</th>
<th>Adult Learning Theory</th>
<th>Motivational Interviewing (Process)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>CNCs (N=9; n=7)</td>
<td>7</td>
<td>2</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>CNSs (N=4; n=2)</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>GCNs (N=14; n=3)</td>
<td>1</td>
<td>2</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>AWARENESS</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>mentioned/described</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>CNCs (N=9; n=4)</td>
<td>4</td>
<td>4</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>CNSs (N=4; n=1)</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>GCN (N=14; n=2)</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>APPLIED</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>named and applied</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Key: CNC = Clinical Nurse Consultant (Cardiac rehabilitation n=7; Heart Failure n=3)
CNS = Clinical Nurse Specialist; GCN = Generalist Community Nurse

In all, less than half of the nurse participants either discussed or claimed to have an awareness or knowledge of one or more behavioural theories or related approaches. The majority of the nurses stated that they were not aware of any specific formal behavioural theory or approach even though some recalled being exposed to behavioural theories or theoretical models in the past. Typical responses were:

“I studied behaviour change at uni but can’t remember anything specific”

(Audrey CNC: Semi Rural)
“I'd have to go back in the books. I can't think of any at the moment”

( Frances CNC: City)

I don't know of any behaviour change models. I don't know if the cardiac rehabilitation nurses that run the group use one. If they do, I don't know.”

(Allison GCN: Semi-Rural)

That some of the nurses were unable to recall behavioural theories and/or models raises the question as to whether exposure to theory can result in its meaning being assimilated into nurses’ thinking while the theoretical language and labels are forgotten. This question comes to the fore when nurses claim to be unaware of behavioural theories and models and yet talk about processes and strategies that resemble them. This finding is elaborated on later in the chapter and is evident in the specialist nurses’ texts who, as a group, articulated greater understanding of various behavioural theories and approaches than their non-specialist nurse colleagues.

The majority of clinical nurse consultants said they were aware of one or more behavioural theories and/or models during the research interview. These nurses commonly referred to the construct of “self-efficacy” which is a fundamental component of Social Cognitive Theory (Bandura 1977, 1986, 1996) and the “Stages of Change Model” which is also known as the Transtheoretical Model of Behaviour Change (Prochaska & Di Clemente’s 1983; 1985). While some of the participants also articulated an awareness of other theoretical models, only a small number demonstrated an understanding of these theories and/or models and fewer still described their application in practice (see Table 5.1).
It is interesting that the nurses who did convey an understanding and application of theoretical models revealed that they did not apply one theory or model exclusively, nor did they routinely apply them in a formal or structured sense. For the most part, their behaviour change practice draws together theoretical, experiential and practical knowledge to shape an overall approach that can be best explained as ‘eclectic’.

Metaphorically, this eclectic approach is a multicoloured patchwork of practice, where formal theory and other forms of knowledge are combined in an assortment of ways. The nurses weave these understandings together to create the fabric that forms the different layers and facets of their practice.

The nurses’ selective adaptation of theory to practice is revealed in several of the texts. For example, the nurses who were familiar with the Stages of Change model explained that it provided a useful guide for assessing where “patients are at” in the change process. As illustrated in the passage below, this understanding informed the nurse’s subsequent strategies:

I look at that Prochaska and Di Clemente approach, particularly when people are pre-contemplative. It is useful because you know not to waste time and not to antagonise them by pushing things at that stage. So really, it’s for my benefit, to recognise that I’m probably not going to get anywhere with them. But, what I do with people in that stage is ask for their permission to send a brochure and my details and if they need anything in the future they can contact me. Others may be pre-contemplative in one particular area but ready to make changes in another, so I work with that. (Beatrice CNC: Semi-Rural and Rural)
The above example is fairly typical of nurses’ talk about their understanding of Prochaska and Di Clementes’ Stages of Change Model and how they apply it in practice. An important detail, which signifies a developed understanding of the model is the nurses’ recognition that a patient may be in a particular stage of the behaviour change process for one health related behaviour and that they can simultaneously be in a different stage of change for others.

Although the Stages of Change model outlines five stages of a continuum, the majority of the nurses who conveyed familiarity with the model limited their talk to the first or pre-contemplative stage, which is when a person has no intention to change a particular behaviour in the foreseeable future (see Chapter 3). The nurses’ talk about this stage provides several interesting illustrations of how particular ways of thinking can be imposed on the interpretation of theory. For the most part, the way the nurses describe their application of a theory demonstrates how developed their understanding of a particular theory is; for example:

Last week, a person said "I understand what your program is about but I'm perfectly fine, I don't want you to waste your time with me, you need to go and see those other people; and my doctor said I was great!" So really, she is a pre-contemplator, I'm probably not going to get far with her; there’s no point flogging a dead horse. (Beatrice CNC: City)

In the previous two examples, the nurses describe how their understanding of the Stages of Change Model informs their decision-making. However, the last passage conveys a rigid interpretation of the model where the nurse assumes the patient is a pre-
contemplator because she chooses not to participate in the program, when this may not have been the case. That the nurse sees herself as having little or no control over the patient’s decision leads her to consider the patient as not only non-compliant but also unamenable to change. The rigidity in the nurse’s interpretation is typical of the way some nurses with limited understanding of the model apply it in practice in that it is used as a recipe or definitive formula rather than a flexible guide.

In contrast, the next passage illustrates an alternative and more developed understanding of the model and its application:

If they're in denial you need to move them into acceptance, or they may be pre-contemplators, which means they haven't considered changing or they don't believe they have a problem that needs changing. Most people don't stay in denial. I guess some people do; they stay a pre-contemplator. I guess if that was happening for a longer than normal time I would actually try and find out why. Why, what is it that's holding them there? Is it because they really don't believe there's a problem? Is it because they're afraid of failing again cause they have tried to give up so many times before? Or is it that they like what they do and they don't want to change. Some people really don't want to. So I would work with those things. The other thing I do is I try and raise their self-efficacy. I do that in a number of ways…… I'd just keep working, look at their history, look at their failed attempts and their self-efficacy, their self-image, and try and tease out what's actually going on. What's holding them back from changing? I’d look at self-esteem, look at what's going on, what their self-talk is.

(Deidre CNC: City and Urban)
Unlike the previous illustration, the passage above is resplendent with psychological speak. More importantly it illustrates the nurse’s understanding of factors that influence the behaviour change process. This nurse has reached a level of skill where she moves beyond a superficial understanding of the psychological to working towards an understanding of the “why” of where patients “are at” in terms of change.

“Knowing where the patient is at”, for several of the nurses, is an understanding that is pivotal in their decision making about how to progress with the intervention process. As discussed in the next chapter, when they consider patients to be resistant to change or lacking in motivation, knowing where the patient “is at” provides them with a reference point for concentrating their behaviour change efforts. This provides the nurses with an understanding of the patient’s thinking in relation to changing their health related behaviours.

The last passage also highlights some nurses’ understanding of the interrelatedness of thought and action and how patients’ thinking about ‘self’ impacts on their perceived ability to change. The concept that several of the specialist nurses talk about is “self-efficacy” even though they do not generally associate it with its source; that is, Bandura’s Social Cognitive Theory (see chapter 3).

As previously explained, the construct of self-efficacy is defined as “belief in one’s capability to organise and execute the courses of action required to manage prospective situations” (Bandura 1997:2). The stronger an individual’s self-efficacy for a particular task the more persistent their efforts in performing it. When nurses decide that a lack of
self-efficacy constitutes a barrier to patients making and maintaining positive behaviour change, increasing their self-efficacy becomes a major objective for their behavioural interventions.

Although the nurses try to increase patient self-efficacy in various ways, a strategy that several nurses talk about is to “build on patients’ strengths”. The next passage provides an example:

I talk to them about why they think it (behaviour change) is hard. And they say things like: "Well I'm really frightened about having this happen to me again." So it’s working through those barriers. Also following them up. They may be willing to take that first step but it's that contact, that follow up that’s important. "How are you doing with that? You didn't do so well, that's OK. That was that day; let's start again. ........ So, it’s giving them positive feedback about the things that they have already achieved and building on that self-efficacy. So if they're saying "I can't possibly do this", try and get them to talk about things they have achieved in the past, get them to talk about their strengths and not their weaknesses.

(Beatrice CNC: Semi-Rural and Rural)

Except for the three nurses who associated this strategy with Motivational Interviewing or the Stages of Change model, those who talk about building on patients’ strengths explain that it is “just part of what they do”; a process that is based on their “common sense” understandings of “where the patient is at”. The nurses explain that once they understand what prevents patients from changing behaviour, they can then work with them to identify their strengths by exploring the successes they have had in the past.
The nurses then reinforce the patients’ strengths and provide constructive feedback when change is attempted, achieved or maintained.

The next passage is also of interest as it conveys the nurse’s perspective of the important aspects of behavioural interventions. It also reveals the nurse’s persuasive tactics as she draws on one type of knowledge and discursive approach to serve the purposes of another. In other words, the nurse works towards gaining an understanding of the patient’s thinking so as to achieve the medically prescribed goals of cardiac rehabilitation:

So you have to know what they think and what they feel about change and whether they have the confidence. It's all about confidence and motivation. So I try to get to that level and find out where they're at and what they think they can do about it. And then I tell them what the outcome they could achieve is, what the benefits of making changes would be. So you have got to give them the carrot. You have got to explain to them that they will live longer. ………You have got to give them something to work towards. But how they do that you have to work out together. It's interactive. They can't be the victims. They have to be part of the team. And that's the most important thing. Letting them realise that they're part of a team and they're responsible for the management of their own symptoms and reporting these things at an early stage. (Jane CNC: Semi-Rural)
The passage above is about the art of persuasion and a process of manipulation. It is the nurse’s talk about managing symptoms and “reporting these” that exposes the medical discourse that shapes the rationale for this nurse’s practice. The choice of words “you have got to give them the carrot”, while seemingly manipulative, demonstrates one of the nurse’s understandings of how to motivate patients to change.

Aside from the nurse’s use of the terms “confidence” and “motivation”, which are an accepted part of nursing speak, the passage above is devoid of specific psychological language. Instead the nurse conveys her understanding in everyday talk. The nurses’ texts reveal that generally, the language of psychology has been poorly assimilated into the discourses that shape the nurses’ behaviour change practice.

This does not mean that it is devoid of practice that focuses on the psychological however. On the contrary, many of the nurses’ texts are resplendent with attention to the psychological. The majority of the nurses’ focus on the psychological is not informed by formal theory however, but the nurses’ own personal theories of “what works and what doesn’t”. This is particularly important because the nurses who do recall and are familiar with theoretical approaches to behaviour change explain that they find theory limited in its capacity to inform the development of the skills and processes that they believe are fundamental to this area of practice. Although they describe theory as providing explanation and informing their practice to some degree, they reveal that while it is useful in the background, most of their practice is not driven by it.
5.2.2 Assimilated Perspectives and Diversity in Practice

The origins of the nurses’ personal theories of behaviour change are at times obscure. Even the nurses who attribute various aspects of their approach to their knowledge of theory and related models or frameworks claim that most of their understanding about the behaviour change process comes from experiential learning. They explain that what their experience has taught them, is that their approach needs to flexible and “tailored” to the individual.

The nurse who provided the passage below, when prompted, revealed that she was familiar with the Stages of Change Model however she did not apply it in practice. Given the nurse has some understanding of the model, the passage illustrates how theory can sit “in the background” while knowledge gained from experience remains foremost in nurses’ thinking:

Finding out where they're at the time, that’s the first thing, the most important thing to know; whether they want to change, whether they're prepared to make the change. Like I said, the majority of people we see in the first few weeks after their event are so motivated; probably because they’re scared it will happen again or because they might die if they don’t do something. They're prepared to do anything and everything, to make the changes they need to make. And, it's a bit of a problem really in as much as our program is finite. We see them perhaps eight weeks at the most…..But I think we need to do more with them at this stage because it's then that they regress. Once they start to feel well it’s so easy for them to go back to their bad habits. I often think we have to be more actively involved with them at this stage but because we get so many referrals I just can't see that
happening. But it would be interesting to really more follow up with them down the track. It makes me wonder how effective our intervention is in the long term.

(Bronwyn CNS: City and Urban)

The example above clearly reflects the approach outlined in Prochaska and Di Clemente’s Stages of Change Model (see Chapter 3). However, as the nurse made no reference to the theory when describing her practice, it is likely that the understanding she conveys has stemmed from her own practical experience. She has come to know that most patients are motivated to change their behaviour soon after a cardiac event. She has also come to understand that motivation, being linked to a temporary state, can decline as the patients’ health status improves.

The extent to which theory informs practice, or whether it actually does, is also difficult to ascertain in the next passage. The nurse states that she vaguely recalls having heard or read about various behavioural theories and theoretical models, but is unable to remember them. Her talk however, clearly reflects a combination of theoretical perspectives:

There are other things I've learnt along the way. Education doesn't change behaviour but repeated behaviour changes behaviour. You've got to start really little. I can have all the knowledge and information about what constitutes a good diet. But I mightn't want to do it thank you very much. I like what I eat. I might know that smoking is really bad for me and that smoking and nicotine addiction is a known disease in itself. You know, a few years ago there was a lot of victim blaming. But now we know that only one in two people can walk away from it.
One in two people have serious troubles in walking away from nicotine so you can give them all the information in the world but if they don't want to do it, they don't want to do it, even with all the support and all the help. So you need to make changes or suggest changes to them that are really tiny, almost not noticeable. And once that almost not noticeable change becomes normal habit you add another almost not noticeable change.

(Marion CNC: Rural and Semi-Rural)

Firstly, in the last passage the nurse’s talk conveys a behaviourist perspective, which maintains that changes in behaviour can lead to a shift in thought processes; principles that underpin behaviour modification and operant conditioning. In addition, the nurse also considers that patient motivation is a factor that influences their behaviour. The belief that in situations where motivation is lacking patients need to be encouraged to make small, repeated and incremental changes, demonstrates thinking that reflects both behaviourist and motivational perspectives.

The two perspectives evident in the passage above make it difficult to assign her understanding to a particular source. It may have come from past experience, from forgotten theoretical knowledge that the nurse assimilated into her thinking and practice, or from a combination of these. There are numerous examples of how nurses incorporate different psychological perspectives in the nurses’ texts, even though many of these have become divorced from their theoretical origins.
One of these perspectives, the behaviourist, has made its way into nursing work under the guise of a “tool” designed to facilitate the process of behaviour change:

We find that the best way to go is with adult learning principles. I suppose, reinforcement, reiteration. So at each visit we ask them questions from this questionnaire. For example, "what is angina" and we score them, we actually give them a score. They could answer it correctly, or they could answer it after prompting, or remembered it only after being told the answer. And (during) each visit you go through this. "Can you name four locations on the body a person may experience angina?" "If you were to experience angina what would you do first?" And that sort of thing; we actually ask them these questions so that they remember, you're reinforcing. We use this with everyone, and they know that this is serious stuff. They've got to learn it.  (Julie GCN: Provincial)

The tool described above seems fairly neutral in that it assesses patients’ understanding of angina. However, the way that the nurses are required to administer it sees them adopting an approach that calls for repetition as well as positive reinforcement when patients give the correct responses. Although some of the nurses who discussed this educational “tool” found it useful, their talk reveals how it fosters a culture of practice based on standardised processes that exclude alternative ways of doing things.
Identifying the psychological perspectives evident in nurses’ talk and the extent of their influence on the nurses’ practice is fraught with difficulty. This is because of the overlap between the different schools of psychological thought and how some theoretical models and frameworks, such as the Stages of Change model, draw on multiple theoretical perspectives.

Some of the difficulty in identifying these perspectives also lies with the incongruence between the psychological jargon that some nurses adopt for labelling their practice and the way they describe what they actually do. However, while some nurses may lack a definitional understanding of the jargon they adopt, when their talk about the psychological components of their work is teased out from the rest, it becomes apparent that many aspects of their practice do reflect various schools of psychological thought.

5.3. Theory from Practice: “Knowing What Works”

I don't know if what I do, and how I do it, has a name because I haven't researched enough into behaviour change, other than twelve years of knowing what works and what doesn't work. I'm not saying that those who do know all of those things, that their work is less valuable than mine. It's just different. A bit like college nurses and hospital nurses. It's just different. I have read some work on behaviour change and that, about the effort and the relapse and all of those sorts of things. And I’m mindful of those sorts of things when I’m working with patients. But at the end of the day, it's your skill that helps them to change.

(Marion CNC: Rural and Semi Rural)
This section of the chapter focuses on how nurses have gained the knowledge and skills to carry out their behavioural interventions from practical experience. The findings reveal how, in the absence of nursing specific guidelines for their behaviour change practice, many of the nurses rely on experiential knowledge for this area of work.

5.3.1. Learning Along the Way

The nurses who talk about experiential learning or as some put it, “trial and error learning”, reveal that the knowledge that comes from this process does not come together to provide a single understanding or approach to bringing about behaviour change. Instead they explain that it provides them with multiple understandings of how behaviour change can be brought about; the only shared and fixed understanding being that the processes for bringing about behaviour change need to be both flexible and diverse.

The next passage illustrates how some nurses have come to understand and adapt to different situations through experiential learning. The nurse explains how her newly gained knowledge is stored in his/her “mental” bank that can be drawn on according to what she feels will be most appropriate at a particular time:

At assessment, you know, you're doing the physical things like measuring their observations, working out their activities, counting how many steps they have got to climb each day. But in that process there are always other things that you're tuning into. And that comes from trial and error learning in the past. And there would be no checklist anywhere that would tell you all of those things. It's things that you have learnt along the way. When you go into the house, the first thing
you notice, the colours, the smell, the environment, the cleanliness of the place, how you're greeted and received. Some people’s homes are absolutely spotless and you’re the reverent guest. And in others’ you're tripping over kids and stuff to get to where you want to be. And not that one's better or worse than the other but from that you can start to work out family dynamics. And you've only just opened the door and walked in. So you're assessing all these things. And this stuff you don't even write down. It's all there in the mental bank sort of thing, which helps you formulate your response. So, it's just, there's so many skills in it.

(Marion CNC: Rural and Semi Rural)

Also of interest in the passage above is that it demonstrates how some nurses articulate their understanding of behaviour change practice through the use of metaphor. While this nurse explains that newly gained understandings go into their “mental bank”, others talk about drawing on experiential knowledge by “pulling it out of a hat” or taking it out of their “bag of tricks”. However, while these metaphors support the notion of the nurse being able to choose from multiple alternative strategies their meanings differ considerably.

Drawing from a “mental bank” suggests a deliberate action that the nurse knows will lead to a specific result. Pulling something “out of a hat” or taking something out of a “bag of tricks” however, introduces an element of chance or surprise. While the nurse has an understanding of the ‘what’ and ‘how’ of practice and is able to anticipate patients responses to some degree, whether or not a particular strategy will work and the patient’s response to these, is not really known beforehand. In this way, the strategies
nurses employ when trying to bring about behaviour change are continually part of their “trial and error learning”.

The nurses describe their “trial and error learning” as a process that assists them to recognise and respond to different patterns in patient behaviour. Although they talk about adopting an “individualised” approach, the nurses recognise that some patients display patterns in their thinking and behaviour that are either similar or dissimilar to those of other patients. It is these patterns that inform their own personal theories of behaviour change and that enable the nurses to respond in ways that they know are likely to work. The next passage provides further illustration of the nurses’ reliance on past experience to inform their practice:

When you speak to them, you don't say, "How are you today?" because their normal reaction is going to be “Fine”, even though they may have a migraine or a bellyache. You need to say, "How have you been since I saw you last? How are you recovering?" Maybe ask some specific questions and then open-ended questions, so that you get the responses you want. That comes from years of experience, study, reading, evidence-based practice, observing and just experiencing people in the same situation year in and year out; experience and knowing what's important and what's not. Someone might be explaining something to me and it isn’t really what I’m looking for but I’ll listen…then you have to skilfully bring them back to where you want them to be.

(Jane CNC: Semi-Rural)
The passage above illustrates how a nurse draws on her communication skills to elicit information. The nurse’s approach doesn’t guarantee that patients’ responses to “open-ended” questions will provide information that she considers relevant however. It simply means that in the past she has found her particular approach to be useful for achieving her specific objectives. By not directing the conversation and listening to what patients consider relevant, the nurse creates the impression that they have freedom of expression and control over their communication. However, she deftly manipulates their conversation by directing its focus to what she needs to know.

The nurses who describe themselves as being experienced in bringing about behaviour change, convey the understanding that certain strategies work with certain patients and not with others, in some situations and yet not in others. As well as underpinning their belief that behavioural interventions should not be standardised, this understanding leads to their exploring other approaches and strategies and assimilating these into their practice. At times, this knowledge comes from the nurses’ observation of other professionals; for example:

You pick up things and clues from others as well. They don't even know that you're watching. And sometimes I think that you don't even know that you're doing it yourself. You're learning from each other all the time. You see other people do things and you see their skills and you think, “Yeah, that worked there” or you see people, and you think "Oh, I'd like his social skills” or “I'd like his bedside manner, I'd like her this and that”.

(Marion CNC: Rural and Semi-Rural)
I watched her do it for years (previous CNC). I learnt so much from her. Of course, I do it my own way but I learnt the core aspects from her. She was an expert at what she did. (Elizabeth CNC: City)

The last example demonstrates that, for some nurses, the process of learning from others is selective. Their existing knowledge becomes the base for comparison, which helps them to decipher and absorb the knowledge or aspects of practice they wish to develop while discarding others.

The nurses’ talk about their experience in delivering behavioural interventions reveals that it confirms, builds on, or brings into question what they already know. This experience sometimes reinforces new or different types of knowledge to the stage where they become embedded in their thinking and practice so that they become a part of what the nurses “just do”.

5.3.2. Perceptions and Practice

It is important to note, that while understandings gained from the nurses’ experience play a fundamental role in shaping their practice, the extent to which they are assimilated into the nurses’ thinking is also influenced by their pre-existing knowledge and practice. The data reveal that the nurses’ understandings, beliefs and attitudes influence how they perceive, interpret and respond to their experiences. This point is based on the next three passages, which clearly illustrate how nurses perceive and respond differently in similar circumstances:
I do have a sort of list within myself of the things that I'd rather them change. I do that because I think that it's difficult. This is just me putting my own beliefs into somebody else. It's hard to change completely everything. So I say to them, "Well I really want you to take your tablets, do the exercise and if you're still smoking then I'm not happy with that" those sorts of things. But whether or not they can change is another matter. Some of them are just in too hard basket and there’s no point pushing it.  

(Angela CNC: City)

I tell them smoking is bad for them, and I tell them what it's doing to them, but I don't push them to stop, not right away. Cause they'll just cut you dead. They just don't want to know. They don't want anybody to say to them "don't do" anything. When they think like that I think harm minimization is the best way to go.  

(Sally CNS: City and Urban)

If someone is asking you for help, if they want information about making behaviour change then they're already motivated. They’re completely different to those who are resistant to change and my strategy would be completely different too. I must say my great love and my biggest challenge are the ones that come into cardiac rehab that don’t want to be there. One person comes to mind……..we established this wonderful rapport and I didn't tell him, I wanted to say, "Would you like to see the statistics on smoking?" But he would have completely sealed up then and I wouldn't have, not gained his trust. So I didn't mention smoking. I could smell it all over him for weeks. And then OK, then once I knew we were working together, I then started to raise his level of fear. So I use techniques, depending on where they're at.  

(Deidre CNC: City and Urban)
The three passages above illustrate how nurses can respond differently to similar circumstances, in this case patients that they consider to be lacking in motivation. The first example illustrates how one nurse relinquishes her responsibility for the behaviour change process because she perceives certain patients to be non-compliant. The second passage shows how one nurse, when she thinks that a patient is unlikely to give up smoking, introduces an additional layer of practice which focuses on harm minimisation rather than withdraw her efforts. The third illustration reveals yet another mindset. When the nurse perceives patients lack motivation or are resistant to change she craftily moves them towards being more open to making change, firstly by gaining their trust and then by introducing an element of fear to motivate them.

Given that nurses’ understandings, beliefs and attitudes are shaped and dominated by particular discourses, their experience serves to either confirm and build on or bring into question their thinking and ways of doing things. Unlike the nurses who have assimilated psychologically focused strategies for shaping their behaviour change practice, some of the nurses have continued to adopt approaches that are congruent with their clinical or medically focused practice, for example:

We’ve found that if you take an educational format it seems to empower people to want to change or to at least think about changing. Our program is based on the various health components related to cardiac rehabilitation. Things like, client's understanding of their cardiac event, their quality of life for which we have to use a tool, their medication compliance, their ability to recognise angina and to respond to it correctly, rigidly, you know. And their blood pressure, do they know what their blood pressure is? Do they understand why they take the tablets and which ones are for that? Learn how to check their own heart rates, their own
pulses so that they know if it's getting a little bit too low, this might make them get a little bit dizzy and then they have to take themselves off to the doctor. So it's all teaching them, empowering them to go off to the doctor when they need to.

(Julie GCN: Semi-Rural)

The above passage is typical of how nurses, whose practice is dominated by medical discourse, describe their cardiac rehabilitation practice. The lack of talk about the psychologically focused aspects of their work highlights they have either become an invisible part of their work in that they aren’t articulated or that they don’t exist. The nurses’ talk about standardised approaches to patient education reveals that they adopt an objectivist perspective, positioning themselves as experts in the nurse patient relationship. One of the most significant features of such approaches is that, in isolation, they exclude consideration of patients’ individual needs, learning styles and general ways of thinking.

In contrast, there are nurses who acknowledge the individuality of every patient. As illustrated below, they describe processes such as “tapping into the personal” which take into account the emotional, psychological and spiritual dimensions of the patient:

When I start to use all my other skills that aren't specifically related to cardiac but to general health, their social wellbeing or social interaction, whatever it might be, then it helps. When I'm looking at the client, I really look at the physical, emotional and spiritual and I think that that's a really important area that, if you're trying to make behaviour changes. If you're just looking at the physical you're not going to do it. That's the way I see it. If you can tap into that person in the emotional and the spiritual side then, that's when I see results happen. And you
think, well, how do you actually do that? And, with time you start discovering it.
You start to tap into what it is that's deep down there, in that person. So, to me
that's one of the most important things. (Gaye CNS: Semi-Rural)

As revealed in the passage above, the nurses who focus on the psychological explain
that part of their practice is focused on trying to gain an understanding of their patients’
subjective experience. This in turn informs their decision making about how they
approach their behaviour change practice. Like many of the nurses who talk about the
processes of “finding out where the patient is at” and “connecting with the patient” as
being fundamental to their practice, the nurse who provided the passage above is adept
at combining multiple approaches, depending on the purpose at hand. However, as
revealed by her comments below, the nurse exposes an interesting phenomenon that has
been described to some degree earlier in this chapter. Although the nurse’s talk about
her holistic approach is consistent, she reveals that this preferred way of working serves
as an effective means of persuasion. After having explained her holistic approach to
practice, she went on to say:

So, it's a bit about them seeing that you do have an understanding of what all their
needs might be, looking at the whole holistic approach. You know, use those
general community nurse strategies to get them to do what I want them to do.

(Gaye CNS: Semi-Rural)
The approach described above, while holistic is also manipulative in that the nurse draws on one discourse or type of knowledge to serve the purposes of another. In this particular illustration, the nurse’s thinking is dominated by medical concerns and she in turn positions herself as dominant in the nurse patient relationship. The nurse has assimilated alternative forms of practice into her work because they better enable her to steer patients towards changing their behaviour which meets the medically defined goals of her cardiac rehabilitation work.

The nurses’ talk reveals that the discourses they draw on to shape their behaviour change practice, while reflecting the types of knowledge the nurses have available to them, serve as tools of persuasion. While some of the nurses are limited in the ways they are able to carry out this practice, others have assimilated multiple understandings that they consciously select from and draw on to shape their practice in ways that they think will achieve their intended results.

5.4 Conclusion

The findings presented in this chapter highlight the complex ways that nurses bring together different types of knowledge to inform their behaviour change practice. In much conventional nursing work, nurses’ clinical knowledge provides them with an understanding of a specific ‘what’ and ‘how’ of practice. In contrast, when it comes to the nurses’ behaviour change practice, experience provides many nurses with multiple understandings of what can be done and how it can be achieved.
Theory also plays a role in informing some nurses’ behaviour change practice. However, unlike the understandings gained from practical experience it remains “in the background” providing some explanation for the process of behaviour change. Theoretical explanations are a tool of reference with which nurses can compare their own personal experiences and assumptions of “where the patient is at” and what is likely to work in certain circumstances.

While theory provides some nurses with certain knowledge or explanation, the nurses who are experienced in carrying out behavioural interventions rely primarily on their experiential knowledge to guide their practice. These nurses consider that skill in this area of work is not based on their ability to perform discrete tasks or doing things in a particular or ‘correct’ way. Instead, they believe the trial and error learning they have undergone over several years has equipped them with the diverse understandings necessary for successfully carrying out this type of work.

Irrespective of the type of knowledge that informs their behaviour change practice, it serves to meet the medically defined goals of the nurses’ cardiac rehabilitation work. The nurses who describe a developed understanding of the behavioural aspects of their intervention however, draw predominantly on psychological discourses to shape their practice. This finding provides the major focus for the next chapter, which moves from the theory that underpins the nurses’ behavioural interventions to exploring and explaining their actual practice or the “doing”.
CHAPTER SIX: DOING BEHAVIOUR CHANGE; ‘THE EXPERTS’

6.1 Introduction

Whenever anything which has several parts is such that the whole is over and above its parts, and not just the sum of them all, like a heap, then it always has some cause.  


The findings presented in this chapter differ from those discussed in the previous chapter in that they explore the behaviour change practice of the subset of nurses who are the designated specialist cardiac rehabilitation nurses; that is the clinical nurse consultants and the clinical nurse specialists. The rationale for limiting the findings to these advanced practice nurses is that, given the diverse ways that nurses seek to bring about behaviour change, it was considered important to capture the practice of nurses who are considered to be skilled or “expert” in this area of nursing work. This chapter does not attempt to qualify whether these nurses are indeed experts in this area of nursing work but rather accepts their specialist designation qualifies them as being advanced practitioners in this area of work.

Unlike the standardised medically focused aspects of their cardiac rehabilitation work and the standardised approaches to group-based programs, the specialist nurses adopt what can be best described as an ‘eclectic’ approach to the behavioural aspects of their individually focused interventions. However, while their behaviour change practice is diverse, in that it is tailored to individual patients, this group of nurses shares a common
understanding of the processes they consider fundamental to their behaviour change practice.

In essence, this chapter is about nurses’ persuasive practice and not the overt and formal stages of the “nursing process” per se, those of assessment, planning, treatment and evaluation. By focusing on their shared understandings, it provides a description and explanation for the core behavioural strategies that the “expert” nurses weave throughout their individually focused cardiac rehabilitation work. These strategies differ considerably from those the nurses adopt in their group interventions in that they are eclectic as opposed to the relatively standardised format the nurses apply in group-based practice.

The chapter begins by explaining the concept of “eclectic practice”. It then presents the findings that describe some of the persuasive processes that the nurses incorporate into their practice. While some of these reflect contemporary medical and organisational influences, others reflect the nurses’ understanding of the psychological. Fundamental to the nurses’ behaviour change practice is a skill or attribute that this research has called “discursive flexibility”. This construct basically refers to the eclectic nurse practitioners’ ability to draw on multiple discourses to facilitate the patients’ understanding of what they are trying to convey. This sometimes involves recognising the discourses that shape the patients’ communication, and then drawing on these to communicate in a way that reflects the patients’ way of thinking and communicating.
The chapter then presents findings that reveal the core processes and understandings that are shared amongst this group of nurses. These include “knowing where the patient is at”, “connecting with the patient” and “moving the patient on”. Although seemingly self-explanatory, the way these constructs are described and manifested in the nurses’ practice reveals understandings that are specific to this group of nurses.

6.2. Eclectic Practice

The majority of designated ‘expert’ nurses working in cardiac rehabilitation describe themselves as adopting diverse flexible approaches when working with individual patients. This research has labelled their approach “eclectic”, a term that is usually applied in the context of psychological therapies. Not only do these nurses carry out their behaviour change practice in individualised and multifarious ways but they draw on their knowledge of the psychological to gain an understanding of the way individual patients’ think and to interpret the way patients respond to their communication. This understanding also informs their decision making about how to progress their practice throughout the intervention process.

The specialist nurses describe their understanding of working with the psychological as the most fundamental aspect their behaviour change practice. They describe this practice as being focused on a process of dynamic interaction that calls for continuous observation and adaptation to the nuances that present in the practice situation.
Unlike the nurses who seem to have a limited understanding of how to bring about behaviour change, the specialist nurses do not take knowledge about their patients as being absolute. Instead they test it over time so that it becomes part of a broad “repertoire” of “what works and what doesn’t” in particular circumstances. They explain that these understandings help them to piece together the strategies and micro-processes for each of their behavioural interventions. One nurse explains:

It evolves with time and it evolves with practice, how you communicate with them (patients). And how you learn that is by trial and error. I remember saying things when I first started and thinking back I cringe and think, "Oh my God, I said that?" So you develop like a repertoire of the way you say things, the way you hold yourself, your choice of words, the way you articulate them. And what you say, it doesn’t have to be scientific. It simply needs to be put in a way that they understand and it can be very different. It depends on the person and where they’re at. And one of the things I think nurses are getting better at is the use of no words……That's a trial and error learning thing which I couldn't teach to somebody because it's related to exposure, and time, and being with different people, and getting it wrong a lot of times. And thinking, “Alright”, this goes to the mental bank, "That worked that time but it didn't work this time", and so you put it in the right place. (Marion CNC: Rural and Semi-Rural)

The above passage highlights the importance that the nurses place on skills of communication. Part of their developing these skills is coming to recognise and work with the ways that individual patients think, and responding to their communication accordingly. This understanding enables the nurses to shape or tailor their communication so that it meets with the desired response. This requires them to be
flexible in not only deciding the content of their communication but also in the way they convey its particular meaning to different patients.

The nurses believe that the knowledge they have gained from their experience is the most important factor that informs their communication. Not so much by providing the opportunity to improve their skills through repetition as is the case with much other nursing work, but rather in its providing the opportunity for trial and error learning, experiencing, recognising and coming to know how to work with patients’ similarities and differences.

### 6.3 Persuasive Processes

The data leave no doubt that the practice that distinguishes the expert nurses from other nurses working in cardiac rehabilitation relates to their skills of persuasion. While the goal of bringing about patient behaviour change is common to all the nurses participating in this research, the findings demonstrate that the specialist nurses go about achieving this in more diverse, multidimensional, and at times surreptitious ways.

Underpinning the nurses’ persuasive efforts is positive intent, which is motivated by their conviction that persuading their patients to change will be in their best interest. This belief is grounded in what the nurses recognise as medical ‘truths’, an understanding that they consider is also held by their patients. Reinforcing this is the
nurses’ perception that patients’ expect them to be medically knowledgeable and competent.

The process of persuasion generally begins with the nurses’ initial contact with patients while they are still hospitalised following their cardiac event. Nowhere in the data are contemporary marketing influences on organisational discourse more apparent than during this early phase of the intervention process. It is interesting that eclectic nurse practitioners describe this process by drawing on language that constructs their patients as potential customers with cardiac rehabilitation being the commodity or product they are required to “sell”. Conversely, they also consider it to be a product that the patients need to have.

6.3 1 Securing the Customer Base

Talk about “selling” the program is common amongst the eclectic nurse practitioners and exposes several of the persuasive elements in their practice. Particularly relevant is the way the nurses draw on their understanding of the psychological to take advantage of the patients’ situation, for example:

Your assessment skills are pretty important. Then to communicate what you need to do. How you go about that, is the make or break of whether it's going to work. You pretty much only get one chance to sell it. If you don't sell it right, you can have problems. Creating in the client, or patient, the need. So that they know that there's a need, that they want it, "oh yes, yes, I want this" and it really is a sell

---

3 This only applies to the specialist cardiac rehabilitation nurses as the majority of generalist nurses working in cardiac rehabilitation are referred patients that have already agreed to participate in a home-based program.
job……. We try and see them within the first week. We have to strike while the iron is hot. It's the time when they are the most motivated. They are usually concerned about what will happen to them.

You know, I have a program that does this, this and this, a program that could meet your needs? So, it really is a sell.

(Marion: Rural and Semi-Rural)

Influencing patients by capitalising on their psychological state is only one of the persuasive strategies described by the nurses. Persuading, manipulating and at times coercing patients are common and accepted approaches to “get patients into the program”, or as some nurses put it “recruiting” or “getting them into the system”.

Not only do some of the nurses try to “market” or “sell” a cardiac rehabilitation program by creating a need in the patient but they also put the program forward as a timely and appropriate solution for meeting this need. Emphasising the potential benefits of participation, they make their proposed solution more attractive to their patients and therefore more difficult for them to resist.

Another persuasive strategy that is commonly articulated during this “marketing” phase of the program is offering patients a “choice” of either home-based or group cardiac rehabilitation programs. However, as illustrated below, some of the nurses reveal that although they offer patients a choice, their communication of the alternatives is for various reasons biased towards their own preference:

---

4 In two of the areas patients were allocated to one or other program and patients were only offered an alternative option if the patients considered the allocated option was unsuitable.
The whole time during that initial contact we try to sell the program to them. We get a feel for what they want, whether they're interested in the home-based or the group program.

We do offer them a choice but, myself I try (pause), I try, I prefer to put someone in a group because I never know what I'm going to find at home.

(Bronwyn: City and Urban)

While seemingly a benign tactic, some of the nurses explain that offering patients a choice of program options serves to initiate the behaviour change process as it leads them to consider which program might be more suitable. As one of the nurses explains, it moves patients who are “resistant” or “undecided” from a stage of “pre-contemplation to contemplation” which according to the Stages of Change Model is the pre-cursor to taking action (see Chapter 3).

Some of the nurses describe a different perspective and motive for offering patients a choice and reveal how they implement this strategy in a somewhat provocative way. As illustrated below, they offer their patients the choice to do nothing, for example:

I'm not there to tell them what to do, but there are ways you can get them interested. I advise them about the benefits of the program, put the information in front of them and say, "Well, I think it will help you recover. You can take it up if you want to, but you don’t have to do anything if you don’t want to, you can choose to do nothing. That’s up to you as well." And saying that keeps everything at a good level. If you push yourself in there too hard they won't even want to talk to you. But this way it’s harder for them to say no. When you give them that
choice of doing nothing, they usually take up the program and that's a good sign
because it means that they trust you and will take your advice.

(Sally CNC: City)

Although patients have the option of not participating in, or complying with, cardiac
rehabilitation, being formally asked if they would prefer to do “nothing”, deftly
challenges those who are undecided or resistant towards participating. It also challenges
those who, once having commenced cardiac rehabilitation, are ambivalent about or non-
compliant with their behavioural regime. Knowing that their patients are unlikely to
choose to do nothing, the strategy creates incongruence between what patients say and
what they do and is intended to bring the patients towards taking action.

An alternative, but more commonly described persuasive strategy is the nurses’ drawing
on various influences to augment their own efforts. As illustrated below, one of these is
the power and authority of the medical profession.

If they have been referred by a doctor or cardiologist then I mention that, because
that will tend to get them, bring them towards participating in the program.

(Beatrice CNC: Rural and Semi Rural)

The nurse’s drawing on the influence of the medical profession brings an additional
layer of meaning to the persuasive process however. Due to the general acceptance of
medical authority, the nurse creates a shift in meaning from one of patient choice about
participation, to one of compliance and non-compliance.
There are also nurses who, by treating non-participation as non-compliance, shift their persuasive efforts to coercion. They do this by emphasising the negative consequences of non-compliance such as disapproval or disappointment from the patients’ medical practitioners, relapse and even death. Although the following passage is atypical, in that most nurse participants are not as ominous in their comments, it does illustrate the coercive elements of one nurse’s communication:

I can only explain to them why it's important for them to do that (change behaviour) and I'll reiterate it a number of times, but it still becomes their decision and I can’t, you know, force them……. There's nothing I can do if they’re not going to make that behavioural change. I can then try and monitor, make sure they monitor themselves more closely so that an outcome of a better, positive life is still achieved without doing it (behaviour change). With them it's (their) knowing the consequences of their actions. And I will scare them. I'll tell them that they could die if they don't take their tablets. You can get as sick as you were or even worse.  

(Angela CNS: Urban)

Colourful in the way the nurse creates fatalistic consequences for patient non-compliance with medication orders, the passage above reflects practice dominated by medical discourse. What is particularly interesting is that when it comes to patients being compliant with required behaviour change the nurse grants them legitimate choice; however, should they choose non-compliance with their medication regime, the nurse threatens dire consequences.
Informing patients of the potential consequences of non-compliance with their medical regime is a common theme throughout all the nurses’ texts. Another persuasive tactic is nurses’ drawing on social and cultural influences, such as the concerns of family or carers; for example:

It's all bound up in their culture and their images, patriarch and so on, so we have to work very carefully around that and very often because family is very valued. So we might use that as a little bit of a lever to bring about some changes. I might say “They want to see you, they want a grandpa and you want to see your grandchildren”. So we often use the family.

(Carmen CNS: City and Urban)

As illustrated above, the nurses are usually aware of the manipulative nature of their persuasive ploys. However, they rationalise them by conveying the belief that their actions will ultimately benefit the patient. The following passage, while atypical in its candour, is particularly interesting as it clearly illustrates a nurses’ manipulative intent:

You want to get close to them. To be able to get close to them you have to play their game a little bit. I mean nurses have always got to be able to, not manipulate people, but you know, get what they want. They might have to go around it a whole lot of different ways but they will get what they want in the end.

(Sally CNC: City)

The above quotation exposes how one nurse builds rapport or “get(s) close to” her patients in order to meet her practice objectives. It also reveals the complexity and interrelatedness of the persuasive process in that it is woven throughout nurses’ overall
practice and comprises multiple strategies tied to their verbal and non-verbal
communication with the patient.

One of the most fundamental of these strategies is building rapport. The nurses explain
that “establishing”, “building” and “maintaining” is their first priority as it is essential to
facilitating the patients’ openness to other intervention processes; for example:

The processes I would use whether it's a hospital setting, in a home setting or in a
group setting or whatever, would probably be the same. I think that probably the
most important thing that you need to do before you can do anything with people
is develop rapport. (Deidre CNC: Rural and Semi-Rural)

The nurses describe several reasons for establishing and building rapport with their
patients. They talk about the reciprocal nature of the process and explain how it requires
them to engage with the patient by demonstrating respect and empathy and that this
goes hand in hand with their gaining the patients’ trust. They also explain that gaining
the patients’ trust serves to facilitate their co-operation and compliance with the
rehabilitation process. However, in order to achieve this, the nurses realise they have to
firstly convey their own trustworthiness to the patient; this is where many of the nurses
draw on their medical knowledge to convey their status as expert.

The nurses’ share the understanding that while drawing on medical discourse can be a
useful strategy for building rapport, there also needs to be a dimension of ‘explaining’
that goes with the ‘telling’. They make clear that the skills they draw on to provide these
explanations include their ability to “tune” into their patients and being able to present
their message in flexible ways. One nurse explains her approach as follows:

Some patients are able to understand a lot of scientific stuff. They want to know
"What is actually wrong with me?" So, I've actually gone through a lot of
anatomy and physiology with them. A lot of the men are really good with that sort
of stuff. They understand pumps, so sometimes I use that and they get the picture.
They realise why things aren't working and they go "Oh, I see, I see." So I've
explained a lot of quite technical stuff that I wouldn't go through with some
people. Each person, you have adjust to their level of learning and what they can
take in.  (Angela CNC: City)

The nurses place importance on their ability to “get the message across” in ways that
patients can understand. There are several examples where the nurses discuss this skill
to distinguish and add value to their role. A common way they do this is by creating a
comparison between their own ability to explain the physical and that of their patients’
medical practitioners; for example:

We look at their knowledge so that we can fill in the gaps. What do you
understand about your cardiac event? And that can be an eye opener. People don't
understand. They've been told but they haven't understood it. That's incredibly
common. People have said to me "My goodness that's the first time anyone has
ever explained it like that before! Why didn't someone explain this to me weeks
ago or months ago?" And I would say "Well your doctor hasn't had time, he or she
is busy." But it's really the skill in explanation. It's the ability to get down at their
level and describe things at their level and get feedback to see that they have
understood.  (Jane CNC: Provincial)
In the above example, the nurse does not present the possibility that patients may not have assimilated what they have been told due to factors such as stress or information overload. Instead the nurse focuses on her ability to educate, implying that she is more proficient at this work than the patients’ doctors. Providing patients with new understandings grants the nurses higher standing and potentially facilitates the nurse patient relationship. The nurses explain that the importance of building this relationship is that it “gives you (them) an in” to bringing about change by making patients more open to their suggestions.

Once the nurses feel they have “establish(ed) rapport” or “connected” with the patient they introduce further strategies to facilitate the persuasive process; one of these is goal setting. Described as an activity that “motivates” their patients, it is described by the majority of nurse participants as a routine part of their cardiac rehabilitation work. However, in contrast to the nurses who adopt a direct and medically focused approach, specialist nurses motivate their patients in a way that sees the patients generating their own goals.

### 6.3.2 Purposeful Goal Setting

All the nurses describe their goal setting approach as being underpinned by pre-determined medically defined goals. However, many of the specialist nurses manipulate the process in a way they believe enhance its effectiveness. Instead of dictating the goals for behaviour change the nurses reframe the process so that it is focused on the patients’ concerns; an indirect approach to meeting the medically defined goals of cardiac rehabilitation. This approach is illustrated below:
I ask them, “What are the five main activities that your illness interferes with or prevents you from doing?” Then I get them to grade these from most important to least important. I look at what these five activities are and modify the exercise program to meet them, to get maximum effect. Some of them have very specific goals, "I want to go walking on the beach", "I want to go back to line dancing" we've got one that's gone back to tennis. It's their goals that are more likely to motivate them. They have to come from them or they’re meaningless and they won’t try so hard to achieve them. So we design the exercise program to help them achieve whatever it is they want to do.

(Marion CNC: Rural and Semi Rural)

The passage above illustrates how a nurse adopts two interconnected motivational strategies rather than prescribing specific goals for the patient to achieve. The first involves her asking the patients to contemplate the impact that their condition has had on their usual activities; this reinforces or brings them to the realisation that their cardiac event has affected their life and how. The second involves reframing the goal setting process so that it focuses on these patients’ issues; the nurse then modifies the patients’ activity regime accordingly. What the nurses convey is that they believe patients are more likely to accept and be compliant with the rehabilitation process if it is shaped by their own reasoning and driven by their own concerns.

Many of the eclectic nurse practitioners describe how they take patients’ attitudes and beliefs as part of the goal setting process. This additional layer of practice incorporates their understanding of where their patients “are at”; a construct that represents the
nurses’ understanding of the way patients think about their condition and the behaviour change process. One nurse explains:

All patients have their own understandings about what brought on their cardiac event. Many of my patients can't take on board that it's been their risky lifestyle. They often attribute it all to stress, where they might have a full house of risk factors. This isn't uncommon. So, you need to take this into account, sometimes you have to be fairly focused in your goal setting and do a little fairly coercive interviewing. I think it's important to remember that these patients, and other patients like them, are in a position where they need to make behaviour change rather than want to make behaviour change. They wouldn't normally do it if they had not been in this position, being hospitalised. So, I think you're starting from back there where they may not be considering making change, so we really have to motivate them, change their thinking around. (Carmen CNC: City)

As illustrated above, for some of the nurses the process of goal setting is clearly a persuasive strategy. Although the nurse is aware that some patients don’t want to change their “risky” behaviours, her belief in medical ‘truths’ sees her efforts shift from medical to psychological where her aim is to “change their (patients’) thinking around”. The texts reveal how the nurses’ persuasive ability is underpinned by astute communication skills, which involve listening as well as getting messages across. More specifically, the effectiveness of the nurses’ communication rests with their ability to manipulate it in such a way that it achieves the desired results.
6.4. Shaping Talk: Discursive Flexibility

Central to the communication of the specialist nurses is the characteristic this research has called “discursive flexibility”, which refers to the flexible ways they draw on language and discourse. This research has defined the construct as the ability to realise, enter into, and then draw upon the discourses that reflect or are “in tune” with another individual’s thinking and way of communicating.

The nurses’ talk about their communication with patients, reveals that discursive flexibility is a skill that is both informed by and assists the nurses to know where “the patient is at”. It also facilitates the processes of building rapport and “moving patient on” through the change process. Some of the nurses consider this ability as intuitive, in that it is spontaneous or comes about with little thought. Their talk about how they apply it in practice however, reveals that it comes from conscious deliberation.

The nurses explain how they observe and listen to their patients, how they draw on their existing understandings to interpret the patients’ communication and then how they reciprocate in a way that is “in tune” with the patients’ ways of thinking. This enables the nurses to tailor their communication so that it is likely to convey its intended meaning and have the desired effect. In order to achieve this, they firstly need to gain an understanding of their patient’s way of thinking.
6.4.1 Gaining Understanding

The nurses’ explanations of how they come to understand their patients are complex. They reveal that their understanding of patients is not finite but continues to shift and change according to “where the patient is at” during the various stages of the intervention process. The nurses explain how through “trial and error learning” they continually “test the water” to gauge “where the patient is at” which in turn informs their decision-making and communication.

This is particularly the case during the earlier stages of their interventions when the nurses are unfamiliar with their patients and are forced to rely on what they “think will work”. That is, the nurses rely on strategies based on the knowledge and understandings they have gained in the past. As the nurses become more familiar with their patients their practice evolves to incorporate their newly gained understandings of particular patients and their circumstances.

The next illustration is typical of the way that the specialist nurses describe their communication approach. The nurse expresses the understanding that communication with patients needs to be individualised. However, while similar to previous illustrations this passage includes an additional dimension of practice:

You have to adjust to each person. You have to adjust to what they are able to take in, what they want to take. A lot of people say "Oh, I don't want to know, I don't want to know." And so you know there is no point in going there with them and you try something else. So, you move into different sorts of, different levels of education and support for various people. That's what I find anyway. What I do
is I test the water. I push a little bit on that boundary and then I'll see if they accept it. I'll see if they take the bait. (Sally CNC: City and Urban)

The above passage illustrates the complexity of the nurses’ communication skills and the strategies they put into play. The metaphor, “testing the water” refers to the nurse adopting a cautious approach to her communication by carefully gauging her patients’ responses before continuing on with or changing her communication tack. Being able to accurately interpret her patients’ responses also informs her of the patients’ ability to understand what she is trying to convey and their readiness or motivation to continue. Once they “take the bait” the nurse knows it’s safe to make her next move.

While describing the intricacies of interpersonal communication is beyond the scope of this research, the data do provide several illustrations that explain the ways that the nurses manipulate their communication to inform their understanding of the patient:

You become mindful about what you're saying because you know that they're hanging on every word. You're very tuned into what they say back but trying not to read too much into it, because you can go off onto the wrong track, but you always tend to want to seek clarification. Like "I don't quite understand what you mean", “Can you explain that again?" "Oh, did I misinterpret this?" So that you try and get clear, really clear ideas from the patient about what they think, where they want to go and what their problems are. So, you're really continually trying to seek this clarification, to try and understand them better so that when you do comment back, it’s really in tune with them. As much as you’re conscious of what you're saying, you also need to be mindful and conscious of what they're saying.
back. So you've really got to listen with both ears. And you're watching all sorts of things, their dynamics, their timbre, their tone, their non-verbals and the partner's non-verbals, that's a scream. The patient will say something and the partner raises their eyebrows and you think, "All right there's something going on here".

(Marion CNC: Rural and Semi-Rural)

The last passage clearly describes processes of active listening where the nurse is mindful of not only the patients’ communication but also of her own. The comment, “You've really got to listen with both ears” reveals how the nurse attempts to gain an in-depth understanding of what her patients are saying; a process that requires more than just casual listening to the content of dialogue. Several of the nurses explain that it is the sum of the patients’ communication, their language, behaviour and discourse that enables them to understand or know “where the patient is at”.

The nurses’ mindfulness of the patients’ partners’ non-verbal responses is also of interest as it signifies the nurse’s attention to the social context of the intervention. The information gained from observing others present during the nurse’s interaction with patients provides her with knowledge that may inform decision-making. In the above illustration the partner’s raising his/her eyebrows alerts the nurse to the likelihood that what the patient has said is incongruous with the partner’s perspective. Recognising “there's something going on here” prompts the nurse to question the patient’s account.
6.4.2 Knowing Where the Patient Is At

“Knowing where the patient is at” is an understanding that the specialist nurses explain is essential to their behaviour change practice. As explained above, this involves their observing and “tuning in” to their patients’ verbal and non-verbal communication to gain an understanding beyond the “what” of their communication to the meanings that underpin it. Although some of the nurses describe their understanding of the patient as intuitive, they reveal that it is their ability to compare their current perceptions of the patient with their existing knowledge that informs their knowing “where the patient is at”. The next illustration typifies the type of understandings that the nurses gain from being attentive to their patients:

You just kind of get a sense for whether or not they will be compliant, whether they have ownership of their health, whether they are already responsible for looking after their health and they're proactive about things. You get a feel for that first. Some people have been through a lot. They've been hospitalised, had by-pass grafts or heart attacks and some people have been resuscitated so their confidence is not so good. ……………So, you've got to just get a feel for whether there is fear, whether there is a knowledge deficit, whether there's a denial component going on. It's all that psychological stuff. You assess where they're at. I look at their understanding of their condition. You just get a feel from talking to them about what their lived experience is like, what's happening in their lives.

(Bronwyn CNC: City and Urban)

The passage above suggests that the nurse’s understanding of her patients comes from a combination of intuitive and deliberate processes. However, the next passage reveals that some of the understandings that nurses consider to be intuitive come about because
they actually recognise patterns in their patients’ communication. While they talk about intuitive practice they inadvertently reveal that this is rarely the case; for example:

Most of the time it's intuitive, you just do it, all the time. It's just part of what you normally do. But sometimes it’s deliberate. Take Fred, (pseudonym), I'm working with him on smoking. I've just been trying to build a relationship with him. I have to know when he's ready for me to make a move because otherwise I could lose him. …… It's part of what I always do. It's natural. I watch his body language. Wait for the slightest flicker of the eye to see where he's at. It’ll tell me whether his response is positive or negative. His body language will let me know. If it’s positive then I've got the go ahead to go a bit further. It takes energy to do this but if you don't, then you can lose them. When you stop doing it, is when you miss something and you can go down the wrong track

(Deirdre CNC: City and Urban)

The example above suggests that the nurse’s assessment techniques have become so habitual that that she considers them to be “intuitive”. However, the nurse reveals that the way she interprets this information is quite calculated as it alerts her to the patient’s readiness to initiate change. This is evidenced in the nurse’s comment about the possibility of going down the “wrong track” if she is not mindful of the patient’s responses.
6.4.3 The Patient’s Story

Eclectic nurse practitioners explain that one of the core processes that inform their “knowing where the patient is at” is allowing or encouraging patients to “tell their story”. It is interesting that all the specialist nurses explain that listening to the patient’s story is a fundamental part of their behaviour change practice and a core process which facilitates their understanding of “where the patient is at”, which in turn is an antecedent to the nurses’ decision-making.

The nurses explain how listening to “the patient’s story” serves multiple purposes; some of which are illustrated in the next three exemplars. The process enables them to come to understand the patient’s experience of their cardiac condition, related events and whether or not they have come to terms with it. They also consider it provides them with an understanding of “where they are coming from”, their beliefs and attitudes in relation to their health and illness.

The nurses also believe that “telling their story” has therapeutic value for the patients. They explain that the process enables patients to revisit and reinterpret their cardiac event which in turn facilitates their making sense of what has occurred and putting some meaning into their experiences; for example:

"It's often they want to tell you how their sickness has affected them. That would probably be a common theme; they need to tell their story. What it (episode) meant to them. How they interpreted it. And it’s important for me to know what their understanding is, to know where they’re coming from. Sometimes they just..."
want to go over that experience and try to put some meaning onto what they have been going through.  (Deirdre CNC: City and Urban)

The next passage illustrates the depth of understanding that the nurses are able to gain from listening to the patient’s story. The patients’ subjective experience can inform them of issues and concerns that need to be addressed as part of the rehabilitation process; issues that would otherwise remain hidden if nurses do not deviate from standardised assessments:

A lot of people, when they first develop heart disease, really have trouble coming to terms with it and that's a major stress in itself let alone other stressful issues in their lives. I had a young fellow last year who had by-pass and he couldn't handle the fact that he had this scar now and he wasn't going to be a man in his friends’ eyes. How could he go to the beach, he was a member of the zipper club. It was sort of like, “I'm not the man I used to be anymore.” So his problem was how his friends were going to react to the fact that he's not the person that he thought he was. He thought that he'd also let them down as well. He thought that the more people that knew about his illness, the weaker it made him seem; do you know what I mean? So often you find there are lots of issues. I actually did a home program with him. It took a bit of doing but I also ended up getting him to agree to see our psychologist.  (Frances CNS: City and Urban)

The next passage illustrates other understandings the nurses gain from listening the patient’s story:
They need to tell their story, talk about what they have been through …… I ask them, "Now, what's happened to you?" Even though it's written down in front of me, I want to hear what they think happened. And that's often a bit different to what's on the discharge notes……... So I ask them what they know. And, then they'll tell me their story. Not because I want them to talk for ten minutes about something terrible but because it often brings out something that's been on their mind, that I need to know about. I'll move on to the medical nursing assessment, but I always let them tell their story first, to find out where they’re at and if there are any problems that are going to stop them from moving forward.

(Jane CNC: Provincial)

Not only does listening to the patient’s story inform the nurses of their patients’ subjective experience but it also alerts them to factors that may impede or prevent patients from progressing with the behaviour change process. The nurses also explain that their understanding of “where the patient is at” largely informs the “what I do next” during the various stages of the intervention process.

6.4.4 Facilitating Understanding and Conveying Meaning

The findings presented so far have established the link between discursive flexibility and the nurses’ understanding of individual patients and the way they communicate. This section explores how the nurses adapt this skill to manipulate their communication to make their messages understandable to individual patients. One of the areas of talk where this is most apparent relates to patient education, particularly when the nurses are
trying to facilitate patients’ understanding of things medical. Another relates to nurses’
descriptions of the persuasive strategies they put into play.

The nurses explain that in order to convey their messages successfully they need to be
able to discriminate between what is likely to work and not work in particular
circumstances; for example:

People, I think we (nurses) sometimes fill them with jargon to maintain our power
base, or whatever we do it for. We don't connect with, come to the level of these
people at all. And I think we have to. At least that’s what I try to do. That's the
most important part for getting that rapport with them. It means communicating in
a way they relate to. We have to understand them so that we can talk on their
level, so that they understand us. It's for them that we're here. If we walk out of
the room after we’ve filled them with jargon they don't understand won’t achieve
anything. (Audrey: CNC Provincial)

The above passage illustrates one nurse’s awareness that professional language may not
bring about the desired understanding in their patients and that it can act as a barrier to
the nurse-patient relationship and the intervention process in general. It is interesting
that the nurse is aware that the way she communicates also impacts on the power-
relations between nurses and their patients.

At this point it is important to distinguish between the ‘meanings’ that relate to the
descriptive or specified content of speech and the social meaning that is conveyed by
particular discourses that underpin what is said. The findings presented in this chapter
are predominantly descriptive and focus on ways that the nurses try to make patients understand the information they want to put across. The nurses’ texts contain several colourful examples of how they do this. While the most usual approach is to draw on common “everyday” speak, they also draw on metaphor, story telling, and scenarios to not only make their message understandable but also to help patients remember what was said.

Some of the nurses explain that they have a “repertoire” of strategies that they “know” will work with certain patients. The next passage illustrates this point:

You could explain their medication so technically that there’s no way a patient would understand it. They might say "Oh, look at that nurse she knows so many wonderful things!" but if you can't share it and the patient doesn't learn anything from it, what is the point? So, you explain it by telling them interesting little stories that go with it and they remember all the side stuff. And at the same time they're having fun and they are learning, and they don't even realize they're learning. If you ask my patients about Warfarin, they all know it works like Ratsack.5  (Marion CNC: Semi-Rural)

Other analogies that the nurses say they regularly adopt in their communication include likening the heart and circulatory system to a “Rolls Royce engine” or a “water pump”. One of the nurses explains how she commonly adopts the analogy of carbon monoxide to convey the dangers of smoking and how it affects the body:

5 “Ratsack” is a brand name for a type of rat poison that works by thinning the blood to the degree that it results in internal bleeding.
I don’t do this with everyone because some people understand the medical stuff, but a lot don’t, especially the older patients. So I tell them we're trying to reduce the workload of their heart, because it's running out of get up and go. So you've got to get it right, in their language, which takes a bit of doing. I often use my carbon monoxide scenario. "All these red blood cells are running around in your body and their job is to carry the oxygen. It can’t get around your body any other way, so when you have a cigarette, it’s like breathing in carbon monoxide”. Everyone knows that you can gas yourself by breathing in carbon monoxide! "So this carbon monoxide stuff jumps onto your red blood cells and stops the oxygen from getting on. So you're blood’s going round your body with no oxygen”. I exaggerate but they have a laugh. I mean basically, that is what happens. It’s a very brief, simplistic way of looking at it but it gets the message home to them.

(Sally CNS: City)

In the above example the nurse exaggerates the effects of smoking by making the association between carbon monoxide and suicide, a message that conveys the meaning that smoking is a form of self-harm. Not all the nurses adopt such dramatic analogies as those in the last two exemplars however. Some of the nurses describe how they use humour. Others talk about communicating messages that they consider their patients would find difficult to understand in “small”, “gradual” and “digestible” steps.

There are also nurses who adopt a confrontational or provocative approach when they feel it is warranted; a tactic they generally reserve for patients who are “in denial”, “resistant” or simply “non-compliant”. They explain that they adopt this approach for its “shock” value and its potential for motivating patients to change. They achieve this in a
variety of ways. Some of the nurses draw on medical facts to highlight the consequences of non-compliance, for example:

So they might have relapsed with smoking but you can re-motivate them. By this stage I figure if rehab hasn't worked so far then maybe fear will. So I actually say, "Don't you know that more people who do smoke drop dead than people who don't smoke?" (Deidre CNC: City and Urban)

Not all the nurses adopt such a blunt approach to instilling fear as the one described above. A more commonly used tactic is for the nurse to express a degree of concern and then let the patients come to their own conclusion. As illustrated below, some of the nurses describe this persuasive strategy as “sowing a seed” and explain that it is aimed at getting their patients to think about what the results of non-compliance might be:

There are times when I try and put the fear of God into some of them (patients); getting them to recognise that they have fear. I begin with statements like; I've got a little handbag full of them you know. I'll say something like, “I'm worried about you. I'm really very worried!” And that’s how I would come across. I’d say "I'm so worried that I'm going to end up seeing you in Casualty again with another heart attack and you're so young". That's what I actually said to one patient and then I just left it with him. I was hoping that would mobilise him, get him thinking. Usually we try to stop them from being fearful but he needed it; he was still in denial three weeks after his heart attack and he needed it.

(Deidre CNC: City and Urban)
While only a small number of the nurses articulate the type of provocative approaches described by the nurse who provided the last two illustrations, the information provided by the nurses indicates that it is common for some nurses to exaggerate the message they are trying to put across. In contrast, several of the nurses describe how they sometimes understate or play down their communication to reduce patients’ fear or anxiety.

Another consideration that is evident in the nurses’ talk about their communication is the nurses’ attention to timing. They explain how knowing ‘when’ is just as important as their knowing ‘when not to’ communicate and how this is influenced by their interpretation of patient’ “readiness”; what they understand as the patients’ willingness or ability to take in information. The nurses have come to know that timing is of the essence in the persuasive process and that “misreading” or “misinterpreting” patient readiness can cause the patients to “close off” which jeopardises not only the nurse-patient relationship but the persuasive process overall.

The construct of “patient readiness” is integral to the nurses’ understanding of “where the patient is at” which informs the way that the nurses decide to “move the patient on”. As previously explained, some of the nurses associate this construct with the Stages of Change model. However, this construct is also described in the texts of the specialist nurses who did not articulate an awareness or understanding of the model.

Moving the patient on is not as straightforward a process as it seems. The nurses explain that while some patients progress and change their “risky” behaviours, others are
“stuck”, unable or not wanting to change their familiar ways of doing things. What the nurses do in such situations is try to find what will “shift” their patients’ thinking and motivate them to change.

6.4.5 Finding the Key

"If you want results you have to tune in to where the client is at. If they're at where you're at, it's easy but it doesn't happen that way. You have to find the key that opens the door but it's not always obvious. And you can only do that by listening." (Jane CNC: City and Urban)

The findings presented in this section describe an elusive understanding that is common amongst the eclectic nurse practitioners. Although it is not articulated in the language of medicine, organisation or psychology, the nurses draw on metaphor to explain what they consider is a “key” to connecting with the patient and bringing about behaviour change. They describe this understanding as being dependent on their ability to engage or “connect” with the patient and as evolving from the process of coming to know the patient; processes that determine the extent of rapport that develops between the nurse and patient.

The next illustration introduces the construct of “finding the key” by providing a contrast for subsequent examples. The passage enables some understanding of what happens when nurses are unable to find the “key”, the “door” or, as this nurse describes, the “gate” that enables them to “get in” and connect with the patient:
Some are the ones you call them difficult patients. They're the ones that you go round and round and round and you still can't get near them. That's why they're called difficult patients, because you've tried everything, gone round and round looking for the gate to get in. And the walls keep coming up, or the excuses, or the barriers. And we say that they're difficult patients. And they're probably not difficult. It's getting in that's difficult. They're the ones that we're still in trial and error learning with, trying to find the right way, the right skill to get in.

(Deirdre CNC: Rural Semi-Rural)

An important feature of this construct is that the nurses’ understanding of what constitutes the “key” varies with individual patients and that it is only through trial and error learning that they come to know what will work. The nurses describe it as a type of knowledge that cannot be generalised and explain that its acquisition and application in practice is not amenable to standardisation.

Although the process of gaining this understanding is at times straightforward it can also be equally complex in that it requires considerable thought and effort. The difficulty that the nurse describes in the passage above reveals the depth of thought that can be involved in the process, particularly when her initial attempts at finding the key fail. The nurse continues to explain that the way she pursues the “key” is by identifying and then dealing with barriers or obstructions that are preventing the patient from moving forward; a process that is intended to make the patient more open to her efforts at facilitating behaviour change. She continues:
By listening to them, really acutely listening to them, you know where they're at and you know what their obstructions are. Whether they're real or perceived they'll tell you what’s preventing them from changing that behaviour. Maybe they're at sort of a denial point. You need to go right back to that basic. Maybe they don't even realise that they need to change their behaviour. Maybe they don't want to. Maybe they know, but they're just not going to do it. So you need to look at all of those sorts of things. And they're non-verbals will tell you what their obstructions are, if there are any. So you need to work on the real or perceived obstructions. That then opens the door that you can get in to start talking about behaviour change. (Deidre CNC: Rural and Semi-Rural)

There are nurses who, as illustrated below, focus on other dimensions of the patient to find a way to connect:

I'd sit there and listen to her over and over and over. This went on for ages. And then eventually one day she said to me, "Oh, did you see the flowers out there?" and I thought "No, I didn't even see them" and then it clicked with me, it made me realize that she sat there every day and looked at her flowers and that was part of her spiritual being. And so I realised then, when I walked in the door and sat down and talked about the flowers, it just opened up this side of her that gave me a way in. You don't always see it straightaway but if you can somehow unlock that key. And it's not by just doing the physical. It’s about attending to the spiritual. (Gaye: CNS Provincial)
Talk about the patients’ spirituality is not common amongst the nurses. However, the eclectic nurse practitioners do share an understanding that there are aspects of every patient that, once understood and reflected back in their communication, enables the nurse to establish a type of rapport that is more profound than could otherwise be achieved. This type of rapport enables a “connection” with the patient that facilitates the nurses’ behaviour change efforts by mobilising them towards behaviour change.

The passage above, like many other illustrations in this chapter, highlights the inquiring and exploratory nature of the specialists approach to practice. Unlike the majority of generalist nurses who describe routine approaches to their behaviour change practice, the specialist nurses are more flexible and varied in their approach. As the findings in the next chapter reveal, the specialist nurses are able to work in this way because they are allowed considerable autonomy in their practice. Paradoxically, while they adopt an eclectic approach and focus on their patients’ subjective experiences the specialist nurses guiding the work of their generalist colleagues, seek to control their practice by advocating standardised approaches to practice.

6.5 Conclusion

The findings presented in this chapter explore processes that the specialist cardiac rehabilitation nurses consider to be fundamental to their behaviour change practice. This group of nurses are players in the sense that they demonstrate a type of flexibility in their practice that is brought about by their ability to manipulate language, discourse
and processes so as to achieve the medically defined goals and objectives of their practice.

In essence, the nurses’ behaviour change practice is a complex multifaceted process of persuasion that relies on their ability to understand their patients and then to apply these understandings to their decision-making so as to individualise their practice. While some of the nurses’ strategies are overt attempts at motivating their patients to change, for example goal setting, others are woven through different layers of practice and remain hidden to the patient.

The nurses’ “knowing where the patient is at” is one of the most fundamental understandings the nurses describe. It involves an ongoing process of astute observation and interpretation. This understanding informs the nurses’ ongoing decision-making about the strategies they adopt to shape their behavioural interventions; it informs the doing.

The findings not only provide evidence of the complex and varied processes that shape the nurses’ practice but also that an essential part of this practice is exploring patients’ values, attitudes and understandings. Without this knowledge the nurses’ strategies would be perfunctory. With it, they are able to individualise their practice and mobilise patients that otherwise would likely remain resistant to change.

The findings presented thus far have revealed that the specialist nurses rely on an ongoing process of exploration that delves into the patient experience to gain
knowledge that informs their behaviour change practice. In contrast to the generalist nurses who are expected to work in largely pre-defined ways, the specialist nurses are granted the autonomy to incorporate multiple strategies and approaches into their practice.

The next chapter explores organisational practices that have led to the generalist and specialist nurses working in such different ways. The findings explain how these practices have facilitated or, as is the case with generalist nurses constrained the behavioural aspects of their cardiac rehabilitation role. In summary, the chapter is about the influence of context on how the nurses’ role and practice have evolved.
CHAPTER SEVEN: CONTEXT AND PRACTICE

7.1 Introduction

This chapter revisits the organisational context to present findings that, when combined with those discussed thus far, provide an in-depth explanation for why cardiac rehabilitation nurses behaviour change practice is the way it is. The findings that follow reveal the complex ways that the context serves to facilitate and, in many cases, constrain this aspect of nursing work. They also reveal the vast differences that exist in the ways that specialist and generalist nurses’ go about their behaviour change practice, many of which have been brought about by organisational practices. Acknowledging that the “organisation” is shaped by shifting contemporary discourses, for the purposes of this study the “organisation” is taken to mean not only the participants’ employing body but also the practices, beliefs and values it espouses.

The chapter begins by presenting the nurses’ accounts of their transition to the cardiac rehabilitation role and explains how they initially adapted to, what was for most of them, an unfamiliar area of practice. It is interesting that their recollections of coming to and adapting to this new role featured prominently during their interviews. This not only highlights the significance of this period for the nurses but also provides a point of comparison for the nurses’ current practice. The nurses’ talk about their transition also sheds light on the factors that have shaped the diverse ways the two groups of nurses comprising the study sample developed their behaviour change practice and cardiac rehabilitation work overall.
At this point it is important to reiterate an important difference between the two groups of nurses that comprise the study sample. Thirteen of the participants pursued and were appointed to specialist cardiac rehabilitation roles, either as clinical nurse consultants or clinical nurse specialists. In contrast, the fourteen community nurses that participated in the study were required to incorporate the delivery of Phase II cardiac rehabilitation services into their broader generalist community-nursing role. As can be expected, the circumstances that brought the nurses to their cardiac rehabilitation role influenced their attitudes and expectations towards it.

The next section of the chapter explores the way the nurses describe their cardiac rehabilitation role. It reveals how, as a professional group, the nurses commonly draw on medical and organisational discourses as tools for legitimising their professional identities and the overt aspects of their cardiac rehabilitation work. These discourses clearly dominate most of the nurses’ talk during the initial stages of the interview and in so doing make known the nurses’ expectations of what is required of them by the organisation as well as the professional image they wish to portray. While some of the nurses’ talk continued to be shaped by these discourses, others introduced understandings of the psychological to reveal how they incorporated alternative practices into their work.

That some of the nurses have and others have not assimilated alternative practices into their work raises the question as to why this is the case. While this question has been partly answered by earlier findings about the theory underpinning practice, there are more complex extrinsic factors that influence the nurses’ work. The most fundamental
of these are the organisational practices that facilitate and at times delimit or constrain their day-to-day practice.

The most influential of these customs is the level of autonomy the nurses are allowed in their practice. The specialist nurses, who experienced greater autonomy than their generalist colleagues, explained how it allowed them the opportunity to explore different ways of working which subsequently saw their practice blossom. On the other hand, many of the generalist nurses described practice that was strangled by various organisational limitations and constraints such as the expectation that they practice in standardised ways. They explained how, coupled with the increasing workplace demands of their “other” nursing work, they found it difficult to develop their cardiac rehabilitation role beyond the predefined “basics”.

The different levels of autonomy experienced by the nurses, in the areas where both generalist and specialist nurses delivered Phase II cardiac rehabilitation services, was instrumental in the evolution of a discourse of specialisation. This was manifested in talk that revealed a complex interplay of power relations between the two groups of nurses. The specialist nurses, in effect, became extensions of the organisation with their influence over the work of their generalist colleagues serving as a means of maintaining order.

The chapter continues to expose some of the consequences that various organisational practices have on nurses’ cardiac rehabilitation work; the most crucial being that they render some nurses incapable of carrying out their behavioural interventions in
comprehensive and patient centred ways. Some of the nurses with broader generalist roles explain how they find themselves practicing in suboptimal ways by “just attending to the basics” or “cutting corners” in order to meet day to day workplace demands.

The chapter concludes by exploring some of the less obvious ways in which organisation influences the nature of nursing work and how these serve to achieve and maintain control. The discourses that shape conventional organisational practices and those that many of the nurses’ draw on to describe their individually focused behavioural interventions, represent different ideologies, which means that at times they are competing and contradictory. Although there are clearly areas of overlap between some of these discourses, the data reveal ways that the dominant organisational discourses, which include those of medicine, technology, managerialism and economic rationalism, act to lessen the power of competitive discourses by forcing them to conform to the organisation’s preferred way of doing things. Various means of organisational control, under the guise of “best” and “evidence-based practice”, “efficiency” and “cost effectiveness” also act to quash nurses’ preferred ways of working, particularly those that have a predominant focus on holistic and person-centred care.

7.2 Transition: Understandings and Expectations

‘Nursing practice’ while a construct that can seemingly be objectively defined in that it represents something that nurses do, cannot exist independently from the nurses themselves or the context in which it occurs. This section of the chapter is based on the
premise that in order to gain a comprehensive understanding of nurses’ behaviour change practice, one needs to have an understanding of where the speakers are coming from. The rationale underpinning this view is that the participants, through their interactions, form part of the social context in which their practice occurs. In this way they contribute to the milieu in which their practice evolves.

The majority of participants came to their cardiac rehabilitation role when the service was being newly established in the community sector of their Area Health Service. While the specialist nurses were appointed to their role on the basis of their clinical expertise, which for the majority was in cardiology and/or other areas of critical care, the generalist community health nurses were expected to incorporate this work into their existing role with ‘guidance’ and ‘support’ from one or more of the specialist nurses in their area of work. All the generalist nurses were responsible for delivering home-based cardiac rehabilitation services; the three who worked in rural and remote areas were also required to facilitate group-based programs.

Understandably, the participants’ diverse backgrounds strongly influenced their perceptions of their cardiac rehabilitation role and expectations of what it would entail, particularly the aspects aimed at bringing about patient behaviour change. These factors were also instrumental in shaping their understanding of what skills they would need to develop to advance their expertise for this area of practice. While some of the nurses considered bringing about behaviour change to be an extension of their educative role, others situated it outside their scope of expertise. As a result several of the nurses, as illustrated below, pursued further understandings about this area of work:
It was really daunting to move into a role of community health anyway without having to take on this health promotion role. I’ve never sort of done anything as specific in health promotion before, so I was really confused. I felt that I was out on a limb. I mean (nurse manager) was a really good support person but I basically had to get the service up and going myself. So I did lots of talking to other people, got in touch with other centres that already had cardiac rehab going. I found out a lot from them. (Barbara GCN: Rural)

Despite the majority of participants stating they had prior experience in behavioural interventions, many explained that they initially feared not having the skills necessary to carry out this work in this particular service context. While they talked confidently about the assessment, monitoring and educational aspects of their work, they considered themselves as being “inexperienced,” “unqualified,” “unsure” and “out of my (their) depth” when it came to facilitating patient behaviour change. One nurse commented:

I’m not an expert, I’m a community nurse and they’d (cardiac rehabilitation patients) would be better off talking to someone else. (June GCN: Rural)

The generalist nurses explained that their already demanding and, what some nurses referred to as, “unmanageable” workloads further exacerbated their uncertainty about their new role. The time and effort they believed was required to bring about behaviour change contributed to them perceiving the work as interfering with their ability to carry out “other” or “usual” nursing “duties”. Consequently, some of the nurses were pessimistic about their “having to” take on cardiac rehabilitation work and, contrary to
those who tried to “squeeze” it into their existing workload, resisted the behavioural aspects of this work.

As previously explained, not all the community nurses responded in this way. When faced with what they perceived to be a “challenge”, several of the nurses pursued further understanding to assist them to develop their cardiac rehabilitation role. Some explained that they sought information from the literature, others pursued further education and/or training and, as illustrated in the next passage, some consulted other disciplines to learn more about the behavioural aspects of this area of nursing work.

What is particularly relevant to this research is that some of the nurses recognised that incorporating a behavioural component into their role would require additional skills and a different approach or way of working; for example:

Initially, it was hard coming to terms with it. It was actually hard to define because there was no role when we started. I really didn't know what I was getting myself into, in terms of what sort of a job it was. I mean it sounded good. That's why I applied for it. I thought I could use my skills from intensive care. But, I realised fairly quickly that it was about adult teaching and behaviour modification. I read. I went to all sorts of people for information.

(Beatrice CNC: Rural Semi Rural)

Irrespective of the nurses’ initial perceptions of the role, many described their transition to cardiac rehabilitation as being marked with uncertainty. They explained that customarily, bringing about patient behaviour change was an adjunct to their clinically
focused work, practice that was mostly limited to “patient education” and “information
giving”. In cardiac rehabilitation however, it became a major focus for their practice.

The nurses’ uncertainty was further exacerbated by their colleagues’ naivety about what
this area of nursing work entailed. That cardiac rehabilitation had only recently been
established in the community sector meant that it was also an “unknown” for other
nurses working in the community, a point illustrated in the passage below:

When I took on this job (community based cardiac rehabilitation), the role was a
bit blurred. I didn't even know how the program was going to evolve. You don't
actually belong anywhere. Which is a problem, because you're wandering around
in this new area and everyone is going "What are you doing?" "Who are you?"
And so, the role, I don't know! I just feel it's a very extended role. Well, obviously
we're responsible to certain people, we're obviously responsible for the program,
we've got our protocol set up and our policy set up, and those are the best practice
guidelines that you stick to. And we have to remember to be completely safe in
our practice; that we’re not going to give anyone any bad advice.

(Sally CNS: City)

The above illustration highlights how cardiac rehabilitation was initially a poorly
understood area of nursing work and how this contributed to some of the participants
feeling alienated from their peers. It also illustrates how the nurses claimed their
professional identity by situating this work within existing nursing, medical and
organisational parameters. This meant that the nurses rummaged through conventional
understandings of nursing work to find similarities that they could draw on to describe
and legitimise their role.
7.3 Legitimising Practice

A consistent feature in all the nurses’ texts is the way that they draw on medical and organisational discourses to convey their cardiac rehabilitation role, particularly during the initial stage of their interview. This can be expected given my status as nurse-researcher was known to the participants and these discourses dominate contemporary nursing speak. They also served an additional purpose, which was to maintain the status quo. By drawing on these discourses the nurses demonstrated compliance with organisational norms and its expectations of how they should work. However, as illustrated in the passage below, the organisation’s expectations sometimes conflicted with the nurses’ beliefs about the most appropriate ways of practicing:

When I started practicing cardiac rehabilitation, I had from the beginning felt that I really needed to look at behaviour. And I have to say it wasn't something that was encouraged by nurse managers. At that stage it was thought to be, not really our field. They thought that we were case managers, case managing a client just like any other client and really didn't need to look into that behaviour aspect at all.

(Beatrice: CNC: Semi-rural and Rural)

Several of the nurses recalled how they found themselves working in a context where, for various reasons, the behavioural aspects of the nursing role were undervalued. That some managers did not consider this type of work should be part of their role not only reinforced the dominant medical and organisational discourses but also served to curtail the nurses’ pursuit of new and alternative forms of knowledge such as those stemming from the field of psychology.
The data reveal diverse effects that the organisation’s privileging medical and organisational discourses had on the nurses’ behaviour change practice, particularly that of the generalist nurses who, due to their limited autonomy and workplace demands, were less able to adopt alternative ways of working. Some of these nurses continued to practice in conventional ways, relying on patient education and information giving for bringing about behaviour change. There were others however, who took their managers’ views and/or lack of understanding about the behavioural aspects of their cardiac rehabilitation role as reason for delimiting or divorcing this aspect of practice from their work. Interestingly, as explained later in this chapter, the organisational practices that have been put in place to monitor and standardise nurses’ work are the ones that, through omission, allow the illusion that behaviour change strategies, other than patient education, are being carried out.

The specialist nurses on the other hand, had a vested interest in developing all aspects of their cardiac rehabilitation role. Being recognised as advanced practitioners is fundamental to their status of “expert”. Given this, the specialist nurses were granted considerable authority and autonomy to develop their role as individuals and as a professional group. By outwardly privileging the dominant organisational discourses when communicating their role and practice they ensured the organisation sanctioned their practice, which in turn created space for them to develop professionally. However, while they exercised their power and freedom to gain new knowledge and develop their expertise, they also applied their autonomy to shape, control and thereby restrict the work of their generalist colleagues.
7.4 Shaping Practice: Autonomy and Agency

As a professional group working in the same area of practice, the participants experienced quite different levels of autonomy and exercised their agency in different ways. For the purpose of this research “autonomy” relates to freedom and choice, the extent to which nurses can work independently. Personal agency on the other hand is what people draw on to exercise choice in negotiating their way through the power relations in their social context (Davies and Harre; 1990 Weedon 1997).

The extent to which the participants realised their autonomy and agency in their actual practice was determined by multiple interrelated and varied factors. While some of these, as revealed in the last two chapters, related to the perceptions and understandings of the nurses themselves, others were context related. Just as ‘practice’ cannot exist independently of the practitioner and the context in which it occurs, the findings demonstrate that nurse ‘autonomy’ and ‘agency’ are subject to similar influences.

The relevance of the organisational context to the way the nurses’ deliver their services cannot be overstated. While the data that relates to common service delivery models in some of the study sites allow some generalisations to be made, many of the findings are specific to their area and service context. The excerpt below clearly illustrates this point:

I’m very autonomous and basically I have to say that, other than my cardiac rehab colleagues, nobody else really knows what I do, in terms of my daily work practice….. The positives are that my colleagues and I can adapt a program and can adopt approaches that we think are appropriate at the time. We're not dictated to.

(Beatrice CNC: City and Urban)
The comment above illustrates the freedom or autonomy that some specialist cardiac rehabilitation nurses were granted in developing their role, particularly in areas where they were solely responsible for the delivery of cardiac rehabilitation services, as is the case in the example above. In contrast, the generalist nurses carried out this work under the auspices of one or more specialist cardiac rehabilitation nurses who provided guidelines and/or instruction as to how it should be undertaken.

The lack of autonomy experienced by the generalist nurses in their cardiac rehabilitation work led to many of them being dissatisfied with it. Some perceived that the control managers and/or clinical nurse consultants exercised over their work challenged their professionalism in that they were not able to practice independently. Others felt that their cardiac rehabilitation role was devalued as they experienced greater autonomy in their generalist community health role. As well as this, the generalist nurses found themselves in a subordinate position to nurses who, while specialists in the practice of cardiac rehabilitation, were not their line managers. One nurse commented:

"We used to do this all the time, now others are telling us what to do and how to do it".  
(Sandra GCN: Semi-Rural)

As indicated in the passage above, some of the generalist nurses questioned the authority and expertise of the specialist nurses and/or managers in guiding the behavioural aspects of their cardiac rehabilitation role. Given their community health experience, some of them felt better equipped to decide on how this work should be undertaken. What is of particular interest is that the majority of these nurses were not
familiar with alternative ways of working and considered patient education and information giving to be sufficient for bringing about patient behaviour change.

The specialist nurses on the other hand, although required to situate their practice within the existing broader Australian “Phase II” cardiac rehabilitation guidelines, were granted the freedom to develop their expertise as they saw fit. While these guidelines provide a framework and standards for cardiac rehabilitation and recommend a “stage approach” for bringing about behaviour change, they do not include protocol or instruction for carrying out the behavioural aspects of cardiac rehabilitation work (ACRA 2008; Goble and Worcester; 1999NHF 2004).

The specialist nurses soon came to realise that educative practices were usually not sufficient for bringing about patient behaviour change. They explain how this led to their seeking further understanding from cardiac rehabilitation nurses working in other health services and from allied professionals such as social workers, psychologists and health promotion professionals. The resulting exchange of knowledge saw them become a community of practice with shared understandings and ways of working which can be evidenced in the content of group programs and the core processes in their individually focused interventions.

This pooling of knowledge provided the nurses with understandings they needed to address the diverse components or dimensions of cardiac rehabilitation work. More importantly, it exposed them to alternative discourses and ways of working that many of
the specialist nurses assimilated into their own behaviour change practice. One nurse explains:

It (bringing about behaviour change) is a complex process, you become almost a counsellor, a facilitator and a mediator and while that's never written anywhere or never explained anywhere in a job description, you sort of fill in those roles. And it's one of those things, a bit like, how you communicate to people, it's something you can't measure, it's something you can't explain, it's just something that you do. You know, you see that need or that gap. So you're doing all those things.

(Marion CNC: City and Rural)

The above passage is typical of how the specialist nurses talk about their role, specifically the behavioural components of their interventions. However, as illustrated above, while the specialist nurses share similar understandings about the nature of their work as a professional group, the behavioural aspects of their work remains largely hidden as they find it difficult to explain. The difficulty the nurse experiences in articulating her role reveals that her behaviour change practice is shaped by discourses that are relatively unfamiliar in that they do not define the same processes and protocols that shape and delimit medically-focused nursing work.

Interestingly, the specialist nurses have made the medically focused aspects of their work highly visible in standardised group programs and through the introduction of pathways, guidelines and protocols. They do not however, expose the behavioural dimensions of their individually focused cardiac rehabilitation work in the same way.
Shaped primarily by psychological discourse, these alternative aspects of their practice involve processes that move beyond the provision of information and patient education, to strategies that focus on the patients’ thinking. The data expose a paradox. While the specialist nurses describe the psychologically focused aspects of their interventions as being fundamental to their behaviour change practice, they underplay these aspects of practice when guiding their non-specialist colleagues.

The data reveal various reasons why the specialist nurses privilege medical and organisational practices in their instruction; most associated with their intent to encourage and facilitate “best” and “safe” practice. Realising the complexity of behavioural interventions and the skills required to achieve positive outcomes, the specialist nurses tend to keep their instruction to generalist nurses within the parameters of what they consider to be the scope of their colleagues’ capabilities. They also consider behavioural theories and models to be limited in their ability to guide effective behavioural interventions. While they consider theory to be useful “in the background” the specialist nurses believe that experiential learning is needed to recognise and work with the similarities and differences that present in individual practice situations (see Chapter 5).

The data also reveal covert reasons why the specialist nurses underplay the psychologically focused aspects of their work. By promoting practices that reflect organisational values and standards they maintain the status quo. In other words, advocating practice that rests within the parameters of the nursing ‘norm’ poses little or no challenge to their conventional way of doing things. Keeping this practice within the
specialist domain also inadvertently serves to maintain the exclusivity of their practice and expertise.

The guidance provided by the specialist nurses to their generalist colleagues is not totally void of a focus on the psychological. They promote practices such as establishing rapport and advocate patient education as a way of increasing patient self-efficacy and empowerment.

The generalist nurses’ accounts of practice also include some focus on the psychological, although there are differences. Like their specialist colleagues they recognise the importance of processes such as engaging with their patients and building rapport to the overall nursing process. They also describe their use of standardised tools to assess various aspects of psychological functioning; for example: various depression scales, measures of cognitive functioning and quality of life questionnaires. More commonly however, they talk about their attention to the patients’ psychological well being as part of their holistic practice.

Describing and interpreting the nurses’ talk about the psychological focused aspects of their practice is complex and problematic. The discipline of psychology is multifarious as is psychological discourse and encompasses multiple ideologies. The nurses’ talk about the psychological also illustrates how it is not a unitary concept but comprises several discourses; some in keeping and some incongruent with prevailing contemporary organisational values and practices. When talking about their attention to the “psychology” of their patients, they describe practice aimed at gaining an in-depth
understanding of their patients’ thinking, which in turn informs their interventions. When talking about the patients’ psychological wellbeing, they are usually referring to the patients’ overall state of mind. In contrast, when the nurses talk about assessing the psychological, they convey their purpose as identifying patients who deviate from the ‘norm’.

7.4.1 Discourse of Specialisation

The specialist nurses’ talk about their awareness of and ability to draw on various psychological discourses, sets their understanding and practice apart from that of many of the generalist nurses. It also reinforces the exclusivity of their practice and contributes to the discourse of specialisation that situates them in a privileged position within the organisation.

Their “expert” clinical knowledge and their understanding of the psychological, legitimises and strengthens their credibility within the organisation, which in turn grants them the power to direct the work of their non-specialist colleagues. In effect, the specialist nurses are extensions of the organisation in that they influence the work of generalist nurses in ways that perpetuate organisational values and preferred practices.

The passage below illustrates this point. Here, one specialist nurse constructs herself as a conscientious expert by directing her efforts to ensuring that generalist nurses carry out their work in a standardised and comprehensive way. By virtue of her status and expertise, the specialist nurse advocates that the non-specialist nurses work in a governed way while stating that her own work does not require such direction:
I was concerned that different nurses would be giving different information and not following at least some sort of standard guideline. …..Their actual ability to teach a skill or to discuss a matter with someone, that's still poetic license. Teaching ability is still up to the individual. The subjects will hopefully all be covered by introducing a clinical pathway. It takes away the chance of something being forgotten………. I don't like clinical pathways myself. I think if it were one nurse doing it, who was an expert in the area, you wouldn't need a clinical pathway.  

(Jane CNC: Rural and Urban)

The discourse of specialisation that is evident in the passage above, while granting the specialist nurse greater authority and credibility, hierarchically devalues the work of her generalist colleagues. The nurse rationalises the introduction of a clinical pathway by constructing ‘other’ nurses as needing to conform to prescribed practice in order to achieve the desired standard of service. The clinical pathway then, acts as a tool for maintaining order, a means of organisational control which serves to exclude alternative discourses and approaches to practice.

The organisation’s maintaining control through its emphasis on standardised practice is also evidenced in the specialist nurses’ talk about educating other nurses. That the specialist nurses have advanced knowledge means they are in a position to pass it on to other nurses, which is one way in which they exercise their power. The nurses who assimilate and in turn express this knowledge in effect conform to prescribed standards and practices and, as illustrated below, are at times rewarded with certain privilege and/or advanced standing:
I trained one of the community nurses up and she's now used as their resource. So, if they want to know something they'll talk to her and she trains other nurses up as well. She’s doing a great job with them. Another one called Cathy (pseudonym) she takes an interest in cardiac rehab as well. Neither of those girls have cardiac backgrounds but they have got a world of other experience behind them. They have also had additional training to learn about patients’ experiences with a cardiac event and what the latest cardiac medications are. At the very least they're skilled enough to pick up problems before they become major and they’ll know when they have to contact me. (Jane CNC: Rural and Urban)

The passage above illustrates how gaining specialised knowledge saw one nurse’s status within the organisation change from that of clinician to valued “resource”. It is interesting that the nurse who made these comments describes the community nurse as a resource for things ‘medical’ rather than the behavioural aspects of the role.

This does not mean that non-specialist nurses did not have opportunity or were prevented from gaining the broader understandings of behaviour change practice described by the specialist nurses. Several generalist nurses communicated their intention to undertake additional education and/or training to develop their expertise in this area of work while others had already attended short courses in cardiac rehabilitation. A finding that is particularly relevant to this research is that the nurses, both generalist and specialists, who had already undertaken such training considered that while it increased their clinical knowledge it did not prepare them for the behavioural aspects of the role.
Other factors also influenced the way the generalist nurses developed their practice. Unlike the specialist nurses, whose work efforts were directed solely to Phase II cardiac rehabilitation, the majority of the generalist nurses found it difficult to balance their “usual” caseload with the additional demands of cardiac rehabilitation work. Although they usually talked about a single difficulty or issue at a time, each of their texts revealed how multiple interrelated factors impacted negatively on their practice. While some of these related to the incongruence between organisational and their own personal expectations of the role, others pointed to the various ways the organisation limits and constrains their practice.

7.5. Organisational Requirements, Limitations and Constraints

One of the most visible ways that the organisation influences nurses’ work is through the various “tools” it provides to facilitate aspects of their practice. Most of the nurses talk about the checklists, questionnaires and reports that they are required to complete and the pathways, protocols and guidelines they are required to follow; “tools” that act as means for shaping, monitoring and ordering their work. Many of these, for example clinical pathways, have been designed by nurses for nurses which, as previously discussed, positions them as extensions of the organisation in that they perpetuate organisational control over nursing work.

Several of these tools or aspects of them, for example questionnaires that elicit information about psychological and/or social issues, reveal various discourses have been assimilated into the organisational milieu even though they sometimes serve
rhetorical purposes. For example, some of the nurses equate the introduction of routine psychological and social measures evident in a questionnaire, to the assimilation of psychological and social practices into their work. While this may be the case, the objectification of patient information is in keeping with positivist ideology. This is useful to the organisation as it allows classification and also serves to meet organisational interests by providing the data required for purposes of accountability.

The nurses’ talk about completing the comprehensive assessment tool is particularly interesting. While the nurses describe this assessment as “holistic” they reveal how it privileges medical and organisational interests over those that place greater emphasis on social and psychological factors. This point is illustrated in the next quotation where a nurse acknowledges the holistic nature of the assessment process but focuses predominantly on the patients' physical concerns:

> On this initial assessment we just go through some demographics, their social history, whether they live alone and what nationality they are, whether they speak English. Then we look at a brief risk factor profile to get a bit of a feel for what their risks are. We talk a little bit about our program options to see whether they're interested or not…….When we go to their home, we'll do this comprehensive assessment, which often takes about an hour and a half. It goes into a lot of detail about what their risk factors are. What their knowledge of coronary artery disease is, a lot of psychosocial stuff. You know, the different stresses they have in their lives. We look at their diet history, whether they've got high cholesterol and how they're managing it and whether they're on cholesterol lowering medication and whether they're also following a healthy eating pattern. We find out whether they're actually aware that they have to watch their saturated fat intake……. We
find out whether they need further help with losing weight and we just find out whether there are any cultural problems there. Often we will find there might be other issues happening at the time, whether there are issues with loose teeth or what have you. So we try and address them or maybe refer them on to someone who can. 

(Bronwyn: CNC: City and Urban)

The matter-of-fact way the nurse describes the information elicited by the assessment tool described above clearly reflects a dominant focus on patients’ physical concerns. It also conveys that the assessment process involved is akin to going through the motions or finding out the basics. Whilst the majority of the nurses acknowledged the value of this assessment, in that it obtains information required to identify, validate and guide their services, they were not as accepting of some other assessment tools they were required to complete. Their criticisms of these tools focused not so much on the purpose of the tools, but on the nature of the questions and the process of completing them, which included the assessment tools’ terminology and the time required completing them.

The passage below conveys the dilemma that one nurse experienced when required to demonstrate accountability through various documentation requirements. Although she communicates an understanding of the underlying rationale for their use, the nurse considers they have a negative impact on the dynamics of the intervention process including the natural flow of communication:
A lot of assessment tools, they’re pretty much just tools to measure things, they take you through the motions. Some of them are just over the top. Like we're just measuring ourselves to death, where a good nurse would just pick all of that up anyway, and more than that. So, I think for our funding we need to have measurable proovables, and that's why we do it. But there are some things you just can't measure. They (tools) get in the way. Sometimes trying to measure, asking those questions changes the dynamics of the process. It changes the interaction into something that's more formal with the measurement tool being a sort of barrier in between. (Marion CNC Rural and Semi-Rural)

Several of the nurses consider that the formality associated with applying various assessment tools forces unnatural and depersonalised communication. They explain that unless they mould these tools to a more natural or conversational format they act as a barrier to their “connecting with the patient” and “building rapport”; processes they consider to be fundamental to facilitating patient behaviour change. The nurses also describe a more indirect way that some organisational tools constrain the intervention process, particularly those aimed at assessing psychological and social factors. They explain that, while “it helps to get necessary information”, objectifying the assessment process not only delimits the information that is sought but also curbs patients’ freedom to express concerns and experiences that fall outside the pre-determined categories.

The way the nurses explain this, reveals that they see these tools as reflecting the normative values that underpin contemporary organisational practices. They revealed that as well as changing the wording of some of the tools they also augmented the
assessment process by encouraging patients to talk freely about their situation and then by exploring the issues that arise.

Some of the nurses expressed concern about how the organisation’s emphasis on standardisation and measurability causes them to fall short of the purpose of their interventions, especially patient behaviour change. This is illustrated in the next passage where the nurse’s main focus is to ensure the patients successfully complete an assessment tool:

We do have some tools that we have to use. I mean, if your goal is ‘the client is able to demonstrate an understanding of an event or a condition’ as you know, you have to be able to reasonably evaluate it. There’s this (title) assessment tool. It's just a very simple tool. It's there to provide a means of assessing the client's understanding of their cardiac condition and to act as guideline for the nurse-client information exchange. To keep it standardised. And you've got questions like "can you explain what you understand about your heart condition" and you know, if they're able to give you a reasonable answer to that then fine, the goal has been achieved. (Julie GCN: Rural and Semi-Rural)

The passage above clearly illustrates nurse-patient “exchange” governed by specific process and content and how complying with this has become the raison d’etre for the nurse’s intervention. Of the four participants who were required to administer this particular tool, two described it as being “helpful” for shaping their behavioural interventions. They did not articulate an understanding of behavioural theory and instead described medically focused practice.
### 7.5.1 Competing Interests: Hidden Consequences

The tools provided by the organisation are not the only factors that influence how the nurses’ carry out their behavioural interventions. The majority of nurses who expressed difficulty and/or dissatisfaction with their cardiac rehabilitation role attributed it to limitations and constraints that stemmed from what they considered to be inadequate staffing levels, which resulted in their inability to meet the increasing demands on their time. As illustrated below, some of the nurses were not hesitant in articulating the paradox that existed between what the organisation required of them and what they felt they could actually achieve:

> Because I have (amount of time allocated by management) that I do cardiac rehab, it's almost, well, it is too hard. I get too overwhelmed. There are too many other things that I have to do as well as. So, I tend to skirt around the edges of lots of things rather than doing it the way that it's recommended. I do what I can do in the time that I have to do it. So, if that just means a quick natter on the run, if it means giving them a handout and saying look this is what we need to do, that's what I'll do.  

(Gabrielle GCN: Rural)

“Taking shortcuts” is a common theme throughout the nurses’ texts and usually appears in their talk about dealing with time constraints. They describe it as a coping strategy that remains hidden and therefore without direct consequence. For some generalist nurses it has become a form of covert resistance towards being required to carry out work they consider should not be part of their role. By delivering basic services and complying with documentation requirements, these nurses overtly comply with what the organisation expects while directing their main efforts to their preferred nursing activities: One nurse explains:
(Cardiac rehabilitation) It’s time consuming because I do it with all my other clients, all my dressings and blood pressures and other things……So if I have a (names other area of work) rehab, a cardiac rehab and then a couple of dressings, a blood pressure. Well, on paper it looks like it’s there, but it’s time consuming. And, I don’t think anybody understands that. 

(Rachael GCN: Rural)

As illustrated below, some of the nurses try and maintain a balanced approach to their overall practice by prioritising certain aspects of their work

I don’t measure outcomes. I don’t have time. I suppose I should but I don’t have time. I document the six-minute walk test but I don’t measure other outcomes. I just know that the program is successful. I barely have the time to follow up the clients that have to be seen. 

(Narrelle GCN: Rural)

In the passage above the nurse does not measure outcomes other than the “six minute walk test”, which is commonly used in cardiac rehabilitation to measure levels of patients’ physical activity. What is interesting is that the nurse values this particular measure yet elects to replace others with her own subjective understandings; in this example, ‘just knowing’ that the program is successful.

There are other nurses who reveal they are less willing to find a compromise between what they consider to be their “different roles”. The next illustration was provided by a generalist nurse who worked in a rural setting. The nurse had previously explained the long distances she was required to travel to see patients in their homes impacted greatly
on her time and her ability to meet the demands associated with her role. What is of particular interest is the way the nurse prioritises her work and her approach:

I have a generalist workload in aged care. I just don’t have the time to do cardiac rehab. But if someone lives out of town and they can’t get into the program for some reason, then I always say, “Well look, I’ll come out and do a home visit.” I just run through a few things and let them know about the dietician, different types of services they can access and answer any questions that they might have ….. I think you would be able to get onto your referrals much quicker and follow people up a bit more if you were given more time, you know, the referrals may not sit on your desk for a couple of days, until you can get round to them. I mean, as it is I’m employed as an aged care community nurse, I’m not employed as a cardiac rehab co-ordinator. Therefore my priority has to be towards aged care. But, that doesn’t mean to say that I leave referrals on my desk for two weeks. If I did have more time then you could sort of say, “Alright, I’ll do all the referrals”.

(Marie GCN: Rural and Remote)

The passage above clearly illustrates the struggle that many participants explained they experience when having to cope with not only time constraints but also having to assimilate an additional, diverse and time consuming role into their practice. The nurse rationalises the scant attention she gives to her cardiac rehabilitation work by prioritising her focus on aged care. However, like other nurses who place lesser importance on the behaviourally focused aspects of their cardiac rehabilitation work, as one nurse explained, by “skirting around them”, she inadvertently perpetuates the dominant organisational discourse by privileging the medical. The nurses’ resistance to, or non-compliance with, carrying out the behaviourally focused aspects of their work, is
in effect sanctioned by the organisation in that it remains unseen and therefore is not subject to any direct negative consequence. By exercising their agency in deciding to curtail some of the tasks required of them, the nurses maintain a degree of control over their practice by relieving some of the pressures that are placed upon them.

Several of the generalist nurses talked about their efforts to maintain a balanced approach to their work which involved meeting the needs of multiple interests, including those of the patient, the medical establishment and the organisation. They explained that this required them to have an understanding of and valuing both objective medical ‘truths’ and the patients’ subjective understandings. As the following passage illustrates, this equates to the nurses recognising and being able to avail themselves of different ways of working:

Assessment tools, they can't break it down to the finest element. They break it down to the best measurable element. So it's all measurable stuff. It's like if you can't measure it you can't make improvement. If you can't make improvement you can't see gain. And it's that sort of thinking that’s out there. But there are so many things we do that are not measurable. We spend time doing the measurable stuff but at the same time we're observing and doing the non-measurables and there’s a fairly equal element of what's measurable and what's not measurable in our work every day. (Marion: CNC Rural and Semi-Rural)
The above passage differs considerably from earlier examples where nurses explain that they give preference to their “other” medically focused nursing work. This talk is not so much about struggle or resistance, but the nurse accommodating the different nature of the processes required to carry out her work and maintaining some equilibrium in her approach.

Not all the nurses articulated an ability to maintain a balanced approach. Several revealed how their efforts to accommodate workplace requirements, or as some put it “trying to keep up” with work demands, came at a personal cost and at times at a cost to patients. As some of the nurses explained, this was particularly the case when they became “overwhelmed” with what the organisation expected of them.

Aside from various workplace demands that several of the nurses considered detracted from the comprehensiveness and quality of their behavioural interventions, the nurses explained how the service delivery model in which they operate dictates the scope of their interventions; one nurse explains:

The real problem is we don't have that sort of time and the program is limited. That's a real worry…. They’re discharged home, they do a four to six week course and then they’re out on their own ….I'm not saying it's ineffective. I think it's just a tragedy that you're trying to achieve so much in such a short period of time. So you're giving them all the information that they need to do it, and all the encouragement they need to do it, but you're not giving them the time it takes to work it through. Behaviour change takes time.

(Natashia: Rural and Semi-Rural)
The example above conveys one nurse’s concern about the limited scope of the service she is able to provide. The most salient point in the passage above is that the nurse understands that bringing about patient behaviour change usually requires considerable time and effort and that the services they are able to provide often fall short of assisting patients to achieve this goal. In some of the areas cardiac rehabilitation includes additional follow-up and support in a stage of cardiac rehabilitation called “Phase 3” or “maintenance”. The nurses who are providing these services however, explain that it is becoming increasingly difficult due to a growing demand for cardiac rehabilitation services overall.

The passage above also brings to light another dimension of contemporary organisational practice. The nurses provide patients with the information or educative “tools” that are considered appropriate for facilitating change. This approach quickly transfers the responsibility for change from the nurse to the patient by discounting the need for a health professional to facilitate the ongoing change process.

### 7.5.2 Maintaining Order: Other Means

This final section of the chapter focuses on how organisational interests and professional control are manifested through the preferred approaches to service delivery. The first to be discussed are differences between the two main approaches to Phase II cardiac rehabilitation services; these are individually focused or home based programs and the group-based programs.
In each of the participating area health services, the specialist cardiac rehabilitation nurses favoured the group program approach. This included the specialist nurses who worked in areas where home-based and group programs were run in parallel and who were experienced in delivering both approaches. This finding is of particular interest because specialist nurses preferred patients to attend the group program despite the majority considering home-based programs to be more conducive to facilitating patient behaviour change.

The nurses maintained that “patients are more relaxed in their own homes” and that home-based interventions can be “tailored to meet individual needs”. More importantly, several of the nurses considered that individually focused approaches enabled the therapeutic-like processes they described as being fundamental to behavioural interventions. As described in the last chapter, these include “building rapport”, “knowing where the patient is at” and “moving the patient on”.

The most common reason the specialist nurses gave for preferring the group-based approach was that it is a more efficient use of their time. However, their talk revealed the most salient reason for this preference was that they experienced a greater sense of control over the patients and the intervention process overall.

This sense of control was partly attributed to their ability to predict the type of patients who elected to attend the group programs. The nurses believed that these patients were more motivated and compliant than those they encountered in individually focused home-based programs.
In the areas where the specialist nurses facilitate group programs and generalist nurses deliver the home-based cardiac rehabilitation, the specialist nurses allocate the patients to one or other program. In these areas there was a general belief amongst the generalist nurses that the patients they were allocated are “more difficult”, “less compliant” or “unsuitable” for the group program. One nurse explains:

I'm looking at a home-based program, which is quite different from a group program ………. I think the group program is a lot more structured, and people are really quite keen generally to go along to that program. So I think there's, you know, they tend to be a lot more enthusiastic and really wanting to make changes. I think that the people in the home, the clients that I have been working with, it's a little bit different. You try and encourage them to look into making changes and they're not necessarily so keen to be compliant. And they tend to be clients that are much more chronic in their disease process. So you're working with much more difficult variables as well. (Gaye CNS: Semi-Rural)

Given the complexities associated with delivering home-based interventions, it is surprising that in two of the three areas where both home and group programs were offered, the supposedly less skilled generalist nurses, were allocated the patients assigned to the home-based program. This occurred despite a shared understanding about the complexity of individually focused home-based interventions.

---

6 The exception to this was in two rural and remote areas of one Area Health Service where generalist nurses were responsible for both the group and home-based programs.
The “efficiency” the specialist nurses attributed to the group-based program, was associated with what can best be described as, a production line approach that enabled the nurses to deliver cardiac rehabilitation services to multiple patients simultaneously. As well as meeting the increasing demands for cardiac rehabilitation, the group program approach also eased the time and workload pressures of delivering home-based services. One nurse commented:

“We couldn’t get to them if we had them all on the home based program.”

(Bronwyn CNS: City and Urban)

The nurses also revealed that group programs are conferred greater status by the organisation due to their greater visibility and associated accountability. The standardised program content, usually provided by or informed by various health “experts” also enabled the nurse to have control over the process.

The nurses also measured their proficiency or expertise in facilitating group programs by their ability to execute and maintain professional control over the participants. They achieved this through processes such as “supervising”, “co-ordinating” and “facilitating” the participants’ progress through the standard and routine components of the program and by preventing things from getting “out of hand”. In contrast, the home-based interventions take place in the patients’ ‘territory’, which diminishes the nurses’ control and ability to predict the process and outcome; one nurse explains:
The patients are always different. You just never know how you have to approach them until you get there. Some are young, some frail, some are depressed or in denial. Some really don’t want change anything and then you get the other extreme where they do everything you tell them. You just have to walk in the door and you take it from there. (Jacqui CNC: City and Urban)

The standardised approach, format and content of group programs differ markedly from home-based interventions as the nurses have overt and direct control over the process. The exemplar below is particularly interesting as it not only illustrates this point but also how one nurse enters into a discourse of specialisation to explain the need to maintain control over the group situation:

I always say to people, “If you're running groups and you haven't had a lot of experience be very careful about how you go about it. Keep an eye on the group all the time, never let it get out of hand because it can end up in a bit of a brawl if you're not careful”. And that should never be allowed to happen. That's why I firmly believe group-work should be done by people who have had quite a bit of experience. I always say, “Sit in on some groups if you haven't done it before because you could open up a can of worms and you better be ready if that happens.” (Carmen CNC: City)

The same nurse who provides the above example also spoke about the patients having “input into the group” and their being able to “direct” group discussion. The above passage exposes how her role as facilitator involves restricting or curbing the extent to which this occurs. In this illustration the nurse’s having control over the group process
is viewed as a means of maintaining order, which serves to prevent potentially negative or traumatic incidents from occurring.

There is considerable overlap in the assessment and educational components of both group and home-based programs however there are fundamental differences between the two. One of the most interesting findings that relates to the specialist nurses’ preference for the group-based approach is that, although they experience considerable autonomy in their practice, they favour the service delivery approach that most reflects the current organisational milieu which privileges standardisation and efficiency over individually tailored and person centred interventions.

7.6 Conclusion

The level of autonomy granted to cardiac rehabilitation nurses by the organisation greatly influences their role and practice. Those who are the designated experts are not only conferred higher status but they are also allowed the authority to influence cardiac rehabilitation work of their generalist colleagues. However, while many of the non-specialist nurses are appreciative of the direction and support they are offered, others exercise their agency to resist what they consider to be additional role demands that the organisation places upon them.
The inequality that exists between the two groups of nurses is cultivated by a discourse of specialisation that assigns greater value and credibility to the knowledge and practice of the specialist nurses by the way it constructs the hierarchical relationships between them. Acting as extensions of the organisation, the specialist nurses perpetuate its interests by actively supporting a culture that conforms to organisational values and standards by promoting standardised and economically driven approaches to cardiac rehabilitation work.

In contrast, the autonomy granted to the specialist nurses’ sees their practice flourish through the introduction of new and alternative ways of working, mainly those developed from their pursuit of knowledge about the psychological. Whilst specialist nurses consider these alternative understandings to be fundamental to the development of their own behaviour change practice they exclude them from the direction and guidance they provide the non-specialist nurses in the same area of work. This not only serves to secure the specialist nurses exclusivity as a professional group but it also serves to maintain the status quo by providing training, direction and support that is in keeping with organisational values and practices.

The influences of the organisation are evident throughout the nurses’ accounts, which reveal the complex interplay of power relations that stem from its practices. These steer the efforts of the majority of its nurses towards ordered, controlled and seemingly efficient ways of working. The way the organisation exercises its power and control does not however remain unchallenged. This is evidenced in the way some nurses exercise their agency to resist various aspects of their work and what some consider to be unmanageable workplace demands.
To avoid negative consequence the nurses comply with the requirements the organisation considers essential aspects of practice; these usually relate to assessment, documentation and medically focused nursing work. The practices that have not been assimilated into the organisation’s expectations of the nursing role, such as those stemming from the field of psychology, remain invisible to the organisation and are generally those that the nurses curtail or put aside. While such practices may escape organisational consequence, the nurses reveal that they come at a cost to the patients. Additionally, the nurses’ awareness that they are practicing in suboptimal ways increases their overall dissatisfaction with this area of nursing work.

The findings presented in this chapter highlight several of the ways in which the organisational context influences the nature of nursing work. While certain practices facilitate professional growth and expertise, others can constrain nurses’ work to the extent where they are unable to work in optimal ways. When workplace demands force nurses to prioritise their work, the balance understandably shifts to those areas of practice that are deemed more necessary than others, usually the medically focused aspects of nursing work and those required to demonstrate accountability.
CHAPTER EIGHT: DISCUSSION AND CONCLUSION

8.1 Introduction

The purpose of this study was to explore nursing practice for bringing about patient behaviour change, the participants’ understandings of what this practice entails and the factors that facilitate and constrain it. What seemed like a simple research question however, has uncovered an area of nursing work that is characterised by varied and inconsistent practices. Consequently, the diverse ways nurses try to bring about patient behaviour change evade a single theory or set explanation of what it is they actually do.

In keeping with the methodological premise that informs this research, the interpretation of this chapter should be based on the understanding that nursing work is historically and socially situated. As such, the way nurses think and go about their practice is not fixed but rather bound by temporal and definitional boundaries (Cheek 2000). Although characterised by some specific attributes, nursing work develops and changes over time in response to the various influences to which nurses and nursing as a profession become exposed.

This chapter brings together and discusses the main findings of this research, those that meet the research objectives as well as important findings that were not anticipated at the commencement of the study. In doing this it brings to light new knowledge as well as adding to what is already known. The research objectives are listed below and are discussed in detail in the chapter. These were to explore and identify:
• The nurses’ expectations and understanding of their cardiac rehabilitation role;
• The nurses’ perceptions and understanding of the processes, theories and models of behaviour change;
• What the nurses actually do to bring about behaviour change;
• The facilitators, limitations and constraints on the nurses’ behaviour change practice.

This research was not intended to give a complete or definitive account of this area of nursing work, nor is the aim of this discussion to restate what is already known. Rather its focus is on findings that provide new insights and add depth to our understandings of what constitutes an area of practice that differs from clinically focused nursing work, not only in terms of its focus but also in the context in which it is carried out.

The chapter commences by introducing the overarching theme of this research, that is, the diversity that exists in this area of nursing work. The ensuing discussion then deals with each of the research objectives in their own right, excluding the first objective. During the course of analysis it became apparent that the nurses’ expectations and understandings of their cardiac rehabilitation role were fundamental to the other three objectives. In light of this the findings that relate to this first objective are included within the remaining three as this approach enhances the comprehensiveness of the discussion.
It is important to recognise that this work is not informed by a specific theory per se, therefore there is no “accurate” or “best” approach that can be drawn on for comparison. Nor can the nurses’ behaviour change practice be discussed in terms of outcomes, as the aim of this study was to explore and describe practice rather than determining its effectiveness. The following discussion does shed light on this diversity by comparing different types of practice and exploring the content and philosophy of these differences. Collectively, the findings provide a multifaceted depiction and explanation of nurses’ behaviour change practice and highlight concerns that are of relevance to a wide audience of health care professionals.

8.2 Diversity in Practice

The overarching theme in the nurses’ accounts of their cardiac rehabilitation role and their behaviour change practice is that this area of nursing work is diverse. In précis, the nurses create multiple, different and at times conflicting realities about what constitutes the behaviourally focused aspects of their practice. This rules out any distinct theory or explanation for the way this work is carried out.

The different voices encountered in this research also reveal that the nurses working in cardiac rehabilitation do not share a common culture but rather operate within different contexts shaped by varied and at times competing and contradictory discourses. This is not surprising given the different service delivery models that operate in the area health services, the different groups of nurses that undertake this work, the varied circumstances that brought them to their cardiac rehabilitation role and, the most
obvious reason, that the nurses brought with them different understandings, knowledge and types of experience.

There are also less obvious explanations for the diversity in this area of nursing work. Some of these relate to the nurses’ personal qualities and their underlying philosophical beliefs about the nature of nursing work. Others are contingent on how organisational practices operate to either facilitate or constrain this area of practice.

### 8.2.1 Cardiac Rehabilitation Nursing: A Patchwork of Practice

That nursing work is diverse is by no means a new revelation, the phenomenon being the subject of a considerable body of literature. Nursing is described as a “bricoleur activity” (Gobbi 2005), a concept derived from the work of Levi-Strauss (1966:16-17) who used the term to mean “A jack of all trades or a kind of professional do-it-yourself man.” There are many authors, including Georges (2003), Tarlier (2005), and Algase (2006), who discuss the epistemological diversity that shapes nursing work. There are others including Darbyshire (1999) and Gobi (2005) who draw on the familiar adage of nursing as “art” and “science” to differentiate, explicate or debate the different ways of knowing in nursing; those derived from “objective” science and those that are its antithesis: intuition, artistry and creativity.

The diversity in the nurses’ work is also evident when narrowing the scope from “nursing” to the specific area of cardiac rehabilitation nursing given it combines practices that reflect medical, nursing, psychological, sociological and organisational interests. One simply has to refer to contemporary cardiac rehabilitation guidelines to
uncover the multifaceted nature of this work (ACRA 2008; Goble & Worchester 1999; NHF 2004). The concern of this discussion however, is not the diversity of practice within cardiac rehabilitation per se, but the differences in the way nurses try to bring about patient behaviour change within this service context. Having said this, the findings of this research demonstrate the interconnectedness of practice and “context”, which includes the immediate ‘interactional’ context, the service context as well as the broader context in which practice occurs.

Community-based cardiac rehabilitation comprises different yet overlapping areas of practice. Some of these are couched in the dominant discourses of medicine, managerialism and nursing which emphasise scientific, efficient and standardized approaches to practice. Others reflect the influences of psychology and shape many of the behavioural components of this work. The extent to which these discourses shape practice varies considerably and is contingent on the context, the clinicians and the time in which practice occurs. This point is illustrated in the findings below.

Specialist cardiac rehabilitation nurses explain that initially their practice was medically driven but with time and gaining new knowledge it evolved to an approach with a major focus on the psychological and their practising in flexible and individually tailored ways. Their generalist colleagues however, explain how their behavioural interventions are constrained by organisational factors, which see the behavioural components of their cardiac rehabilitation role being viewed of lesser importance than their “other” more pressing medically focused work. As a consequence, their behaviour change practice is given less attention and is carried out in ways that are shaped by the dominant influences of medicine and organisation.
The differences described above were not directly apparent however as most of the nurses initially described their role in contemporary nursing language and it would seem contemporary nursing discourse. However, the nurses’ talk about practice reveals considerable inconsistency between what some nurses profess to do and what comprises their practice.

8.2.2. Diverse Understandings, Talk and Discourse

Cardiac rehabilitation nurses, and other health professionals, have available to them a number of discourses or ways of thinking, talking and doing, when they explain and attend to their behaviour change practice. These discourses, rather than specific words or language, define and delimit this work. Examining the findings through a discursive lens is a useful way for explaining the diversity in nurses’ behaviour change practice in that it reveals that certain discourses have more prominence in some nurses’ practice than others.

On first reading the nurses’ texts it seemed as though the nurses shared a common culture and approach to bringing about behaviour change given they draw on similar language to describe their practice. The nurses draw on terms such as “holistic” and “individually focused” to label their approach and words including “health promotion”, “prevention”, “education” and “counselling” to portray what their interventions entail. What the nurses’ talk about practice exposed, is that these taken-for-granted terms are not understood in consistent ways. As Crowe (1998: 339) explains, while words operate as a predetermined system for allocating meaning, “they are not reflections of an external reality but expressions of group convention”. 
There are several researchers who discuss the inconsistency between contemporary nursing speak and practice. These include Allen et al. (2007) who explore the importance of language for nursing and whether it conveys commonality of meaning. The language of concern in this research however, relates to nurses’ understandings of the less traditional areas of nursing such as prevention, health education and health promotion. Maben and Clarke (1995), Norton (1998) and Piper (2007), amongst others, highlight the confusion and lack of conceptual clarity that surrounds these concepts. Similarly, the distinction between cardiac rehabilitation and secondary prevention has been described as unclear (Astin & Closs 2007; Thompson & Oldridge 2004). Whitehead (2004) attributes some of the inconsistency in the way these terms are understood to the terms health education and health promotion being used interchangeably. The “recognised paradigm war” that surrounds these areas of practice signifies one of the complex ways discourse serves to maintain the dominance of particular interests (Whitehead 2003: 796).

The findings of this study suggest that despite the evolution of competing health discourses, and the language associated with these being assimilated into nurses’ talk, it is medical discourse that remains dominant in the social context of the nurses’ cardiac rehabilitation work. Even where nurses draw on alternative discourses to shape their eclectic approaches to bringing behaviour change, they serve as tools to meet medically defined ends. The diversity that exists in this area of nursing work reflects not only the language and discourses that the nurses have available to them but also how these interact in a constant struggle of competing influences within the context of health care.
Evidence of the diversity in this area of nursing work and the way it is shaped by competing influences can be found woven throughout the findings of this research. The ensuing discussion, particularly that which focuses the power play that exists between specialist and generalist nurses, brings these to the fore.

8.3 Behavioural Theory: Understandings and Practice

The focus of this discussion is the objective that focuses on nurses’ knowledge and understanding of behavioural theories, models and frameworks and the extent to which they apply them in their cardiac rehabilitation practice. There are five key findings that meet this objective.

Firstly, the nurses who are the designated experts in cardiac rehabilitation have different levels of knowledge and understanding about behavioural theory and related intervention frameworks. These nurses assign theoretical knowledge lesser importance than the experiential knowledge they gain in practice. Secondly, the patterns that are evident in the behaviour change practice of expert nurses, strongly suggest that a lack of formal education about behavioural theory and related models and frameworks does not equate with a lack of competence in this area of work. It will be remembered that by calling nurses “expert” this research does not make claims about nurses possessing a level of expertise per se; instead, the term refers to the nurses who are recognised as having considerable expertise in cardiac rehabilitation by their employer and their colleagues.
Another key finding is that the type of knowledge expert nurses consider is needed to inform their behaviour change practice shifts as they become more proficient in their role. It changes from a focus on specific methods to an understanding that bringing about behaviour change requires knowledge that can inform flexible decision-making.

The fourth finding is that while some expert nurses claim they do not have an understanding of behavioural theory, their talk about practice suggests this is not the case. It is likely that in the course of the nurses’ experience, threads of behavioural theory are transferred in everyday language without being obvious that they have assimilated this into their thinking and practice. It is also likely that during their experiential learning they have come to know some of the important factors that theory contends are fundamental to understanding behaviour change.

Lastly, unlike the expert nurses whose behaviour change practice is a complex process of persuasion, generalist nurses’ descriptions of their practice are consistent with traditional patient education. While they draw on language that suggests they have assimilated contemporary nursing approaches, they construct their practice with a predominant focus on the medical.

What the findings demonstrate is that the nurses’ behaviour change practice is not driven by formal theory and that their perceptions and understandings of theory are as diverse as their practice. In the case of expert practitioners, theory “sits in the background” while they draw on knowledge stemming from “trial and error” learning about “what does and what doesn’t work” in certain situations. The theory-practice
relationship, as it relates to nurses’ behaviour change practice, is complex and cannot be simply or objectively explained. It is dependent on multiple interrelated and delimiting factors, not just the knowledge and skill that nurses have available to them.

8.3.1 Theory Informing Behaviour Change Practice

The clinical nurse consultants and clinical nurse specialists, who are the designated “experts” in cardiac rehabilitation, have different levels of knowledge and understanding about behavioural theory and related intervention models and frameworks. Those who profess to have an understanding of behavioural theory grant it lesser importance than the knowledge they have gained from experience. Less than half of this group of nurses apply this theory and/or related models and frameworks in their behaviour change practice.

Consistent with the definition of theory that sees its function as characterising, explaining or predicting phenomena within a given context (Timpson 1996) expert nurses contend that theory provides them with an understanding of factors they consider are important for understanding individual behaviour and behaviour change. However, while their practice is not theory-driven in the formal sense, it is not void of theory. To the contrary, theory “sits in the background” while the nurses draw on knowledge gained from “trial and error” learning; a process that sees them gaining experiential knowledge and subsequently developing their own personal theories for bringing about behaviour change.
There are several possibilities as to why formal behavioural theory remains behind the scenes in expert nurses’ practice, and why it is lacking or misconstrued in the practice of others. Those ascertained from this research are: the nurses’ understanding of the concept of theory and their knowledge of theoretical content; the practical value they assign to behavioural theory; and finally the limitations and constraints placed on their practice, particularly in the case of generalist nurses who are granted less autonomy than their specialist colleagues.

The way that nurses interpret the concept of “theory” also impacts on their practice, not in the sense of applying theoretical content per se but rather in the manner in which they adopt theory. This is particularly evident when comparing the way expert or specialist cardiac rehabilitation nurses utilise theory with that of their generalist peers. The expert nurses consider theory as a reference point, a means of understanding “why”. In contrast, the generalist nurses with some understanding of behavioural theory describe their application of theory in what can be described as a technical-rational way, in other words a recipe for practice.

Kondrat (1995) distinguishes between technical-rational theory and a theory intended for understanding, explaining that the latter refers to grasping how people give meaning to their actions and the social world and that adopting theory from this perspective sees practice dependent on the situation or circumstances in which it occurs. In contrast, adopting technical-rational theory equates to applying it in a dogmatic way; it is likely to stifle innovation and has a conservative effect in that it acts as a way of maintaining order (Floersch 2004).
It is interesting that many of the nurses who claimed an understanding of the Stages of Change Model (Prochaska & Di Clemente 1983) spoke of it as a recipe for practice, which may explain its popularity amongst them. It is also interesting that few of these nurses articulated a comprehensive understanding of the model and that the majority only applied it to assess the stage of change rather than adopting it as means for guiding the elements of the intervention. The majority of nurses who discussed the model also applied it in inflexible ways, their talk suggesting a lack of awareness of the theoretical concepts that underpin it.

At this point, it needs to be stressed that objectifying the way nurses utilise theory in their behaviour change practice by polarising it into distinct approaches, is over simplistic and the relevance of the context in which practice occurs needs to be taken into account; the focus of this research being individually focused interventions.

To illustrate this point, expert nurses apply theory differently in various practice contexts. Their talk about group interventions sees them applying aspects of theoretical models and frameworks, such as Miller and Rollnick’s (1991, 2002) motivational interviewing approach and/or Prochaska and DiClemente (1983) Stages of Change Model, in standardised ways. When carrying out their individually focused interventions however, they adopt flexible individually focused approaches using different methods in particular nurse-patient situations.
This raises the question as to the practical value that expert nurses assign to theoretical models and frameworks in their individually focused interventions, which are the focus of this research. That they readily apply a theoretical model, or parts thereof, in group-based programs and not when working with individual patients suggests that these approaches do not allow for the flexibility that the expert nurses consider is fundamental to individualised interventions. This reinforces a finding by Estabrookes et al. (2005: 464) who explain that nurses use academic and other documentary sources of knowledge infrequently because they “do not address the nurses’ immediate and context-specific needs”.

In the context of the overall intervention process however, the need for flexibility does not only rest with the behavioural components of the nurses’ work. This research highlights that flexibility is also required in the way nurses interweave the elements of their behaviour change practice through the overall intervention process. This requires nurses to draw on different forms of knowledge to address specific concerns as they arise in the immediate interactional context.

Also relevant to the discussion on the practical value that expert nurses assign to behavioural models and frameworks is their applicability in multifaceted interventions, those with a medical and behavioural focus as well as those that address multiple behaviours which is often the case in cardiac rehabilitation. Villarruel et al. (2001:158) bring attention to the use of “borrowed” theories in nursing work in areas requiring patient behaviour change and argue that while such theories are of value and continue to be used, little attention has been given to determining whether such theories provide “empirically adequate descriptions, explanations, or predictions of nursing phenomena”.

220
8.3.2 Practice Creating Behavioural Theory

The patterns of practice that exist across the group of expert nurses strongly suggest that a lack of formal education about behavioural theory and related models and frameworks does not equate with a lack of competence in this area of work. To the contrary, the nurses explain that they draw on several forms of knowledge to construct their behaviour change practice and their personal theories of what does and does not work in certain situations. These personal theories are developed through complex and iterative processes that the nurses describe as “trial and error” learning.

The most fundamental process in the nurses’ “trial and error learning” is what Schon (1983) calls “reflective-practice” also referred to as reflection-in-action. Arnd-Caddigan and Pozzuto (2008: 64) describe reflective-practice as a clinician’s “ability to make moment-by-moment decisions on what to do next, based on the specific context rather than abstract theory”. Rolfe (1995: 95) adopts the axiom reflection-in-action and explains that its significance is not just in problem solving “but that it does so through the construction of informal theories, which are being constantly tested, modified, retested and so on in a process of on the spot experimenting.

The expert nurses also engage in an informal process of critical reflection with peers and other members of the multidisciplinary team, questioning what seemed to work well and what could have been done differently. These findings are consistent with those of research conducted by Eastabrooks et al. (2005) and Ehrenberg and Estabrook’s (2004) who found that the sources of knowledge preferred by nurses are often informal and interactive. Having said this, the processes of reflection described above differ
considerably from the ways the nurses sought to learn about behavioural interventions in the early stages of their cardiac rehabilitation role.

8.3.3 Evolving Practice

The type of knowledge expert nurses consider is needed to inform their behaviour change practice changes as they gain experience in this area of work. During the initial stages of their role the nurses sought specific and concrete methods to guide their practice. With experience however, they came to the understanding that bringing about behaviour change requires knowledge that can inform flexible decision-making.

The majority of the specialist cardiac rehabilitation nurses came to their role from the hospital setting. While they were employed as the designated “experts” for this area of work on the basis of their proficiency in clinical practice, they explained that they were novices in relation to the behaviour change aspects of the role. Recognising that their a priori knowledge was not sufficient for this area of practice they turned to “the guidelines”, the literature and other health professionals who carried out behavioural interventions as part of their usual practice, seeking some sort of definitive method to guide their practice.

That nurses draw on multiple formal and informal sources of knowledge including the expertise of others to inform their clinical practice has been well established in previous research (Estabrooks et al. 2005; McCaughan et al. 2001; Thompson et al. 2001). However, the nature of behavioural interventions differs considerably from clinically
focused work and little attention has been given to the nature of knowledge that nurses seek at different stages of their skill development in this area of practice.

Talk about the way their role evolved and changed over time was prominent in the specialist nurses’ texts and represented a process of discovery. They explained their clinical and technical competence, which was usually demonstrated in their ability to perform in consistent and standardised ways, was insufficient preparation for the behavioural aspects of their cardiac rehabilitation work. Much of the difficulty they initially experienced related to lack of predictability in this aspect of their work. In order to demonstrate competence in this area of work they had to deal with this lack of predictability and become adept at working with individual differences in ways that would achieve the desired outcomes.

The nurses recognised that they needed knowledge that would equip them with alternatives rather than specifics and that the “art” of practice was in flexible decision-making; knowing which options to choose and when. Over time, with experience, experimentation and reflection their approach to behaviour change practice shifted to one that is akin to a therapeutic intervention which sees them adopt an eclectic approach, selecting and deciding on the elements of the intervention with on-the-spot decisions based on the nurses’ perception of the immediate interactional situation.
8.3.4 Assimilated Theory

While some expert nurses claim to have little or no formal knowledge of behavioural theory and related approaches, the fourth finding, they do convey understandings and describe elements of their practice that reflect these theories. This finding is explored in light of the discussion so far, that theory informs practice and that practice is a source of theory.

It is likely that in the course of the nurses’ experience, threads of behavioural theory are transferred without it being obvious to the nurses that they have been assimilated into their thinking and practice. As previously mentioned specialist cardiac rehabilitation nurses turned to the literature and other health professionals for knowledge to guide their practice. This finding is consistent with earlier literature on the sources of nursing and nurses’ knowledge and the types of knowledge nurses draw on to shape their clinical practice (for example: Clark & Wilcockson 2002; Estabrookes et al. 2005).

As novices in this area of work having little knowledge of behavioural theory or related approaches, it is likely that they assimilated the aspects of theory that they were able to understand and that were relevant to them at the time. As they continued to learn, new sources of knowledge were combined with the old, augmenting some and changing or negating others. From this perspective, nurses’ understanding of theory is about “how humans use ideas and perspectives to negotiate the world, not about the world itself” (Arnd-Caddigan & Pozzuto 2008: 63). In this case, nurses looked to what the theory had to offer as opposed to the “theory” itself; in other words theoretical concepts or ideas
may be assimilated into the nurses thinking whereas the name and/or the language of the theory is not or perhaps has been forgotten.

Learning from their peers and other health professionals also presents interesting scenarios, particularly when the learning is informal as is the case when nurses approach them because they have specific concerns to be addressed. It is unlikely that such communication transforms into a cohesive and comprehensive lesson about theory or theoretical approaches. Specific theory or elements of theory may not be mentioned at all while being conveyed in everyday terms. As Simons and Chabris (1999) explain, generally people don’t perceive or think in a concise or pristine manner. If the same holds for informal communication, then speakers communicate what they consider to be pertinent in similar ways and what is assimilated into the nurses’ thinking are the elements of communication that are understood and considered to be relevant at the time.

It is also likely that during their experiential learning expert nurses have come to know some of the important factors that behavioural theory contends are fundamental to understanding behaviour and behaviour change. As previously discussed, they develop their own personal theories to guide their behaviour change practice. This suggests that the nurses adopt, what is described as a “commonsense approach”, which sees practice as a source of theory and the nurse as theorist (Benner 1984; Carr 1986; Ellis 1992). There is also considerable and longstanding support for the view that theory and knowledge for nursing practice should be gained through an understanding of practice (for example Benner and Wrubel 1989; Gadamer 1975; Lauder, 1994; Schon 1983; Titchen & Ersser 2001). Chinn and Kramer (2008: 65) adopt a more recent adage when
they refer to as “practice-based evidence” where “evidence is generated out of, or situated in, the context from which it is generated”.

The relevance of this discussion to the current research is that behavioural theory and related approaches are not the product of philosophical musings but rather they stem from knowledge gained from practice, whether that of the theorist themselves or through observations or the study of others’ practice. Molloy et al. (2007: 116) point out “most if not all recognised clinical procedures used in psychological interventions are derived from single-case studies”. Given the expert nurses’ experience in the conduct of behavioural interventions and the process of reflection that informs their practice, it is likely that they encounter and come to understand similar phenomena to those explicated in behavioural theory. Ignoring semantics, a clear example of this is when nurses’ convey the understanding that in order to change, patients require confidence and the belief that they can actually achieve this change, an understanding that reflects Bandura’s (1977; 1997) concept of self-efficacy.

To date, the view that theory and evidence can be generated from practice, while widely accepted in contemporary nursing literature seems to have had little influence in the context of increasing managerialism and economic rationalism that governs current health service delivery (Rycroft-Malone et al. 2004). Efforts to meet the popular call for “best-practice approaches” for the prevention of chronic disease through behavioural means have mainly been channelled into methods of inquiry governed by scientific rationality rather than those more suited to the human sciences and sensitive to individual difference (Molloy et al. 2007).
The intention of this discussion is not to devalue science however, but to propose that viable alternative forms of evidence, such as those uncovered in this research, can complement the traditional scientific ways of understanding practice, theory and knowledge. As suggested by Rycroft-Malone et al. (2004) the evidence that informs evidence-based practice should be derived from a variety of sources that have been subjected to testing and found to be credible.

8.3.5 Different Forms of Practice

Unlike the expert nurses, whose behaviour change practice involves engaging patients in a complex process of persuasion, the way generalist nurses describe their practice constructs them as traditional educationalists. While they draw on contemporary nursing speak, which suggests that their practice has assimilated knowledge from other disciplines, they construct their actual practice in ways that reveal it is predominantly medically driven.

While expert nurses work towards developing their personal theories of “what works and what doesn’t” with individual patients and in certain circumstances, the generalist nurses tend to work in routine ways and attempt to mould their behaviour change practice into the more familiar patterns of their clinically focused work. In the main, it involves patient education that at times comprises solely of information giving; an approach that sees their behavioural interventions constrained by the legacy of the medical model even though many of these nurses label it with the umbrella term “health promotion”, which encompasses individually-focused, community focused and population focused approaches (Patterson 2008).
This finding supports earlier research focusing on the health-promoting role of nurses in the community setting; the overall consensus being that the majority of these nurses are educationalists (Downie et al. 1996; Norton 1998, Whitehead 2001; 2004). Despite many of the nurses’ using the term “health promotion” they fail to demonstrate an understanding of the difference between the broader concept of health promotion and education. The question as to whether generalist community nurses are able to carry out effective behavioural interventions, either in the context of their health promotion practice or in their usual practice setting, has previously been raised (Whitehead 2001, 2002). However, the question of ability rests with the discourses and related knowledge they have available to them rather than capability. It also relates to the context of practice.

In conclusion, the findings discussed in this section highlight the secondary role that behavioural theory plays in nurses’ cardiac rehabilitation work. They also raise concern regarding the lack of such knowledge amongst generalist community nurses given that bringing about behaviour change is considered to be integral to their role.

While behavioural theory has a lot to offer as it provides nurses with an understanding of factors relating to behaviour change, the findings suggest that they may not be empirically adequate in the nursing situation. They also suggest that elements found in expert practice can contribute to a conceptual model for behavioural interventions in nursing situations. This is reinforced in the next section, which discusses fundamental aspects of expert nurses’ behaviour change practice.
8.4 Behaviour Change Practice: The Doing

At the time this study was undertaken, published data revealed that little is known about the way that nurses seek to bring about behaviour change in the community health context (see Chapter 2). The findings discussed thus far have highlighted the diversity in this area of practice, which provides some explanation as to why this area of nursing work is poorly understood.

The focus of this discussion is what nurses actually do when they attempt to bring about behaviour change; that is, their practice. It concentrates on the four key findings relating to this objective. Each of these is integral to the way the nurses perform the art of persuasion, which is the concept that encapsulates the nature of their practice.

The first finding relates to the overall approach that expert cardiac rehabilitation nurses adopt in their behavioural interventions. This approach can best be described as “eclectic”, given the nurses carry out this practice in individualised and multifarious ways that are informed by their understanding of individual patients.

The second key finding is the discovery of a skill or attribute that this research has termed “discursive flexibility”. Fundamental to the way nurses communicate with their patients, the construct refers to the nurses’ ability to draw on multiple discourses to facilitate the patients’ understanding of what the nurses are trying to convey.
The third finding is about how the nurses’ rely on their understanding of “where the patient is at”. This construct differs from that of “knowing the patient”, which has received much attention in the nursing literature. While it incorporates knowing about the patient and recognising individual differences, the construct represents a more fluid understanding of individual patients’ thinking at various stages of the intervention process.

The remaining finding is that the way expert nurses make decisions to inform their communication during the behavioural aspects of their interventions involves deductive reasoning rather than intuitive process.

This section focuses on findings that relate to the patterns of practice evident in the talk of the specialist nurses, the designated “experts” in this area of work. By comparing the way two groups of nurses go about their behaviour change practice, namely generalist community health nurses who undertake cardiac rehabilitation as part of a broader role and the nurses who specialise in this area of work, this research has revealed that there are major differences in their approach. It should be noted that some of the generalist nurses articulated elements of their behaviour change practice that were similar to those described by the specialist cardiac rehabilitation nurses. These did not constitute a pattern amongst the generalist nurses however; those who did articulate similar practices were in the minority and the practices they described were not consistent amongst this group of nurses.
In essence, this chapter is about the art of persuasion and the skills and processes that the specialist cardiac rehabilitation nurses consider are fundamental to their behaviour change practice. Of importance, is that unlike many of the generalist nurses who saw bringing about behaviour change as an isolated and discrete activity, the specialist nurses demonstrate that the elements of this practice can be carried out concurrently with the other aspects of their cardiac rehabilitation role.

8.4.1. The Art of Persuasion

The findings leave no doubt that the practices that distinguish the expert nurses from other nurses working in cardiac rehabilitation relate to their skills of persuasion. Unlike the generalist nurses who are more direct in their approach, and who rely on means such as their own and medical authority as strategies such as giving information and education to obtain compliance, the specialist nurses attempt to persuade their patients in more diverse, multidimensional, and at times surreptitious ways.

The term “persuasion” is not new to nursing. To the contrary, it has been used and misused to simplify a myriad of approaches and related strategies in numerous nursing contexts. The vast body of literature that sees patient non-compliance as a problem that needs to be resolved provides ample evidence of this (see Murphy & Canales 2001). However, as stated by Haynes et al. (2002) few effective interventions have emerged from this work. Suggestions as to how nurses can play an instrumental role in changing health related behaviours, with the aim of improving patient compliance, have ranged from a focus on forming ‘therapeutic relationships’ (Lund & Frank 1991) to instilling fear through various forms of communication (Cameron 1996).
Until recently, the nursing literature has paid little attention to the complex nature of persuasion in the area of behavioural interventions, including those aimed at addressing patient non-compliance. Historically, persuasion as a nursing process has been devalued; for example, Stubblefield (1997) contends that the primary role of a health-promoting nurse is usually that of a mere persuader, a perspective that assigns this approach low repute.

The negative connotations associated with the concept of “persuasion” are partially tied to associated practice, including health education, being based in an authority model (Naidoo & Willis 2000) and that its very nature involves behavioural outcomes being pre-selected and nurses attempting to coerce patients towards the desired response (Brown & Piper 1995).

Persuasion has long been considered a type of manipulation or, what van Dijk (2006) more aptly describes as a type of social power abuse in that it can be viewed as a form of influence that aims to move people towards the adoption of an attitude, idea or action. Without entering into a philosophical debate about the ethics and nature of persuasive tactics, that behavioural outcomes are predetermined in the context of contemporary healthcare is par for the course. This is particularly the case in areas of health care that focus on addressing the prevention or amelioration of disease and/or associated risk factors. Cardiac rehabilitation and chronic disease management are two examples of such areas and as the findings demonstrate, nurses justify such processes as legitimate nursing work because they consider them a means to an end that they believe is in the best interest of the patient.
Given that health promotion and health education outcomes tend to be based on predetermined and defined epidemiologically driven government targets such as those proposed by the Australian National Health and Hospitals Reform Commission (2009), it stands to reason that addressing these is what publicly funded health care organisations and hence many nurses are expected to do. The focus of this discussion however, is not justifying nurses’ persuasive tactics for bringing about behaviour change but the way they go about it.

More specifically, this discussion is about the way that most expert nurses incorporate persuasive aspects within their practice. While the findings do present examples of instances where specialist nurses adopt coercive strategies; for example instilling fear in their patients, such overt demonstrations of power are not the usual case. Expert nurses tend to camouflage their power in a skilful and often covert process of persuasion by creating the illusion that patients have control over the intervention process.

The nurses’ descriptions of “goal setting” provide an excellent example of how they create such an illusion. Unlike the generalist nurses who identify the goals of intervention and then jointly work out a plan for how these are going to be addressed, expert nurses apply a patient-centred approach where the patients determine the goals they wish to achieve. These goals generally relate to quality of life rather than specific risk factors. Some nurses ask patients what they would like to achieve that their current illness is preventing them from doing; others elicit the patients’ fears and concerns about their illness and focus on these. Addressing behavioural risk factors then, becomes the means for achieving the patients’ ends.
The process of persuasion as described by the expert nurses is referred to as “art” because it is fluid and woven throughout the entire intervention process. It is not confined to specific strategies or communication. The nurses shape their practice in a way that sees persuasion as the core process with other aspects of the intervention reinforcing it. These processes are detailed in Chapter 6 and also in the discussion that follows.

8.4.2. Eclectic Practice- Drawing on Different Ways of Knowing

An important finding in this research is that expert cardiac rehabilitation nurses adopt an “eclectic” approach to their behavioural interventions. This approach is underpinned by the way they understand and utilise theory in their practice, the sources of knowledge they draw on to inform it and the varied processes they employ throughout the intervention process. Fundamentally, their approach is patient focused, as it is responsive to individual differences and individual circumstances.

The way expert nurses’ apply theory in their practice has been examined earlier in this chapter. What is relevant to this discussion is that their individually focused interventions are not theory-based but rather what Michie and Abraham (2004) refer to as “theory inspired”. Instead of adopting an explicit theory-based causal pathway to guide their behaviour change practice, theory provides them with a background understanding of the factors that are important to the behaviour change process. Both the nurses who are, and those who are not, familiar with behaviour change obtain many of these understandings from their own personal theories crafted from their practical and personal experience.
Eclectic practice, whether inspired by formal theory or personal theories is in direct contrast to the contemporary notion of standardised practice. While there is scant literature that relates to eclectic approaches in this area of nursing, they have been the subject of much criticism in the psychological literature. The main concern has been that behavioural interventions that lack specific causal pathways cannot be tested for clinical effectiveness within randomized controlled trials (Francis et al. 2007).

Foy et al. (2007) further the critique by arguing that even the large body of literature on behaviour change may not offer guidance on how to design an intervention if it lacks a specific and consistent theoretical base. Michie et al. (2008) reason that theory should guide the design of behavioural interventions by arguing that behavioural interventions are likely to be more effective if they address the causal determinants of behaviour and behaviour change, which requires a theoretical understanding of what these determinants are. They also argue that theory-based interventions facilitate an understanding of what works and therefore “are a basis for developing better theory across different contexts, populations and behaviours”. Having presented these arguments, Michie et al. (2008: 662) then go on to state that “even with a theoretical framework, there is little information about how to develop theory-based interventions” with the notable exception of Bandura’s Social Cognitive Theory (Bandura 1997).

The above arguments reflect what Fealey (1997) describes as theory-practice dualism in that they represent positivist thinking and the tendency to view theory and practice as separate endeavours. It is interesting that the specialist nurses initially sought knowledge that would guide their practice in specific ways but with experience they
came to recognize the need for flexibility and the ability to apply varied approaches in response to the situation at hand.

8.4.3. Discourse Informing and Shaping Communication

The “what” and “how” of nurses’ communication with their patients is pivotal in their approach as it conveys the essence of their practice. Perhaps the most significant finding of this study is that many expert nurses have developed a skill this research has called “discursive flexibility”. The construct refers to their ability to draw on multiple discourses to facilitate meaningful communication with their patients. It is fundamental to the expert nurses’ practice as it facilitates not only common understandings but also the elements of their persuasive processes.

The way nurses described their approach in common everyday language constructs “discursive flexibility” as requiring an openness to, as well as curiosity about, how patients’ see their world and how they construct their reality, which includes their beliefs about and attitudes towards their illness. It also requires the nurses to be aware of their own way of thinking so that they can recognise how the patients’ way of thinking differs.

The nurses gain the understandings that inform their discursive flexibility from a variety of means that encourage and enable patient talk. One of these is by asking open-ended questions. However, the most valued and common practice amongst this group of nurses is “listening to the patient’s story”; a process that serves multiple purposes. It enables the nurses to come to understand how the patients experience their condition
and related events and whether or not they have come to terms with them, from the
patients’ perspective. The process also provides them with an understanding of “where
they are coming from”, the patients’ beliefs and attitudes in relation to their health and
illness.

Communicating with “discursive flexibility” moves beyond translating nursing and
medical speak into everyday language. It involves constructing talk so that it reflects the
patient’s way of thinking. In terms of the persuasive process, it may be about creating
the image of an equal relationship or it may be about demonstrating authority and
expertise, depending on the patients’ view of the world and how they situate themselves
in relation to other people including the nurse.

While there is a growing body of literature that explores the discourses that shape
nursing and other areas of health care (for example: Hardy et al. 2002; Georges 2003;
Kelly & Symonds 2003; Leonard 2003; Turner et al. 2007; Richman & Mercer 2004), to
date, nursing research exploring the use of discourse as a means for facilitating patient
behaviour change is lacking. While nursing has been focusing on the theory-practice
gap and the search for suitable theoretical approaches that can be slotted into nursing
work, the field of psychology has been advancing the concept and practice of
“discursive psychology”.
Wood and Kroger (1998: 266) discuss the “turn to discourse in social psychology” which involves an important shift from the conventional view that language is a tool for description and a medium for communication to a view of language as social practice, a way of doing things. The assumptions underlying discursive psychology are those put forward by discourse theorists who maintain that talk is constitutive of language and that the phenomena of interest social and psychological research are constituted in and through discourse (Potter 1996).

One of the strengths of discursive psychology is considered to be its usefulness for analysing interactions in clinical settings (for example: Bishop & Yardley 2004; Potter & Hepburn 2005). Recent developments in the area have also given rise to the advent of “discursive therapy” (Hepburn & Wiggins 2005). Therapists practicing from a discursively informed perspective require an “ability to reflectively and resourcefully engage in different forms of discourse with clients-flexibly” (Strong 2002: 218). Strong explains:

“The challenge for discursive therapists is to engage speakers in how they articulate and hear meanings, to work from within their ways of conversing.”

(Strong 2002)

Of considerable significance is that the approach to communication described by the expert nurses, while not articulated in the terminology of discursive psychology, reflects this approach hence the term “discursive-flexibility”
8.4.4. Understandings of the Patient

The third key finding about the way nurses seek to bring about patient behaviour change is that the nurses’ rely on their understanding of “where the patient is at”, which is a concept that plays a pivotal role in the nurses’ decision-making. Intrinsically linked to the concept of “knowing the patient,” which has been discussed extensively in the nursing literature by authors including Jenny & Logan, (1992), Tanner et al. (1993), Radwin, (1995a, 1995b, 1996), Whittmore, (2000) and Speed and Luker (2004), the concept of "knowing where the patient is at" takes on a distinct meaning in the context of nurse delivered behavioural interventions.

This construct incorporates two dimensions of “knowing”. The first is “knowing the patient” which includes knowing the patient’s usual pattern of responses to clinical or therapeutic measures and knowing the patient as a person (Radwin, 1996, 1998; Tanner et al. 1993). A dimension of “knowing the patient” that has not been discussed in previous nursing literature is an understanding of the discourses that shape the patients thinking, which informs the way expert nurses communicate with their patients, as previously described in relation to the concept of “discursive flexibility”. Another, dimension of “knowing where the patient is at” is having an understanding of individual patients’ thinking and responses at various stages of the behaviour change process; whether these are positive or whether they are negative indicating resistance.

The importance of “knowing the patient” in relation to clinical decision-making has been widely discussed in the literature (Carnevali & Thomas 1993; Radwin, 1995b; Tanner, et al. 1993). It is important to highlight however, that the concept of “knowing
where the patient is at” is not specific to the nursing context but has been described in other health-related fields, although is expressed with different phraseology. For example, in the health and social sciences literature the concept of “starting where the client is at” emerged as a basic premise for humanistic counselling (Bower 2005). “Starting where the client is at” is a shared value in social work practice where it has long been considered as a fundamental premise for engaging the client in the therapeutic process (Bently 2002; Bower 2005; Galper 1980; Sheafor et al. 1988).

The widespread application of similarly labelled concepts has led to the concept of “knowing where the patient is at” being assigned numerous interpretations and meanings. However, despite the apparent longstanding “universality” of this concept (Duehn & Mayadas, 1979) and the emerging body of nursing literature focusing on “knowing the patient”, few empirical studies have focused on this seemingly core aspect of health care practice; particularly where health behaviour change is the desired outcome.

In the nursing literature there has been a tendency to describe “knowing the patient” as an all-pervading element of nursing practice that goes beyond knowledge of physical signs and symptoms. The relationship of this concept to various aspects and levels of nursing practice suggests that it is multi-dimensional and integral to advanced and expert nursing practice (Radwin & Alster 2002; Radwin 1995b, 1996, 1998; Tanner et al. 1993).
As an important component of the decision making process, "knowing the patient" has been described as a pre-requisite for individualised patient care (Radwin 1995a, 1995b; Speed & Luker 2004) and as being relevant to the therapeutic choices selected (Radwin 1996). The concept is reflected in practice that considers the uniqueness of the individual (Whittemore 2000).

The elements that have been identified as constituting “knowing the patient” are the patients’ responses to therapeutic measures, their routines and habits, coping resources, physical capacities and endurance, and, body typology and characteristics (Tanner et al. 1993). Radwin (1995) also includes elements that are based in the nurses’ insight of patient experiences, behaviours, feelings and/or perceptions. More recent research with nurses working in the community setting has also emphasised the importance nurses knowing the patient’s family and/or carers as important antecedents to the provision of quality care (Luker et al. 2000; Speed & Luker 2004).

The broad scope of knowledge that has been ascribed to "knowing the patient" implies a high degree of skill in what can be described as the more therapeutic aspects of the nursing role. Past research has assigned the more advanced levels of practice associated with this concept to expert nurses, with their experience in caring for patients being one of the most important enabling factors for knowing the patient (Jenny & Logan 1992; Radwin 1995a, 1995b; Swanson 1993; Tanner et al. 1993). Other factors identified as influencing "knowing the patient" included chronological time and a sense of closeness between the nurse and patient. However, in defining the actual strategies and processes of "knowing the patient" the nursing literature becomes less specific.
None of the nurses in this research described such a comprehensive “knowing” of the patient. However, they did discuss the components of “knowing” that were crucial to and facilitative of their behavioural interventions. “Getting to know the patient” and the patient’s circumstances was considered to be fundamental to the nurses’ role as it facilitated the overall intervention process. Getting to know “where the patient is at” involves more concentrated effort however, as it relates to the patient’s thinking and responses in the immediate interactional context throughout the various stages of the intervention process.

As patient responses are not predictable and no stage of the intervention process is constant, gauging “where the patient is at” involves a continual process of “tuning in” to the patients’ verbal and non-verbal communication in order to gain an understanding beyond the specific content; the “what”, of their communication. The nurses look for non-verbal signs that may reinforce or be incongruent with the patients’ talk. They also attempt to understand the social meanings that underpin it.

8.4.5. Informing Decisions

Gauging the patients’ understandings and responses is fundamental to the nurses’ decision-making process about how to proceed with their communication during any stage of the intervention process, which calls for on-the-spot decision making. Another key finding of this study is that when trying to bring about behaviour change, the expert nurses’ on-the-spot decision making is based on conscious deliberation rather than intuition. The knowledge they gain from “trial and error learning” is paramount in their decision-making as it provides them with a repertoire of possible strategies to apply in
various situations. Fundamental to the nurses’ decision-making, about how to proceed is recognising patterns in their patients’ responses as these provide the nurses with cues as to what strategies are most likely to have the desired effect.

Pattern recognition developed through experience in similar situations has long been recognised as an important feature of expert nurses’ decision-making (Benner 1984; Benner & Tanner 1987; Corcoran-Perry & Bungert 1992; Deber & Bauman 1992; Fisher & Fontain 1995). While the “expert” nurses did not articulate this concept in the terms “pattern recognition” they conveyed it in their talk about “trial and error learning” and their coming to know “what works and what doesn’t work” with certain patients and in particular circumstances. However, explaining the decision-making process during the behavioural aspects of the “expert” nurses’ interventions is neither a simple nor straightforward endeavour. The findings suggest that their reasoning incorporates processes that cut across different models of decision-making and that they vary according to the circumstance and the elements of their behavioural interventions.

There are times when the nurses’ describe decision-making processes that resemble the hypothetico-deductive reasoning model (Tanner 1987), in that they generate a hypothesis about what is likely to work or not work with certain patients and in particular situations. The nurses then test this hypothesis during the course of the intervention. However, rather than it being a hypothesis about what might be the patient’s problem, derived from assessment and diagnosis as described in the nursing process (Alfaro-LeFevre 1998), it’s a hypothesis about how the patient is likely to respond to certain cues, comments and/or suggestions.
The nurses’ hypotheses, or their own personal theories of what is likely to work or not work, are not concrete or based in formal theory. Instead they are based in the knowledge they have gained from practical experience. In this respect, their decision-making reflects the Knowledge-Driven Decision-Making model, which is based on the assumption that people try to understand new information based on what they already know (Cholowski & Chan 1995).

It can be said that their practice also reflects some aspects of the Intuitive-Humanist Approach to decision-making which considers that practice knowledge is gained from experience and recognising similar and dissimilar situations, and that action precedes rational analytic thought (Harbison 1991; Tanner 1987). However, the latter point, that action precedes rational analytic thought, is inconsistent with the findings of this research.

That “expert” decision-making is based on conscious deliberation rather than intuition is evident in the way the nurses describe the core processes that comprise their behaviour change practice. It is particularly evident in the nurses’ talk about engaging or “connecting with” resistant patients where they talk about “finding the key” that will enable them to establish genuine rapport. The “key” is a metaphor that represents knowledge relating to specific individuals, as such it cannot be standardised and learnt in the same way as clinical procedures.
Another core construct in the nurses’ practice is “moving the patient on” which relates to the nurses progressing their patients through the processes of change. This process relies on the nurses’ interpretation of patient’ “readiness” which is integral to the nurses’ understanding of “where the patient is at”. The nurses associate this state with the patients’ willingness or ability to take in information during particular phases of the intervention process. These processes of assessing “where the patient is at” continues throughout the intervention process and given that the process is dynamic and in a constant state of flux, even when patterns are recognised, they only relate to particular elements of the process.

In conclusion, the findings discussed in this section are those that meet the objective which focuses on “the doing” of behaviour change practice. They relate to the diversity in this area of nursing work and the eclectic approach that “expert” nurses apply to their practice and core processes that constitute it, highlighting the skill of “discursive flexibility” which has not previously been recognised in the nursing literature. There are obviously some similarities and factors that overlap between this area of nursing practice and other nursing work, particularly those relating to nurse-patient communication. However, the findings reveal that individually focused “expert” practice for bringing about behaviour change is not amenable to standardisation as are clinically focused nursing procedures.

The next section of this chapter builds on the understanding of nurses’ behaviour change practice by discussing findings that relate to the limitations and constraints on this area of nursing work.
8.5 Context: Influencing Practice

This research sought to identify and explore the facilitators, limitations and constraints on the nurses’ behaviour change practice, which are the primary foci of the following discussion. Earlier discussion revealed that some of these factors relate to the nurses themselves; for example their knowledge and skills in this area of practice. The primary focus of this section however, is the organisational context in which the nurses work, specifically the practices that comprise it and how these impact on nurses’ behaviour change practice. While some of these, such as resource availability and increasing work demands commonly feature in the nurses’ talk, others are less obvious and arise from the relationships between and amongst the organisation and the people who comprise it.

During analysis it became clear that the organisational context cannot be divorced from or discussed without considering the complex interplay of power relations that shape it. Therefore, the following discussion takes the discourses evident in the nurses’ talk into account. The key findings are summarised below:

Firstly, the level of autonomy nurses are allowed in practice is fundamental to their status and the way their cardiac rehabilitation role and behaviour change practice evolves.

Secondly, as part of an organisation nurses are controlled and seek to control other nurses in various ways. This interplay of power-relations is instrumental in facilitating the development of some nurses’ practice while constraining that of others.
The third key finding relates to organisational expectations and demands and how these are at times incongruent with the rhetoric of health care and the way nurses believe they should practice. This incongruence can and does negatively impact on nurses’ practice.

Fundamental to this discussion is the way that “organisation” is defined, given the varied interpretations conveyed in the literature. As stated in chapter seven, the definition of “organisation” adopted by this research moves beyond that of an institution to include the practices, beliefs and values espoused by the people who comprise it. The “organisation” then, is not a discrete entity but instead a set of practices and actions (Grant & Hardy 2004) that comprise its continually interacting systems and structures (McCormack et al. 2002). In this sense, organisations are “continually being created and recreated in the acts of communication between organisational members, rather than being independently out there” (Iedema & Wodak 1999: 7).

Essentially, organisational practices constitute a powerful influence on nursing work as they define and delimit what nurses do and to a considerable extent determine the nature of their practice. As part of the organisation, nurses are also a source of influence. They exercise their autonomy and agency in various ways; at times perpetuating organisational values thus reinforcing organisational power while at other times they challenge, resist and undermine its influences.
8.5.1 Nurse Autonomy Advancing Practice

The findings of this research suggest that the level of autonomy granted to nurses working in cardiac rehabilitation is a pivotal factor in the development of their knowledge and skills for their behaviour change practice. Autonomy is instrumental in the uptake and translation of new knowledge into practice and subsequently in the development of nurses’ expertise.

Despite the importance of nurse autonomy being discussed extensively in the literature, definitions of the term have been inconsistent, loosely explained or inferred, which has created ambiguity in the way the concept is defined and understood. For example, Laperriere (2008: 391-392) explains that professional autonomy is thought of as “freedom for action” and “freedom for thought”; Holland-Wade (1999: 310) defines it as “belief in the centrality of the client when making responsible discretionary decisions”, while Demster (1994: 227) described it as “a dynamic process demonstrating varying amounts of independent, self-governed behaviours and sentiments.” Common to these and most other definitions is the perspective that autonomy denotes freedom and independence.

Viewing autonomy as freedom, whether freedom of thought or action, is overly simplistic however, as it ignores the social relatedness of nurses within a shifting organisational context. As the specialist nurses reveal, the level of autonomy they experience in their role, and the freedom and power associated with it, is conditional. The nurses maintain their status and autonomy by outwardly espousing organisational
values and practices. This supports the notion of nurse autonomy as being relational (see Donchin 1995; MacDonald 2002; McKenzie and Stoljar 2000; Sherwin 1998).

Sherwin (1998) explains, autonomy is not something that individuals can possess or exercise in isolation from the social context in which they are situated. Instead, individual autonomy is socially constructed, and as such it is reliant on the social conditions that foster autonomous action.

The generalist nurses described having less autonomy in their cardiac rehabilitation role than other areas of their community nursing practice and many expressed frustration and resentment due to the increasing demands being placed upon them. The diminishing autonomy associated with increasing demands can be explained by drawing on previous research and the concept of “contractual space”. Cash (2001) explains that the degree of contractual space nurses are allowed in practice is positively correlated with the degree of clinical autonomy they experience; as the specification of the contract increases the degree of autonomy decreases. Similar to Cash’s findings (2001), the reduction in the generalist nurses’ contractual space saw them reduce their cardiac rehabilitation practice to the technical and medically focused aspects of practice. That is, the behavioural aspects of their role were either omitted or confined to patient education and/or information giving.
MacDonald (2002) explains that effective autonomy, which fosters the uptake of new knowledge and the development of proficiency and expertise, is best achieved when the social or organisational conditions that support it are in place. These supportive conditions include not just the material security required for an individual to have a range of options, but also “supportive structures - both personal and political – that give one the confidence to take charge of choices” (MacDonald 2002: 198).

These supportive conditions were more readily available to the specialist nurses. By virtue of their specialist status, on commencing their cardiac rehabilitation role they were supported, enabled and expected to pursue the knowledge required to develop their expertise in this area of practice. These supportive conditions did not equate with being “supported” as a generalist nurses however. Support without granting autonomy facilitates compliance as opposed to enabling choices that potentially lead to change and innovation. The support provided to the generalist nurses was aimed at facilitating practice in predetermined and fairly standardised ways.

The autonomy experienced by the clinical nurse consultants was instrumental in motivating them to gain new knowledge and develop their specialist skills. Together with their specialist peers they became part of an “expert” community of practice, which constitutes what MacDonald (2002: 198) would classify as a “supportive structure”. In contrast, many of the generalist nurses, not being granted similar autonomy to their specialist colleagues, did not attempt or were unable to advance this area of their practice. This suggests that autonomy is an important enabling factor that contributes to the development of expertise.
Strength can be added to the above summation by reviewing the knowledge and skills that the two groups of nurses’ brought with them to the cardiac rehabilitation role and the different ways their practice evolved. Unlike the community nurses who considered that practice for bringing about behaviour change was integral to their generalist role, the majority of the specialist nurses came to their cardiac rehabilitation role from the hospital setting without an understanding of or experience in behavioural interventions. Of interest is that the specialist nurses’ behaviour change practice evolved to a complex and skilled process of persuasion whereas the majority of generalist nurses continued to practice in their traditional ways, restricting their behaviour change practice to giving advice and direction, patient education and information giving.

The importance of autonomy for the development of expertise is also highlighted in a recent quantitative study that found that there was a statistically significant correlation between professional nursing autonomy and nursing expertise in the clinical setting (Kumar 2008). However, there is little research examining the relationship between professional nursing autonomy and nursing expertise that can be used for comparison. In her seminal work, “From Novice to Expert” Benner (1984) acknowledged that not all nurses with experience become experts. There has been little subsequent research aimed at determining why this is so. The level of autonomy nurses are granted in their practice and the supportive conditions that foster this autonomy are possible explanations for this phenomenon.
Nurses’ autonomy has other implications besides enabling the development of expertise. Being granted higher status and greater autonomy within the organisation than generalist nurses sees the specialist nurses as being in a position of greater power compared to their non-specialist colleagues. The next section of this chapter discusses how this power is instrumental in shaping not only the context of practice and consequently the practice itself.

8.5.2 Power-Play Shaping Context

Specialist and generalist nurses are positioned differently in the social structure of cardiac rehabilitation nursing, however both groups of nurses use all sorts of processes and techniques to enforce their power and maintain control. This power play sees outward compliance with organisationally espoused values and practices as a means of maintaining the status quo. One way this is manifested is the way nurses draw on dominant medical and organisational discourses to construct and convey their professional identity and cardiac rehabilitation role. Foley and Faircloth (2003) reported similar findings in a study of midwives who drew on medical discourse as a means to legitimise their role and construct the validity of their profession. While this is of interest, what is more pertinent to this research is why some nurses entered into the discourses of medicine and organisation when describing their role, and yet excluded those that reflected the behavioural aspects of their practice.

Drawing on the work of Michel Foucault, Cotton (1997: 25) explains that it is through discourse that the social production of meaning occurs and that “certain discursive meanings may give greater credence and legitimisation to some speakers than others,
while hierarchically excluding or devaluing others.” It makes sense then, that in order to maintain power within the organisation, the specialist nurses need to communicate a discourse of specialisation that reflects and perpetuates the dominant values of the organisation. Further evidence of the way specialist nurses draw on medical and organisational discourses to maintain their power is the way they guide and control the work of the generalist nurses.

Specialisation is a discursive practice, and as such the specialist nurses gain power and legitimacy simply from the way their role is situated in relation to their peers. As advanced practice nurses the role of the specialist cardiac rehabilitation nurses involves “supporting”, “guiding” and in some locations “supervising” their generalist peers. Their power and influence over generalist nurses extends beyond this however. As well as having a voice in determining the models of service delivery, they are also instrumental in developing the guidelines, pathways and protocols that the generalist nurses are required to follow. In this way their power and control over the way the generalist nurses conduct their practice is manifested in the “tools” of practice that serve the organisation as a means of maintaining order by standardising practice.

The specialist nurses on the other hand, reveal that they seek to bring about patient behaviour change in alternative and individualised ways, deeming standardised approaches as being sub-optimal for this type of practice. The exception to this is the specialist nurses’ involvement in group-based cardiac rehabilitation programs, which in most areas were the specialist nurses’ preferred mode of service delivery. Unlike home-based interventions, the work involved in coordinating and facilitating group programs is highly visible and is perceived to be more efficient and cost effective. Ironically, in
the area health services where both generalist and specialist nurses are responsible for delivering cardiac rehabilitation services, generalist nurses are allocated to home-based interventions despite the specialist nurses perceiving individually focused interventions to be more complex.

8.5.3 Organisational Expectations and Demands: Competing Interests

In essence, this discussion is about competing discourses that are manifested in the social interactions within the “organisation”. These interactions can either uphold organisational values and interests or they can introduce new and/or alternate ways of thinking and practicing that potentially serve to diminish or increase the power of the more dominant influences.

Cardiac rehabilitation nurses have available to them a number of discourses and discursive practices, ways of thinking, talking and doing, when they talk about their cardiac rehabilitation ‘practice’. The most prevalent discourses are those of medicine, the pervading discourses of the ‘organisation’. Throughout the nurses’ accounts there is evidence of their frustration and dissatisfaction with the organisation’s increasing focus on rationalisation and standardisation, which is manifested in an increasing call for accountability through various forms of measurement and documentation. Many of the nurses, particularly those who consider they have little autonomy in their practice, see many of the changes associated with this shift in focus as detracting from their ability to work in individualised and patient-centred ways.
This is reflected in the nursing literature where there is increasing consensus that contemporary organisational influences have replaced the traditional systems of health care delivery. The public health service approach that emphasised humanistic objectives has been replaced by a market-driven approach shaped by the discourses of “managerialism” which emphasise rationality, efficiency, accountability and impersonality (Crowe 2000; Richman & Mercer 2004). This shift in focus shaped a health care arena that is dominated by the view that health care is a commodity to be bought and sold (Crowe 2000) which is also supported in the findings of this research. Patients are viewed as potential ‘clients’, ‘consumers’ and ‘customers’ for services that the organisation requires to be standardised, cost-effective and efficient.

This research also highlights how the organisational practices that are characteristic of the contemporary health care milieu have contributed to the significant gap that exists between the rhetoric and reality of nursing work, which contributes to many of the inconsistencies that exist in the ways nurses approach their behaviour change practice. Some understanding of these phenomena can be gained by examining the ways that certain influences or discourses maintain their dominance over others.

Rolfe (2002) explains that generally, only one particular discourse dominates a discipline at any one time and that the dominant discourse can usually be spotted simply by the fact that it does not have to justify itself. Such is the medical model, which currently prevails in community-based cardiac rehabilitation despite competing influences that espouse a holistic and social view of health.
That medical interests are upheld and served by the organisation signifies and perpetuates medical dominance. While this can be expected, given that medical influences have been credited with dominating not only health care practice and the health care system generally (Adamson et al. 1995; Kelly & Symonds 2003), maintaining dominance necessitates excluding or diminishing the power of alternative influences.

The practices that signify various influences competing and struggling for power are not always obvious. To the contrary, power is only tolerable on the condition that it masks a substantial part of itself and the extent of its influence is proportional to its ability to conceal its own mechanisms (Foucault 1976). The rhetoric of nursing work, and that shaping the face of the health care organisation, represents the assimilation of alternative and diverse values and practices; in other words, alternative discourses. As Rolfe (2002) explains the consequences of such diversity inevitably lead to a dilution of the power and authority of the dominant discourse.

Of interest is that the specialist nurses’ practice evolved as they increasingly assimilated new and alternative understandings into their practice. Gavey (1997) points out that, when different meanings are recognised and attempts are made to adopt them, power becomes challenged, disrupted and at times displaced as new forms of power come into being. The specialist nurses sought new and alternative understandings and assimilated these into their practice. However, in order to maintain their power within the organisation the specialist nurses needed to be seen as buying into, or conforming to the dominant ideology. They did this by promulgating organisational values, advocating
medically driven practice and approaches that conform to the organisation’s demands for accountability, evidence-based and standardised approaches to practice.

The processes associated with maintaining the status quo impinge on practice that is shaped by alternative discourses, for example behavioural interventions that are shaped by the discourses of humanistic and social psychology. While the benefits of alternative forms of knowledge may be acknowledged by the organisation, the power of the dominant discourses, which is manifested in competing organisational demands, reduces the contribution of competing discourses to a subservient role (see Rolfe 2002).

The discourses that shape nursing work are constantly being reworked however, which creates the social conditions for possible change. Individually, and as a professional group, the specialist nurses have more power in the organisational hierarchy than their generalist peers. While some of their power is channelled into augmenting the organisation’s efforts to maintain order, they also strive to evolve their behavioural interventions through the juxtaposition of alternative discourses.

**8.6 Conclusion**

**8.6.1 Overview of Research**

Bringing about behaviour change has long been considered an integral aspect of nursing work where the prevention an amelioration of disease through behavioural means is a goal of practice. The concern addressed by this research is that very little is known
about how nurses working carry out the elements of their behavioural interventions in the context of their everyday clinical work. Therefore, purpose of this research, has been to explore nurses’ behaviour change practice; the theory that underpins it, the practice itself and the influences that serve to either facilitate or constrain it.

The insights gained from this study are based on the perspectives of both generalist and specialist nurses delivering Phase II cardiac rehabilitation services in four Area Health Services within the state of New South Wales Australia. These perspectives were captured through an in-depth interviewing process that utilised a semi-structured approach.

Data analysis involved the adoption of a progressive approach. Initially, the data were coded thematically; a method enabled a descriptive account of this area of nursing work. During this phase of analysis it became evident that issues of power and control permeated the nurses’ accounts of their cardiac rehabilitation role and behaviour change practice; these were explored by seeking and examining the discourses shaping and surrounding related text. This analytical approach was intended to facilitate exploration rather than confine it to the boundaries of a single predetermined path or method. As such, it yielded a multifaceted perspective of this area of nursing work and a depth and breadth of information that could not have been obtained by other methods.

In the service context of cardiac rehabilitation, nurses’ behavioural interventions are characterised by diverse practices. While some of this diversity can be expected, much of it is underpinned by their varied and at times conflicting understandings about what
this work entails and how this work should be carried out. Developing practice knowledge and skills for bringing about patient behaviour change is complex and relies largely on trial and error learning; this type of learning assists nurses to develop the flexibility which enables them to work with both the patterns and nuances that present in nurse-patient interactions.

This study has found that a factor fundamental to the development of expertise for carrying out behavioural interventions is the level of autonomy nurses are allowed in practice. Autonomy enables nurses’ proficiency and expertise to develop through exploration and experimentation; processes that are instrumental in facilitating behaviour change practice that is characterised by an eclectic approach.

This research has also highlighted the power of contextual influences on nursing work and the tension and struggle that can be brought about by organisational expectations and demands. Clearly, the relationship between context and practice is complex as the two are interrelated and in a state of constant flux. The current managerial culture that dominates the Australian health care system emphasises standardisation and taxonomies that are largely incongruent with present-day understandings of how health care organisations can foster improvement and innovation. Kitson explains:

The healthcare system is a complex, interactive, organic entity where experimentation, experiential learning and reflection are central to creating a culture of innovation, improvement and consequently effectiveness

(Kitson 2009: 218).
The incongruence between the rhetoric and reality of the current health care culture brings to light the constant interplay of power relations that shape the context of health care. This power-play forces many nurses to conform to managerial and medically defined ways of working which are often incongruous with the processes and strategies that expert cardiac rehabilitation nurses describe as being fundamental to their behaviour change practice. While many organisational practices are intended to improve the effectiveness and efficiency of nurses’ behaviour change practice, they can actually serve to delimit and constrain it.

On the basis of the findings, this research contends that if there is to be innovation and improvement in the way nurses carry out their behavioural interventions then the nurses who are “experts” in cardiac rehabilitation, and other areas of nursing work where bringing about behaviour change is a goal of practice, should be the primary source of practice knowledge. The findings also reveal that the knowledge and skills in this type of nursing work are not sufficient for ensuring optimum practice. Organisational practices are instrumental in determining whether certain knowledge and skills for delivering behavioural interventions are gained in the first place, as well as whether nurses are enabled to translate these into actual practice.

8.6.3 Limitations of Research

It is important to address the limitations of this study. This was a qualitative study with a non-probability sample and as such the findings cannot be generalised to either the population of cardiac rehabilitation nurses or the population of generalist community nurses. In addition to this, the findings are intrinsically linked to the time and context in
which the study was conducted, which includes the varying service delivery models operating within the participating area health services.

There were also fundamental differences between the two groups of nurses participating in this study. The most prominent of these were the circumstances that brought the nurses to their cardiac rehabilitation role, which impacted on their attitudes towards this area of work and subsequently the way they carried it out. If the nurses, who did not wish to take on the cardiac rehabilitation role, had not volunteered to participate in this research, the findings may have been different. Having said this, the differences in the nurses’ accounts expose much of the diversity that exists in this area of nursing work and the delivery of cardiac rehabilitation services in the Area Health Services that participated in this study.

Additionally, the study was conducted at a time when nursing shortages added to the burden of increasing service demands for acute and chronic care. These demands clearly impacted some nurses’ ability and willingness to deliver the behavioural components of their cardiac rehabilitation role.

It is also acknowledged that while the specialist cardiac rehabilitation nurses who participated in this study are the designated “experts”, it does not necessarily mean they had attained the same level of expertise, or that they were in fact experts in their practice. Their level of proficiency cannot be determined from the data as this study drew its findings from their descriptive accounts and not evidence relating to the outcomes of their practice. In addition to this, there are no nursing “standards” or
nursing specific protocols for behavioural interventions with which to compare the findings of this research. More importantly, this research raises question as to whether conventional means of assessing nursing practice are appropriate for this type of practice. In terms of this research, the ultimate test of credibility rests on the degree to which the participants and other nurses’ recognise the experiences and practices that are reported in the findings as their own.

8.6.4 Suggestions for Future Research

This research leaves little doubt that cardiac rehabilitation nursing necessities a marriage between knowledge and skills based in the natural and human sciences. It stands to reason then, that in order to better understand this work and processes that comprise it, different types of evidence will be required. The current approach of evidence-based practice, and the research that informs it, have created a trend that pays scant regard to processes in naturalistic settings and the contextual factors that influence and shape them.

As this was an exploratory study, the findings can be used as a springboard for further research. While it is crucial to determine the effectiveness of behavioural interventions in nursing contexts, there also needs to be a much stronger focus on understanding what nurses currently do to bring about patient behaviour change and in identifying what are the strengths of this practice. More research into the way this work is carried out in naturalistic health care settings is warranted, particularly if organisations and clinicians are to address increasing demands for the prevention and amelioration of chronic disease.
The value of existing behavioural theories and frameworks in providing nurses with an understanding of the factors associated with individual behaviour and behaviour change is acknowledged. However, this research raises question as to whether deeming specific theoretical frameworks as best practice approaches for guiding nurses’ behaviour change practice is appropriate. It also brings into question whether these theories and frameworks are able to provide empirically adequate descriptions and explanations of nursing phenomena. These concerns raise further possibilities for future research.

This research suggests that there are differences in the nature and development of expertise for carrying out behavioural interventions compared to that related to treatment focused aspects of nursing work. Further research into the development of expertise for behaviour change practice is crucial as it can potentially contribute to the advancement of this area of practice by informing the education and training of nurses and other health care workers.

The processes that this research has identified as being fundamental to the specialist nurses’ behaviour change practice, the “doing”, also provide fertile ground for further research. Previously a hidden part of many nurses’ everyday practice, the skills and practice associated with “discursive flexibility” hold particular promise. A better understanding of this phenomenon could inform future developments in this area of nursing work and behavioural interventions in health care generally.
Another area for future research is the analysis of discourse in relation to the assimilation of alternative or non-clinically focused practice into nursing work. While this study explored the discourses that nurses’ draw on to construct their role and practice, and briefly examined issues of power and control, it was not within its scope to provide a comprehensive analysis of the discourses shaping these phenomena.

Finally, whatever directions are taken in this research area, a focus on nurses’ behaviour change practice and the context in which it occurs, can only further the advancement of this area of nursing work, irrespective of whether it identifies its strengths or weakness. Such advancement can improve the standard and effectiveness of individually focused interventions aimed at the prevention of chronic diseases and those focused on health improvement through behavioural means.
REFERENCES


Ashworth, NL, Chad, KE, Harrison, EL, Reeder, BA & Marshall, SC 2005, Home versus center based physical activity programs in older adults. *Cochrane Database of Systematic Reviews*, Issue 1, Art. no.. CD004017.

Astin, F & Closs, JS 2007, Cardiac rehabilitation, secondary prevention or chronic disease management? Do we need a name change? *European Journal of Cardiovascular Nursing*, vol.6, no.1, pp.6-8.


Australian Cardiovascular Health and Rehabilitation Association 2008, A practitioner's guide to cardiac rehabilitation. Lane Cove, NSW, ACRA.

Australian Institute of Health and Welfare 2001, Australia's Welfare, AIHW, Canberra, Cat. no. AUS 24
Australian Institute of Health and Welfare 2004, Australia's Health 2004, AIHW, Canberra Cat. no. AUS 44.

Australian Institute of Health and Welfare 2006, Chronic Diseases and Associated Risk Factors in Australia. AIHW, Canberra, Cat. no. PHE 81.


Balady, GJ, Ades, P Cosmos, P, Limacher, M, Pina, IL, Southard, D, Williams, MA & Bazzare, T 2000, Core components of cardiac rehabilitation/secondary prevention programs: a statement for healthcare professionals from the American Heart Association and the American Association of Cardiovascular and Pulmonary Rehabilitation Writing Group, Circulation, vol.102, no.9, pp.1069-1073.


Beck, CT 1993, Qualitative research: the evaluation of its credibility, fittingness and auditability, *Western Journal of Nursing Research*, vol.15, no.2, pp.263-266.


Curtis, J 2002, Power, Control and Empowerment in Alcohol and Other Drug Treatment, Doctor of Philosophy, Department of Nursing, University of Wollongong, Wollongong,


Finfgeld, DL 1999, Use of brief interventions to treat individuals with drinking problems, *Journal of Psychosocial Nursing and Mental Health Services*, vol.37, no.4, pp.23-30.


Foster, C, Hillsdon, M & Thorogood, M 2005, Interventions for promoting physical activity, *Cochrane Database of Systematic Reviews*. Issue 1, ART No. CD 003180.


Gavey, N 2002, To and beyond the discursive constitution of subjectivity, *Feminism and Psychology*, vol.12, no.4, pp.432-438.


Haynes, RB, Montague, P, Oliver, T, Mckibbon, KA, Brouwers, MC & Kanani, R 2002, Interventions for helping patients follow prescriptions for medication, *Cochrane Library of Systematic Reviews*, Issue 2, Art. no.. CD 000011


Jolliffe, JA, Rees, K, Taylor, RS, Thompson, D, Oldridge, N & Ebrahim, S 2007, Exercise-based rehabilitation for coronary heart disease, *Cochrane Database of Systematic Reviews*, Issue 1, Art. no.. CD001800


Keleher, H, Parker, R, Abdulwadud, O, Francis, K, Segal, L & Dalziel, K 2007, *Review of Primary and Community Care Nursing*, Australian Primary Health care Institute, Canberra


Kumar, MK 2008, *Relationships among professional nurse autonomy, perceived organisational support, and clinical nursing expertise*, Doctor of Philosophy, Graduate College of Humanities and Social Science, University of Iowa, Iowa.

Lai, D, Qin, Y & Tang, J 2009, Motivational interviewing for smoking cessation, *The Cochrane Database of Systematic Reviews*, Issue 1, Art No. CD006936.


MacDonald, C 2002, Nurse autonomy as relational, *Nursing Ethics*, vol.9, no.2, pp.194-291.


McDonnell, A., Davies, S., Browne, J., Shewan, J. and Crookes, P. 1997, *A detailed investigation of factors associated with the implementation of research-based knowledge by practice nurses in the prevention of cardiovascular disease and stroke. Final Report to the National Health Service Executive Research and Development Program (Cardiovascular Disease and Stroke)*, School of Nursing and Midwifery, University of Sheffield, Sheffield.

McDonald, J & Hare, L 2004, *The contribution of primary and community health services*, Centre for Health Equity, Training, Research and Evaluation, University of New South Wales,


Miller, WR & Rose, GS 2009, Toward a theory of motivational interviewing, American Psychologist, vol.64, no.6, pp.527-537.

Molloy, GN, Murphy, GC & King, NJ 2007, On the decline of n=1 research in behaviour change: the rise of the evidence-based practice movement as one explanation for the trend, Behaviour Change, vol.24, no.2, pp.114-121.


Morse, J 1999, Myth 19: qualitative research is not systematic, *Qualitative Health Research*, 9, 573.

Muenchberger, H 2007, *Evidence-based practice in rehabilitation: a process for synthesising knowledge*, Doctor of Philosophy, School of Human Services, Griffith University, Brisbane.


National Heart Foundation of Australia 2003, Heart Foundation Releases Updated ‘Stress’ and Coronary Heart Disease Position, *Heart, Lung and Circulation*, vol.12, no.3, p.207.


Radwin, LE 1995(b), Conceptualizations of decision making in nursing: analytic models and "knowing the patient", *Nursing Diagnosis*, vol.6, no.1, pp.16-22.


Rice, VH & Stead, LF 2008, Nursing interventions for smoking cessation, *Database of Systematic Reviews*, Issue 1, Art No. CD001188.


Seibold, C 2001, Qualitative research from a feminist perspective in the postmodern era: methodological, ethical and reflexive concerns, Nursing Inquiry, vol.7, no.3, pp.147-155.


Sharma, M 2007, Behavioural interventions for preventing and treating obesity in adults, Obesity Reviews, vol.8, no.5, pp.441-449.


Stead, LF & Lancaster, T 2005, Group behaviour therapy programmes for smoking cessation, *Cochrane Database of Systematic Reviews*, Issue 2, Art. no.. CD001007


Swanson, KM 1993, Nursing as informed caring for the well-being of others, *Image: Journal of nursing Scholarship*, vol.25, no.4, pp.352-357.


Tarlier, D 2005, Mediating the meaning of evidence through epistemological diversity, *Nursing Inquiry*, vol.12, no.2, pp.126-134.


Thompson, RL, Summerbell, CD, Hooper, L, Higgins, JP, Little, PS, Talbot, D & Ebrahim, S 2003, Dietary advice given by a dietician versus other health professional or self-help resources to reduce blood cholesterol, Cochrane Database of Systematic Reviews, Issue 3, Art. no. CD001366.


Whittemore, R 2000, Consequences of not knowing the patient, *Clinical Nurse Specialist*, vol.14, no.2, pp.75-81.


APPENDIX 1: COPY OF THE ETHICS APPROVAL FROM THE UNIVERSITY OF WOLLONGONG

LETTER of APPROVAL

University of Wollongong

19 December 2001

Ms Lucia Apolloni
9 Gowen Brae Avenue
Mt Ousley NSW 2519

Dear Ms Apolloni,

Thank you for your response to the Human Research Ethics Committee’s requirements for your Human Research Ethics application HE01/222 “Bringing About Behaviour Change: An exploration of the autonomous practice of cardiac rehabilitation nurses in the community setting”. Please forward IAHS Authority letter when received.

Your response and amendments meet with the requirements of the Committee and your application was formally approved on 19/12/2001.

You can now proceed with your research.

Yours sincerely,

[Signature]

Karen McRae
Secretary to the
Human Research Ethics Committee

Cc: Tineke Robinson, IAHS
APPENDIX 2A: UNIVERSITY OF WOLLONGONG;
PATIENT PARTICIPANT INFORMATION SHEET

RESEARCHER: Lucia Apolloni
SUPERVISORS: Dr Lindsey Harrison
DEPARTMENT: Graduate School of Public Health

My name is Lucia Apolloni and I am undertaking research for the degree of Doctor of Public Health at the University of Wollongong. My background in nursing and psychology have led to a special interest in nursing practice for health promotion which is the focus for this research.

The research project is titled "Bringing about behaviour change: an exploration of the autonomous practice of Cardiac Rehabilitation Nurses in the community setting," and it aims to provide an understanding of what nurses do to help clients reduce their risk of illness. Very little research has explored nurse practice in this area and it is hoped that the findings from this study will be able to improve health care practice by informing the development of future guidelines. Your participation in this research will be greatly appreciated.

In order to gain a practical understanding of community based cardiac rehabilitation services I am asking if I can accompany your visiting Cardiac Rehabilitation Nurse on a routine visit to your home. You will not be expected to answer any questions and no notes or recordings will be made during the visit. I will be making some notes regarding the intervention process following the visit. Confidentiality and anonymity will be assured. Anything you say, or anything I am told will be kept in confidence and your name or any other identifying information will not be revealed to anyone.

Your participation in this research is voluntary and you are free to withdraw from the research at any time. Your refusal to participate or withdrawal of consent will not in any way affect the service provided to you or your relationship with the area health service in any way.

If you have any inquiries about the research, please contact me or my supervisors and we will gladly help you with any queries or concerns you may have in relation to this research:

- Lucia Apolloni on (02) 42 213555 or e-mail lucia.apollonil@uow.edu.au
- Supervisors: Dr Lindsey Harrison (02) 42213555.

If you have any concerns or complaints regarding the way the research is or has been conducted, you can contact the Complaints Officer, Human Research Ethics Committee, University of Wollongong on (02) 42214457.

Looking Forward to Your Involvement in this Research

Lucia Apolloni
APPENDIX 2B: UNIVERSITY OF WOLLONGONG;
NURSE PARTICIPANT INFORMATION SHEET

RESEARCHER: Lucia Apolloni
SUPERVISORS: Dr Lindsey Harrison
DEPARTMENT: Graduate School of Public Health

My name is Lucia Apolloni and I am undertaking research for the degree of Doctor of Public Health at the University of Wollongong. My qualifications and experience are in nursing and psychology and I have a special interest in health promotion particularly in relation to nursing practice.

The research project, titled "Bringing about behaviour change: an exploration of the autonomous practice of Cardiac Rehabilitation Nurses in the community setting," aims to provide an in depth understanding of what nurses do to facilitate client behaviour change. Very little is known about nurse practice in this area and by providing a description and explanation of these processes the results of this study will be able to inform the development of future guidelines. Your participation in this research will be greatly appreciated as it was considered that cardiac rehabilitation is one area of nursing practice where there is considerable expertise in bringing about client behaviour change.

What you will be asked to do for this research is participate in an interview that will last for approximately one hour. With your consent I will tape-record this interview. Tape recordings and subsequent transcripts will be coded to ensure confidentiality and ensure anonymity. No personal identifying information will be used during any stage of data processing or reporting. You may also be asked to allow me to accompany you on a home visit so that I can gain a practical understanding of the study context; I will not be recording any conversation or taking any notes during this process. Any information that you provide regarding your clients will be kept confidential and their anonymity is assured.

Participation in this research is voluntary and you are free to withdraw from the research at any time. Refusal to participate or withdrawal of consent will not affect your relationship with the University of Wollongong or your relationship with the area health service in which you are employed in any way.

If you have any questions about this research please feel free to contact either myself and/or my supervisors. The contact details are listed below:

- Lucia Apolloni on (02) 42 213555 or e-mail lucia_apollonil@uow.edu.au
- Dr Lindsey Harrison (02) 42213555.

If you have any concerns or complaints regarding the way the research is or has been conducted, you can contact the Complaints Officer, Human Research Ethics Committee, University of Wollongong on (02) 42214457.

Looking Forward to Your Involvement in this Research

Lucia Apolloni
APPENDIX 3A: UNIVERSITY OF WOLLONGONG;
PATIENT PARTICIPANT CONSENT FORM

RESEARCHER: Lucia Apolloni (Phone 42 271228; e-mail: lucia_apolloni@uow.edu.au)
SUPervisors: Dr Lindsey Harrison (42 213555)
DEPARTMENT: Graduate School of Public Health

TITLE: Bringing about behaviour change: An exploration of the autonomous practice of Cardiac Rehabilitation Nurses in the community setting.

I have been given information about the proposed study and have discussed the research project "Bringing about behaviour change: an exploration of the autonomous practice of Cardiac Rehabilitation Nurses in the community setting" Lucia Apolloni. I understand that this research is being conducted as part of the degree of Doctor of Public Health at the Graduate School of Public Health, University of Wollongong.

I understand that, if I consent to participate in this project I will be giving permission for Lucia to attend and observe a routine visit to my home with the Cardiac Rehabilitation Nurse. The reason she wishes to observe the home visit has been explained to me. I have also been told that confidentiality and anonymity will be maintained and that I will not be expected to answer any questions and no notes or recordings will be made during the visit. I have been informed that some notes will be made following the visit. I have been assured that anything I say will be kept in confidence and my name will not be revealed to anyone. I have been advised of the potential risks and burdens associated with this research and have had an opportunity to ask Lucia Apolloni any questions I may have about the research and my participation.

I understand that my participation in this research is voluntary, this means that I am free to refuse to participate and I am free to withdraw from the research at any time. My refusal to participate or withdrawal of consent will not affect my treatment in any way. I am aware that if I have any inquiries about the research, I can contact Lucia Apolloni, Dr Lindsey Harrison (contact details above) for further information. And, if I have any concerns or complaints regarding the way the research is or has been conducted, I can contact the Complaints Officer, Human Research Ethics Committee, University of Wollongong on 42214457.

By signing below I am indicating my consent to participate in the research entitled "Bringing about behaviour change: an exploration of the autonomous practice of Cardiac Rehabilitation Nurses in the community setting" conducted by Lucia Apolloni as it has been described to me in the information sheet and in discussion with me. I understand that the data collected from my participation will be used for purpose of a thesis and journal publication, and I consent for it to be used in that manner.

Signed

................................................................. Date

.................................................................

Name (please print): .................................................................
APPENDIX 3B: UNIVERSITY OF WOLLONGONG;
NURSE PARTICIPANT CONSENT FORM

RESEARCHER: Lucia Apolloni (Phone 42 271228; e-mail: lucia_apolloni@uow.edu.au)
SUPERVISORS: Dr Lindsey Harrison (42 213555)
DEPARTMENT: Graduate School of Public Health
TITLE: Bringing about behaviour change: an exploration of the autonomous practice of Cardiac Rehabilitation Nurses in the community setting.

I have been given information about the proposed study and have discussed the research project "Bringing about behaviour change: an exploration of the autonomous practice of Cardiac Rehabilitation Nurses in the community setting" with Lucia Apolloni. I understand that this research is being conducted as part of the degree Doctor of Public Health at the Post-Graduate School of Public Health, University of Wollongong.

I understand that, if I consent to be involved in this project, I will be asked to participate in a taped one-hour interview where I will be asked questions relating to nursing practice in cardiac rehabilitation. I may also be asked to participate in an observation session where the researcher will accompany me during a routine home visit for the purpose of gaining a practical understanding of my work practice. I have been assured that confidentiality and anonymity will be maintained throughout research and reporting processes.

I understand that my participation in this research is voluntary which means that I am free to refuse to participate and I am free to withdraw from the research at any time. My refusal to participate or withdraw consent will not affect my relationship with the University of Wollongong or my relationship with the area health service in which I am employed in any way. I have been advised of the potential risks and burdens associated with this research and have had an opportunity to ask Lucia Apolloni any questions I may have about the research and my participation.

I have been informed that if I have any inquiries about the research, I can contact Lucia Apolloni, Dr Lindsey Harrison (contact details above) and if I have any concerns or complaints regarding the way the research is or has been conducted, I can contact the Complaints Officer, Human Research Ethics Committee, University of Wollongong on 42214457.

By signing below I am indicating my consent to participate in the study titled "Bringing about behavior change: an exploration of the autonomous practice of Cardiac Rehabilitation Nurses in the community setting." The project has been described in the information sheet and has been discussed with me by Lucia Apolloni. I understand that the data collected from my participation will be used for purpose of a thesis and journal publication, and I consent for it to be used in that manner.

Signed ................................................................. Date ...........................................

Dear Name (please print): ........................................................................................
APPENDIX 4: THE INITIAL AND REVISED INTERVIEW SCHEDULES THAT GUIDED DATA COLLECTION

I am interested in finding out about your practice as a cardiac rehabilitation nurse.

- Can you tell me how you came to be a Cardiac rehabilitation Nurse?
- Can you tell me about as much as possible about what you typically do for clients from the time of your initial contact until they are discharged from your care?
- Can you tell me about cases that haven’t fitted this pattern?
- You mentioned (smoking, physical activity or nutrition), can you tell me more about what you do to help people address this (these) issues?
- There are many different approaches to bringing about behaviour change. In your opinion what do you think is the best approach to take?
- How useful do you think some of the theoretical approaches to behaviour change are in the context of your work?
- I would also like to know how you document your intervention in client files. How do you document the processes involved in your intervention, for example client assessment?

Prompts:  
What about the documentation of client progress relating to (target for intervention).

What are the standard requirements for documentation?

Is there any additional information that you provide?

Note: Concerns about the quality of the data led to the interviewing schedule being altered. The 5th and subsequent interviews commenced with the open-ended question: “Can you tell me about your role in cardiac rehabilitation; what you typically do?” The questions above were asked towards the end of the interview if the participants had not provided information relating to the research objectives (see Chapter 4).
APPENDIX 5: AIMS OF CONTEMPORARY CARDIAC REHABILITATION

Broad aims of cardiac rehabilitation:

- Maximise physical, psychological and social functioning to enable people with cardiac disease to lead fulfilling lives with confidence.
- Introduce and encourage behaviours that may minimise the risk of further cardiac events and conditions.

Specific aims of cardiac rehabilitation:

- Facilitate and shorten the period of recovery after an acute cardiac event.
- Promote strategies for achieving mutually agreed goals of ongoing prevention.
- Develop and maintain skills for long-term behaviour change and self-management.
- Promote appropriate use of health and community services, including concordance with prescribed medications and professional advice.

From: National Heart Foundation & Australian Cardiac Rehabilitation Association, 2004, p1
APPENDIX 6: RISK FACTORS FOR CARDIOVASCULAR DISEASE

Major Traditional Risk Factors for Cardiovascular Diseases (including Coronary Heart Disease)

<table>
<thead>
<tr>
<th>Behavioural Risk Factors:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Tobacco smoking</td>
</tr>
<tr>
<td>• Physical inactivity</td>
</tr>
<tr>
<td>• Poor nutrition</td>
</tr>
<tr>
<td>• High consumption of alcohol</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Bio-medical Risk Factors:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• High blood pressure (hypertension)</td>
</tr>
<tr>
<td>• High blood cholesterol</td>
</tr>
<tr>
<td>• Being overweight</td>
</tr>
<tr>
<td>• Diabetes, including metabolic syndrome.</td>
</tr>
</tbody>
</table>

Adapted from: Access Economics & National Heart Foundation of Australia (2005)
APPENDIX 7: PROCESSES OF CHANGE

Consciousness raising:
Efforts to seek information and to gain understanding and feedback about the problem behaviour / observations, confrontations, interpretations, reading

Counter-conditioning:
Substitutions of alternatives for the problem behaviour / relaxation, desensitization, assertion, positive self-statements.

Dramatic relief:
Experiencing and expressing feelings about the problem behaviour and potential solutions / psychodrama, grieving losses, role playing.

Environmental re-evaluation:
Consideration and assessment of how the problem behaviour affects the physical and social environment / empathy training, documentaries.

Helping relationships:
Trusting, accepting, utilizing support of caring others during attempts to change the problem behaviour.

Reinforcement management:
Rewarding oneself or being rewarded by others for making changes / contingency contracts, overt and covert reinforcement, self-reward.

Self-liberation:
Choice and commitment to change the problem behaviour, belief in the ability to change / decision making therapy, resolutions, commitment enhancing techniques.

Self-re-evaluation:
Emotional and cognitive re-appraisal of values with respect to the problem behaviour/value clarification, imagery, corrective emotional experience.

Social liberation:
Awareness, availability and acceptance by the individual of alternative, less problematic lifestyles in society / empowering, policy interventions.

Stimulus control:
Control of situations and other causes which trigger the problem behaviour / adding stimuli that encourage alternative behaviours, re-structuring the environment, avoiding high risk cues, fading techniques.

Adapted from: Access Economics & National Heart Foundation of Australia (2005)
APPENDIX 8: PRINCIPLES OF MOTIVATIONAL INTERVIEWING

Express Empathy:

- Acceptance facilitates change
- Skilful reflective listening is fundamental
- Ambivalence to change is normal

Develop Discrepancy:

- Change is more likely to occur when one’s behaviour is seen as conflicting with important personal goals.
- Amplifying discrepancy facilitates individuals exploring the importance of change.
- Allow the client to present reasons for change.
- Eliciting and reinforcing change statements strengthens motivation.

Roll With Resistance:

- Avoid arguing for change.
- Resistance is not directly opposed.
- New perspectives are invited but not imposed.

Support Self-efficacy:

- A person’s belief in the possibility of change becomes a self-fulfilling prophecy.
- The client not the counsellor is responsible for choosing and carrying out change.
- The counsellor’s own beliefs in the person’s ability to change becomes a self-fulfilling prophecy.