August 2022

Perianesthesia Discourses on Directives Limiting Care: A Foucauldian Case Study

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PERIANESTHESIA DISCOURSES ON DIRECTIVES LIMITING CARE: A FOUCAULDIAN CASE STUDY

by

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A Dissertation Submitted in

Partial Fulfillment of the

Requirements for the Degree of

Doctor of Philosophy

in Nursing

at

The University of Wisconsin-Milwaukee

August 2022

ABSTRACT

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The University of Wisconsin-Milwaukee, 2022
Under the Supervision of Professor Jeanne Erickson

Current practice recommendations suggest mandatory reconsideration of pre-existing Do Not Resuscitate (DNR) orders and other directives limiting care when adults undergo surgery with anesthesia. However, many perianesthesia clinicians believe that these policies are inappropriate and difficult to implement, and patients may have unclear expectations about anesthesia, creating discord between patients and clinicians. Research about what discourses dominate how patients and clinicians talk about advanced directives in the perianesthesia setting, and how those discourses relate to power-knowledge is limited. This inquiry, guided by the emancipatory theory of compassion, used Foucauldian poststructural case study design and contextualizing analysis to explore this problem. Data were collected through interviews and observations of patients with existing advance directives who underwent surgery, family members, and perianesthesia clinicians who participated in their care. Twenty-seven participants completed the observation and interview components, and eighteen additional participants agreed to observation only. Four authoritative discourses were identified. The "We'll just suspend the DNR…" discourse permeates perianesthesia culture and produces a will among clinicians to automatically suspend the limiting directive. Other discourses related to a lack of time for discussion, a desire not to talk about advance directives unless essential to care, and

confusion about who is responsible to address the limiting directive. The investigation found that patients talked about functional outcomes as stopping points for resuscitation while clinicians talked about intervention-based stopping points, making meaningful communication challenging between groups. Finally, the inquiry demonstrated support for the theory of emancipatory compassion and provided qualitative evidence to support the theory's key conceptual elements. These results suggest that even where policies of mandatory advance directive reconsideration exist, patients may experience environments that constrain their choices. Strategies to address power-knowledge inequity should be implemented when developing advance directive policies or making practice decisions.

To my mother, Robin D. Beavers, RN (1953-2006),

who taught me that good nursing takes time

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ACKNOWLEDGMENTS

First, I would first like to thank all the participants—patients, family members, nurses, organizational leaders, and physicians—who contributed to this inquiry. This work is impossible without you.

Drs. Jeanne Erickson, Daniel Goldstein, Natalie McAndrew, and Lucy Mkandwaire-Valhmu—thank you all for your support and patience. I can imagine no better dissertation committee. I would like to especially acknowledge Jeanne Erickson, PhD—my committee chairperson and major professor—for her insight, expertise, guidance, and mentorship.

I also wish to acknowledge and thank Ruth Bryant, PhD for her clinical sponsorship and guidance. Dr. Bryant went above and beyond her warrant and acted as a mentor during this inquiry. In addition, I thank Patricia DeShong, RN, my first clinical manager, who taught me how to lead other professionals with respect and collegiality. And Michael Swift, RN who—like so many of my LGBTQIA+ family—died too soon.

Thank you also to the Minnesota Nurses Association Foundation (MNAF) for their generous grant that allowed me, in some small way, to compensate the inquiry participants. I would also like to acknowledge the Jacksonville Historical Society for allowing me to use their photograph titled "The Kiss of Life." Similarly, thanks to Elsevier Science & Technology Journals for granting permission to use and modify tables I developed for a previously published work in this dissertation.

I am forever grateful to the patients and staff of Parkland Hospital in Dallas, Texas for my education in critical care nursing. Likewise, I cannot express enough gratitude to the nurses and other clinicians at United Hospital in Saint Paul, Minnesota for teaching me about perianesthesia care.

Thank you, Marcia, who revealed the possible, and Esther, Jackie, Juanita, and Retha who imparted the stuff it took to get there—alongside Floyd, JD, Ollie, and Ollie D. I suppose Homer also played a part, so I recognize that contribution. And Ronni who remains always in my heart.

Thanks to Mom, to whom this dissertation is dedicated, and Jackie Thomas, both gone but never forgotten.

Finally, thank you to my long-time friend Dee Dee Morgan who showed me unconditional positive regard and taught me how to listen, make hard choices with dignity, have difficult conversations with empathy, and navigate uncharted terrain. Wherever I am, you are welcome.

Chapter One – Part 1

Overview

Historically, clinicians automatically rescinded Do Not Resuscitate (DNR) orders and other directives limiting care before administering anesthesia to patients undergoing surgery (Burns et al., 2003; Walker, 1991). Although the practice of automatic revocation of DNR orders was scrutinized and rejected in the literature as early as 1991, evidence suggests that the unethical practice continues today (Hardin & Forshier, 2019; Hiestand & Bieman, 2019; Nurok et al., 2014). Even where perianesthesia clinicians have acceded to contemporary recommendations that suggest mandatory preoperative reconsideration of DNR orders (American Society of Anesthesiologists, 2018; American Society of Perianesthesia Nursing, 2018), patients are often led to believe that suspending their DNR orders is the only action acceptable to the anesthesia clinician. Hardin and Forshier (2019) labeled this phenomenon a *de facto* automatic revocation of the DNR order. Given the unequal power differential inherent to relationships between clinicians and patients, perianesthesia patients require support for their decisions to retain or modify DNR orders. Moreover, patients need not shoulder an undue or coercive burden because of that choice. Problematically, a dichotomy exists between the wants and actions of perianesthesia clinicians and the patient's right to make informed choices about their end-of-life care in the perianesthesia setting. This dichotomy suggests a discourse that renders patients' needs unheard while privileging the wants of the medical community. Nevertheless, whether the DNR order is automatically revoked without the patient's consent or in a de facto way with the patient's *uninformed* consent, the practice undermines human dignity, erodes autonomy, and is unjust.

Echoing Michel Foucault's introductory words to *The Birth of the Clinic*, the inquiry described in this dissertation is about language, space, death, and power in the perianesthesia setting (Foucault, 1994). Broadly, Foucauldian philosophy provides a framework that facilitates a reexamination of the prevailing discourses shaping the ethical choices available to perianesthesia clinicians and patients. At the practice level, Georges' (2013) Mid-Range Theory (MRT) of emancipatory compassion for nursing provides relevance grounded in praxis while imparting clinical usefulness and discipline-specific meaning to the proposed inquiry. Part 1 of this introductory chapter will familiarize readers with Foucault and Georges and set the stage for a more comprehensive examination in Part 2. Part 1 of the Introduction will also outline the problem, establish the problem's significance, and articulate the inquiry's purpose. Additionally, Part 1 will orient readers to the dissertation's manuscript format. Unlike a traditional dissertation, this document is formatted as a series of chapters and manuscripts. Thus, readers should think of Part 1 as a roadmap explaining and introducing this novel presentation format. Each chapter builds upon the preceding chapter with increasing complexity as readers are oriented to Foucauldian poststructuralism and a different way of investigating nursing phenomena.

Problem

Ethically managing end-of-life decisions in the perianesthesia period challenges long-standing, normative assumptions about the care of patients undergoing anesthesia. In the past, patients' DNR orders and other orders limiting care (e.g., advanced directives, living wills, Physicians Orders for Life Sustaining Treatment) were automatically rescinded before anesthesia and surgery (Burns et al., 2003). Although the automatic revocation of DNR orders is ethically untenable (Walker, 1991; Hardin & Forshier, 2019), evidence suggests that the practice persists today (Hiestand & Bieman, 2019). Moreover, even where perianesthesia Registered Nurses,

Certified Nurse Anesthetists, and Anesthesiologists (i.e., anesthesia clinicians) have taken a more enlightened approach toward perianesthesia DNR management, DNR orders are often suspended for the perianesthesia period without patients' informed understanding of their rights to retain or modify their DNR orders. In this case, a *de facto* automatic revocation of the DNR order occurs (Hardin & Forshier, 2019).

The reality constructed in the perianesthesia setting is that retaining a DNR during surgery is a safety risk because it will unduly handicap clinicians by eliminating life-saving treatments indivisible from good perianesthesia practice. For example, blood pressure often plummets in response to vasodilation from induction anesthetics; therefore, clinicians administer vasoconstrictive medications to counteract this response. A reasonable extension of this premise is that patients who choose to retain directives limiting treatment fail to grasp the intricacies of anesthesia and surgery. However, retaining a directive limiting treatment does not impede clinicians from acting quickly to reverse homeostatic changes that regularly occur as part of anesthesia. The premise's fault is the presumption that the patient conceptualizes success and failure in the same way as the clinician. In this problematic status quo, clinicians—perhaps subliminally—position their objectives and voices as paramount to the patient's position. The directive limiting care troubles the problem by forcing the patient's wishes to be considered first. Thus, patients who threaten the status quo by retaining their DNR orders during surgery risk having their views marginalized or even disregarded. The reasons underlying this disciplinary response are genealogical and contextual.

Epistemologically, knowledge about how perianesthesia patients want to use their DNR orders and express their end-of-life wishes in the perianesthesia period developed in two ways. First, the state of the science evolved through ethical dialectics between anesthesia providers

(e.g., Truog, 1991; Walker, 1991). Alternately, knowledge has accumulated through surveys that principally investigated how clinicians feel about managing DNR orders in the perianesthesia period (e.g., Clemency & Thompson, 1993; 1994). As a result, current practice standards reject using either automatic or defacto perianesthesia DNR revocation in favor of policies requiring mandatory reconsideration of DNR orders before anesthesia (American Society of Anesthesiologists, 2018; American Society of Perianesthesia Nursing, 2018). Outmoded practices and beliefs about DNR orders are deeply ingrained in perianesthesia ethos and transmitted through powerful historical forces buttressed by inculcating and disciplinary techniques, however (Burns et al., 2003). Thus, directives limiting care are currently positioned as barriers for providers and clinicians to overcome. Liaschenko et al. (2006) describe the "tragic case" phenomenon that results from biomedicine's focus on dilemma-based decision-making. Instead of conceptualizing ethics as something that pervades every social interaction, biomedical ethical frameworks tend to present ethics as isolated problems with discreet resolutions.

For example, in many biomedical ethics courses, students are given a challenging ethical dilemma and asked to resolve the problem (Benner, 2005; Liaschenko et al., 2006). Students learn how to apply ethical principles by "solving" increasingly complex dilemmas. Often, these scenarios involve high-stakes ethical decisions and life or death choices. Hence, the term "tragic case" evolved. Understanding ethics as isolated dilemmas leads to oversimplification and minimizes the importance of interpersonal relationships. Additionally, the tragic case phenomenon places ultimate decision-making authority in clinicians' hands while simultaneously limiting the patient's sense of agency. Perhaps unsurprisingly, tragic case phenomenon is associated with biomedical and principle-based ethical frameworks. Consequently, while targeted quality improvement initiatives have reported measurable improvements in knowledge,

skills, and attitudes toward perianesthesia DNR orders, notions among perianesthesia clinicians that DNR orders are inappropriate for the perianesthesia setting have proven resistant to change. It is, therefore, unclear whether the advancements recently reported in the quality improvement literature will result in lasting or meaningful changes in practice (Baumann et al., 2017; Urman et al., 2018).

Simultaneously, patients' perspectives on managing their DNR orders during anesthesia remain unexplored or rendered secondary to the needs of perianesthesia personnel. Framing the problem in a way that centralizes patients and their families' needs and desires instead of constructing it as a clinical obstacle in search of a solution is an equally valid, and perhaps ultimately more productive, avenue for inquiry. The underlying discourses sustaining contemporary conceptualization of perianesthesia DNR orders as an obstacle to good care are underexplored. Questions about how ethical discourse is constructed in the perianesthesia setting and how patients are supported or marginalized are scarcely addressed in the literature. Thus, a crucial reason that progress toward the standard of care for advance directive management is so slow may be that the body of knowledge on perianesthesia DNR orders lacks a qualitative foundation—especially from a constructivist perspective (Hardin & Forshier, 2019; Hiestand & Bieman, 2019). The nature of knowledge development in the perianesthesia setting and gaps in knowledge evident in the literature point toward a significant problem.

Purpose and Significance

The purpose of this inquiry is to understand better how adult patients with pre-existing directives limiting care, their families, and clinicians make decisions about resuscitative status during anesthesia by investigating ethical discourses on Do Not Resuscitate (DNR) orders and other directives limiting care in the perianesthesia setting. Ideally, this will help perianesthesia

clinicians better understand and support patients' values and objectives (i.e., subjectivities). At the same time, this inquiry will privilege patients' voices (if not their subject position), thus, speeding the erosion of existing power imbalances and easing the tension between patients and healthcare professionals. Although this inquiry is not about clinicians' perspectives or insights on ethical conflict or the distress caused by those situations, the investigation may tangentially intersect with that body of literature (see McAndrew et al., 2018; McLeod, 2014; Pavlish et al., 2012; Pavlish et al., 2015). Similarly, literature explicating ethical decision-making schema and ethical codes may intersect and aid clinicians in assimilating the inquiry's contribution, but those lines of research do not predicate this investigation (e.g., Beauchamp & Childress, 2009; Crisham, 1984; Dahnke, 2014; Manson, 2012; Porter-O'Grady & Malloch, 2013).

This inquiry aspires to investigate the discourses that construct the choices available to patients and clinicians and examine that reality in relation to power (Wetherell, 1998). Therefore, the inquiry's purpose best aligns with literature focused on constructivist inquiry, deconstruction, and discourse analysis. For example, Foucault suggests that language constructs reality and, resultantly, constitutes how patients and clinicians understand perianesthesia DNR orders. Within a Foucauldian poststructural framework, reality does not make language, language constructs reality. Thus, language does not provide a transparent portal that researchers may use to understand patients' cognitive decision-making schema. Instead, language creates our shared understanding of reality, and it is these discourses that are available for inquiry. Understanding the ethical discourses acting upon patients' decisions about the disposition of their DNR orders in the perianesthesia setting is, therefore, key to understanding patient's values and objectives for resuscitative status during the perianesthesia encounter. However, investigating the problem risks replicating and perpetuating existing regimes of truth that create environments that allow for the

silencing of patients' rights. Expanding upon the complicated theoretical and reflexive assumptions underlying the inquiry is essential to understanding and justifying its purpose.

Therefore, the discord between patients' values and objectives and those of anesthesia clinicians when making decisions about perianesthesia DNR orders presents a significant problem for patients and anesthesia clinicians (Waisel et al., 2003). This problem creates tension, subverts patient autonomy, self-efficacy, and human dignity while forcing deference to the biomedical hegemony. Furthermore, Margolis et al. reported in 1995 that 15 % of patients presenting for surgery had a DNR order. Current researchers often cite Margolis' prevalence rate as a baseline in the literature. However, the prevalence is likely higher today given the requirements of the Patient Self Determination Act (PSDA, 1990) that hospitals offer resources for completing advanced directives alongside an aging population in the United States (US). Today, approximately 37 % of people in the US have an advance directive (Yadav et al., 2017). Advanced directives and DNR orders do not preclude the possibility that patients may seek surgical intervention requiring anesthesia, however. For example, someone with a DNR order may seek surgery to repair a hip fracture for pain relief, or a patient with nonsurvivable cancer might want a percutaneous feeding tube to prolong the time available with their families. These patients have myriad reasons for seeking anesthesia care (Scott & Gavrin, 2012). Patients' reasons only become problematic within a construct that positions limiting care directives as barriers to safe care and values clinicians' objectives above patients' goals.

The prevalence and threat of this problem mean that the intransigence displayed by perianesthesia clinicians addressing perianesthesia DNR orders is of immediate concern. When DNR orders are automatically revoked or rescinded, even in a de facto fashion, patients' autonomy and human dignity are threatened. Winland-Brown et al. (2015) observe that the first

four provisions of the *Code of Ethics for Nurses with Interpretive Statements* focus on respect for human dignity, the importance of respecting the nurse-client relationship, and the significance of the patient's right to self-determination. The American Nurses Association (ANA) reaffirmed this position in 2017 by urging nurses to affirmatively ally with marginalized and oppressed populations to dismantle health inequities, a position many scholars view as central to nursing's core values (Weitzel et al., 2020). For example, deconstructing and challenging forms of knowledge production that perpetuate inequity and social injustice while elevating social consciousness are framed as ethical responsibilities for nurses in *The Nursing Manifesto* (Kagan et al., 2009). Furthermore, this inquiry aligns with the National Institute of Nursing Research's (NINR) emphasis on end-of-life planning and decision-making for palliative care (NINR, 2020). Thus, the significance of the problem to nursing and healthcare is manifest.

Realizing that a clinical problem exists that threatens patient self-efficacy, autonomy, and dignity is critical. Perianesthesia clinicians are inculcated through education and trained in practice to accept rejecting directives limiting care during surgery and anesthesia as common sense. Consequently, alternate constructions of how best to support patient choices before anesthesia are framed as disruptive or even unsafe. Chapter Two expands on the historical context undergirding those assertions. Before exploring the literature in greater depth, however, this inquiry's theoretical and reflexive positioning must be presented. Next, Foucault, Georges (2013) MRT of emancipatory compassion, and key terms are discussed in preparation for a more detailed explanation in Part 2 of this Introduction.

Constructing Inquiry

Foucault

Michel Foucault was born in 1926. French by birth, Foucault's brilliance placed him on an accelerated academic trajectory. However, his formative years, like most poststructuralists, were strongly influenced by World War Two's events. (Gutting, 2005). By 1969, Foucault was appointed Professor of the History of Systems of Thought at Collège de France. There, in 1970, Foucault presented the inaugural lecture, "The Order of Discourse." The lecture maps Foucault's professional and scholarly interests, but it also delineates the exclusionary force of truth and how truth is constructed through discourse. Moreover, Foucault explicates the nature of power and his method of analyzing phenomena in relation to power. Foucault states of genealogical discourse analysis,

> The genealogical portion . . . applies to the series where discourse is effectively formed: it tries to grasp it in its powers of affirmation, by which I mean not so much a power which would be opposed to that of denying, but rather the power to constitute domains of objects, in respect of which one can confirm or deny true or false propositions. (Foucault, 1981, p. 73)

Here, the genesis of genealogical discourse analysis—Foucault's method of analyzing discourse that would somewhat eclipse his earlier archaeological approach—is evident. Although Foucault retained his professorship at Collège de France until he died in 1984, he accepted visiting professorships and appointments at numerous international universities, notably the University of California, Berkeley. At the time of his death from Acquired Immune Deficiency Syndrome (AIDS), Foucault's lectures on sexual ethics and technologies of the self were seen as extremely influential in the US.

Foucault's works and philosophy provide the overarching framework that will guide this inquiry. Foucauldian thought affords a unique perspective on oppression, marginalization, and the nature of power. Foucault was a prolific philosopher opining on topics ranging from government to sexuality, but his works also intersected with the disciplines of psychology and sociology. Perhaps his most significant contribution as a philosopher is centralizing the importance of historical context to philosophical examination (Hall, 2001). In nursing, Gustaldo and Holmes (1999) surprisingly found that Foucault's works on criminality and sexuality—*Discipline and Punish* and *The History of Sexuality volume 1*— were most cited by scholars. However, in relation to health care, Foucault is perhaps best known for his work, *The Birth of the Clinic: An Archaeology of Medical Perception*. In *Birth of the Clinic* (Foucault, 1994), Foucault identifies, broadly, the nineteenth century as a turning point for medicine as clinicians adopted a systematic and humanistic approach to medical care. Foucault strongly criticized this turn and proposes the existence of a "doctor's gaze" that objectifies patients not as holistic beings but as conglomerations of systems (Foucault, 1994, p. 91).

Crucially, inquiry conducted within a Foucauldian framework stresses the importance of emancipation from existing oppressive power structures created and sustained through discourse. Foucault provides a way to understand power, emancipation, and how human social relationships and institutions promulgate hegemonic oppression. For Foucault, power is intricately bound to knowledge; the two concepts are inextricable. Moreover, power is fluid and exists within and between social relationships. In Foucauldian thought, power is exercised by enforcing truths through often subliminal social cues or governmental rules that are both written and tacitly accepted. Noncompliance with the status quo results in discipline. For Foucault, emancipation requires a conscious awareness of the dominant discourses and how they affect

actions. Changing the status quo—internally and externally—is an essential part of emancipation. Fortunately, because power and knowledge are intertwined, change can occur through seemingly quotidian, often small or routine, actions.

According to Foucault, oppressive structures and liberating truths are transmitted and reproduced through discourses (McCabe & Holmes, 2009). Discourses are statements that produce social objects (Wetherell, 1998). However, this simple definition of discourse belies the concept's complexity. Part 2 of this Introduction will examine discourse at length. At this juncture, acknowledging the centrality of language and texts to discourse and that discourse is productive (i.e., has real-world material consequence) will set the stage for Part 2. Finally, for Foucault, knowledge is historically mediated and uncovered by mining historical texts for genealogical connections to why things are the way they are in the present. In his book, *The Archaeology of Knowledge and the Discourse on Language* (Foucault, 1972), Foucault elaborates on his epistemological perspective and method of analysis presented in "The Order of Discourse."

Methodologically, Foucauldian inquiry is most closely associated with historical or genealogical Discourse Analysis (DA), although poststructuralism broadly and Foucault particularly is skeptical of prescribed methodology. However, Foucauldian frameworks are appropriate for other poststructural methodologies and postmodern approaches to inquiry (e.g., ethnography, narrative inquiry). For example, although Foucault is particularly critical of ethnographic methodology, Holmes (2012) used a Foucauldian framework to explore the hegemonic impact of biomedicine's approach to culturally competent care for migrant Mexican farm workers.

Mid-Range Theory of Emancipatory Compassion for Nursing

Foucault provides an overarching structure or framework for identifying bioethical discourses on perianesthesia DNR orders and synthesizing the extant literature on the problem. However, a discipline-specific lens that grounds the problem in praxis is critical to make findings usable for clinicians. This is especially true for practice-based disciplines like nursing or medicine. The emancipatory theory of compassion for nursing (Georges, 2013) bridges the distance between the decidedly nebulous philosophical Foucauldian poststructural worldview and the concrete realm of clinical practice.

Theorist and nursing scholar Jane Georges is a dean and professor at the Hahn School of Nursing and Health Science at the University of San Diego (University of San Diego, 2020). During the early part of the 21st century, Georges' principal scholarly endeavor was the exploration of suffering as a concept. Between 2002 and 2013, Georges embarked on the scholarly study of suffering, power, and the implications of these concepts for nursing as a science and discipline. During this period, Georges recognized the importance of power in relation to race, ethnicity, class, gender, and sexuality. Notably, the nucleus of the Mid-Range Theory (MRT) of emancipatory compassion for nursing crystallized when Georges undertook a discursive analysis of narratives collected from nurses active in Nazi Germany during the rise and fall of the Third Reich. Her article titled “Nurses in the Nazi Euthanasia Program: A Critical Feminist Analysis” (Benedict & Georges, 2009) provided a model case for Georges’ (2013) article outlining the MRT of emancipatory compassion for nursing. Georges proposes that a) nurses function in political spaces regardless of whether they know it or wish to function in those spaces, and b) critical attributes of biopower (i.e., free-floating responsibility, distancing, and the zoe-bios dichotomy) “. . . render the promotion of suffering by nurses in biopolitical spaces

possible" (Georges, 2013, p. 6). Furthermore, Georges' theory positions compassion as central to nursing and suffering as compassion's antithesis. Georges notes, "compassion is the essential element of nursing . . . persons in the biopolitical space in which nurses practice are at enhanced risk for increased suffering when power relations render compassion impossible" (p. 8). Part 2 of this Introduction discusses each of the critical attributes of biopower along with the MRT's key assumptions and concepts in greater detail. Table 1 summarizes the MRT of emancipatory compassion for nursing.

Table 1

Georges' (2013) Emancipatory Theory of Compassion for Nursing

Paradigmatic Origins	Underlying Assumptions	Major Concepts	Propositions and Conjectures
• Constructivist • Emerging; post-humanist	• Nurses function within biopolitical spaces. • Compassion is fundamental to praxis. • Power relations are fundamental to compassion. • Power relations exist in relation to socially constructed	• Suffering • Compassion • Biopower[a] • The unspeakable • Biotoxic space • Biocompassionate space • Emancipatory practice	• Suffering and biopower are inseparably bound to the existence of compassion. • Nursing cannot exist in biotoxic spaces. • Free-floating responsibility, distance, and the zoe/bios dichotomy are elemental to negative biopower and creating biotoxic spaces. • Nurses can increase compassion by justly sharing power and speaking the unspeakable; these

	statuses and differences.	interventions also decrease suffering. • Nursing cannot exist in biotoxic spaces, but nurses may knowingly or unknowingly sustain biotoxic spaces. • Compassion is the antithesis of suffering. • Decreased suffering and increased compassion will improve patient outcomes.

[a] Georges' concept of biopower is influenced by Agamben (1998). Agamben generally constructs biopower as a negative. Conversely, Foucault tends to view biopower as a positive technology for change. This Table focuses on the MRT's terminology. Georges' (2013) MRT conceptualizes biopower as a negative differential that creates biotoxic spaces where unethical behavior may be tolerated. Part 2 addresses this confusing double-meaning in greater detail.

In summary, this inquiry will use a Foucauldian poststructural framework anchored to praxis by Georges' MRT of emancipatory compassion for nursing (Georges, 2013). Foucault offers a novel way of conceptualizing the problem of patient-clinician discord when managing perianesthesia DNR orders. Whereas most conventional forms of qualitative inquiry in nursing are devoted to studying participants' lived experiences, Foucauldian poststructuralism seeks to deconstruct how power and discourse coalesce to construct truth. Thus, Foucauldian inquiry is less concerned with participants' inner-selves and personal experiences—their subjectivities—but more concerned with how the discourses people create and use become dominant, shape reality, and influence others. Within a Foucauldian framework, discourse produces patterns of

truth observable in local systems or discursive formations (e.g., medicine or mental illness). If that discursive formation is authoritative, over time, it may become an epistemic regime or episteme. An epistemic regime is more dominant, sustained longer, and broadly more historically influential. Georges' (2013) MRT provides a mechanism for making findings constructed using a Foucauldian framework usable in practice. However, like the Foucauldian lexicon, Georges' terminology may be confusing. Table 2 provides a glossary of key terms associated with Foucault and Georges.

Table 2

Glossary of Key Terms Used in this Inquiry

Term	Definition
Apparatus (see also Technologies)	Institutions that use power-knowledge to control people or normalize society.
Biocompassionate Space	A political space where power relations are equitable and just, thus, fostering compassion.
Biopower (see also Technologies)	For Foucault, biopower is a technology used to control, subjectify, or oppress groups (e.g., Foucauldian governmentality). It has negative and positive potentials because biopower can be used, for example, to control *or* liberate. For Agamben (1998), biopower is positioned as a constraining, weighty, and negative force. This dissertation uses Foucault's conceptualization unless the concept is specifically designated *negative* biopower.
Biotoxic Space	A political space where unjust power relations have made compassion almost impossible.
Constitutive Power	Power that acts and circulates within and between social relationships—everyone is both oppressor and oppressed to greater or lesser extents. Unlike hierarchal power, constitutive power is multi-nodal and often exerted through networks. Constitutive power is not necessarily restrictive. Instead, it is productive; it

	creates knowledge and discourse. In other words, constitutive power is a productive network weaving through a society, culture, or system.
Episteme (or épistémè; see also Regime of Truth)	A commanding discourse that characterizes the state of knowledge at any given time in a culture or society. An episteme may marginalize less authoritative discourses. Thus, epistemes have the ultimate attribute of incommensurability.
Discourse	Statements that create social objects.
Discursive Formation	A sustained, authoritative pattern of discursive coalescence about a social object. For example, medicine or mental illness.
Power-Knowledge (Pouvoir-Savoir)	Knowledge is a form of power, but power determines how and when knowledge is applied. Thus, knowledge and power are linked and act recursively in the real-world. For example, knowledge is authoritative and, therefore, has the power to will the truth into being. Consequently, knowledge constructs a truth that reinforces the authority and power of the knowledge that created it.
Regime of Truth	In each culture or society—at a given time—the dominant discourse that constructs the accepted truth. As the term implies, the regime may actively constrain or marginalize less authoritative discourses.
Subjectivities (see also Subject Position)	Individual opinions, perspectives, ideas, and particulars about the world that are shaped and interact with the dominant regime of truth but may also differ from the regime.
Subject Position	For Foucault, the individual person is subjective to discourse. Put another way: "It is discourse, not the subjects who speak it, which produces knowledge. . . . the "subject" is *produced* within *discourse*" (Hall, 2001, p.79).
Technologies	Techniques used by a) institutions to regulate and control, b) people to construct self-understanding, or c)

	people to control or influence others (e.g., technologies of production, sign systems, power, or self).
The Unspeakable	A powerful *will to silence* discourse on the right and good in clinical situations. The unspeakable is a critical attribute of negative biopower that allows for the creation of biotoxic spaces.

Synthesizing the Literature and Justifying Inquiry

Chapter Two of this dissertation approaches the extant literature from a historical perspective. Hall (2001) observes,

> Foucault did not believe that the same phenomena would be found across historical periods. He thought that, in each period, discourse produced forms of knowledge, objects, subjects and practices of knowledge, which differed radically from period to period, with no necessary continuity between them. (p. 74)

Thus, an inquiry conducted using a Foucauldian framework demands historical context. A classic Foucauldian historical genealogy investigating DNR orders in the perianesthesia setting may well be an admirable scholarly pursuit. In Chapter Two, however, a simplified genealogical approach is used to historically position and justify the need for the inquiry. For example, how Cardiopulmonary Resuscitation (CPR) originated and developed in the perianesthesia setting undergirds contemporary discourses constructing patients' and clinicians' choices about their DNR orders before, during, and immediately following surgery. These historical influences continue to shape understanding of directives limiting care today; therefore, illuminating them is essential to inquiry. Indeed, so dominant is the regime of truth surrounding perianesthesia DNR orders that even older artifacts from the extant literature remain salient representations of current discourse. Chapter Two analyzes the historical and cultural forces evident in the extant literature

on perianesthesia DNR orders. From this analysis, the literature is synthesized using Foucault and George (2013) as fulcrums. The result of this synthesis are five research questions that will guide the proposed inquiry.

Research Questions

Guided by the nature of the phenomenon as conceptualized within a Foucauldian framework and the MRT of emancipatory compassion for nursing (Georges, 2013), the following research questions will guide the inquiry:

1. What hidden discourses dominate how patients make decisions about the disposition of their DNR orders or other directives limiting care during the perianesthesia period?
2. How do perianesthesia clinicians talk with patients about DNR orders or other directives limiting care?
3. How do perianesthesia patients talk about DNR orders and express their rationales and motivations for rescinding, modifying, or retaining the orders during anesthesia?
4. How do these discourses relate to power and knowledge in the perianesthesia setting?

Finally, the importance of generating usable clinical evidence that improves Georges' (2013) MRT of emancipatory compassion for nursing justifies a fifth research question.

5. Does the triumvirate of zoe/bios dichotomy, distance, and free-floating responsibility contribute to sustaining a perianesthesia climate that permits the unethical behavior of automatic or defacto DNR revocation?

Unlike research conducted using conventional qualitative research methods, poststructural inquiry appreciates that research questions are not stagnant. Research questions evolve in response to concurrent analysis in the field and participants' narrative will (Cloyes, 2010). Although these questions—like Georges' (2013) theory—are presented a priori, questions

and theories are uncertain and interactive in the poststructural context. As a poststructural inquirist, I am aware of the potential ethical dangers of a priori research questions. Such questions have the power to shape reality and reinforce existing regimes of truth. Nordstrom (2015) notes, “Theory operates in the middle, not before or after” (p.178). Therefore, the preceding questions and theory are best thought of as *a praesenti*—a communication between the participants and researcher that functions throughout the inquiry.

Methods

Unlike a traditional format that uses a three-chapter proposal as a prelude to a five-chapter dissertation, this dissertation substitutes a manuscript for chapter three that explores this study's methods. The dissertation also includes two manuscripts for chapter four that report the study results. A preface introduces each manuscript. The prefaces situates the manuscripts within the larger dissertation and provide readers with the information needed to evaluate the manuscripts. Notably, Chapter Three includes both a Preface and an Afterword. The Preface briefly introduces the methods manuscript, “Poststructural Inquiry using Case Study Design: Toward Fourth Moment Qualitative Methods in Nursing.” The Chapter Three Afterword expounds upon site selection, sample, and other particulars for this inquiry. Read together, the Chapter Three Preface, Manuscript, and Afterword comprise the methods for this inquiry. The remainder of this Introduction summarizes what readers may expect to encounter in the subsequent chapters and manuscripts.

Design

Although the problem addressed in the inquiry arose from personal experience in clinical practice, two articles were especially influential in developing the inquiry's framework and design. First, Holmes' (2012) use of Foucault to frame an investigation into migrant Mexican

Farmworkers' health, "The Clinical Gaze in the Practice of Migrant Health: Mexican Migrants in the United States," was formative. Holmes' work should be credited with the theoretical spark that illuminated a new way to study the intransigent problem of perianesthesia DNR orders. Second, Boles' (2016) dissertation "Deconstructing the Diagnosis: Making the Case for a New Discourse on Childhood Cancer" should be credited with triggering the insight that meaning is created through discourse. Further, that insight led directly to the realization that many of the gaps in knowledge identified by Hardin and Forshier (2019) and delineated in Chapter Two were addressable only through poststructural qualitative inquiry. Moreover, Boles crystallized the revelation that the selected qualitative approach needed to address power in ways that minimized the risk of reproducing unethical discourse.

Holmes (2012) used ethnographic methods while Boles (2016) selected a case study design. Boles concludes, that—given the paradigmatic and philosophical ideas underlying Foucauldian poststructuralism—ethnography and case study designs were the best choices for Foucauldian poststructural inquiry. Interestingly, independent of Boles' conclusion, this disseration arrived at the same impasse: ethnography or case study? While both methods are usable, ethnography sits uneasily alongside Foucauldian poststructuralism. Foucault was critical of ethnography's ties to colonialism and exploitation; moreover, Foucault positions the person as subject to discourse. Boles, conversely, argues, "Foucauldian post-structuralism's . . . insistence on the study of contexts, power relations, and momentary, fleeting truths can be grafted onto Stake's . . . case study methodology with some invocation of imagination" (p. 108). It may well be argued that Boles' grafting of Foucauldian poststructuralism onto Stake's (1995; 2005) case study design created a novel offshoot—Stakes-Boles case study design.

Stake (2005) notes. "Case study is not a methodological choice but a choice of what is to be studied. . .case study is defined by interest in an individual case, not by the methods of inquiry used" (p. 443). For Stake, the "case" need not be a person, nor must it be an individual thing. The case, however, must be a unique, delimited system or phenomenon. The case may be one thing or a group of things. The purpose of the case study may be to better understand a particular person, phenomenon, or system (i.e., intrinsic case study), or it may seek to provide a scaffold so that clinicians and scientists can better understand similar cases when they are encountered (i.e., instrumental case study). Collective case study groups similar cases together. Nevertheless, whether the approach is intrinsic, instrumental, or collective, the object of study is the *case*. For example, Boles (2016) did not study the individual child with cancer, although such a case study is appropriate. Instead, Boles investigated how the child "negotiated discourse within the hospital to construct an understanding of their diagnosis and treatment" (p. 109). The case was not the child, but how the participant children negotiated the dominant discourses on pediatric cancer. In this inquiry, the case is how one perianesthesia department accommodates, constructs, and reproduces the dominant discourse on perianesthesia directives limiting care. Chapter Three explains the details of what constitutes a perianesthesia department, site selection, sampling, and data collection using an instrumental Stake-Boles case study design.

However, Stake's (1995; 2005) case study design relies on conventional qualitative data analysis techniques. A Boles-Stakes case study demands methods of analysis that comport with Foucauldian poststructuralism—Boles (2016) uses contextualizing analysis. Contextualizing analysis is discussed in the Chapter Three Manuscript, but Boles' method lacks clarity about how contextualizing analysis links to Foucault's approach to analyzing discourses. Carabine (2001) submits a Foucauldian process for identifying discourses through the analysis of discursive data.

Carabine's process represents another layer of personal understanding more than a significant adaptation to Boles' method of contextualizing analysis. The amalgamation of Carabine's process into Boles' contextualizing analytic results in a more discourse forward method than the one Boles used with little change to Boles' underlying approach. Instead, Carabine's influence is evident during contextual coding as the analyst looks specifically for patterns of discourse, absences or silence, inter-relationships between discourses, and socio-historic context. The next section summarizes Carabine's approach. Stake-Boles case study design, contextualizing analysis, and its implication for the discipline of nursing are discussed in Chapter Three.

Methodology

Discourse Analysis (DA) is not one unified methodology. Wetherell et al. (2001a) explain that multiple analytic traditions characterize DA. The centrality of language binds together these disparate traditions, but they often differ dramatically in theory and approach. A comprehensive survey of the differences between these traditions (e.g., Bakhtinian versus Discursive Psychology) is beyond this introduction's scope. More importantly, such a survey is unnecessary to understand this inquiry's methodological approach. Wetherell et al. (2001a; 2001b) provide expansive reviews of these disparate DA traditions for interested readers.

What is critical is understanding that as more disciplines adopted DA as a method of inquiry, three broad domains developed. The domains of DA are the studies of a) social interaction, b) how people make sense of themselves, and c) social relations and culture (Wetherell, 2001a). The first domain, social interaction, is of particular interest to sociolinguists and is typified by micro-level conversation analysis. The second domain, making sense, is important to certain psychological and social science disciplines. While conversation analysis is sometimes employed to investigate this domain, macro-level DA is more often used. The sense-

making domain, thus, sustains overlapping micro and macro analytic approaches. The final domain—social relations and culture—relies on macro-level DA for inquiry and analysis. This domain is often associated with Foucault. Therefore, macro-level DA focuses on social relations—particularly as it relates to power—and broader cultural constructs. For example, Shaw and Greenhalgh (2008) analyzed how historical and political discourses shaped the social research policy in the United Kingdom.

This inquiry will *not* be a micro-level conversation analysis, nor is it about linguistic analysis, per se. Rather, as previously noted, discourse refers to statements that construct social objects (Shaw and Greenhalgh, 2008). Foucauldian DA urges investigators to think, not in terms of micro-level linguistics (e.g., turn-taking, footing), but in terms of discourse. Discourse is enmeshed with power-knowledge; thus, discourse in Foucauldian DA is intertwined with historical context and culture. Foucauldian DA's goal is to identify discourses embedded in discursive data and deconstruct the intertwined discourses, thus, rendering them visible and analyzable in relation to power-knowledge.

Carabine (2001) submits a guide for applying Foucauldian DA. While Carabine used Foucauldian genealogical analysis to investigate sexuality discourses on social policies for the poor or underprivileged, Carabine's approach can be applied to "read" other discourses. Carabine notes,

> Because Foucault did not provide us with a “how to” guide to genealogy, the method adopted by individual researchers varies. What is common to all, however, is the application of Foucault’s concepts of discourse/power/knowledge and therefore the lens through which they read their data. (p. 268)

Moreover, unlike other discourse analysts (e.g., Parker, 2015) who contend that DA only provides information about the past, Carabine argues that DA can have contemporary relevance. Although Foucault's approach is historical, Carabine contends that it provides a "snapshot" of contemporaneous events that will tell discourse analysts something about discourse, power, and knowledge today. Table 3 summarizes Carabine's guide to Foucauldian DA. Chapter Three expands upon this process with a methodology—contextualizing analysis—that is amenable to nursing inquiry and meshes well with Carabine's process for reading discourses.

Readers should not interpret Carabine's (2001) guide as a concrete methodology. The "steps" are iterative and recursive. In other words, the steps may occur in different order or overlap. An overly prescriptive methodology is inappropriate for inquiry within a Foucauldian framework as the risk of reproducing existing discourses through such a method is too high. Ultimately, it is perhaps better to think of Carabine's process not as a systematic methodology but as a transparent way of identifying discourses and making meaning in a cultural-historic context. Notably, Carabine's process for reading discourses inspired the analysis of the extant literature presented in Chapter Two and strongly influences my interpretation of contextualizing analysis discussed in greater detail in Chapter Three.

Table 3

Process for Foucauldian Discourse Analysis as Proposed by Carabine (2001)

- Identify Topic
- Know the Data
- Code for themes, categories, and objects
- Look for inter-relationships between discourse
- Identify discursive strategies and techniques
- Look for the unspoken in absences and silences
- Look for resistances and counter-discourses
- Outline the issue's background and contextualize the data in relation to power-knowledge

- Interrogate the data vis-à-vis the discursive regime dominant at that point-in-time
- Disclose the limitation of the research and data with humility

Thus, this inquiry is an embedded, instrumental Stake-Boles case study. Forty-five participants who are relevant stakeholders at a large, midwestern tertiary care hospital's perianesthesia departments participated in this inquiry. Relevant stakeholders include patients, family members, representatives, and clinicians who function as discursive actors in the case. Data were collected through observation, interviews, and the retrieval of artifacts. Contextualizing discourse analysis constructed the discourses, discursive strategies, and ethical terrain that these stakeholders must negotiate when making choices about directives limiting care during anesthesia. Chapter Three discusses the constituent components of the inquiry in detail.

Conclusion

Part 1 of this Introduction identified the problem under investigation as the discord between patients and clinicians when making decisions about DNR orders and other directives limiting care in the perianesthesia setting. Subsequent chapters expand and lend insight and support for these introductory assertions. For example, Chapter Two synthesizes the extant literature to identify gaps in knowledge that support the research questions and justify the inquiry. Based on this problem, the purpose of the proposed inquiry was to investigate how bioethical discourses construct choices available to perianesthesia patients, families, and clinicians. In pursuit of this purpose, Part 1 presented the reader with an integrative road map to this dissertation. Part 2 of the Introduction expanded upon the summary of Foucauldian poststructuralism and Georges' MRT of emancipatory compassion for nursing presented in Part 1. In addition, Part 2 delineated the inquiry's emancipatory aims. Chapter Two positions the inquiry historically and identifies gaps in understanding that justify inquiry. Chapter Two also

demonstrates how the research questions were synthesized from a Foucauldian reading of the extant literature. Finally, this Introduction foreshadowed the case study design and methodology presented in Chapter Three. Chapter Three, traditionally detailing methods, is presented as a Preface followed by a Manuscript and Afterword focused on case study design and Contextualizing Analysis. In summary, this Chapter's goal was to give readers an overall sense and understanding of the inquiry. Next, in the Introduction, Part 2, Foucauldian poststructuralism is examined in greater detail, and the inquiry is positioned paradigmatically, theoretically, and reflexively.

Chapter One – Part 2

Framework and Theory

Part 1 of this Introduction presented the purpose, significance, and research questions for the inquiry. Further, Part 1 introduced Foucault as an overarching framework and Georges' (2013) emancipatory theory of compassion for nursing in broad strokes. Part 2 delves into the philosophical framework and reflexive positions that underpin the inquiry. Part 2 sets the stage for the remaining chapters, but it also begins the critical task of establishing qualitative rigor, trustworthiness, and transferability—key components of qualitative evaluation discussed in Chapter Three.

For inquirists who purport to use Foucauldian postructuralism and engage in discourse analysis, the importance of theoretical and reflexive positioning is heightened. Foucault and, to some extent, Georges' (2013) Mid-Range Theory (MRT) represent a philosophy and theory with radical implications for nursing as a discipline. Whereas nursing has traditionally embraced humanism and phenomenological representation, Foucault suggests a fundamentally different ontology and approach to inquiry. Crowe (2005) observes,

> [Foucauldian Poststructuralism] places the social and historical context, rather than either the researcher's hypotheses or the individual's experience, as central to the inquiry process. It takes a theoretical position that subjectivity and experience are constructed by language and are, therefore, discursively constituted. (p. 56)

Foucauldian philosophy, moreover, challenges nursing's knowledge claims by revealing how, for example, nursing knowledge allows nurses to exercise control over patients. Simultaneously, Foucauldian inquiry exposes new avenues for knowledge development that allow for emancipatory transformation. Clinton and Springer (2015) observe, "When inquiring into

nursing knowledge, [Foucauldian Discourse Analysis] makes it possible to see that an order exists outside the customary boundaries of what nursing knowledge is taken to be . . .” (p. 88). Foucauldian poststructuralism challenges phenomenological certitude and existing onto-epistemological norms for nursing inquiry. In addition, Foucauldian poststructural inquiry is emancipatory because it positions both nurses and patients as political actors. Foucauldian inquiry can, resultantly, illuminate entrenched prejudices, the disciplinary effects of nursing care, and tacitly accepted power relations. Dismantling these traditional onto-epistemological regimes potentiates transformative and emancipatory practices. Thus, Foucauldian poststructuralism is both subversive and transformative; it is deconstructive and constructive. Because of Foucauldian poststructuralism's novel and disruptive nature, simply stating definitions for confusing terms, as was provided in Part 1 of this Introduction, is essential but insufficient (Campbell & Arnold, 2004). A clearly articulated vision of the complexities of Foucauldian poststructuralism and Georges' MRT, as well as the ramifications for nursing inquiry, are vital.

Part 2 of this Introduction examines Foucauldian poststructuralism's development and identifies the attributes distinguishing Foucauldian philosophy from other poststructuralists. Potentially confusing concepts, for instance, discourse, are examined closely. Critically, this inquiry aligns with Foucault’s positions on discourse, truth, knowledge, and power. Some terms and ideas often associated with poststructural and discourse traditions other than Foucault are occasionally employed, however. This tactic aligns with Denzin and Lincoln’s (2018) observation that contemporary qualitative inquiry often demands a pragmatic, bricoleur design approach. Wetherell (2001b) and Campbell and Arnold (2004) caution that muddling different poststructural positions can confuse readers and expose the writer’s poor grasp of poststructural concepts. Therefore, every effort is made to identify when incommensurate or potentially

misleading ideas are introduced. For example, Potter and Wetherell's (1987) concept of the interpretive repertoire—later discussed in greater detail—is not a Foucauldian idea. The interpretive repertoire concept, nevertheless, lends insight into discursive formation. Furthermore, refraining from using helpful terms because they may be confusing or expose personal ineptitude seems counterproductive. Instead, every effort will be made to identify when divergent epistemological positions or traditions are appropriated for the Foucauldian inquiry here proposed.

The discussion on Foucauldian poststructuralism culminates with the enumeration of the inquiry's aims. Next, the inquiry is positioned relative to constructivism and my reflexive assumptions. This section will provide an overview of the constructivist paradigm alongside personal reflexive positions. Then, Georges' (2013) MRT of emancipatory compassion for nursing is examined and applied to the problem of perianesthesia patients with directives limiting care. Crucially, however, investigating the problem—especially from a strong theoretical position—risks replicating and perpetuating existing regimes of truth that may marginalize patients and silence dissent. From an ethical standpoint, cognizance of the productive nature of discourse and how discourse creates marginalization and oppressive truths is vital. Therefore, expanding upon the complicated theoretical and reflexive assumptions underlying the inquiry is essential to understanding and justifying its purpose.

Foucauldian Poststructuralism

Qualitative inquiry in nursing is often conducted using implicit assumptions about the nature of reality. Notably, humanism is so profoundly associated with nursing as a discipline that humanistic assumptions are often unspoken or taken as either axiomatic or common-sense (Nairn, 2019; Roy & Andrews, 1991). St. Pierre (2011) observes that, at the most basic level,

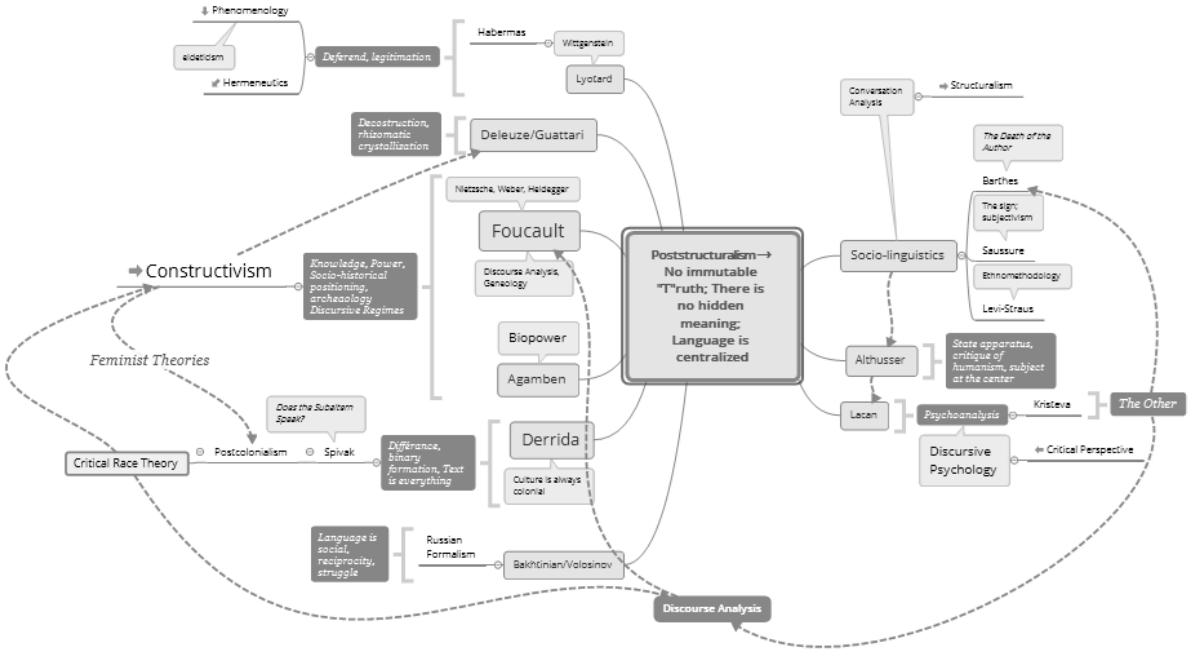
humanism asserts a singular, knowable truth. Nursing qualitative inquiry reflects humanistic assumptions. Denzin and Lincoln (2018), furthermore, observe that most contemporary qualitative research is positioned in a “third methodological moment” (p. 6). Broadly, the term *third moment* refers to two formations of qualitative research—mixed-methods research or interpretivism. For example, Benner's collective works exemplify phenomenologically framed third moment research in nursing. Phenomenologists use ideas like the hermeneutic circle and double hermeneutic interpretation that are consistent with Heideggerian philosophy to interpret data. Research conducted within a third-moment paradigm, like interpretive phenomenology, seeks to understand participants' "lived experience" while acknowledging the importance of the researcher's values, ideas, and judgments to knowledge creation. Both humanism and third moment qualitative research are open to poststructural and postmodern critiques over the transparency and representativeness of language and the assumption that it is possible to know another person's lived experience. Scholars have also raised concerns that interpretive hermeneutic analysis might contribute to the reproduction of oppressive regimes of truth (St. Pierre, 2011). However, a fourth moment, what poststructural scholar Lather (2013) terms QUAL 4.0, is evolving.

Poststructuralism is generally located in the constructivist, interpretive paradigm, although some poststructural investigators remain enchanted by modern empiricism (Belsey, 2002; Wetherell, 2001a). Wetherell (2001a) observes that poststructuralism traverses many disciplines and encompasses multiple traditions. However, poststructuralism is not a cohesive theory. The origins of poststructuralism can be traced to a series of scholarly works, mostly by French writers, in the mid-to-late-twentieth century. St. Pierre (2013) outlines the contributions of writers and philosophers to poststructuralism, for example, Derrida, Deleuze and Guattari,

Lacan, and Lyotard. Additionally, Barthes and Saussure should be recognized for their early contributions to poststructural thinking. Figure 1 displays the notable contributions of these scholars in the context of poststructuralism. Critically, Foucault aligns well philosophically with constructivism. Unlike more empirically grounded traditions for discourse analysis (e.g., conversation analysis) that veer toward positivism, Foucauldian poststructuralism deals mainly with macro-level themes constructed in socio-historic context.

Figure 1

Conceptual Map Depicting the Landscape of Poststructural Philosophy



Note. Do not denote hierarchal order or temporal location from the relational lines connecting concepts. Instead, those symbols are representative of fluid interconnectedness. Poststructuralism should be understood as the center of the map. Discreet arrows (e.g., ←↑→↓) represent the movement of concepts toward or away from the center (i.e., toward positivism, away from postructuralism, or neutral).

Poststructuralism, however, is also the rejection of the linear, normative ontology of logical positivism typifying structuralism. Structuralists believed in linear knowledge

development and naïve empiricism. For structuralists, science was about defining the observable world and the quest for universal truth (Belsey, 2002; Rodgers, 2005). In the structuralist approach to research, systematicity, detachment, and control enhance validity. In addition, structuralism is the progenitor of systems theory. Systems theory posits that—even in a complex system—the whole may be understood by apprehending its constituent parts. Objectivism and positivistic assertions of reality strongly influenced the development of socio-linguistic theory (Belsey, 2002; Kress, 2001). Resultantly, early explorations of language and social formation suggested that language was a gateway to studying inner meaning (Belsey, 2002; Gutting, 2005). In other words, language was considered an accurate representation of reality. However, following the early 20th century's events, especially the atrocities of World War Two, scholars began questioning conventional assertions about how language represents reality. The poststructuralists argued that language is not simply a mirror reflecting people's inner selves—a realization with profound ontological and epistemological ramifications.

However, the modernist schism that culminated in poststructuralism started much earlier with linguists and semiologists such as Saussure and Barthes. Saussure, a linguistic structuralist, had already begun questioning the nature and transparency of language in the late 19th century. Before Saussure, a sign, for example, a word, was conceptualized as a stand-in for something that existed elsewhere in a universally understandable form. Saussure contributed the idea of the sign— a signifier-signified model of representation. Saussure argued that an object (e.g., words, gestures, and many other things) represents a socially constructed understanding of that object. The signifier (object) has no hidden, intrinsic connection to the signified (its meaning). Saussure's observations about language sparked a crisis of representation around the early 20th century. By 1967, Roland Barthes argued that texts should not be "pierced" in search of hidden

meaning. Instead, the text is the object of analysis. Barthes questioned the nature of objectivity and recognized the author's role in perpetuating dominance and oppression in their texts (Belsey, 2002; Kress, 2001). The "posts," as poststructuralists are sometimes referred to in the literature, would, by the 1970s, raise similar concerns about the way that language can marginalize and oppress people (St. Pierre, 2013; Wetherell, 2001b). Poststructuralists also observed—contrary to prevailing discourse at the time—that instead of meaning creating language (representation, positivism), language creates meaning (Wetherell, 2001a). Derrida (2016) explained the importance of difference and binary formations that problematizes Saussure's concept of the binary. For example, the use of binaries, such as good-bad, rich-poor, are often implicated in oppressive and marginalizing discourses (Cloyes 2010; Spivak, 1988). Humanistic certainty, according to the poststructuralists, thus contributed to eurocentrism and othering. While humanists and structuralists believed in immutable and generalizable truth, rationality, linearity, and stability, the posts embraced notions of fragmentation, relativism, and positionality (i.e., constructivism) (St. Pierre, 2013).

The commitment to not replacing one truth with another truth that is equally fleeting and relative makes presenting findings ethically challenging (Graham, 2011) and creates a dilemma for poststructural inquirists. The nomothetic style formats of many health care journals may exacerbate this obstacle, leading many poststructuralists to turn toward alternative ways of disseminating their work. For example, Berbary (2011) contends,

> Poststructural notions of language and Truth have ignited a crisis around claims of representation in qualitative research (Denzin & Lincoln, 2005). In particular, poststructuralism has forced the recognition that language does not name a prediscursive

> Truth, but rather through repetition, constructs the fiction of Truth within a specific discourse. (p. 186)

Here, Berbary critiques the representation of findings in qualitative inquiry. These representational concerns inspired Berbary to report findings in the form of a screenplay. Indeed, the presentation of this dissertation vis-à-vis a problem statement, purpose, research questions, and aims should not be interpreted as necessarily the best or only way to frame the experiences of perianesthesia patients making end-of-life choices. Instead, this format is but one, albeit useful, schema.

Language in the Poststructural Context

Foucault's contribution to the poststructural understanding of language is two-fold. First, and most prominently, Foucault positioned language as a socio-historic and culturally mediated concept. Second, Foucault suggested a fracture between the classical and modern understanding of representation. Reviewing the classical conception of language is beyond the scope of this dissertation. However, understanding the modern functions of language is critical.

According to Foucault, Kantian philosophy helped construct modern, humanistic ideas about the nature and function of language. Kant's transcendental subjectivism troubled Foucault. Foucault explained that transcendental idealism imposed arbitrary limits on human potential (Foucault, 1988). This critique, alongside modern notions of representation, partially inspired Foucault's archaeology of knowledge. Articulated succinctly and somewhat reductively: human self-knowledge is ruled by empirical knowledge that is limited by the transcendental ideal (empirico-transcendental doublet), but the ideal is ultimately unknowable (analytic of finitude and ever-elusive origin). Empirical knowledge is, thus, always incomplete and controlled by gatekeepers, for example, disciplines like biomedicine or institutional apparatuses. Humans seek

this knowledge (the cogito), but human thought, knowledge, and language are constrained by the relative episteme of truth and the historical-cultural frame of reference.

Thus, the foundations of Foucault's archeological inquiry are a) the empirico-transcendental doublet, b) the cogito, c) the analytic of finitude, and d) the ever-elusive origin (Clinton & Springer, 2017). Poststructural scholars in the discipline of nursing Clinton and Springer (2017) summarize, "Foucault shows how certain statements emerge to marginalize others according to historically conditioned rules. Such rules constitute the anonymous ensemble of relations that maintain and transform a system through which language rather than the subject speaks" (p. 5). In contrast with Kant, the importance of human agency and individual subjectivities are negated by Foucault's early work. Later, however, Foucault emphasized the transformative importance of the genealogical subject who uses critique and subjectivity to challenge dominant discursive regimes. Transformation, critique, and the genealogical subject are discussed later in this Chapter.

In summary, Foucault conceptualized language as ephemeral. Language is always changing. Therefore, language cannot be a direct representation of truth. Moreover, language *acts* upon others, often to exert power or control. People may be either aware or unaware of the language games they animate. Also, because language cannot adequately represent every thought, binaries (e.g., sick/well, man/woman) are created. According to Butler (2016), Derrida's works suggest that the limitations of language and construction of binaries and arbitrary categorization can be used to control and oppress. Thus, as language constructs reality, some people may lack the power to resist categorization or labeling (Hall, 2001). Crucially, the discursive construction of reality and oppressive power structures can occur linguistically or non-linguistically. Silence, for example, is a powerful discursive tool (Wetherell, 2001a).

Foucauldian scholars try to deconstruct language "to render strange usual or habitual ways of making sense, to locate these sense-making methods historically and to interrogate their relation to power" (Wetherell, 1998, p. 394). Language, for the posts—including Foucault—is about human activity: how humans are constituted as the subject of discourse and how humans act as instruments of power to create and disrupt regimes of truth. A deeper original meaning does not anchor language (Foucault, 1981; St. Pierre, 2013; Tamboukou. 1999). Finally, Nordstrom (2011) clarifies poststructural thinking on language:

> Language is no longer viewed as hierarchical with clear categories that determine meanings. Language is spatialized as it connects heterogeneous entities. Thought of this way, a spatialized, generative, and connective language is a patois of many discourses and other entities, such as objects, that muddle humanist conceptions of categorization and meaning. (p. 171)

Thus, Foucault is interested in language, not as a linguistic exercise, but as discourse.

Discourse

Conceptualizations of what constitutes discourse differ between various discourse analysis traditions (Wetherell et al., 2001a). However, establishing a common frame of reference that defines discourse is essential for any discourse analysis. This inquiry proceeds from the Foucauldian proposition that language manifests in discourse and that everything that is known or comprehended is constructed through discourses. Discourse, according to Wetherell (1998; 2001a), refers to statements that create social objects. These objects are often associated with material effects. Thus, one attribute of discourse is that they are productive (Carabine, 2001; Wetherell, 2001a). Construction of meaning, understanding, and knowledge occurs using these social objects. Furthermore, Carabine (2001) argues that discourse is how an issue or

phenomenon is “spoken of” (p. 268), not merely linguistically, but through text and practice. Therefore, discourse encompasses the gamut of representation—written, spoken, visual, gestural, and subliminal. Another attribute of discourses is that they are constitutive—they merge to create a specific version of reality that is perceived as truth and governs, often invisibly, human choices (Carabine, 2001).

Identifying discourses from text can be deceptively complicated and describing the nature of discourse is equally complex. Parker (2015), a scholar associated with Foucault, provides additional criteria useful for distinguishing discourses from throw-away statements, discreet themes, or mere utterances, but Parker’s construction of discourse stems from a critical discursive psychology tradition. The boundaries between critical and Foucauldian discourse traditions are evident even as those borders are somewhat blurred. For instance, Parker’s criteria bend toward therapeutic discourse analysis while this dissertation is about inquiry. Shaw and Greenhalgh (2008), nevertheless, used Parker’s criteria as a framework for exploring health policy in the United Kingdom while acknowledging Foucault’s influence on the analysis. Here, Parker’s criteria are delineated to clarify the recognizable attributes of discourses and set the stage for a more fulminant discussion of discourse within a Foucauldian poststructural framework. Also, Parker's criteria will serve as a useful touchstone when identifying discourses during data analysis. The usefulness of Parker’s criteria justifies their inclusion. Table 4 summarizes Parker’s criteria for identifying discourses.

Table 4

Parker's Criteria for Identifying Discourses

Criteria	Description
A Discourse is a Coherent Set of Meanings	The totality of linguistic and non-linguistic texts are statements of reality. Additionally, like statements can be grouped to form a coherent whole.
A Discourse is Realized in Texts	Texts are anything, or in some cases, the absence of a thing made conspicuous by its absence, that is given meaning or the veneer of meaning by human beings.
A Discourse Reflects on its Own Way of Speaking	Every discourse reflects upon itself, either expressly or implicitly, by referencing itself or other texts. Hidden and intuitive meanings can often be located in these reflections.
A Discourse Refers to Other Discourses	Discourses are contextual, and thought is bound to speech. Therefore, discourses are articulated using other discourses. In this way, it is also impossible to analyze discourses without using other discourses.
A Discourse is about Objects	Using language is about referencing objects. The objects may exist only in the discourse or in the discourse and reality.
A Discourse Contains Subjects	Subjects exist within a discourse and give expression. Subjects tell us who we are in relation to the discourse and delimit our responsibilities within discourses.
A Discourse is Historically Located	Discourses are temporally located and inextricably bound to their socio-historical location.

Parker (2015) also identifies three auxiliary criteria for identifying discourses. These criteria are a) discourses support institutions, b) discourses reproduce power relations, and c) discourses have ideological effects. Discourses are indissolubly linked to institutions, and institutions are perpetuated through discourses. This perpetuation extends beyond institutional memory and binds institutional discourses to their socio-cultural contexts. Furthermore, Parker explicitly notes that power and institutional discourse are inextricably coupled. Discourses,

therefore, reproduce power relationships. Finally, although discourses have ideological effects, meaning that discourses are politically influenced and have political consequences, all discourses are not ideological. Nairn (2019) clarifies the distinction between ideology and discourse:

> Discourses are situated knowledges and while they may be utilized to undermine predominant discourses, they are not replaceable by a more truthful one. Ideology seems to suggest that a prevailing view is a perspective that reflects the material interests of a particular social group. . . . (p. 1)

Thus, authoritative discourses are not necessarily supplanted by more truthful discourses, and discourses may exert influence independent of individual or group interests. Instead, truth is created through the discourse. Accepted or authoritative Truth, thus, is an evolving, conflictive dialectic between competing truths. Critiquing ideology may produce a more accurate vision of reality, but critiquing discourse has subversive and emancipatory effects.

Young (1981) acknowledges Foucault's take on the broad, pervasive, significance of discourse noting that knowledge is "willed into being" by discourse and that the "order of discourses" constructs the rules, categories, and systems that are self-sustaining and inextricably bound to power by selective inclusion and exclusion (p. 48). As a point of clarity, however, this dissertation adopts the description of discourse as statements, texts, representations, or silences—indeed the whole range of representations—that create social objects. Cheek (2004) eloquently summarizes the Foucauldian poststructural position on discourse noting,

> Discourses are the scaffolds of discursive frameworks, which order reality in a certain way. They both enable and constrain the production of knowledge in that they allow for certain ways of thinking about reality while excluding others. In this way, they determine who can speak, when, and with what authority; and, conversely, who cannot. (p. 1142)

Cheek makes clear that, within a Foucauldian poststructural framework, human beings are constituted as subjects by discourse; discourse constructs all that we think and how we act (Boles, 2016). The focus on discourses to the exclusion of all else is, arguably, the main scholarly criticism of Foucault's work (Hall, 2001), but it is difficult to deny the significance of discourse within a constructivist paradigm.

Thus, discourse permeates society. How discourses diffuse from language—circulating within and between human relationships—to construct authoritative truths and control human thoughts and actions occurs as a complex interaction of power, knowledge, and discipline. Foucault suggests the analytic device, the dispositive (i.e., dispositif or "device") to understand the apparatuses of discourse coalescence, diffusion, and control. Foucault (1980) offers a parsimonious and famous description of the dispositif:

> What I'm trying to pick out of this term is, firstly, a thoroughly heterogeneous ensemble consisting of discourses, institutions, architectural forms, regulatory decisions, laws, administrative measures, scientific statements, philosophical, moral, and philanthropic propositions—in short, the said as much as the unsaid. Such are the statements of the apparatus. The apparatus itself is the system of relations that can be established between these elements. (p. 194)

The pervasive and encompassing nature of discourses and apparatuses of control establishes a significant rationale for selecting a case study design for the inquiry. For example, observance of space and its disciplinary function may be as essential to understanding discourse as what is said (or unsaid). The rationale for this design is discussed in greater detail in Chapter Three.

For the furtherance of this Introduction, however, a comprehensive exploration of the dispositif is unnecessary. Similarly, Agamben (1998) expands on Foucault's ideas about the

dispositif, but a discussion of Agamben's conceptualization is beyond this dissertation's scope. Instead, subsequent sections on Foucauldian poststructuralism focus on the coalescence and order of discourse and how that creates collective notions about reality that act upon objects. Further, the significance of Foucauldian poststructuralism to nursing as a discipline is considered. To begin, the term regime of truth is examined.

Regimes of Truth and Interpretive Repertoires

Regimes of truth and interpretive repertoires are similar concepts from two distinctive discourse analysis traditions. In Foucauldian poststructuralism, an episteme is a commanding discourse that characterizes the state of knowledge at any given time in a culture or society. An episteme constructs the ways people think and create knowledges about social objects within a society. The episteme pervades speech, text, institutions, and societal practices (Hall, 2001); it is the relative truth at a given point-in-time. However, Foucault argued that truth is not singular or absolute, as portrayed in the transcendental humanist perspective. Instead, truth is maintained through socio-historical bound *regimes of truth* constituted through discursive practices—the rules, systems, and codes that organize discourse. Societal discourse about an object coalesces at given points in time to construct a reality that members of a society accept as truth—epistemic regimes of truth. These regimes create discursive rules, systems, and structures that constrain some discourses while elevating other discourses (Young, 1981). Thus, regimes of truth legitimize some truths while excluding or marginalizing other, less authoritative, truths. Indeed, discursive regimes recursively manifest in discursive *practices* that are often so powerful that they become almost impossible to escape (Young, 1981). The interpretive repertoire concept provides insight into the rules, systems, and codes (i.e., discursive practices) that organize and sustain discourse and regimes of truth.

Potter and Wetherell (1987) define interpretive repertoire as “a lexicon or register of terms and metaphors drawn upon to characterize and evaluate actions and events” (p. 138). Interpretive repertoires use metaphor, consistent themes, and tropes—doxa—to create an easily recognizable line of argument (Wetherell, 1998). Consequently, the line of argument forms a cohesive argumentative texture. The concept of argumentative texture is easily grasped using an analogy submitted by Wetherell (2001b): Imagine each discursive line of argument as a thread in a woven tapestry. A researcher counting thread density could easily draw a circle on the fabric, thus, delimiting their field of inquiry. Nevertheless, the thread, or line of argument, extends beyond the arbitrary delimitation to create the rest of the cloth. Crucially, the idea of argumentative texture described here and first espoused by Laclau, another poststructural discourse analyst, dissolves objections raised by some scholars about the necessity of separating extra-discursive practices from discourse analysis. Inquirists investigating social phenomena are interested in the argumentative texture, not merely one line of argument (Wetherell, 2001b, p. 389). Furthermore, repertoires are delimited, not by group membership or line of argument, but by using specific metaphors, terms, phraseology, stylistic or grammatical choices employed when communicating about phenomena. The empiricist and contingent repertoires used by scientists are examples. Repertoires often compete for primacy with the actor characterizing their interpretation or beliefs as the truth—even when their version of reality is not dominant. However, repertoires are variable, with one actor perhaps using many different repertoires depending on the context.

This dissertation uses the term episteme when discussing dominant macro-level, societal representations of truth at a given point in history. A regime of truth refers to an authoritative coalescence of discourse about a social object while discursive formations "are all the systems

and uses of rules that operate beneath the consciousness of individual subjects by which statements arising in social practices are dispersed" (Clinton & Springer, 2017, p. 89). The notion of interpretive repertoire is reserved for more granular assessments of discourse or discursive practices.

Pouvoir-Savoir et la Réalité

Foucault's book, *The Archeology of Knowledge* (1972), describes how poststructural knowledge is constructed. For Foucault, knowledge is not discovered; it is created. Socio-historic and cultural conditions cause certain discourses to become dominant, while other discourses fade. The pervasiveness of discourse and centrality of language to making meaning may create the appearance that there is objective, rational truth, but this is illusory. Networks of power always shape truth (Hall, 2001). In discourse, "power seems to be the capacity to 'articulate' and to make those articulations not only 'stick' but become hegemonic and persuasive" (Wetherell, 1998, p. 393). As a result, people with power can shape truth, and those without power may be unable to resist. This power may exist as a coercive constraining, top-down force—hierarchal or sovereign power, or distally between and within human relationships. It is the distally located, often subtle, and sometimes opaque acts of *will* —constitutive power— that concerned Foucault. Critically, constitutive power circulates in language, elevating some discourses and discursive practices while constraining others.

Thus, knowledge is inextricably tied to power because those with knowledge can create a truth that works to their advantage— pouvoir-savoir or power-knowledge. The most manifest example of the power-knowledge representation is found in the way power and regimes of truth legitimate and reproduce one another. This example of power-knowledge is strongly associated with institutions, as in the *dispositif*, explained above. However, knowledge does not exist apart

from human beings. Knowledge is created within human relationships through discourse; consequently, it is socio-historically mediated. Furthermore, power circulates and can be found in every social relationship (Hall, 2001). Crucially, however, for inquiries like the one proposed here that seek to analyze discourses, is the realization that power and knowledge act as a dyad to create and sustain truth. Holmes and Gagnon (2018) note,

> knowledge is never neutral, given that it is produced by systems and structures (apparatus) that determine what is considered valid knowledge, . . . how that knowledge must be developed, . . . and, most importantly, who (which individuals) is included in the knowledge production process and can therefore claim authority over it. (p. 4)

Poststructural inquiry can illuminate how power suppresses or creates knowledge, and it can provide a means of resistance for the less powerful to shape truth. Moreover, Foucauldian poststructuralism demands that inquirists appreciate the power-knowledge dyad not merely as a nebulous overarching concept but as an exercise of domination and control with profound human-level consequences (Clinton & Springer, 2017). Therefore, an explicit goal of Foucauldian inquiry is emancipatory empowerment achieved by illuminating unseen discursive regimes and problematizing the status quo.

Critique and Transformation

Foucault's earlier work on the archaeology of knowledge is often criticized as cynical because it minimizes the importance of the human subject—humans are subject to discourse. Followed to a logical conclusion, the anthropologic quadrilateral (i.e., human, cogito, analytic of finitude, and ever-elusive origin model) elevates discourse to an immovable monolithic force where individual agency is completely subsumed by discourse and collapses (Clinton & Springer, 2017). Whether this reading is cynical or the tension between the currently

authoritative humanist discourse and a subversive counter-discourse is unclear. What is evident is that Foucault's later work elevated the genealogical subject and the possibility of transformation. In an interview with Rux Martin in 1982, Foucault reflects:

> Everybody both acts and thinks. . . . In my books I have really tried to analyze changes, not in order to find the material causes but to show all the factors that interconnected and the reactions of people. I believe in the freedom of people. (Foucault, 1988, p. 14)

Although Foucault focused mainly on the technologies of power and truth, technologies of the self allow human beings to control some parts of their bodies, souls, and self-conduct, making transformative change possible. Clinton and Springer (2017) explain, "Foucault uses genealogical analysis to shift the basis for human knowledge and action from the transcendental subjectivity of Kant to historically contingent possibilities for understanding and being" (p. 5). Where there are "contingent possibilities" for being, there is space for individual freedom and transformative change. The genealogical subject is, thus, constituted by discourse but also a thinking actor. While the genealogical subject remains subjectified to discourse, Foucault suggests that individual subjectivities may be used to recognize and critique dominant regimes of truth and trouble normative techniques. Nairn (2019), for example, argues that critique is an inherently disruptive and subversive "assertion of freedom" (p. 6).

Within a Foucauldian framework, we are both constructed and transformed through discourse. Humans experience this creation and transformation as the subjects of discourse. However, we are not powerless cogs moved only by discursive machinery. Foucault's description of the technologies of oppression provides insights into how knowledge, truth, and power are constructed and how to disrupt oppressive discourses. Unlike humanists, Foucault rejects the fiction (i.e*., truth will out* discourses) that knowledge accumulates linearly or that the

accumulation of knowledge leads inexorably toward liberation (Boles, 2016). Albeit not the immediate and revolutionary emancipation typifying critical inquiry (another possible framework for exploring power), emancipation through problematizing existing power structures to aid the struggle for freedom and liberty is an affirmative goal of Foucauldian inquiry (Gordon, 1994; Lincoln et al., 2018; McCabe & Holmes, 2009). The technologies of the self can be used to empower people in pursuit of this emancipatory goal. Indeed, it is through these techniques that humans struggle against oppression, create new knowledge, and construct new discursive regimes.

Foucauldian Poststructuralism and the Discipline of Nursing

Scientists in the discipline of nursing have used Foucauldian poststructuralism to guide inquiry for decades. A literature review published in 1999 by Gastaldo and Holmes found 38 articles that referenced both Foucault and nursing. The bulk of those articles originated in Australia and covered concepts like power-knowledge, panopticism, docile bodies, the clinical gaze, discourse, and discipline (Gastaldo & Holmes, 1999). One salient example from this timeframe is Henderson (1994) who found that nurses in the Intensive Care Unit (ICU) subjectify patients using a nursing (i.e., clinical) gaze and participate in maintaining power relations through surveillance. Gastaldo and Holmes conclude that Foucauldian inquiry can be used to problematize everyday nursing practices. During the first few years of the 21st century, Crowe (2005) observed an increase in discourse analysis and poststructural inquiry. However, the approach remained underutilized in the US with Australia, Canada, and the United Kingdom emerging as leaders on Foucault and discourse analysis. Nairn (2019) suggests that the tension between Foucault's ideas about human agency and nursing's humanist foundations coupled with

Foucault's rejection of meta-narratives limited Foucauldian scholarship by nurse scholars in the US.

Recently, however, Foucauldian poststructuralism has reemerged as an area of interest for nursing scholars both in and outside the US. The domains most actively integrating Foucault and nursing scholarship between 2015 and the present are psychiatric nursing, forensic nursing, and nursing education (see Hörberg & Dahlberg, 2015; Slemon et al., 2015; Smith & Sekula, 2019). Notably, Dillard-Wright (2019) focused on the function of the Electronic Health Record (EHR) as an apparatus of power-knowledge and control. Themes emphasizing surveillance, panopticism, and power-knowledge as a mechanism of control are evident in the current literature. Thus, Foucauldian notions of the dispositif and power-knowledge are emerging as topics of interest to nursing. Interestingly, the ideas of normalization and apparatuses of control (e.g., power-knowledge, EHR, and nursing gaze) extends to a problematization and critique of the nursing process and nursing theory (Holmes & Gagnon, 2018).

Arguably, much of the literature combining Foucault and nursing addresses the implications arising from Foucault's problematization of underlying philosophical assumptions once considered central to nursing science, including humanism, individual agency, and conventional quantitative research and qualitative inquiry. These tensions are complex and need not be reexamined in this section because they are explored in other sections of this Chapter. However, some useful tenets of postructuralism and Foucauldian Discourse Analysis may be constructed from the extant work of Foucauldian scholars in the discipline of nursing. For example, Clinton and Springer (2017) offer ten principles of Foucauldian Discourse Analysis, while Holmes and Gagnon (2018) submit three fundamental poststructural assumptions. Table 5 synthesizes these principles and assumptions and presents them as guidelines for Foucauldian

poststructuralism in nursing. These guidelines will serve as a philosophical touchstone when conducting this proposed Foucauldian poststructural inquiry.

Table 5

Guidelines for Foucauldian Poststructuralism in the Discipline of Nursing

- Understanding of phenomena is not based upon absolute or singular truth.
- Foucauldian poststructuralism subversively critiques the normalizing influences that create our shared reality and disciplinary understanding of phenomena.
- Foucauldian poststructuralism questions power in relation to knowledge production.
- Foucauldian poststructuralism may skeptically challenge things that are taken for granted or perceived as common sense.
- Foucauldian poststructuralism aims to deconstruct existing regimes of truth.
- Critique is a resistant endeavor that is potentially transformative.
- Nurses (and humans more generally) exist in political spaces.
- Avoid linear conceptions of history and knowledge accretion.
- Do not engage in unexamined or unreflexive methodologies.
- Approach overly prescriptive methodologies with skepticism.
- Knowledge is historically contingent. Foucauldian poststructuralism looks for ruptures that create different ways of knowing.
- Mundane, everyday events may coalesce and interact with power to construct truth or disrupt the status quo.
- Knowledge and power exist as a dyad.
- Power circulates in discourses.
- Social forces influence and appropriate power within human relationships.
- There are no "final meanings, weighty intentions, essential conditions, and final causes" (Clinton & Springer, 2017, p. 95).
- Foucauldian poststructuralism aims to make visible hidden discourses and power relations.
- Cross-examine discourses in apposition to power.
- Foucauldian poststructuralism is emancipatory in aim.
- Understand the significance of institutional apparatuses to sustaining and reproducing power-knowledge and power relations.
- "Recognize that our ideas, our thoughts about nursing, our modes of being (our subjectivities) arise as a result of our participation in discourses of social identification and relationships of cultural affiliation that reflect the possibilities and limits of a particular historical context" (Clinton & Springer, 2017, p. 96).

Positioning Foucauldian Poststructuralism

As previously noted, Foucauldian postructuralism aligns with a constructivist paradigm. However, ethical inquiry within a constructivist paradigm requires reflexive disclosure about the author's paradigmatic assumptions—etic—because these assumptions necessarily interact with the views of participants—emic. Constructivist inquiry demands inquirists position themselves as insider/outsider or etic/emic investigators (Dwyer & Buckle, 2009). Therefore, failure to adequately position qualitative inquiry is, first, unethical, but also detracts from trustworthiness.

According to Denzin and Lincoln (2018), paradigms are overarching philosophical and methodological systems that guide how inquirists construct reality. Paradigms are founded upon four foundational positions—ontology, epistemology, methodology, and axiology (Lincoln & Guba, 2013). Constructivism is ontologically relative. Multiple truths are willed to exist by human beings. In a similar fashion, constructivism presupposes that epistemologically knowledge is created by humans, and knowing is highly contextual and transactional. Axiologically, knowledge is co-created and value laden. Constructivist methodology is broadly hermeneutic dialecticism. This position will be discussed in greater detail in subsequent sections of this dissertation. Traditionally, qualitative research was conducted within a positivistic or modernist paradigm. Current approaches to qualitative inquiry include critical inquiry that is guided by critical theories, for example, critical race theory and phenomenological inquiry. Most contemporary qualitative research approaches are rooted in interpretivist or naturalistic presumptions (Lincoln & Guba, 2013).

However, Denzin & Lincoln (2018) observe that as qualitative research has developed, qualitative inquiry has evolved. Despite Kuhnian predictions, the elevation of one paradigm has not necessarily vanquished other paradigms. Consequently, Denzin & Lincoln adopt the term

"moment" to describe the evolution of qualitative inquiry where new theories, paradigms, or worldviews emerge, ebb, and dissolve only to later rematerialize. Lather (2013) adopts digital parlance to describe this paradigmatic movement using classes. The term QUAL 1.0 refers to describe conventional neo-positivistic qualitative research. QUAL 2.0 encompasses qualitative research that is beginning to question humanistic assumptions but attempts to embrace human disorder through research design. QUAL 3.0 embraces poststructuralism and different epistemologies, for example, feminist and critical theory, but struggles to overcome nomothetic attempts at normalization. Finally, QUAL 4.0 is protean—it is actively and contemporaneously *becoming* (Lather, 2013; Richardson & St. Pierre, 2018). QUAL 4.0 rejects normalization and cooptation by more dominant perspectives and focuses on producing different forms of knowledge (Krog, 2018). Post humanist and Deleuzian thought find shelter in QUAL 4.0 inquiry. Boles (2016) used Lather's qualitative classes as a heuristic to help readers understand the link between Foucauldian poststructuralism, paradigm, and reflexive positioning, and I employ that same strategy for this inquiry. Table 6 compares the presumptions of each paradigm vis-à-vis my own reflexive beliefs about science and the nature of reality.

Table 6

Comparison of Paradigmatic Movements, Foundational Presumptions, and Inquiry Positions

Qualitative Paradigmatic Movements	Prototypical Forms	Foundational Beliefs	Reflexive Positions
QUAL 1.0	**Positivistic**. Typified by naïve empiricism and the hypotheticodeductive model. Inquiry is experimental.	Unproblematized use of conventional interpretive methodology. Subject interviews are structured for optimum control, and questions are formulated a priori and are immovable.	

	Postpositivism.		
	Empirical voice is privileged. Theory driven qualitative inquiry emerges as relevant not in its own right but in-so-far as it expands the realm of quantitative study.	Humanistic subjects with transparent voices that reflect a truthful representation of the subject's thoughts, feeling, cognition, and worldview. Ethics tend toward deception because objectivity is centralized. Verificationism is common. Rich descriptions and deep exploration of lived experiences bring researchers closer to a singular Truth.	
QUAL 2.0		Multiple perspectives and truths about the nature of reality are accepted. Knowledge continues to accumulate through accretion.	
	Grounded Theory. Inquiry focused on theory development using qualitative methodology and liberalizing theory development. Adopted specific criteria for evaluating qualitative research but advocated disinterested objectivity and positivistic notions of reality. Early grounded theory emphasized methodological systematicity and formulaic procedure.	Remains bound to the humanistic subject. Notions of power, oppression, privilege, and emancipation are still conceptualized as binaries. Systematicity denotes validity. Typified by applying quantitative concepts of rigor, generalization, and validity to qualitative methodology in a nomothetic attempt to "fix the research process" (Lather, 2016, p. 635).	Using theories is essential for discipline-specific knowledge building, but theories should be approached

	Later grounded theory (e.g., Glaser; Charmaz) embraced a postmodern turn.		with skepticism and an awareness of the coercive and colonizing risks associated with their use.
QUAL 3.0		Postmodern theories begin to trouble previously normalized concepts: power, authentic voice, knowledge development, and a priori study design, for example.	
	Critical and Feminist Theory. Sociohistorical values shape reality. The aims of inquiry are explicitly emancipatory. Values non-dominant ways of thinking and knowing. Embraces difference in social positioning.	Accepts relativism, transactional subjectivism, hermeneutic dialecticism, and the illusion of objectivity as foundational positions. Values diversity, equity, reflexivity, and a social justice ethic.	Investigator is granted insider/outsider status and assumes the role of "passionately interested" inquirist (Wetherell, 2001b, p. 394). Participants are co-creators of knowledge.
	Constructivism. Reality is constructed through a coalescing of human will. Inquiry is about understanding and deconstruction. Values of all participants are embraced as essential to knowledge development.	Participants are co-creators of knowledge. Structuralism remains influential as nomothetic ideas about triangulation and mixed methods reassert dominance.	Inquiry findings must be usable for clinicians in practice. Generalization has no meaning in qualitative inquiry. Instead, trustworthiness and transferability are appropriate criteria.
	Participatory Action. Findings are co-created and bound to the practical. Inquiry aims		

are shared and continuously evolving as participants interact with their socio-historical-political realities.	Qualitative evaluative criteria for quality include fairness, ontological authenticity, educative authenticity, catalytic authenticity, and tactical authenticity.
Arts-Based Inquiry. Challenges dominant regimes of truth and ways of knowing by investigating and presenting creations in ways that resist normalization. Inquiry is explicitly emancipatory and decolonizing. Recognizes the hegemonic influence of conventional methodology and reporting technique. Emphasizes the fluidity of knowledge.	Quantitative (i.e., nomothetic) criteria for rigor are rejected and have no meaning—even as heuristic scaffolds—when evaluating qualitative inquiry. A priori study design may promulgate oppressive regimes of truth. Emotions are essential to ethical inquiry. Discourse creates meaning. Language is not transparently representative. Truth is the coalescence of dominant discursive regimes at a given point-in-time within a given society.

			The purpose of inquiry is emancipatory.
QUAL 4.0	**Deleuzian Inquiry.** Challenges the normative author function. Inquiry is by assemblage, and findings—insofar as the word is meaningful and not destructive— are constructed through crystallization. Inquiry is collaborative and realized in writing. Posthumanist theory is evident.	Questions implicit ideas of humanism. Rejects nomothetic attempts at normalization. Recognizes the role of prescribed methodology in perpetuating injustice and accepts an affirmative responsibility to mitigate that perpetuation. Focuses on emancipation and consciousness raising. Seeks new ways to construct knowledge. Including post-coding analysis, for example, rhizomatic crystallization.	Results of inquiry are "narrated into being," tenuous, and fleeting (Wetherell, 2001b, p. 396) Questions the common-sense position of humanism in Western discourse

Note. The epistemological and ontological assertions presumed by constructivist positioning does not negate the existence of an objective, measurable reality explorable through hypotheticodeductive research, for example, basic science research. The presumptions apply to human and social sciences inquiry.

Crucially, adopting a constructivist position logically leads to a series of "conjectures" that comprise a fully rounded worldview (Lincoln & Guba, 2013, p. 43). For example, a positivist who accepts the epistemological position that knowledge development is linear may logically subscribe to a hypotheticodeductive model for knowledge development. Similarly, a constructivist who believes in transactional subjectivism might insist that knowledge is created and not discovered. The consequences of paradigmatic assumptions manifest in subtle and overt

ways. For example, the use of personal pronouns is intentional in poststructural inquiry. While quantitative research and post-positivistic researchers seek control and objectivity, constructivist inquirists eschew notions of objectivity as illusory. Indeed, poststructural inquirists are keenly aware of the control and disciplinary actions often transmitted through scientific discourses and use personal pronouns in scientific writing to trouble this opaque form of oppression (Lincoln et al., 2018). However, paradigmatic presumptions and conjectures also inform inquiry in more substantive ways. For example, this dissertation's aims are guided by Foucauldian poststructuralism and constructivist presumptions about the nature of reality.

Finally, the clinical gaze represents an epistemic shift in the patient-physician relationship that occurred in the late 18th and 19th centuries and, arguably, persists into modernity. Whereas before the shift, physicians viewed illness as embodied by the person, the clinical gaze focused clinicians' attention onto a localized area of infection or category of disease (Holmes 2012). Foucault (1994) writes of the clinical gaze:

> One now sees the visible only because one knows the language; things are offered to him who has penetrated the closed world of words; and if these words communicate with things, it is because they obey a rule that is intrinsic to their grammar. (p. 115)

Thus, in clinical areas where productivity is valued above personal connection, it is possible to see how attempts at self-agency, like modifying or retaining a DNR order during surgery, could easily be characterized as an impediment to care. In such a relationship, the actor—a clinician—with knowledge and who is "initiated into true speech" (Foucault, 1994, p. 115) has inherent constitutive power to shape and construct patients' reality. Thus, an often-unrecognized power imbalance that extends beyond mere hierarchal or sovereign authority and favors clinicians is evident in the perianesthesia setting.

Power, according to Foucault, is relational, dynamic, positioned distally, often mundane, and typically sustained subliminally (Foucault, 1994; McCabe & Holmes, 2009; Rodgers, 2005). In addition, power is not necessarily hierarchal. Power is constitutive. Power-knowledge acts through discourse to shape who people are and how they function in society. Consequently, troubling or disrupting normative discourses can effect practical change. From a Foucauldian perspective, the resistance of perianesthesia culture to change suggests a hegemonic biomedical discourse that normalizes inequality between clinicians and patients. Making the subliminal power inequity between patients and clinicians explicit problematizes the biomedical hegemony and opens the possibility of reconceptualizing perianesthesia DNR orders as a patient strength instead of an obstacle to care. Such a reconceptualization is inherently transformative and potentially emancipatory. The inquiry's aims draw inspiration from Foucault's positions on power and emancipation.

Aims of this Inquiry

Foucauldian poststructuralism is emancipatory in its goal of revealing hidden discourses that may create oppressive regimes of truth. Nurses working in a Foucauldian framework are obligated to affirmatively target oppressive discourses and power relations for critique. The aims of third and fourth moment Foucauldian inquiry are, consequently, transformative. Holmes and Gagnon (2018) argue,

> Foucault’s work demonstrates that regimes of truth also elicit resistance from the people they target; poststructuralist analysis allows them to better understand the positions in which they have been placed, that is subjugated. This realization is the first step towards creating subversive practices that serve as forms of resistance. (p. 5)

The significance of power-knowledge to constructing reality and marginalizing divergent subjectivities is a significant threat to patient well-being in the perianesthesia setting. Therefore, informed by the Foucauldian concepts of power-knowledge, the dispositif, and the clinical gaze, this inquiry aims explicitly to:

1. Elucidate how perianesthesia discourses construct patient DNR and advanced directive options.
2. Trouble the current epistemology that privileges anesthesia clinicians and refocus knowledge development with patient emancipation as the goal.
3. Expose the institutional apparatuses and practices that create these discourses and maintain their power effects; and
4. Erode the power imbalance between perianesthesia clinicians and patients in the future by empowering them with knowledge of the usually hidden power relations and discourses shaping end-of-life choices in the perianesthesia setting.

Mid-Range Theory

Investigators using biomedical frameworks to scaffold health research rarely explicitly disclose that biomedical theoretical assumptions underpin their studies. So dominant is the biomedical discourse that these assumptions are often left as implicit—mere common sense—presumptions. Humanist presumptions about the nature of reality, language, and social discourse are, similarly, accepted as axiomatic. Indeed, Foucault's critique of the clinical gaze is about biomedical discourse and humanism, not nursing inquiry, although the critique is certainly applicable to nursing science as well. When Foucault wrote *Birth of the Clinic*, he likely would not have recognized nursing as a discipline, much less as an authoritative scientific voice. Even today, nursing discourse remains marginalized (McAndrew & Hardin, 2020); correspondingly,

the contributions of nursing science are not as easily recognized. Nurse researchers need to explain what is unique about the knowledge they create, or the knowledge will be misunderstood or coopted by more dominant discursive regimes. Additionally, health care researchers have an affirmative responsibility to generate knowledge usable in practice (Sandelowski & Leeman, 2012). Georges' (2013) emancipatory theory of compassion provides a discipline-specific lens that both grounds this inquiry in a Nursing praxis while generating research questions and theoretical assumptions that comport with a Foucauldian framework.

The Emancipatory Theory of Compassion for Nursing

Georges' (2013) Mid-Range Theory (MRT) centralizes compassion as the raison d'être for nursing practice—without compassion, nursing cannot exist. Georges defines compassion as the conscious awareness and desire to ease suffering in others. Furthermore, Georges notes, "I theorize that suffering and biopower are inextricably linked to the presence or absence of compassion in the practice context" (p. 2). In brief, Georges theorizes that nurses act within biopolitical spaces (e.g., hospitals, clinics, schools) where some humans have political agency and their voices are authoritative ("bios") while others are marginalized ("zoes" or "bare life"). Humans exist on a spectrum with these two positions as polarities. People can move between "bio" and "bare life" using their own power or be relegated to an inferior status because of power exerted by another person or institution. Georges MRT was strongly influenced by Agamben (1998)—a contemporary Italian philosopher.

Agamben (1998) suggested the bios/bare life dichotomy. Agamben's book *Homo Sacer: Sovereign Power and Bare Life* explores and expands on many Foucauldian concepts, for example, biopower. In the book, Agamben suggests that some life can be killed but not sacrificed. Some life is bare or naked (zoe), while some life is sacred (bios). Agamben's thesis is

that the sacredness of life developed not from morality or religion but as a politico-legal construct (Cloyes, 2010). Agamben used historical genealogy to demonstrate how humans exist in political spheres that act to maintain power structures. Cloyes (2010) notes, "the power to constitute bare life . . . plays out on and among real bodies singly and in groups with tangible and often devastating material consequences" (p. 237).

Crucially, according to Georges (2013), this process is often hidden because the divide between zoe and bios is so comprehensively pervasive that it is perceived as conventional or even appropriate. Georges (2013) observes,

> patients may be covertly assigned a "zoe" status because of some socially constructed difference across the axes of ethnic, socioeconomic, or sexual orientation. Within the sociopolitical space, no one openly states this. The assignment to zoe status is "unspeakable." (p. 4)

Like all human beings, nurses have a vested interest in maintaining their statuses within this dichotomy. Therefore, nurses a) remain silent about marginalizing or unethical behavior in healthcare settings lest they be assigned zoe statuses themselves; or b) exert power to make the usually opaque processes of oppression and marginalization visible, risking assignment to bare life status as a consequence. According to Cloyes (2010), the challenge for nursing practice and inquiry is "developing an ethics that won't reproduce bare life" (p. 235). Georges summarizes: "I consider it axiomatic that nursing must find ways to decrease suffering, share power, increase compassion, and speak the 'unspeakable' "(p. 8). Thus, compassion, suffering, biopower, and the constituent notion of the unspeakable are foundational concepts to Georges' theory.

Biopower

The concept of biopower has contradictory definitions. Foucault used the term biopower to describe the circulating networks of power that exist between human relationships and produce subjectivity or authority. For Foucault, biopower was framed as a potential space where free will and choice are best realized (e.g., technologies of the self). Agamben, however, conceptualizes biopower as a "toxic" and violent space that acts to sustain and reproduce the zoe/bio dichotomy (Cloyes, 2010). While this dissertation accepts Foucault's conceptualization of biopower as central to technologies of empowerment, Agamben's skepticism and appreciation of the historically negative shadow-side of biopower is appreciated. For example, Cloyes (2010) identifies two critical attributes of biopower relevant to Georges' (2013) MRT:

> First, biopower does not establish marginal categories once and for all but works to constantly reproduce these categories in our everyday actions and thoughts and in "common sense." Second, biopower depends on making "logics of exception" appear to be a natural foundation of our political and ethical practices, through which legitimate agency is represented as the counterpart of bare life. (p. 237)

Georges' theory draws from both Foucault and Agamben. While Foucault conceptualized power as constitutive, Agamben (1998) often constructs power as hierarchal. Instead of sovereign power, this dissertation aligns with Foucault's emphasis on power's circulatory and constitutive attributes. Nevertheless, the tension between Agamben's conceptualization of biopower and Foucault's perspective distills toward a common denominator. The best chance for constructing emancipatory change requires the positive use of biopower to create compassionate spaces for nursing care.

Posthumanism

Foucault and Agamben are united, however, in their critique of humanism. Foucault identifies the 18th and 19th centuries as an inflection point for the development of contemporary medical discourse (Dreyfus & Rabinow, 1983; Foucault, 1994). During this period, clinicians adopted a systematic and humanistic approach to medical care and created a clinical discourse that continues to influence practice, known as the clinical gaze. Immanuel Kant (1970) suggested that an individual's innate value and human dignity came from their Creator. Austriaco (2011) explains that theologians of the time reasoned that because God created human beings in His image, human beings represent a reflection of God. Therefore, debasing a human being is sacrilege. Although it is an oversimplification, western conceptions of innate human dignity developed from this reasoning. This era is known as the Enlightenment. The Enlightenment resulted in the establishment of freedom and liberty as basic human rights as they are conceptualized in Eurocentric cultures.

As previously noted, the basis of Foucault's critique of humanism is the rejection of Kantian transcendental idealism and the myth of a pre-reflective (naïve) knowledge (Boles, 2016). In Kantian philosophy, the notion of a prediscursive subject suggests the existence of a transcendent human ideal. The prediscursive subject is the constituent notion of humanism. However, Foucault refutes this idea. For poststructuralists, language creates reality, but language is fleeting. There is no fixed point of truth or ultimate, omega-point state of existence. Foucault argues that humanism sets arbitrary limits on human capability by suggesting an ideal human state-of-being. In other words, there is nothing beyond the ideal state; it is the predefined limit of human capability. Agamben (1998) adds to Foucault's critique of humanism by suggesting that humanism is not merely a post-Enlightenment development. Instead, Agamben argues that

millennia of unexamined humanist thought may be responsible for the covert othering so prevalent in Western cultures. In other words, humanism may construct the binary formations—la différance in the Derridian sense—that create ethical and political systems that produce and perpetuate oppressive and marginalizing regimes (Cloyes, 2010; Derrida, 2016; Georges, 2013). Cloyes (2010) summarizes Agamben's position:

> Western politics depends on groups of human beings who are identified as bare life, in each era and each mode of government. Having an "other" is not only built into the framework—it is the stuff from which the frame is constructed in the first place. The "other" is constituted by dividing bare life from legitimate agency. (p. 239)

If Foucault and Agamben's critiques of humanism are accepted, posthumanist inquiry has profound implications for all nursing domains. Posthumanist inquiry urges a critical examination of how nursing, given our humanist foundations, may inadvertently perpetuate marginalization or oppression.

Theory Application

Finally, Georges (2013) defines the unspeakable "as patterns of discourse that appear so 'natural' to the speaker that he or she is no longer consciously aware of such patterns" (p. 13). In the MRT of emancipatory compassion for nursing, the "unspeakable" is the relational concept linking compassion, biopower, and suffering. Georges realized this connection based upon a discursive analysis of interviews with nurses who committed atrocities in Nazi Germany during the Holocaust. There, a critical interaction between the zoe/bios dichotomy, an atmosphere of free-floating responsibility, and distance (both physical and metaphorical) made possible the commission of not just unethical but heinous behaviors (Georges, 2013). There is no direct

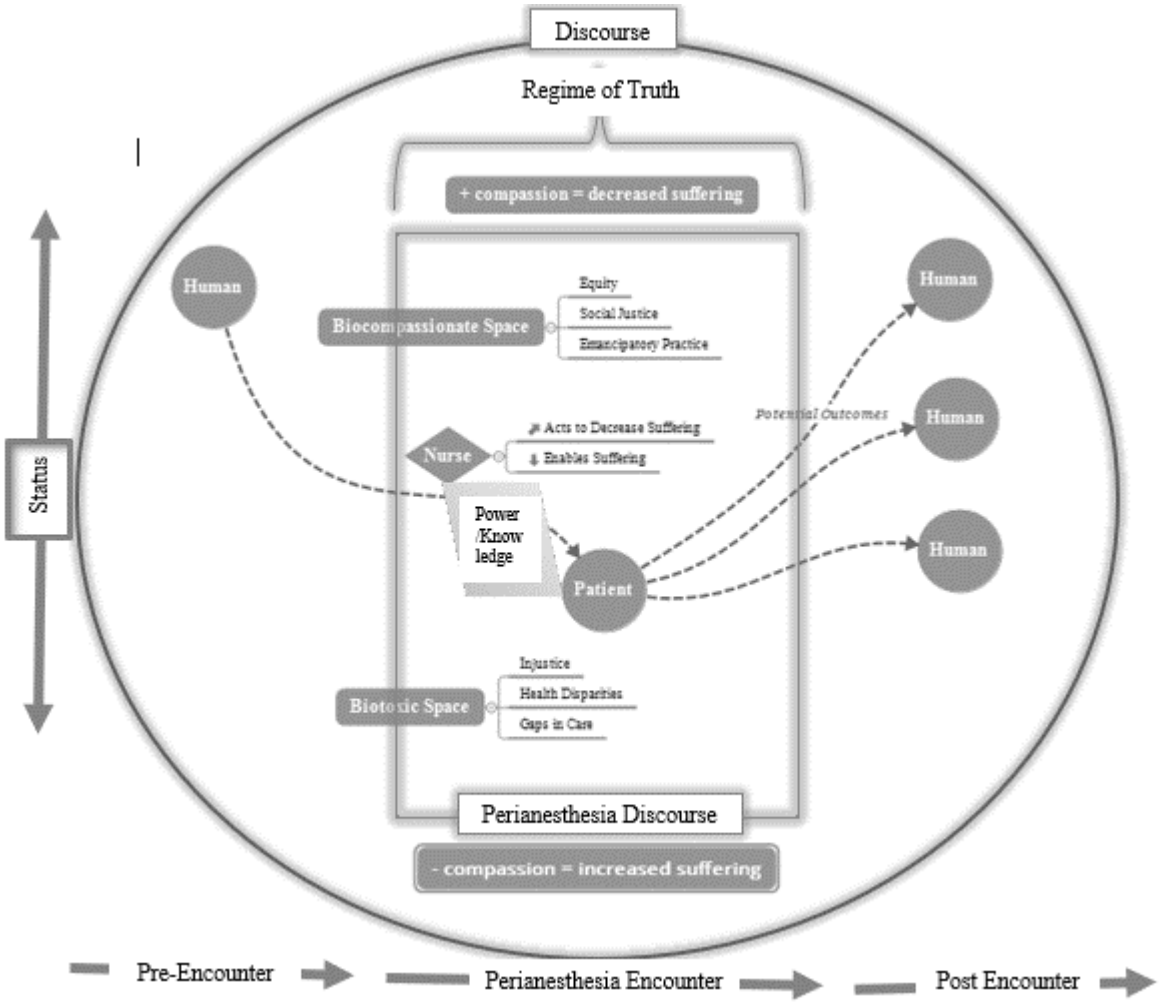
comparison between the horrors of the Holocaust and potentially unethical behavior in contemporary perianesthesia practice.

However, the mechanisms that allow potentially unethical behavior to become common sense continue to exist in hospitals and clinics today. Furthermore, the reasons why such behavior remains hidden and well-meaning clinicians fail to intervene are similar. For example, a principlist assessment of the perianesthesia process may conclude that the goal of preanesthesia care is to ensure a safe surgery and anesthesia encounter, and that assessment is a valid construction. Consider, however, and ideally say aloud this counternarrative: "To ensure safety: when people have anesthesia, their status is often reduced to bare life. They will be separated from family, relieved of their clothing and belongings, and held in special observation areas. Those of higher status—anesthesia clinicians—best know what patients need. If someone of real-person status disagrees with this process, then they are probably not a fully equipped person either." One ramification of such a construction is a bioethical discourse that increases suffering. Figure 2 graphically depicts Georges' MRT of suffering constructed within a Foucauldian framework in the perianesthesia setting.

Georges' (2013) MRT of compassion for nursing further refines how the discord between patients' values and objectives and those of anesthesia clinicians when addressing directives limiting care exists in practice. While Foucauldian poststructuralism provides an abstract framework for understanding the problem, Georges' MRT grounds the investigation in Nursing praxis, making potential findings accessible for clinicians.

Figure 2

Georges' MRT of Compassion for Nursing Constructed Within a Foucauldian Framework



Note. This figure applies Georges' MRT of compassion for nursing to the perianesthesia experience. Here, human beings exist in their usual state outside the perianesthesia setting. However, perianesthesia discourse constructs a new regime of truth through discipline, distance, and discursive practices (i.e., dispositif). Patients, nurses, and other clinicians use power-knowledge to sustain their statuses and create either biotoxic or biocompassionate spaces for patients. The effective alleviation of suffering impacts patients' post-encounter outcomes in terms of improved or degraded status and power-knowledge. Crucially, notice how discourse pervades every aspect of the model and the relational nature of power-knowledge. Readers should not, however, mistake the placement of concepts, for example, placing discourse at the top of the figure, as denoting hierarchy or a top-down construct. Placement is mere deference to the restrictions of a two-dimensional figure.

Conclusion

The object of Part 1 of the Introduction was to articulate the problem, purpose, and research questions for this proposed inquiry and briefly familiarize readers with the inquiry's framework and theoretical underpinning. The goal of Part 2 was to delve deeper into Foucauldian poststructuralism and position it in relation to science, nursing practice, and my subjectivity as an inquirist. The principles of Foucauldian poststructuralism explored in Part 2 provide the foundation and justification for the inquiry's aims. Indeed, the concepts discussed in this Chapter scaffold the proposed inquiry and are essential for establishing trustworthiness, fairness, and ontological authenticity—essential components for evaluating qualitative investigations.

In summation, Foucauldian poststructuralism exists within a constructivist paradigm. The crux of that paradigmatic-theoretical intersection manifests in discourse—statements that create social objects—and how discursive practices shape human subjectivities. Unlike many nursing inquiries grounded in humanist constructions of the self, this investigation eschews fixed truths and notions that language is a transparent link connecting outer behavior with an interior "self" world. Instead, the inquiry proposed here will analyze how discourse constructs reality in the perianesthesia setting and how that reality creates the choices patients make. Simultaneously, this inquiry's relevance to nursing practice was conceptualized using Georges' (2013) theory of emancipatory compassion for nursing. Within a Foucauldian framework, the application of Georges' MRT to the problem of managing perianesthesia directives limiting care suggested the research questions introduced in Part 1.

Next, a review of the extant literature will justify the significance of these questions and illuminate how this inquiry will contribute to filling gaps in knowledge about perianesthesia

ethical discourse. Just as importantly, Chapter Two will problematize current perianesthesia discourse in apposition to the history of Cardiopulmonary Resuscitation (CPR) and end of life directives in the US. Finally, ethical concerns derived from Foucault and constructivist presumptions about reality were threaded throughout the preceding text. Crucially, ethical inquiry begins at the most basic level of design and extends throughout the investigation. This is so because the risk of reproducing toxic discourses and sustaining oppressive regimes of truth is an ever-present danger. As much as the aims and research questions, ethical concerns drive the selection of methodology. These ethical considerations will be discussed in more granular detail in the Chapter Three Afterword.

Chapter Two

Literature Review and Problematization

At the beginning of the last century, the suffering caused by prolonging a life without quality was not an everyday ethical concern in hospitals. Ethical tension and moral distress pivoted on the clinician's impotence in the face of death and disease. Death was positioned as the cause of distress and ethical conflict, and the resolution was to increase the quantity of life. During the mid-to-late 20th century, rapid technological, pharmaceutical, and practical advancements in care expanded lifespans in many countries and enhanced quality of life in the United States (US). As a result, today's healthcare professionals face more frequent and complex ethical challenges than in the past. The point of ethical inflection is not just suffering from the inability to prolong life. Now, clinicians and patients must together confront when the ability to delay death is the cause of suffering and ethical conflict. Although the form and presentation of this decision-point vary between settings and contexts, the conflict is interconnected with power, discipline, and social expectations. It is perhaps unsurprising, however, that a perianesthesia community trained to preserve life at all costs might sometimes be placed at odds with patients and families with different values and objectives.

Although the health care literature writ large is replete with strategies for managing DNR orders and other directives limiting care, these directives remain a frequent source of ethical consternation in perianesthesia nursing. One particularly vexing situation, the automatic revocation of DNR orders during the perianesthesia period, remains a threat to human dignity, autonomy, and self-efficacy. Though concern over this problem appears in the literature as early as 1991, it has proven resistant to most quality improvement efforts, and investigative research into the phenomenon is stagnant. Studies examining intransigence around the automatic

revocation of DNR orders before anesthesia reveals processes deeply engrained in perianesthesia culture. Moreover, the phenomenon intersects with several other ethical discourses in the perianesthesia environment, for example, production demands, hegemonic masculinity, and power inequities between anesthesia clinicians and patients.

Foucault's archaeology of the clinic and contemporary medicine suggests a new way of framing the extant literature. Foucault proposed new avenues for inquiry and mechanisms of sense-making that may be better positioned to explore ethical issues that are entwined with power in the perianesthesia setting. In *The Birth of the Clinic*, Foucault (1994) observes, "Behind the doctor's back, death remained the great dark threat in which his knowledge and skill were abolished; it was the risk not only of life and disease but of knowledge that questioned them" (p. 146). Thus, death is situated as the ultimate foe of modern clinical medicine. Death renders the clinician's power-knowledge irrelevant. Consequently, death is both unseeable and *unspoken*. The discussion or even mere contemplation of death challenges the "true speech" of biomedicine in the clinic. Foucault observes of the clinical gaze:

> one now sees the visible only because one knows the language; things are offered to him who has penetrated the closed world of words; and if these words communicate with things, it is because they obey a rule that is intrinsic to their grammar. (p. 115)

According to Foucault, in the modern clinic such a barrier as death is to be at all costs resisted through whatever mechanisms exist for sustaining power. In the perianesthesia setting, these mechanisms include distance, discipline, and a language—materialized in practice—that is unavailable to most patients. Georges (2013) suggests that these criteria, combined with a culture of free-floating responsibility, have historically constituted situations vulnerable to unethical behavior. This chapter will demonstrate that such conditions exist in the contemporary

perianesthesia setting through a synthesis of the literature. Fortunately, the history of end-of-life care and its intersection with the perianesthesia setting is constructible; therefore, designing new ways of exploring the gaps in knowledge in the literature is possible.

The following chapter summarizes the history of end-of-life directives in the US and the current literature surrounding adult perianesthesia DNR orders and other limiting directives. This examination is undertaken with a Foucauldian bent toward constructing a historical context that illuminates gaps in current knowledge about perianesthesia directives limiting care. This historical and theoretical analysis of the literature—what is known and unknown—justifies the proposed inquiry. Next, the utility of using a Foucauldian and Georges' (2013) Mid-Range Theory (MRT) of compassion for nursing to make sense of the body of knowledge about perianesthesia directives limiting care is demonstrated. Finally, historical context and the prevailing ethical discourses in the perianesthesia setting constructed from the available literature are synthesized to inform the research questions that will guide the proposed inquiry.

Historic Entrenchment of Cardiopulmonary Resuscitation

Kouwenhoven et al. (1960) reported the first successful clinical trials on humans involving closed cardiac massage at the Johns Hopkins Hospital in the US. Kouwenhoven et al. (1960) was the apex of a series of clinical trials undertaken by scientists and physicians at Johns Hopkins in their efforts to develop a portable defibrillator and devise a treatment for sudden death outside the operating room (Kouwenhoven & Kay, 1951; Kouwenhoven & Milnor, 1954; Kouwenhoven et al., 1957). The Johns Hopkins clinical trials were preceded by animal studies and anecdotal evidence collected from the 1940s and 1950s. However, the Kouwenhoven studies laid the foundation for modern Cardiopulmonary Resuscitation (CPR) by proving the efficacy of closed chest cardiac massage and electrical countershock defibrillation in cardiac arrest. Before

this time, open cardiac massage was the standard of care, but it was practicably limited to the operating room. Of note, even after Kouwenhoven et al. (1960) demonstrated the effectiveness of CPR, Jude et al. (1964) reported resistance to external cardiac massage from surgeons and anesthesiologists trained in open cardiac massage.

The culminating and seminal evidence-based protocol for CPR by Jude et al. (1964) marks the modern era of sudden death resuscitation. Jude et al.'s work is remarkable today, however, for reasons beyond the groundbreaking protocol. First, the protocol for CPR delineated by Jude et al. is little changed today. The modern process and rationale for CPR are curiously like the protocol and clinical reasoning explained by Jude et al. in 1964. Second, the historical context that made developing a treatment for sudden death miraculous is evident in the narrative of the Kouwenhoven, Jude, and Knickerbocker studies in the 1950s. Jude et al. detail the history and development of CPR prior to 1960. Simultaneously, the Kouwenhoven, Jude, and Knickerbocker reports offer glimpses of clinical practice before CPR. Here, the historical intersection between CPR and perianesthesia care is most evident. As an illustrative example, Jude et al. recount the events surrounding the death of Hannah Greener in 1848. Greener, a young girl, suffered sudden cardiovascular collapse during the removal of a toenail. The iatrogenic cause of her death was likely an overdose of chloroform. The lack of efficacious treatment for anesthetic overdose and Greener's attending surgeon's distress is evident in the physician's testimony. Thus, fear of iatrogenic death—of causing death—became inextricably bound to anesthesia during the mid-nineteenth century and likely continued into modernity.

It is easy in today's technologized clinical environment to forget that until Kouwenhoven et al. (1960), the only efficacious treatment for sudden arrest was open cardiac massage—a procedure of dubious efficacy requiring expert surgical skill. Beck et al. (1947) reported the first

successful use of open cardiac massage to resuscitate a patient undergoing cardiac surgery for pectoris excavatum. Beck et al. noted that sudden cardiac death occurs during surgeries and that the case report of successful open cardiac massage for patients in ventricular fibrillation represented a step forward for surgeons and anesthesiologists. Interestingly, it was an incidental finding during the Kouwenhoven experiments when clinicians noted a small increase in blood pressure from the force of applying external defibrillator paddles that the potential for closed cardiac massage was realized (Jude et al., 1964). It is not difficult to imagine that—even in the mid-twentieth century—the feelings of powerlessness experienced by operating room clinicians continued to resonate during sudden cardiac death.

Along with other studies of the time, Klassen et al. (1963) finally affirmed the efficacy of closed cardiac massage in perianesthesia patients. The importance of having an effective treatment for cardiac collapse during anesthesia at that time is difficult to overstate. Recall that only a few decades before, Beck et al. (1947) first demonstrated the efficacy of exposing the heart for manual massage during cardiac arrest in the operating room. Even in the 1960s, defibrillators were scarce and novel instruments of cumbersome design (Jude et al., 1964). Moreover, clinicians often resisted the new intervention of external cardiac massage in favor of the less reliable but better accepted open technique. The frisson permeating even the logical positivist articles and narrative reports of the time is palpable. For example, Edmond Eger, II, an anesthesiologist practicing during that time, explains the anesthesiologist's feeling after successfully intervening when someone stops breathing from an iatrogenic cause. Eger observes, "imagine the impact that it'd have on a first-year medical student the power, my God the control. What a wonderful specialty this must be" (Wood Library-Museum of Anesthesiology, 2021). It

is this historical moment where power-knowledge finds meaningful material expression in the perianesthesia setting.

Institutionalization of Cardiopulmonary Resuscitation

The Kouwenhoven studies in the 1950s and 1960s laid the foundation for modern CPR by proving the efficacy of closed chest cardiac massage. Soon, operating rooms adopted CPR protocols for intraoperative resuscitation. Not surprisingly, the use of CPR quickly spread from the operating room to the rest of the hospital and into the field over the next two decades. Despite the ethical and moral forewarnings issued by Jude et al. in 1964, the treatment escalated into the 1970s (Bishop et al. 2010). During this time, concerns over the pervasiveness of CPR and its usefulness in caring for terminally ill patients emerged; nevertheless, many clinicians argued that CPR should be universally applied and withheld only for the "irreversibly, irreparably ill patient whose death is imminent" (Rabkin, 1976, p. 365). This doctrine permeated policymaking, but it also created tension in practice when clinicians realized the suffering created by some resuscitations. For example, the "slow code" phenomenon where clinicians purposively delayed intervention at the end of life to prevent futile resuscitation. Nonetheless, CPR was inculcated in medical education and entrenched in hospital cultures by this time. Indeed, CPR remains the only invasive medical treatment commonly undertaken without consent (Zinn, 2012). Furthermore, CPR pervaded the popular discourse as evocative images like Morabito's (1967) "The Kiss of Life" made CPR both mainstream and heroic.

Figure 3

Example of CPR in Public Discourse

Note. This image, originally published in the *Jacksonville Journal* newspaper, captures a utility worker successfully administering mouth-to-mouth resuscitation following an accidental electrocution. The photo titled "The Kiss of Life" won a Pulitzer Prize in 1967 and was widely circulated to broad public acclaim. From the Florida Times Union Collection, by R. Morabito, 1967, “The kiss of life." Copyright 2020 by the Jacksonville Historical Society. Reprinted here with written authorization by the copyright holder.

Heretofore underexamined ethical concerns stemming from the extension of biological life, CPR, and the rise of biomedical technology coalesced with the high-stakes nature of healthcare. These concerns demanded a new branch of ethical philosophy. Bioethics developed from a need for ethical decision-making with meaning for practicing clinicians (Callahan, 1974).

In the seminal essay, “Bioethics as a Discipline,” Callahan articulates the foundation of modern bioethics. Callahan advocated a systematic and clinically situated process that better addressed the problematic ethical issues encountered by clinicians. Callahan’s call for the development of bioethics as a discipline contrasted with the more theoretical and academically contemplative philosophical ethicists available as resources to clinicians at the time. Critically, as Callahan notes of the new discipline,

> by far the most difficult task is that of helping scientists and physicians to make the right decisions, and that requires a willingness to accept that at some discreet point in time all the talk has to end and a choice has to be made, a choice which had best be right rather than wrong. (p. 68)

Callahan argued that bioethics must satisfy the unique requirements of real-life health care decision-making. Bioethics, while informed by philosophical ethics, is unique because of the special requirements of clinical medicine.

In 1979, Beauchamp and Childress produced their seminal work, *Principles of Biomedical Ethics,* in response to the specific needs of bioethics as a discipline outlined by Callahan (1974). Beauchamp and Childress delineated a set of ethical decision-making principles, autonomy, beneficence, nonmaleficence, and justice. These principles are the tenets of bioethical decision-making (Beauchamp & Childress, 2009). When faced with ethical conflict, decision-makers may use these principles to choose the most ethical option to resolve the dilemma. Thus, the rapidly developing discipline of bioethics supported the formation of dichotomies—either-or choices. Moreover, ethically troubling phenomena were constructed as problems seeking discreet resolutions.

In the broader culture, two formative legal cases about the use of lifesaving and life-sustaining measures, such as CPR and end-of-life care, developed around this time. The case of Karen Quinlan sparked a debate about quality of life. In 1975, Quinlan's father brought a lawsuit against his daughter's hospital. He wanted to remove his 21-year-old daughter's ventilator because she was in a vegetative state. Quinlan's father testified that his daughter would not want to live in her condition. Before Justices could issue a decision, however, Quinlan was weaned from the ventilator, and she existed in a vegetative state for another ten years (*In re Quinlan*, 1976). Years later, in 1983, another noteworthy case again thrust the "right to die" argument into the American consciousness. In *Cruzan v. Director, Missouri Department of Health* (1990), Nancy Cruzan's parents brought their quest to discontinue their daughter's feeding tube to the US Supreme Court. Like Quinlan, Cruzan was a young woman also in a persistent vegetative state. The Court found that although patients have the right to die, the states must establish the rules governing the withdrawal of medical treatment (Miller, 2017). The Missouri Supreme Court returned the case to the lower court, but Cruzan's parents could not prove that their daughter would not want to live in her condition—the legal criterion at the state level. In these two cases, the Court's rulings cemented the importance of making clear one's end of life wishes before a life-threatening incident occurs and, optimally, memorializing those wishes in writing.

By 1983, implied consent for CPR would be formalized as the default standard of care in hospitals when the *Presidential Commission for the Study of Ethical Problems in Medicine and Biomedical Research* (1983) determined that CPR should be initiated in the event of pulselessness unless expressly rejected by the patient before the event. Notably, the Commission also concluded that, in most circumstances, autonomy is the preeminent ethical tenet in healthcare—outweighing notions of beneficence or nonmaleficence on the part of the clinician.

Simultaneously albeit somewhat paradoxically, the Commission also constructed a self-perpetuating framework for future biomedical research, thus, elevating analyses that favor safety and preserving biological life while marginalizing divergent viewpoints. Examples of divergent points-of-view include the suggestions that quality of life may outweigh quantity of life or that death and dying are natural, culturally bound phenomena that have become overly medicalized.

While CPR's universal rightness was establishing dominance in the biomedical, legal, ethical, and popular discourses, a paradigm shift in the provider-patient relationship occurred. The last 50 years witnessed a change from the paternalistic attitudes of the past, placing a new emphasis on patient-centered care (American Nurses Association, 2001, 2015; Bishop et al., 2010). These developments—alongside the Quinlan and Cruzan cases—led to the Patient Self-Determination Act (PSDA). The PSDA codifies the patient's supremacy when making decisions about their care at the end-of-life. The PSDA and its subsequent revisions a) ensure that patients are provided information about their rights to accept or refuse treatment; b) require that facilities screen and honor advance directives (to the extent directed by state law); c) mandate health care staff and public education on advance directives; and d) require states to pass *flexible* laws on advance directives (PSDA, 1990). These standards are currently regulated by the Joint Commission (Joint Commission, 2016) and the Centers for Medicare and Medicaid Services (Miller, 2017; PSDA, 1990; Zinn, 2012). The PSDA increased the number of adults with executed advance directives. Estimates from 1995 suggested that 15 % of hospitalized patients had a DNR order (Margolis et al., 1995). By 2017, Yadav et al. found that approximately 37 % of people in the US have an advance directive.

From the 1990s until today, US clinicians have based choices about death and dying on the belief that the patient has the right to self-determination (Bishop et al., 2010). Nevertheless,

there remain lingering and confusing clinical situations not explicitly covered by the PSDA. For example, anesthesia care blurs the demarcation between usual perianesthesia treatments and resuscitation (Zinn, 2012). An example provided in an earlier chapter was the relatively straightforward administration of vasoconstrictive medication in response to anesthesia-induced vasodilation. Based on findings from their simulation-based study, however, Waisel et al. (2006) observe, "The increasing uncertainty of the likelihood of a successful intervention increases the subjectivity of what may be considered a 'temporary and reversible' condition" (p. 74). In the study, Waisel et al. (2006) engaged 30 anesthesiologists in a simulation where a patient with a documented DNR order wanted only 'temporary and reversible" interventions during anesthesia. Regardless, 90 % of the subjects followed the simulation to its near conclusion before halting resuscitation. This meant that in simulation, the anesthesiologist subjects inserted chest tubes, defibrillated lethal dysrhythmias, and even started Intra-Aortic Balloon Pump (IABP) cardiovascular support. Waisel et al.'s (2006) analysis showed that anesthesiologists rationalized that even very invasive interventions bound to require prolonged, intensive care management were temporary. The iatrogenicity of the precipitating event seemed to be a contributing factor to their reasoning.

The preceding exemplar illustrates the complex and subjective attributes of decision-making during and immediately following anesthesia. Perianesthesia clinicians must make these decisions in-the-moment without direction from the unconscious patient or family members who are not present in the operating space. They are dependent on their understandings of vague terms like "temporary" and "reversible." Early 1990s health care literature was rife with debate about intraoperative DNR orders, but automatically revoking DNR orders for the perianesthesia period was especially troubling for clinicians both for and against suspension (Waisel et al.,

2002). The confluence of literature suggests the development of a schism between the management of DNR orders in the perianesthesia setting and the rest of the hospital. This divergence developed around the time the PSDA was enacted.

Many anesthesia clinicians practicing when the PSDA took effect believed that performing surgery under general anesthesia without the option to resuscitate the patient was like asking the anesthesiologist to commit murder (Truog, 1991). They believed that the nature of anesthesia required frequent resuscitation (Waisel et al., 2002). Zinn (2012) postulates that this incongruity stems from difficulty differentiating aggressive intervention from actual resuscitation in the perioperative environment. However, Walker (1991) constructs the countervailing ethical argument that automatic revocation of DNR orders before surgery or anesthesia is unethical. Furthermore, in an editorial response to Walker, Younger et al. (1991) concur that there is a difference between aggressive intervention and resuscitation identifiable to experienced clinicians and that automatic DNR revocation is ethically untenable. Nevertheless, similar concerns affirming the anxiety surrounding perianesthesia directives limiting care is evident in Bastron's (1996) critique of Fine and Jackson (1995) and Fine and Jackson's response (Bastron, 1997). Similarly, Cohen and Cohen (1997) submit a letter to the editor of *Anesthesiology* addressing the concerns raised by Bastron, such as informed decision-making and the limits of autonomy.

These dialectics—Walker-Truog and Fine and Jackson-Bastron-Cohen—likely underpin policies of mandatory reconsideration of DNR orders before anesthesia—the current standard of care (Hardin & Forshier, 2019). Nevertheless, a pervasive and—in hindsight—a paternalistic sense that patients with DNR orders should not receive surgical intervention because the patient's condition was likely terminal was not resolved through these ethical debates (Bishop et al., 2010;

Coopmans and Gries, 2000; Younger et al., 1991). Zinn (2012), alongside Scott and Gavrin (2012), undermine the assertion that it is illogical to seek surgical intervention when dying by observing that there are multiple reasons that someone with a DNR order may want or need surgery. One likely example is the surgical repair of a painful hip fracture in a patient with metastatic cancer who otherwise had a good functional status. Confusion and conflicts about patients' motivations, values, clinical status, and care goals or objectives when executing DNR orders continue to trouble perianesthesia clinicians today.

Contemporary Construction of Perianesthesia Directives Limiting Care

Current thinking about perianesthesia DNR orders originates with Walker's (1991) explication of the ethical principles underlying DNR management. Although the debate about how to best manage directives limiting care would continue, Walker represents a realization among some clinicians that the old way of managing perianesthesia DNR orders with automatic revocation was ethically unsustainable. However, over time Walker's recommendations evolved into a complex epistemological construct. Hardin and Forshier (2019) used a five-sided schema to explore the different dimensions of thinking about perianesthesia DNR orders. The five facets are ethical, legal, practice guidelines, policy development, and human/clinician. Based upon the findings of that systematic literature review, Hardin and Forshier provide compelling evidence of scholarly consensus in four of these five dimensions. Of the five facets, the human/clinician dimension remains most contested in the literature. The findings from each of the five dimensions constructed by Hardin and Forshier are summarized below. Readers are referred to Hardin and Forshier for an exhaustive analysis of the extant literature.

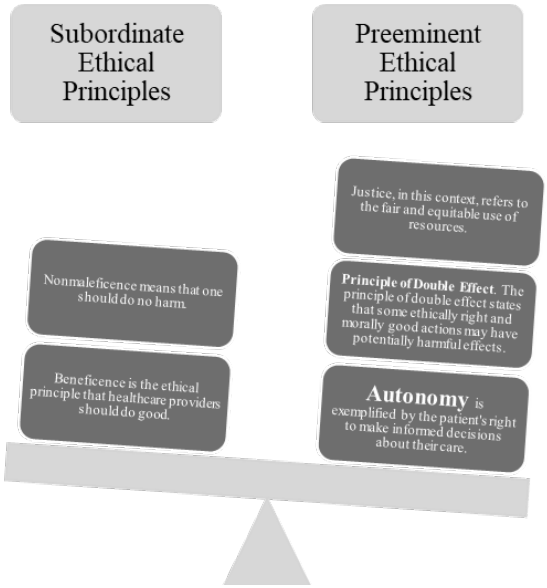
Ethical Dimension

Scholarly work on perianesthesia DNR orders developed in an environment influenced by post-positivistic approaches to science. In the ethical dimension, this influence is evidenced by a universally principlist approach to resolving the problem of automatically revoking perianesthesia DNR orders. Principlism, as previously explained, is epitomized by the works of Beauchamp and Childress (2009). Principlists weigh ethical tenets, for example, autonomy, beneficence, nonmaleficence, and justice, in context to arrive at ethically sound decisions.

Although plagued by varying degrees of oversimplification, principlism dominated the formation of ethical opinion on perianesthesia DNR orders. Like the Presidential Commission in 1983, the bulk of the literature on the ethical dimension concluded that autonomy and self-determination are the preeminent principles when making decisions about perianesthesia DNR orders. Bastron (1996) articulates the minority opinion based on the limitations of autonomy, while Bishop et al. (2010) provide an intriguing alternative lens for rethinking how DNR orders are managed. Nonetheless, Hardin and Forshier (2019) concluded through a preponderance of the evidence that automatic revocation of DNR orders is ethically unacceptable (Ball, 2009; Byrne et al., 2014; Crigger & Sindt, 2015; Ewanchuk & Bradley, 2006; Guarisco, 2004; Loch, 1994, Margolis et al., 1995; Reeder, 1993; Sumrall et al., 2016; Zinn, 2012). Put succinctly: patients have the right to refuse medical treatment—including limiting resuscitation options during surgery—even if it results in their deaths (Walker, 1991). Moreover, according to Walker (1991), while the iatrogenic nature of the patient's death during anesthesia is morally burdensome to clinicians, iatrogenicity is not a justification for supplanting patient autonomy. Principlist thought on perianesthesia DNR orders, as synthesized from the literature, is displayed in Figure 4.

Figure 4

Current Principlist Ethical Reasoning on Perianesthesia DNR Orders



Note. Adapted from "Adult Perianesthesia Do Not Resuscitate Orders: A Systematic Review (Table 2)" by J. B. Hardin and B. Forshier, 2019, *Journal of Perianesthesia Nursing, 34*(5), 1054–1068. doi: 10.1016/j.jopan.2019.03.009. Copyright 2019 by Elsevier. Reprinted here with written authorization by the copyright holder.

Legal Dimension

Waisel et al. (2002) provide a comprehensive review of the laws and legal precedent impacting perianesthesia DNR orders. In summary, the risk of liability from a patient with a DNR order who dies intraoperatively is low. The authors suggest that the liability risk from performing an unwanted resuscitation in a patient who survives the resuscitation is higher than if the patient died, either from their underlying condition or iatrogenically. A clinician who performs any treatment against a patient's expressed wishes may have committed a battery and may be prosecuted (Pope, 2017). Nevertheless, it is clear from a review of the relevant literature that perianesthesia providers are concerned about liability (Waisel et al., 2006; Younger et al.,

1991). Resultantly, the legal recommendation constructed from the literature is that the anesthesia provider and the patient have a preoperative conversation about how to handle their DNR order (or other directive limiting treatment) during the perianesthesia period. Furthermore, it is incumbent upon the anesthesia provider to effectively communicate these decisions about DNR status to the entire perianesthesia team and provide adequate documentation in the medical record. Finally, another stream of concern relates to intraoperative death reflecting negatively on the surgeon's reputation, the anesthesia team, or the hospital. Younger et al. (1991) and the Joint Commission (2016) concur that correctly documenting patients' DNR wishes before surgery ensures that the death is classified as anticipated for regulatory and reporting purposes rather than an unanticipated death.

Practice Guidelines Dimension

The American Society of Anesthesiologists (ASA, 2018) urges a mandatory reconsideration policy for all perianesthesia DNR orders or other directives limiting care. In addition to the ASA, the major professional societies most directly involved in this process are the American College of Surgeons (ACS), the Association of Perioperative Registered Nurses (AORN), and the American Society of Perianesthesia Nurses (ASPAN). These organizations have issued position statements that concur with the ASA's guidelines (ACS, 2014; AORN, 2020; ASPAN, 2018). Interestingly, the ASA and ACS first issued a joint statement in 1994 that called the practice of automatically rescinding DNR orders before surgery ethically untenable (ACS, 1994). Notably, perhaps crucially, the recommendations are ambiguous as to who ultimately has responsibility for addressing the limiting directive—anesthesia provider, surgeon, or internist.

Since the standard of care is unanimous across disciplines, it is difficult to imagine that a clinical problem still exists. However, research suggests a need for further education surrounding perioperative DNR orders (Urman et al., 2018). A study conducted by Coopmans and Gries (2000), five years after the initial joint statement, found that only about half of the responding Certified Registered Nurse Anesthetists (CRNAs) surveyed indicated that their facility had a policy governing intraoperative DNR orders. A recent replication of the survey found that today's facilities are more likely to have policies supporting *routine informed suspension* of DNR orders (Gu et al., 2021). In particular, Schwarze et al. (2013) found that surgeons may contract for preoperative "buy-in" from patients that they will allow life sustaining treatment postoperatively. Sixty percent of the surgeons Schwarze and colleagues surveyed might refuse to operate if limiting directives prevented aggressive postoperative intervention. Nurok et al. (2014), found similar resistance to embracing mandatory reconsideration to those expressed by CRNAs in 2000. The paucity in practice change to reflect current practice standards combined with the frequency with which anesthesia providers encounter patients undergoing surgery with DNR orders underscores the need for education and continuous quality improvement efforts (Hardin & Forshier, 2019; Baumann et al., 2017).

Currently, the standard of care is the enactment of policies requiring mandatory reconsideration of DNR orders before surgery or anesthesia. Clinicians' ability to familiarize themselves with the patients' goals and objectives for retaining or modifying DNR orders in a high-production, time-sensitive environment is questionable, however (Waisel et al., 2002). The tendency in clinical practice, therefore, may be to conflate patients' autonomy with the physicians' autonomy (Cohen & Cohen, 1997). Thus, ceding patient decision-making to the

physician for the duration of anesthesia may ease tension between clinician and patient, but it does not enhance the patient's well-being or offer safeguards that ensure ethical choices.

Policy Development Dimension

Mandatory reconsideration is a goal-directed treatment strategy whereby the anesthesia providers tailor treatment to the patient's goal, values, and objectives based upon a preoperative evaluation of the DNR order and a discussion with the patient. Notably, according to the ASA (2018), patients may choose to rescind, modify, or retain their DNR orders during anesthesia. Waisel et al. (2003) recommend developing *written* policies that are specific to the institution, flexible, explicit, require documentation, and enumerate resources for help. Historically, policy development evolved from automatic revocation to detailed policies that allowed patients to pick-and-choose the interventions they wanted during anesthesia, and, finally, to today's mandatory reconsideration and goal-directed treatment guidelines (Reeder, 1993; Hardin & Forshier, 2019; Waisel et al. 2002). Hardin and Forshier (2019), however, observe that goal-directed treatment is susceptible to paternalism because—once again—the anesthesia provider is placed in the role of the patient's health care proxy. At the institutional level, mandatory reconsideration policies may manifest in practice as routine suspension where patients are notified that their advance directive will be suspended for surgery (Gu et al., 2021). Whether patients attain an informed understanding of alternative choices is unclear in the literature.

Human/Provider Dimension

The human/provider dimension is simultaneously underexplored and essential to transformative practice change (Hardin & Forshier, 2019). The mass of knowledge about patients' values, perceptions, and objectives surrounding perianesthesia end-of-life care and those of clinicians comes from eleven articles: a classic series of three articles by Clemency and

Thompson (1993, 1994, 1997) alongside seven additional contributions: Coopmans and Gries (2000), Waisel et al. (2006), Scott and Gavrin (2012); Burkle et al. (2013), Schwarze et al., 2013, and Nurok et al. (2014). In the ninth article, Hiestand and Beaman (2019), studied 17 hospitalized surgical patients with DNR orders using conventional qualitative methods. Finally, Gu et al. (2021) updated and redeployed a web-based version of Coopmans and Gries' CRNA survey. Gu et al. found increases in institutional policies of mandatory reconsideration and a decrease in automatic revocation. Concerningly, however, Gu reports that familiarity with required reconsideration was associated with providers declining to care for patients continuing their DNR orders during surgery. Of these studies, only Clemency and Thompson (1997), Scott and Gavrin, and Burkle et al. focused (to greater and lesser degrees) on patients' attitudes toward DNR orders during anesthesia. Notably, Hiestand and Beaman add to qualitative understanding, but a lack of qualitative foundation for inquiry remains evident. The remaining articles focused on clinicians, both surgical and non-surgical. The results of these nine articles are summarized in Table 7 and comprise the bulk of knowledge about patients' values and objectives for perianesthesia resuscitation.

Table 7

Evidence Underpinning How Patients and Clinicians Manage Perianesthesia DNR Orders

Reference	Sample Description	Salient Findings
Clemency & Thompson (1993)	453 surveys sent to anesthesiologists who were active members of the Georgia Society of Anesthesiologists in 1990	• Anesthesiologists are disinclined to follow DNR during general anesthesia • Most anesthesiologists (60 %) believe that DNR orders are automatically rescinded during general anesthesia • Even if they had previously agreed to honor a patient's DNR order, most anesthesiologists would override a patient's DNR if the cause of the patient's death during anesthesia was directly related to anesthesia administration

	193 (n=193) surveys were returned and analyzed	• The sample overrepresented the 30-39-year-old age range but underrepresented anesthesiologists 55 and older ($p<0.001$). The sample also underrepresented solo practitioners ($p<0.001$) • 46% of respondents would require suspension of DNR orders during general anesthesia. However, respondents were more likely to retain a DNR order for spinal and Monitored Anesthesia Care (MAC) scenarios • Foundational Study
Clemency & Thompson (1994)	600 internists and 600 surgeons from Georgia were surveyed by questionnaire This was compared with 420 surveyed anesthesiologists. 192 (internists), 199 (surgeons), and 190 (anesthesiologists) responses were analyzed.	• Anesthesiologists (60%) are more likely than surgeons or internists to assume that a DNR order is automatically suspended before surgery ($p < 0.01$) • Foundational Study
Coopmans & Gries (1995)	500 active members of the American Association of Nurse Anesthetists (AANA) were surveyed by questionnaire The response rate was 45.6% (n=228)	• Most Certified Registered Nurse Anesthetists (CRNAs) are disinclined to follow DNR orders during general anesthesia • 67.2% of CRNAs assume that DNR orders are automatically rescinded during general anesthesia. Even if aware of an active DNR order, 40% of CRNAs would perform CPR
Clemency & Thompson (1997)	18 terminally ill perianesthesia patients	• Patients with active DNR orders desire surgery for a variety of reasons, from palliation to primary treatment

	with DNR orders interviewed from 1994-1995	• Because of different intents behind each patient's DNR order—for example, fear of prolonged intubation versus willingness to tolerate short periods of mechanical ventilation--assumptions about rescinding the order for surgery cannot be justified • Anesthesiologists must address DNR orders on a case-by-case basis
Waisel et al. (2006)	Descriptive Study N = 30	• In a simulation-based investigation, 57 % of anesthesiologists addressed resuscitation, 27 % suspended the DNR order against the patient's wishes. Ninety percent of participants continued simulated interventions until the simulation ended. This indicates continuing interventions well beyond the level of reversible complications. • Most preoperative reevaluations of DNR orders are of inferior quality • Only about half of the anesthesiologists surveyed were familiar with the ASA recommendations for perianesthesia DNR orders • In the simulation, patients' DNR orders were not adequately reevaluated, leading to miscommunication that resulted in the DNR being revoked without patient permission or physicians • Anesthesiologist participating demonstrated actions in the simulations indicating that they did not understand or actively disregarded the patient's DNR preferences • Anesthesiologists seemed less able to comprehend patients' preferences to refuse resuscitation than the patients' desires to receive resuscitation • Providers tended to overestimate the chances of successful resuscitation • The physicians in the study often based their decisions on the iatrogenicity of the potential death • Group-think may influence the persistence of automatic revocation of DNR orders and resuscitation in the perianesthesia environment

		• Simulation-based learning is an effective modality for learning about perianesthesia DNR orders
Scott and Garvin (2012)	Expert Opinion	• Integrates the patient's feelings about retaining or rescinding their DNR orders for anesthesia—includes patients' fears of being neglected if they retain the DNR order • Recommends that palliative care patients with DNR orders undergo an extensive negotiation with their anesthesia providers regarding their resuscitative wishes preoperatively • Provides extensive guidance on perianesthesia management of patients choosing to retain their DNR status
Burkle et al. (2013)	Survey of 500 sequential patients (84% response rate) 384 anonymous, online surveys of anesthesiologists, internists, and surgeons were included (53% response rate)	• Most surgical patients (57%) agreed that their DNR orders should be suspended during the perianesthesia period • 92% of patients surveyed believed that a discussion about their DNR orders should occur before surgery • 18% of anesthesiologist would automatically suspend DNR orders before surgery, but the statistic rises to 30% when surgeons and internists are included • 53% of doctors surveyed indicate they would not follow the DNR order if patients experienced intraoperative complications • 55% of doctors found retaining a perianesthesia DNR order illogical
Schwarze et al. (2013)	Survey Bivariate analysis	• 2100 surgeons surveyed. The adjusted response rate was 56 percent. • Surgeons (62 %) contract preoperatively for "buy-in" to allow resuscitation postoperatively • Sixty percent of surgeons surveyed would refuse to operate on patients wishing to limit life sustaining treatment postoperatively.
Nurok et al. (2014)	34 Board Certified Anesthesiologists were surveyed in a True or	• Found inadequate knowledge regarding the American Society of Anesthesiologist's recommendation of

	False fashion. The survey was "surprise" during a commonly attended meeting. Response rates varied from 33 to 34 per question	mandatory reconsideration of DNR orders before anesthesia • 45% of respondents believed that DNR orders should routinely be suspended before surgery
Hiestand & Beaman (2019)	N = 17 patients Conventional Qualitative Study using semi-structured interviews	• Patients' decisions to retain, rescind, or modify their DNR statuses were driven by the natural progression of their illnesses • Patients expected that a discussion with a clinician or expert occur before their DNR status changes • Patients held the strong position that their autonomy is paramount in perioperative DNR discussions
Gu et al. (2021)	N – 207 CRNA respondents. Exploratory quantitative descriptive design Chi Square Analysis	• A redeployment of an updated web-based version of Coopmans and Gries (1995) survey • CRNAs at teaching facility were more likely than those at non-teaching facilities to report familiarity with mandatory reconsideration ($p = 0.001$) • 75.3% of CRNA respondents reported only receiving informal education of mandatory reconsideration • When compared to the Coopmans and Gries findings, facilities are more likely to have policies addressing DNR orders, although CRNAs may not be as aware of the policies existence • CRNAs reported increased mandatory review of DNR orders with patient involvement, decreased automatic revocation, and increased informed routine suspension of DNR orders ($P < 0.001$) • CRNAs identified the patient (55 %) and surgeon (19 %) as most responsible for addressing DNR orders • A significant correlation ($P = 0.004$) exists between CRNA familiarity with mandatory reconsideration and possible refusal to care for a patient with an active intraoperative DNR order.

	• CRNAs report that "routine informed suspension" of DNR orders typifies current culture • Low response rate: 207 CRNAs responded to 3,000 surveys (6.9 %)

Note. Adapted from "Adult Perianesthesia Do Not Resuscitate Orders: A Systematic Review (Table 2)" by J. B. Hardin and B. Forshier, 2019, *Journal of Perianesthesia Nursing, 34*(5), 1054–1068. doi: 10.1016/j.jopan.2019.03.009.

Nurok et al. (2014) support earlier findings from Clemency and Thompson (1993, 1994) that most anesthesia providers are unaware that DNR orders should no longer be automatically suspended before surgery. Waisel et al. (2006), similarly, found that about half of anesthesiologists were unfamiliar with ASA recommendations for managing perianesthesia DNR orders. In addition, many anesthesiologists and CRNAs feel increased anxiety when caring for patients with DNR orders (Clemency &Thompson, 1993, 1994; Coopmans & Gries, 2000). Indeed, many anesthesiologists would intervene against patients' wishes if they felt the cause of death was reversible (Clemency & Thompson, 1993; Waisel et al., 2006). Waisel et al. 2006 found that anesthesiologists' fear of being responsible for iatrogenic death may drive them to pursue resuscitative interventions that are well beyond patients' wishes. There is little evidence to suggest that today's perianesthesia setting significantly differs from the portrait constructed between 1990 and 2014.

From patients' perspectives, Burkle et al. (2013) found that most patients (92%) expected to discuss their DNR status before surgery. Hiestand and Beaman (2019) confirm these findings. However, Burkle et al. also found that the majority (57%)—if given all the relevant information—would choose to suspend their DNR orders before surgery. Cohen and Cohen (1992) prognosticated this outcome. Burkle et al. along with Scott and Gavrin (2012), conclude

that patients choose to retain their DNR orders during anesthesia for a multitude of reasons that may not always seem logical to anesthesia clinicians. For example, having more time to share with loved ones. Patients' reasons for retaining their DNR during surgery are myriad and need not be met with unnecessary scrutiny by clinicians according to Scott and Gavrin. Moreover, Hiestand and Beaman found that patients strongly valued their autonomy to make decisions about perianesthesia DNR status. In support of this conviction, Burkle et al. found that patients were able to understand the complexity and clinical nuances of anesthesia during preoperative consultations with anesthesia providers. However, anesthesia providers often cite the inability of patients to grasp the complexity of anesthesia care as a reason to suspend DNR orders (Clemency & Thompson, 1993; Burkle et al., 2013). Notably, there is scant evidence in the extant literature explicitly investigating the role of the caregiver or health care proxy in the perianesthesia setting. Such an inquiry might lend valuable insights into how patients' values are represented in this process. Nevertheless, the available evidence led Waisel et al. (2003) to conclude that a "value dissonance" (p. 210) exists between the outcomes desired by patients and the values and objectives of clinicians. According to Waisel (2003), physicians concentrate on preventing impending death while patients value preserving functional status.

In summary, there is sufficient evidence to conclude that it is ethically wrong to automatically revoke DNR orders before anesthesia or fail to reevaluate directives limiting care meaningfully. This ethical position is supported legally and with policies at the regulatory and institutional levels. Nonetheless, clinicians have not embraced policies of mandatory reconsideration—the current standard of care. Even where such policies have been enacted, power is exercised to position anything less than rescinding the limiting directive as

unacceptable. The remaining sections of this chapter explore some of the factors sustaining the problem and construct the case for an inquiry that addresses these factors.

Justifying Inquiry into Perianesthesia Directives Limiting Care

Automatic revocation of DNR orders before anesthesia remains a problem in perianesthesia settings today (Hardin & Forshier, 2019; Hiestand & Beaman, 2019). Where policies are created requiring mandatory DNR reconsideration before anesthesia, a culture of de facto automatic revocation may develop (Hardin & Forshier, 2019). In de facto automatic revocation, the ethical climate does not empower patients to retain or modify their DNR orders. In these settings, forced deference to the provider's comfort and objectives is tacitly enforced. More investigation is needed to understand this phenomenon (Hardin & Forshier, 2019). However, this is only one—albeit dominant—discourse constructing the ethical climate in the perianesthesia setting. Other discourses intersect with power to create the biotoxic spaces that allow for automatically suspending DNR orders. For instance, the literature suggests that paternalism, fear, toxic masculinity, and overemphasizing production are discourses that intersect with power in perianesthesia settings. Each discourse helps explain how perianesthesia bioethical discourse writ large creates the ethical choices available to both patients and clinicians.

Power is buttressed by paternalism, fear, toxic masculinity, and production demand, and these discourses are used here as lenses for analysis that explain the formulation of this inquiry's research questions related to power relations. Furthermore, each of the discourses suggested by the literature: a) offer a basis for the development of interview guides and probing extemporaneous interrogatives for this inquiry; b) provides a foundation for the analysis of discursive data; and c) suggests new avenues of inquiry for future investigators.

Paternalism

As previously mentioned, the latter half of the twentieth century witnessed a move toward patient-centered care and a rejection of paternalism (ANA, 2001, 2015). However, procedural areas, like the operating room and perianesthesia departments, clung to paternalism in the name of patient safety. Clemency and Thompson (1993), for example, found that, in practice, 46% of anesthesiologists would not abide by an active DNR order during general anesthesia even though they had agreed to the DNR preoperatively. Indeed, most anesthesiologists continued to assume that DNR orders are suspended before surgery (Clemency & Thompson, 1993). Once the unethical nature of automatic revocation of DNR orders before surgery was recognized, Waisel et al. (2002) observed a distinct turn toward empowering patients to make decisions about their DNR statuses in the literature that persisted for several years. Nevertheless, by 2010, the tide shifted toward goal-directed management. Although well-intentioned, goal-directed management emphasizes the clinician's decision-making and places the anesthesia provider in the role of patient surrogate. Interestingly, many of the older references cited here remain contemporaneously useful and descriptive, indicating only incremental erosion of paternalism in the perianesthesia setting. Also, some early references represent the most recent research addressing the topic. The entrenchment of paternalism in perianesthesia ethos is evident in literature extending from the 1990s through the 2010s, suggesting that the problem is both current and historically mediated. In discourse, paternalism manifests in statements such as, "The best way to avert such confusion is to develop a policy and process that recognize that after obtaining informed consent from the patient, physicians can suspend the DNR order for the operative period" (Franklin & Rothenberg, 1992, p. 182). The hierarchal subject positions are of particular note in this statement.

Fear

Walker (1991) authored the first substantive ethical rebuke of automatic DNR revocation before anesthesia. Indeed, Walker's deconstruction and ethical explication—especially when read as a dialectic with Truog (1991)—remains contemporaneously relevant. Whereas the clinician who inserts a urinary catheter is rarely blamed for a subsequent infection that causes iatrogenic death, anesthesia providers report that they would feel personally responsible for intra-anesthesia death (Clemency & Thompson, 1993, 1994). Fear of iatrogenic death and the moral distress caused by not intervening to restore homeostasis is a significant impediment to patient empowerment (Waisel et al., 2002). Fear of reversible or iatrogenic death may be further exacerbated because patients who experience intraoperative cardiac arrest are more likely than other hospital patients to survive (Kalkman et al., 2016). Furthermore, fear of losing rank or status, for example, Georges' zoe/bios dichotomy, may also contribute to the perianesthesia discourse on directives limiting care. An example of a discursive statement from the literature supporting fear as a discourse: "The patient is not going to die on my watch" (Waisel et al., 2002, p. 468). Interestingly, this statement intersects with discourses on masculinity. For example, while "I" may not allow the patient to die, another, *lesser* clinician will allow their death.

Toxic Masculinity

Walker (1991) notes, "The operating room is a powerful stronghold of pure physician authority. In the OR, there is a strict hierarchy of personnel, with the surgeon in command" (p. 2408). In addition, common statements like, "No one has a DNR on my table," or "No one dies in my OR" (Waisel et al., 2002) may reflect a discourse supporting toxic masculinity that still exists today. Although closely related to—and likely sustaining—paternalism or sublimating fear

in the perianesthesia setting, toxic masculinity emphasizes ownership instead of paternal concern. Furthermore, toxic masculinity may support the defacto DNR revocation phenomenon. As noted, anesthesia clinicians sometimes create an environment that forces deference to their superior knowledge. In this construct, resistance is met with displeasure or even discipline. Additionally, relational discourses are curtailed. For example, feelings, emotions, and narrative reasoning are minimized, and discussion is halted. This discourse may also be evident in nurse-physician interactions. However, knowledge about this discourse is poorly developed. Additional investigation of the phenomenon vis-à-vis perianesthesia decision-making is needed.

Production Demand

Waisel et al. (2002) observe that the operating room and the perianesthesia setting are unique in the hospital. Although financial and economic concerns are present in other areas of the hospital, the perianesthesia department uniquely focuses on production. Here, production refers to throughput and maintaining the operating room schedule to increase monetary income for the organization (Waisel et al., 2006). Perianesthesia clinicians are under consistent pressure to cut-time and maximize the number of surgeries completed on-time. Paradoxically, however, the current standard of care, goal-directed management of DNR orders, requires the anesthesia provider to obtain an operationalizable sense of patients' goals and values. Developing meaningful knowledge about the patient's end of life wishes cannot reasonably be achieved in a brief conversation before surgery and requires an investment of time unavailable in most perianesthesia settings. Therefore, anesthesia clinicians tend to err on the side of sustaining life—regardless of the patient's objectives (Burkle et al., 2013; Waisel et al., 2002; Waisel et al., 2003; Waisel et al., 2006). Moreover, the limited time that clinicians have to interact with

patients creates a distance—both real and metaphorical—that is exacerbated by the absence of family and unconsciousness during anesthesia.

Paternalism, Toxic Masculinity, Fear, and Production Demands in Context

When analyzed contextually, the totality of the literature on perianesthesia DNR management suggests a setting of increased production demand combined with a dangerous culture of hegemonic masculinity that encourages clinicians' heroism while deemphasizing emotion and empathy. Thus, fears of being judged by peers and exposing personal weaknesses in a culture that has constructed death as failure and emotions as deficiencies and threats to productivity contribute to an environment where silencing talk of death is rewarded. The coalescence of these forces resulted in perianesthesia cultures that paternalistically minimize the needs of patients in favor of privileging the needs of healthcare providers and clinicians. The apparatus of control most available to perianesthesia clinicians is power-knowledge. In this construct, the clinician speaks the "true" language of anesthesia, and they are the ones best situated to make decisions. Indeed, the perianesthesia clinician is obligated to maintain the safety of the patient, who cannot full-wittedly understand their peril. Thus, within a historical context, it is possible to see how patients may be systematically oppressed. This imbalanced power dynamic is inherent in every perianesthesia interaction, but it remains relatively unaddressed in the perianesthesia literature.

Gaps in Knowledge

Hardin and Forshier (2019) conclude that the value discord between anesthesia clinicians and patients poses a significant challenge for creating ethical climates that empower patients and elevate human dignity. In addition, the authors identified other gaps in knowledge. For example, evidence missing in the literature includes: a) the attitudes, motivations, feelings, and perception

of clinicians and patients about perianesthesia end-of-life care, b) how patients and families experience the idea of iatrogenic death during surgery, c) patients' abilities to understand and make choices about perianesthesia resuscitation, d) what and how much patients and families comprehend about making decisions on the disposition of their DNR orders during anesthesia; e) how resuscitation is distinguished from routine perianesthesia care; and f) whether patients feel empowered to express their points-of-view when discussing perianesthesia DNR orders before surgery (Hardin & Forshier, 2019). Future inquiries that help clinicians better understand how reality is constructed in the perianesthesia setting and how patients and clinicians formulate their decisions about DNR orders before anesthesia are required.

Synthesis

There is scholarly agreement on the ethics of automatically rescinding DNR orders before anesthesia. The practice is morally and ethically wrong. Nevertheless, the ethical explication has failed to resonate with perianesthesia clinicians. Ethical thinking on this subject developed within a principlist paradigm. Although the dominance of bioethics and principlism in healthcare ethics is undeniable, nurses tend to narratively transfer ethical knowledge and understand ethics in different ways (Benner et al., 2008). Nurses often think about ethics as embodied, practice-based, real-time, emotion and value-laden, and relational (Hardin, 2018). Benner et al. (2010) term this "everyday ethical comportment." Moreover, Benner (2005) suggests that emotions guide nurses and other clinicians when weighing competing goods. Benner (2005) observes,

> Emotional attunement creates the possibility of rational action, despite the fact that emotions can also be the seat of irrational actions. Emotional responses can act as a moral compass in responding to the other and in guiding one's sense of the situation. (p. 154)

Benner's (2005) observation is, perhaps, nursing's most significant discipline-specific contribution to health care ethics. However, discourses like paternalism and toxic masculinity create spaces that marginalize emotions, even as fear permeates those same spaces, hidden to patients and clinicians alike.

Foucauldian genealogy offers a mechanism for making hidden discourses visible. When analyzed in historical context, the clinician's fears about the limits of biomedicine and death begin to crystallize. Similarly, other discourses—paternalism, toxic masculinity, production demand —that have attained authoritative dominance in the perianesthesia setting are illuminated. These discourses exert control and construct reality in the perianesthesia setting to preserve the clinician's power-knowledge. Moreover, in the same way that knowledge is transmitted from clinician to clinician, discourses are—often opaquely—reproduced. The Foucauldian framework proposed for this inquiry is an apt method for investigating the hidden discourses that create the choices available to both patients and clinicians before anesthesia.

Although Foucault will provide the overarching framework for this inquiry, Georges' (2013) Mid-Range Theory of emancipatory compassion for nursing offers a granular, praxis-based lens for analyzing the current body of knowledge as well as future findings. Georges' MRT suggests three common antecedents to creating biotoxic spaces where unethical behavior is possible: the zoe/bios dichotomy, distance, and an environment of free-floating responsibility. The articles, evidence, and literature presented in this chapter demonstrate that these elements may exist in the perianesthesia setting. For example, although consensus exists in the practice guidelines dimension, the current guidelines are unclear where the seat of responsibility for addressing perianesthesia DNR orders lies (i.e., anesthesia provider, nurse, surgeon, internist)—free-floating responsibility. Simultaneously, distance is created through the patient's isolation in

the cloistered perioperative department and by the nature of anesthesia (i.e., production demands, separation, and medically induced unconsciousness). Finally, the literature suggests an inherent power imbalance that perianesthesia discourses and the broader epistemic regime of truth covertly conspire to sustain—the zoe/bios dichotomy. Therefore, based on a review of the literature, Georges' MRT of compassion for nursing provides a justifiable theoretical lens for future analysis and an appropriate mechanism for making sense of the literature.

Research Questions

The research questions presented in the Chapter One were designed to answer gaps in understanding evident in the literature on perianesthesia directives limiting care or assertions suggested by Foucault's work or Georges' (2013) MRT. Table 7 clarifies the gaps in understanding that each research question is intended to address. Again, these questions are submitted a praesenti and may change with the will of the participants and the coalescence of discursive data.

Table 8

Gaps in Understanding Potentially Addressed by the Research Questions

Question	Knowledge Gaps
1. What hidden discourses dominate how patients make decisions about the disposition of their DNR orders or other directives limiting care during the perianesthesia period?	• Discourses and discursive practices vis-à-vis directives limiting care in the perianesthesia setting are not explored in literature.
2. How do perianesthesia clinicians talk with patients about DNR orders or other directives limiting care?	• How resuscitation is distinguished from routine perianesthesia care.
3. How do perianesthesia patients talk about DNR orders and express their rationales and motivations for	• Patients' abilities to understand and make choices about perianesthesia resuscitation. • How patients and families experience the idea of iatrogenic death during surgery.

rescinding, modifying, or retaining the orders during anesthesia?	• What and how much patients and families comprehend about making decisions on the disposition of their DNR orders during anesthesia.
4. How do these discourses relate to power and knowledge in the perianesthesia setting?	• Whether patients feel empowered to express their points-of-view when discussing perianesthesia DNR orders before surgery.
5. Does the triumvirate of zoe/bios dichotomy, distance, and free-floating responsibility contribute to sustaining a perianesthesia climate that permits the unethical behavior of automatic or defacto DNR revocation?	• The attitudes, motivations, feelings, and perception of clinicians and patients about perianesthesia end-of-life care,

Conclusion

This chapter summarized the literature used to construct knowledge about DNR management in the peri-anesthesia setting. Currently, ethical practice is easily bypassed in deference to production demands. Power inequities between clinicians and patients are buttressed by patriarchal discourses, fear, and toxic masculinity. These discourses—historically entrenched and bound to health care, educational, and governmental institutions—are being continuously reproduced. Moreover, the elements for creating biotoxic spaces where unethical choices are more easily constructed exist in the perianesthesia setting, thus, impeding knowledge development as well as patient care. Therefore, ensuring ethically safe and supportive environments where patients are empowered to express their end-of-life choices free from institutional discipline is an essential nursing function. The ability to critique, understand, and periodically trouble these discourses makes Foucauldian inquiry an appropriate investigatory

framework. Moreover, the MRT of compassion for nursing imparts concrete relevance for practicing clinicians.

During the twentieth century, the rapid evolution of healthcare revolutionized how perianesthesia clinicians approach death and dying issues in their setting. The ability to aggressively intervene to maintain homeostasis with an arsenal of efficacious treatments makes anesthesia safer than in the past. However, new approaches and treatments raised new ethical concerns. Before the advent of CPR decades ago, anesthesiologists' options for life-sustaining interventions were limited. The echoes of that moral distress likely continue to reverberate—hidden, unspoken—in perianesthesia discourses. Today, continued rapid progress in health care commensurate with an aging population, limited health care resources, and a perianesthesia culture that overemphasizes production makes understanding the processes underlying perianesthesia choices about directives limiting care essential and imperative knowledge. Consequently, it is incumbent upon every perianesthesia clinician—anesthesiologist, CRNA, and nurse—to create ethical environments and biocompassionate spaces that empower patients.

Chapter Three

Preface

The purpose of the Chapter Three Preface is to introduce and frame the methods Manuscript and Afterword. This Chapter focuses on poststructural case study methods. As noted in Chapter One, the method or process for the proposed inquiry is presented as a manuscript titled "Poststructural Inquiry using Case Study Design: Toward Fourth Moment Qualitative Methods in Nursing." This manuscript is embedded in this Chapter. The manuscript is speculatively prepared following the author guidelines for the refereed academic journal *Nursing Inquiry* (Wiley, 2020). It is written for an audience of nurse researchers as a methodology article. The manuscript describes the novel case study design and analytical method used in this inquiry. The manuscript also provides background and rationale for third and fourth moment case study design as well as the advantages and limitations of the approaches. However, it does not discuss the particulars of the proposed investigation. The Afterword that follows the manuscript details the sample, observation, interview processes, and other inquiry particulars necessary for evaluating the proposed study's merit. Additionally, the Afterword briefly discusses data analysis as a supplement to the manuscript. Next, Chapter Three continues with a manuscript that explores a poststructural case study design.

Poststructural Inquiry using Case Study Design:

Toward Fourth Moment Qualitative Methods in Nursing

Abstract

Case Study Research is an underappreciated but versatile design for nursing inquiry. While some investigators criticize case study as lacking a systematic methodology, the rewards of a contingent and contextualized research design may outweigh lingering post-positivistic concerns about replicability and validity. Depending on the research questions and the investigator's reflexive positioning, inquirists can mold case study research designs to their specific needs. Poststructural case study design is an intriguing new method for inquiry with the potential to advance nursing research toward QUAL 4.0 methods. However, methodological guidance for investigators new to poststructural inquiry is sparse in the literature. Although a dearth of methodological articles may be expected given poststructuralism's nature, new inquirists may struggle with a lack of direction. The purpose of this article is to introduce readers to case study research reimagined as a design for poststructural inquiry and encourage qualitative inquirists in nursing to embrace emerging and fourth moment methods. This article reviews the essentials of case study research before introducing Stake-Boles case study design—a case study method adapted for Foucauldian poststructural inquiry. The article concludes with reflections from a novice poststructural inquirists on designing and implementing a poststructural case study.

Keywords: case studies, methodology, poststructural, contextualizing analysis, Foucault

Case Study Research (CSR) is an underappreciated but versatile design for nursing inquiry (Siedlecki, 2020). CSR situates the case as the object of inquiry. According to Stake (1995), the case is a purposively functioning, bounded, and integrated system. Within this definition, not everything is a case, but there is wide latitude for conceptualizing cases. Stake represents this blurry flexibility by using the Greek letter Theta (Θ) to represent the case. While some investigators criticize CSR as lacking a rigid systematic methodology, the rewards of a naturalistic and context contingent design alternative to conventional qualitative inquiry may outweigh lingering post-positivistic concerns about replicability and validity. Depending on the research questions and the investigator's reflexive positioning, inquirists can mold CSR designs to their specific needs. For example, methods of analysis applied to CSR range from modernist approaches (e.g., conventional survey instruments) to the avant-garde (e.g., rhizomatic crystallization). It is to one of these novel and intriguing approaches arising from emerging or fourth moment methods (Denzin & Lincoln, 2018) that this article turns. Although many methodology articles are available for conventional qualitative inquiry, the methodological literature available for novice post-humanist, emancipatory, and poststructural inquirists is sparse. CSR provides a design option that comports with third and fourth moment qualitative inquiry and an entry point for inquirists exploring complex human phenomena from emerging paradigms perspectives.

This article starts by positioning CSR in relation to other qualitative inquiries using Lather's (2013) "QUAL" schema. Next, an overview of traditional CSR design elements serves as a departure point for redeploying the case study as a poststructural inquiry. Finally, QUAL 4.0 CSR is introduced as a novel postructural research design for nursing. Stake-Boles poststructural case study design is discussed in depth as an example of poststructural CSR. Last, I submit

reflections on lessons learned from designing and implementing an instrumental, embedded Foucauldian case study from the novice inquirist's perspective. The purpose of this article is to illuminate a navigable path toward fourth moment inquiry in the discipline of nursing and an accessible starting point for new poststructural health researchers.

Case Study Research

A literature search was conducted to grasp how CSR is currently conceptualized in nursing and gauge disciplinary interest in the method of inquiry. This section summarizes the extant literature published from 2015 to 2020 on CSR methodology in nursing and identifies essential works necessary for understanding CSR. On 1 December 2020, a literature search was conducted on the CINAHL database using the controlled vocabulary term "MH case studies/MT." In this search term, "MH" indicates database-specific terminology for case studies, and "MT" specifies that only articles on methodology are retrieved. Eighteen results were returned. After abstract review, 14 publications were excluded because the articles a) were not English language, b) did not address case study methods vis-à-vis nursing, or c) were non-contributory. Four salient articles that addressed the purpose of the literature search were selected for a full-article review. Additionally, the author selected five frequently referenced authoritative works identified through bibliographic mining for inclusion. Thus, nine articles or texts—all expert opinion—addressing CSR methods are included in the following overview (see Table 8). In contrast, a title field search of CINAHL using the keywords and operators "'case study research' OR 'case study' OR 'case studies' OR 'case report' OR 'case study design' OR 'case design' AND nursing" returned over 34,000 results for the same timeframe. The disparity between articles focused on case study methodology and case study reports simultaneously

suggests an interest in CSR by nurse researchers, yet a limited exploration of case study methods.

Table 9

Summary of Current Case Study Research Methods

Author(s)	Type and Purpose	Salient Recommendations and Conclusions
Boles (2016)[a]	• Dissertation • Describes a poststructural case study design	• A "grafting" of Foucauldian poststructural inquiry onto Stake's case study method. • Constructivist/interpretivist paradigm • Challenges the normative effect of imposing rigid methodology in search of generalizability. Suggests that Stake's and Yin's acquiescence to conventional evaluative criteria (e.g., validity and replicability) has limited the usefulness of CSR to social science researchers. • Argues that if post-positivistic and quantitative notions of singular truth and linear knowledge development are abandoned, CSR design comports well with the epistemological and ontological demands of poststructural inquiry. • Focuses on the contextual elements of the "case" instead of the individual lived experiences of participants, which aligns with Foucauldian discourse analysis. • In a poststructural case study (i.e., Stakes-Boles case study), the case is not the individual or the phenomenon. The case is the discourses and power relations that constitute the case.
Cope (2015)	• Journal Article • Reviews and evaluates current CSR methods	• Poorly defined processes and procedures have limited CSR as a research design choice in nursing. • The goal of CSR is to answer how and why the case functions as opposed to most qualitative research, which seeks to describe phenomena. • Identifies six analytic strategies used in CSR: ethnographic, narrative, interpretive phenomenological, and content analyses. Also, analytic induction and constant comparative method.

		• Data analysis is usually interpretive, but it may also be quantitative or mixed-methods.
Harrison & Mills (2016)	• Journal Article • Outlines case study methods in relation to nurse midwifery research	• CSR is ontologically, epistemologically, and methodologically unbound. • Identifies eight essential steps for CSR as 1) identify research questions, 2) determine the type of case, 3) define the case boundaries, 4) sample, 5) collect data, 6) analyze data, 7) disseminate findings, and 8) establish quality and rigor. • Uses the term "artefacts" in reference to all extra-discursive evidence accumulated during data collection. • Suggests the CSR is a meaningful method for analyzing nursing phenomena.
Merriam (2009)[a]	• Book • Comprehensively explores qualitative CSR.	• The evolution of CSR has resulted in pragmatic, flexible, and transdisciplinary methods. • Advocates fluidity in methodological approach. • First-generation case studies (e.g., case histories, ethnography) and second-generation (e.g., Stake and Yin) • Types of CSR: particularistic, descriptive, or heuristic • Findings are a thick description of the case that communicates the researcher's understanding of the phenomenon under scrutiny.
Morgan et al. (2017)	• Journal Article • Focused on observational components of CSR methodology	• Interviews are the most common modality for data collection is CSR. • Suggests that Case Study Observational Research (CSOR) is a more pragmatic and useful—albeit underutilized—approach to CSR. • CSOR may be particularly useful in cases involving vulnerable populations. • Three elements of CSOR that distinguish it from conventional CSR: 1) observation data is collected before and transforms non-observation data collection, 2) analytic choices are determined by observation data, and 3) observation data is not marginalized but explicitly cited in the case study report. • Data analysis is the least developed aspect of CSR.

Siedlecki (2020)	• Journal Article • Overview, synthesis, and evaluation of CSR methods	• The main advantage of CSR is that it enables inquirists to investigate cases in a real-life context and from a holistic perspective. • The holistic characteristic that denotes CSR is that it "includes multiple methods of data collection and multiple sources of data" (p. 250). • There must be no arbitrary limits on what counts as case evidence. • Data may be voluminous and should be managed through journaling, the creation of a study database, or both. • Analysis is a pattern driven process where the investigator constructs logical linkages between theory and the research questions or propositions. • Reviews the myriad of case study designs. For example, single nonembedded, multiple nonembedded, single embedded, and multiple embedded. Also, reviews CSR specific terminology. • Provides well-rounded exemplar table (see Siedlecki, 2020, p. 252) summarizing current trends in nursing CSR,
Stake (1995)[a] Stake (2005)[a]	• Book (Stake, 1995) and a chapter in a book (Stake, 2005) • A comprehensive exploration of Stake CSR	• Stake (1995) is a book titled *The Art of Case Study Research,* while Stake 2005 is a chapter in the third edition of *The Sage Handbook of Qualitative Research.* • Asserts that CSR is a research design and not a methodology. • Comports with the constructivist paradigm, although Stakes espouses some nomothetic evaluative criteria (e.g., triangulation). • CSR is experiential, and cases cannot be extricated from social, political, and other contexts. • The object of CSR "is a specific, unique, bounded system" (p. 445). • Defines intrinsic versus instrumental case study. Also, coins the term "embraceability," or the intellectual ability of the investigator to grasp the nature of the case.

		• Research questions or propositions are fluid and, if they are asserted a priori, must develop with the case. • Sampling in CSR is purposive. • CSR focuses on the case function—what it does or its activity; therefore, observation is crucial. • Case reports are interpretivist: "The purpose of the case report is not to represent the world, but to represent the case" (p. 460). • The goal of case reports is to share learnings with humility.
Yin (2018)[a]	• Book • A comprehensive presentation of Yin's CSR approach	• Commonly associated with nursing and other health science CSR. • Theory driven process that emphasizes a priori design protocols (e.g., single, multiple, single embedded, multiple embedded). • Accepts the modernist proposition that a greater number of cases, increased systematicity, and triangulation results in more accurate representations of Truth. • Analysis may be quantitative, qualitative, or mixed methods, but generally advocates that CSR adopt a realist perspective.

[a] Denotes authoritative or essential work.

Positioning Qualitative CSR

Denzin and Lincoln (2018) position qualitative inquiry in the humanities and social sciences as on the precipice of a fourth methodological moment. Whereas the preceding third moment was marked by arguments over evaluative criteria and skirmishes surrounding obedience to post positivistic methodology, fourth moment inquiry unabashedly rejects the normative premise of past arguments. According to Denzin and Lincoln, fourth moment inquiry creates areas that embrace uncertainty while dismantling traditional qualitative methodological boundaries. Simultaneously, fourth moment inquirist are freed to adopt affirmative social justice

and emancipatory platforms because new and emerging qualitative paradigms acknowledge not just social but political context.

Lather (2013) adopts colloquial digital language to describe fourth moment inquiry (i.e., QUAL 1.0 through QUAL 4.0). The term QUAL 1.0 encapsulates conventional neo-positivistic qualitative research. QUAL 2.0 research begins to question ontological and epistemological assumptions about unitary truth and linear knowledge accretion, but those questions are answered with attempts to control uncertainty through the methodology. QUAL 3.0 embraces the idea of multiple truths and different ways of knowing, for example, feminist and critical theories, but fails to overcome the specter of positivism and the perception of quantitative superiority held by some scholars. For instance, QUAL 3.0 CSR often accedes to the fallacy of generalization as a criterion for evaluating qualitative research. Finally, QUAL 4.0 roughly corresponds to Denzin and Lincoln's description of fourth moment inquiry. Like Boles (2016), this article adopts Lather's schema to situate CSR because it presents as a familiar and apprehensible heuristic. Based on a recent literature review, most current approaches to CSR are solidly positioned within a QUAL 3.0 landscape.

Overview of Case Study Design

According to Stake (2005), CSR is typified by design, not methodology. Stake's classic assertion is critical to understanding CSR. Case study is not defined by methodology, but it is epitomized by design choices and the epistemological-ontological perspectives of the researcher. Design choices and philosophical positioning antecede and determine methodologic and analytic choices in CSR. Three authoritative scholars provide distinct but overlapping definitions for CSR—Merriam (2009), Stake (1995, 2005), and Yin (2017). Table 9 summarizes their unique attributes of each approach to CSR. While some case study researchers advocate one approach

over the others, the consensus in the literature is that a pragmatic bricolage approach to CSR design is appropriate. The bricoleur—"pragmatic, strategic, and self-reflexive" (Denzin & Lincoln, 2018, p. 11)—approach to qualitative design advocated by Denzin and Lincoln (2018) may be used to define CSR. In this context, the inquirist draws from an array of case study methods to arrive at a definition of CSR that comports with the demands of the case and the inquirist's reflexive positions. Broadly, CSR is different from other qualitative research modalities because the object of inquiry is the "case." Thus, the case is the critical attribute that defines CSR. The case may be defined as an individual, a phenomenon, group, institution, event, or other constructs with distinct temporal-spatial boundaries investigated to learn how and why the whole functions.

Preparation and Planning

CSR begins with preparation and planning to identify gaps in the available literature about a topic or phenomenon of interest. What is known and unknown about the phenomenon informs research questions or propositions. Theory may also contribute to forming these questions, and CSR can be used to test theory (Stake, 2005). According to Stake (2005), the issues best addressed through CSR are complex, contextual, and focused on relational issues or problems. Furthermore, the questions raised by these issues should lend themselves to studying cases with unique and specific objects that have practicable boundaries for inquiry. While this admonition generically applies to all research questions, it is especially important here because CSR is active and experiential. In other words, questions appropriate for case study deal with activity and function—how and why some condition *happens* (Siedlecki, 2020). Resultantly, a priori research questions must remain fluid. Unlike the questions in quantitative and

conventional forms of qualitative research, research questions may change as the case evolves (Merriam, 2009; Stake, 1995, 2005).

Based on careful preparation, researchers next select the case. The case may be *intrinsic*, meaning that researchers want to deeply learn about the particulars of a singular case or a few cases. Intrinsic case studies may involve a small number—perhaps just one—case. Conversely, *instrumental* case studies are used when the case's intricacies are less important than the contributions the case can make to understanding how and why the case functions. Multiple case studies are extended instrumental studies. Stake (2005) observes, "[multiple case studies] are chosen because it is believed that understanding them will lead to better understanding, and perhaps better theorizing, about a still larger collection of cases" (p. 446). Various permutations of single and multiple case study designs (e.g., embedded designs) are explored by Yin (2018) and Siedlecki (2020), and readers are referred to those articles for detailed descriptions of those designs.

Sampling and Data Collection

Yin (2018) and Siedlecki (2020) advocate the a priori determination of data sources. Here, the researcher identifies the types of data (i.e., interviews, observation, medical records) before field work commences. Merriam (2009) and Stake (2005) argue for the flexibility to alter data collection methods as the inquiry develops and more knowledge is gained about the case. Careful attention to writing the procedure for data collection to balance optimum flexibility with protecting participants is essential; nonetheless, inquiry procedures should explicitly identify inclusion and exclusion criteria for inquiry participants. Participant selection is purposive, and inquirists must retain the flexibility to choose participants who offer the best chance for learning. Determining sample size is equally fluid. Stake (2005) reminds investigators that the sample—

participants, observations, and artifacts—must be intellectually "embraceable." Therefore, the criteria for data saturation must be clear. Whatever balance is achieved, researchers should anticipate voluminous amounts of data from multiple sources. For example, Morgan et al. (2017) argue that data collection should be guided by observations in the field. The authors suggest observation is the most natural and contextual mode for data collection and that case study observations should precede and inform other forms of data collection. What cannot be apprehended through observation, however, may be accessed through other sources, for example, interviews, focus groups, documents, photographs, and other artifacts (Harrison & Mills, 2016).

Advantages and Disadvantages of CSR

Stake (1995, 2005) and Siedlecki (2020) concur that the major drawbacks of CSR are the amount of data obtained and the time required to analyze the data. These authors recommend maintaining a reflexive journal detailing decisions during the inquiry. A database, according to Siedlecki, may also be required to organize the data. Depending on the philosophical, epistemological, and ontological worldview adopted by the case study researchers, other mechanisms for establishing rigor should be employed. For example, researchers bending toward modernist ideas about validity and replicability may favor Yin's (2017) emphasis on systematicity and protocol, while constructivist inquirists might choose memoing, journaling, and member checks to demonstrate rigor. Regardless of worldview and the ways chose to establish validity or rigor, CSR remains inseparable from the real-life context of the case under scrutiny. Indeed, the holistic, contingent, and contextual nature of CSR are the design's greatest advantages, according to Siedlecki and Stake (2005). Achieving a case study design that maximizes those advantages requires a design process that appreciates the fluidity inherent to CSR.

Phases of Design

The process of designing CSR is dynamic and adaptable. While some case study experts recommend systematicity and following a stepwise process (Harrison & Mills, 2016; Yin, 2017), others emphasize fluidity and iteration (Merriam, 2009; Stake, 1995, 2005). Siedlecki (2020) synthesizes the essential components of case study design into phases. Phase One is preparatory and includes planning, literature review, and case selection. Phase Two is data collection and organization. The preceding paragraphs explained the first two phases and are, to greater or lesser extents, applicable to CSR across disciplines and paradigmatic perspectives.

However, Phases Three and Four represent inflection points that are foreshadowed by the selection of a theoretical framework or reflexive work during the preparation and planning phase of CSR. Phase Three is analysis, and Phase Four is dissemination. How data is analyzed and disseminated is both the least well-developed part of CSR and the most transformative. Yin (2018) provides a realist, neomodern approach to case study analysis using mixed-methods analytics to analyze data. Stake's (2005) CSR design is paradigmatically constructivist, but Stake remains rooted in conventional and nomothetic notions of qualitative analysis. Stake's original design uses a method of analysis akin to grounded theory. Boles (2016), however, transforms Stake's case study design into a vehicle for poststructural and emerging paradigms inquiry. Next, fourth moment or QUAL 4.0 inquiry is introduced before explaining how Stake-Boles case study design is appropriate for advancing poststructural and emerging paradigms inquiry in nursing.

Poststructural Case Study – Toward Fourth Moment Inquiry in Nursing

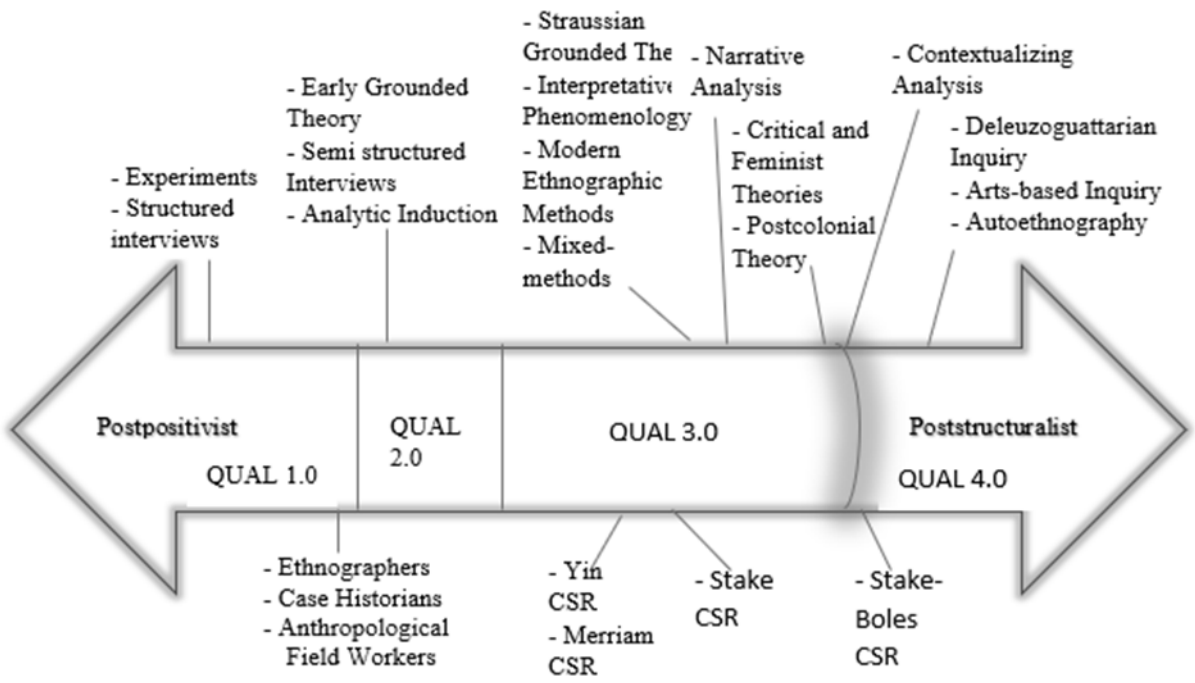
QUAL 4.0 – Fourth Moment Methods and Emerging Paradigms Inquiry

QUAL 4.0 inquirists reject normalization and cooptation by dominant regimes, for example, objectivistic and quantitative research. Instead, the emphasis is placed on constructing

new knowledges. Findings are presented with humility, uncertainty, and often with the explicit goal of co-creating social justice change alongside participants. Post-humanist and poststructural inquiries are examples of QUAL 4.0 research; consequently, the nature of QUAL 4.0 research challenges some basic philosophical beliefs long held as central to nursing. The concepts involved are often poorly defined, and a resistance toward prescriptive methodology makes fourth moment inquiry disconcerting to researchers inculcated to conventional phenomenological inquiry. Lather observes of QUAL 4.0: "This inquiry cannot be tidily described in textbooks or handbooks. There is no methodological instrumentality to be unproblematically learned. In this methodology-to-come, we begin to do it differently wherever we are in our projects" (p. 635). While most CSR is positioned aligned with QUAL 3.0 methods, case study design is sufficiently flexible to accommodate new paradigms and methods of inquiry. Stake-Boles case study design is one example of health research aspiring toward QUAL 4.0. Boles' (2016) design, however, remains in the penumbra of QUAL 3.0 methods. Deleuzoguattarian inquiry is an example of *post*-qualitative QUAL 4.0 research (see Nordstrom, 2015). Figure 5 depicts the alignment of various analytic methods used in CSR with Lather's (2013) "QUAL" schema.

Figure 5

The Evolution of Case Study Research Methods



Note. This figure depicts the alignment of various analytic methods used in CSR with Lather's (2013) "QUAL" model. QUAL 3.0 is the current authoritative regime for qualitative research in nursing. The bent and blurred line of demarcation between QUAL 3.0 and 4.0 represents the vanguard of QUAL 3.0 inquiry and the *becoming* of QUAL 4.0 methods. In this position, QUAL 4.0 methods remain influenced by the penumbra of third moment methodology. It illustrates the uncertain and overlapping nature of an emerging form. Thus, methods and traditions currently positioned as QUAL 3.0 may someday move toward QUAL 4.0 positionality.

Stake-Boles Design

Boles (2016) chose case study to "reconceptualize a methodology that has been conventionalized, to make space for new modes of inquiry" (p. 105). Stake's (2005) approach to CSR provided a methodological template—grounded in QUAL 3.0 methods—with the potential to mesh with Foucauldian poststructural inquiry. Stake's case study design is flexible, allows for creativity of design, and is ideal for testing the boundaries of qualitative research.

Simultaneously, according to Boles, Stake's CSR design is mired in standardization and methodological convention in a quest to produce "generalizable" results. Thus, it is the false promise of conventional methodology (e.g., quantitative triangulation, neutral objectivity, arbitrary controls, technical writing, rigid formatting) that case study researchers use to demonstrate the validity and significance of case study findings that has limited the possibilities for CSR. For example, despite these nomothetic procedures, case study is often classified as lower tier or anecdotal evidence when developing systematic reviews supporting evidence-based practices (Dearholdt & Dang, 2012; Johns Hopkins Medicine, 2020). In contemporary health care research, CSR is found mostly in the realms of education, teaching rounds, or epidemiology at the population level (Boles, 2016; Siedlecki, 2020).

Foucauldian poststructuralism—along with other traditions for poststructural inquiry—emphasizes the fleeting nature of language, socio-historical contingency, and the interrogation of power relations. Boles' (2016) concludes that these overarching poststructural ideas can be "grafted" onto Stake's (2005) case study design. Further, Boles' design provides the opportunity for the "re-appropriation and redeployment of case study methodology from the medical model" (Boles, p. 108) in favor of a design positioned at the vanguard of QUAL 3.0 research with aspirations toward fourth moment methodology. Boles' reimagining of Stake's case study design, however, required abandoning conventional CSR methods. The result of Bole's grafting is a new approach to CSR appropriate for inquiries in various human science disciplines, including nursing. Boles terms the approach poststructural case study, but I propose to designate this type of case study design as "Stake-Boles" case study design. This article, therefore, uses poststructural case study design and Stake-Boles design interchangeably.

Planning and Preparation

Like traditional CSR, Stake-Boles case design emphasizes planning and preparation. Investigators may find the choice of framework or theory particularly vexing. Stake-Boles design certainly provides a path forward for inquirists who may choose to forego explicitly identifying an overarching theoretical or mid-range theory. Boles (2016), however, used both a high-level framework (Foucauldian poststructuralism) and mid-range theory (Vygotsky's sociostructural theory) to scaffold the Stake-Boles redesign. Boles notes of the decision to use Foucault and Vygotsky as theoretical guides: "this study retains a flexibly structured scaffolding of design elements . . ., a conscious testing of boundaries, and an intricate interweaving of macro- and mid-level theory that is highly reminiscent of and rooted in QUAL 3.0 . . ." (p. 105). In poststructural case studies, this decision is even more significant and potentially problematic. For example, because of the nature of discourse, using theory tends to subtly reproduce existing discourses and buttress apparatuses of oppression. Investigators in practice disciplines, however, have an obligation to produce usable knowledge for society's benefit. Thus, even as Stake-Boles case study design aims toward fourth moment methods, a pragmatic, bricoleur approach to design is appropriate and unavoidable. Justifying those decisions and retaining an audit trail is essential.

In classic Stake (1995, 2005) CSR, the case is a phenomenon bounded by space and time. The Stake-Boles case study differs because the object of inquiry is discourse, and discourse is blurrier as an object of inquiry than phenomena typically positioned as objects of case study. In Stake-Boles inquiry, the case is subjectified by discourse. Boles (2016) explains:

> In the post-structural case study, however, the case is not a clearly delineated person or place, as discourse creates ambiguity, temporality, and fluidity to all that it touches. The

> case bends, shifts, morphs, and infiltrates along the way; the object of the case is not the subject, but the discourses, knowledge, and truths to which it is subjected. (p. 111)

In a Foucauldian poststructural framework, the subject is constituted through discourse. While a traditional case study may privilege individual subjectivities (e.g., interior motivations, thoughts, feelings, and perceptions), Foucault focused on how discourse and power construct functional perceptions of reality. Further exploring the concepts of discourse, power, and subjectivity are beyond the scope of this article. Inquirists embarking on a Stake-Boles case study, however, should reflect upon and disclose their understandings of poststructural concepts before beginning the inquiry. Concepts like discourse and power are complicated and prone to misinterpretation (Campbell & Arnold, 2004). Clearly articulating conceptual understanding enhances credibility while providing a common frame of reference for evaluation. In addition to the collected works of the poststructuralist of interest, researchers intrigued by poststructural inquiry but unfamiliar with the essential concepts may find the following resources useful: Dreyfus and Rabinow (1982), Cloyes (2010), Foucault (1981), Foucault (1988), Graham (2011), Hall (2001), Clinton and Springer (2017), St. Pierre (2011; 2013), Wetherell (1998), and Wetherell et al. (2001a; 2001b). Nevertheless, poststructural frameworks and Stake-Boles design insist that inquirists investigate the discourses that underlie and constitute the case.

Case Selection

Case selection for Stake-Boles case study may involve any number of participant stakeholders. Boles' (2016) original study followed 3 participants over 30 months. Stake (2005) suggests selecting participants purposively based on the learning value they bring to the case. Stake's suggestion highlights a major advantage of CSR: the flexibility to select the participants that best inform understanding of the case. Boles, however, cautions investigators that selecting

participants based on their contributory value is an inherent exercise of power that may limit the inquiry's potential. Boles ultimately contends,

> When re-deploying case study methodology with Foucault's . . . post structuralism, the case can be chosen in a variety of ways. It can be something close to or far from the researcher, yet the goal remains to be critical and deconstructive along the way. Furthermore, the questions at hand are not about the individual subject, but the ways in which discourse are reflected through and refracted by the individual's interactions with local situations and forces. Therefore, the case is valuable in its ability to highlight moments of connection and tension, and case selection itself is riddled by moments of power/resistance. (p. 112)

Although Boles used specific sampling criteria, a priori determinations about sample size and inclusion/exclusion criteria should be as adaptable and inclusive as possible. Moreover, poststructural inquirists reject the nomothetic idea that more participants equate with better understanding. Such an axiom suggests a single, knowable truth that might be attained through linear knowledge accumulation. Instead, the criterion for sample size should be an embraceable case that rigorously constructs sharable, context-specific knowledges. Real-world, pragmatic choices about sample selection, sample size, and inquiry duration are discussed later in this article.

Data Collection

Boles (2016) used observation, unstructured interviews, guided activities and prompts, artifact collection, and photo elicitation for data collection. However, an observation first approach, like the method advocated by Morgan et al. (2017) where observation guides or even replaces other modes of data collection, also comports well with poststructural case study design.

Morgan et al. argue that observation should proceed and inform non-observation data collection and involve both participant and non-participant observation. Boles seems to agree citing the importance of providing a cultural milieu and thick description, which may require observing non-participants who intersect with the case. Stake's (2005) traditional case study method also advocates using multiple methods for data collection. Boles, however, suggests a fluid approach to data collection that incorporates multiple traditional and non-traditional sources. Boles summarizes,

> Collecting data from multiple sources not only helped to provide "thick description" (Stake, 1995, p. 39), as conventional humanist qualitative inquiry would require, but also helped to contextualize the movements and interactions of the case, . . . In addition, using several different methods helped to crystallize the data, or acquire a multifaceted view of it much like light refracted through a crystal [Richardson & St. Pierre, 2018], or a rhizome of entangled lines of discourse (Nordstrom, 2015) as the data were assembled, disassembled, and reassembled to produce new understandings. (p. 123)

Boles' original unstructured interview guides were designed to maximize flexibility and minimize the power inequity between interviewer and participant. Boles applies the term "life story interviews" (p. 124) to describe the interviewer's goal. In a poststructural inquiry, interviews should be designed to generate naturalized text for analysis. Observation is, as recommended by Morgan et al., both participant and non-participant. Observations should provide real-life context. Crucially, in Stake-Boles design, appreciation of the potential disciplinary effects of recording devices—including notes taken during fieldwork—is essential. However, unlike in traditional CSR, observations are not confirmatory. In poststructural case study, multiple truths are possible and contextual complexity is embraced.

Analysis

Stake (2005) argues that coding is often helpful but not essential for CSR. Stake-Boles case study design is well-positioned for post-coding analysis. Boles, aligning with the work of Borkan (1999), Augustine (2014), and Richardson and St. Pierre (2018), resists the post-positivistic notion that axial coding lends rigor and validity to qualitative inquiry. Indeed, Foucault spends much of the first half of *The Birth of the Clinic* (1994) explaining how categorization, a process essential to thematic coding, contributed to the clinical gaze. Thus, Foucault urges researchers to avoid arbitrary categorization. Therefore, conventional qualitative coding is an uncomfortable fit with Foucauldian poststructuralism. Boles (2016), however, falls short of eschewing coding altogether, as scholars like Augustine might support. Instead, Boles advocates using contextualizing analysis (see Berbary, 2011) as the analytic method of choice for Stake-Boles case studies. Interestingly, researchers interested in post-coding inquiry may, nevertheless, find Stake-Boles design a useful design with relatively minimal required adaptation.

Contextualizing analysis occurs concurrently with data collection and may be applied to textual data as well as artifacts and observational data. Boles' (2016) approach to contextualizing analysis, although based on Berbary (2011), is adapted for Stake-Boles case studies. Notably, the process is iterative and fluid. While the process is depicted here in a stepwise fashion, it is implemented in an overlapping and recursive style. Discourses may be identified by their repeating patterns; therefore, embracing multiple connections and uncertainty is essential. Unlike conventional or axial coding, Stake-Boles design does not imagine that results emerge or are discovered in the data. In contextualizing analysis, coding is an initially deconstructive process

that makes identification of discourses and power relations intellectually attainable. Table 10 summarizes contextualizing analysis.

Table 10

Contextualizing Analysis

- Organize all data in relation to participants and place into separate folders
- Transcribe all data into text
- Identify codes or concepts by looking for repeating patterns
- Avoiding reductive and single categorization, label these codes using different colors, symbols, or other signifiers
- Develop a "master key" to track the different labels
- Memo specific thoughts or ideas during this process and attach to the codes
- Use the concurrent coding and resultant interpretations to guide on-going data collection
- Reread each participant's experiences from their folder.
- Reread the experiences holistically
- Begin flexibly coding the master key around the study's research questions
- Be open to the assemblage and rhizomatic crystallization process
- Develop a glossary of ideas and concepts in relation to the master coding key
- Construct assemblages or representational forms – may consider rhizomatic diagraming or concept mapping to facilitate the process
- Again, return to the data for line-by-line coding
- Share representational forms with humility

How the final representational forms crystallize is an inductive-deductive process that remains somewhat elusive and under explored in the literature. Rhizomatic crystallization uses intense thought, imagination, reading, and writing to "put together" (Augustine, 2014, p. 749) discursive data with theoretical concepts—in this case, Foucauldian philosophy—through a process called *assemblage*. Assemblage, however, is not merely data assembly. Nordstrom (2015)— addressing the complexity of assemblage as a concept— notes, "I myself am an assemblage, constantly navigating the assemblages that entangle me. . .. I am assemblage – in the middle of vast connective assemblages, trying to make sense of the constructing,

deconstructing, and reconstructing entanglements" (p. 167). In the Foucauldian poststructural context, the goal of analysis is to identify discourses and power relations at work and the construction of how discourse and power relate within the case. The process of crystallization occurs contemporaneously with contextualizing analysis and data collection. Augustine (2014) suggests that after reading and re-reading the text to identify discursive patterns, the analyst begins to compile concepts from the text into protean forms. Reflexive journals, memoing, and rhizomatic diagrams can facilitate this process. Simultaneously, the investigator develops an exhaustive glossary of ideas and theoretical concepts alongside the developing master coding key. The process is iterative and involves continually returning to the text, artifacts, theory, and literature. Augustine summarizes the experience: "Analysis was not simply coding data but the intermingling of data and theory after focused reading and copious amounts of writing" (p. 752). The analysis concludes when the assemblages take-shape or crystallize.

Crystallization intersects with the idea of embraceability presented earlier in this article. Here, crystallization is the point where the contextualized understanding of the case is apprehensible to the inquirist and meaningful to participants and potential research consumers while still retaining an appreciation of the case's underlying complexity. Crucially, crystallization—as the name implies—generates but one possible interpretation of the data. In poststructural case study, findings are unstable, contextual, and contingent; thus, representational forms are but one rigorously constructed interpretation illuminated through a particular facet or context. The crystallized assemblages are complex, uncertain, and interconnected—like light refracting through a crystal. Finally, the crystallized understandings should be returned to the data by undergoing another round of line-by-line coding (Boles, 2016) to ensure that the assemblages are contextual and accurately reflect the case.

The products of analysis are the final representational forms or assemblies. The resulting "findings" should be reported with humility and an understanding of the ephemeral, socio-historical positioned, and jointly created nature of the assemblies. Intriguingly, alternate forms of representation and dissemination, for example, artistic representations, stories, and plays that subvert expected structural norms comport well with reporting poststructural case studies. Traditional reporting modalities, for example, journal articles or scholarly presentations, are also appropriate. For example, Boles (2016), a child-life specialist, reported her findings both traditionally and in the form of a children's book.

Implications for Nursing

The implications of QUAL 4.0, poststructural, and post-humanist research for nursing are consequential and exciting. Nursing literature is rife with case studies indicating familiarity and interest in the format, but traditional CSR is limited because of evidence-based practice appraisal instruments that relegate case studies to the realm of anecdotal reporting. Stake-Boles case study design provides a method that advances the boundaries of nursing science while constructing knowledge that transcends traditional disciplinary silos. For example, the relationship between power, discourse, and clinical decision-making garners interest from nursing, medicine, bioethics, and the social sciences. Furthermore, the relationships identified by poststructural case studies are often complex and difficult to explore using other methodologies. Stake-Boles case studies are, therefore, especially meaningful both to academic scholars and practicing clinicians.

Siedlecki (2020) identified CSR's flexibility as the method's primary advantage, while Stake (2005) noted data management as the main disadvantage. There are other benefits and criticisms specific to CSR in the poststructural, post-humanist context. The advantages and disadvantages of Stake-Boles case study design are presented in Table 11. Notably, many

potential advantages can be constructed as disadvantages and vice versa. Consequently, special care should be taken during the planning and preparation phase to ensure a satisfactory contribution to science and a personally rewarding outcome. The decisions that I made about these issues and lessons learned are disclosed in this article's next section.

Table 11

Potential Advantages and Disadvantages of Stake-Boles Poststructural Case Study Design

Potential Advantages	Potential Disadvantages
• Flexibility • Challenges commonplace humanistic assumptions about power and the nature of reality • Contextual, socio-historically, and politically situated • Opens new possibilities for nursing inquiry • Appropriate for problems and inquiries resistant to other methods of investigation • Meaningful to practicing clinicians • Identifies patterns in seemingly discontinuous or disconnected data • Subverts marginalizing or oppressive norms that are often accepted as commonsense • Challenges dominant research strategies and encourages novel methods for inquiry	• Voluminous amounts of data collected may be overwhelming • Approach may be criticized as subjective or lacking rigor • Analytical results lack measurable significance • Requires significant preparation, planning, and reflection to understand the full ramifications of poststructural analysis • May uncomfortably challenge humanism and the foundations of nursing practice • May be relegated to niche academic journals or anecdotal evidence

Finally, inquirists should prepare themselves to address criticisms of poststructural case study based on the potential disadvantages of the method. First, the premise that generalization, validity, or replicability apply to poststructural or QUAL 4.0 inquiries is faulty and should be rejected. According to Lincoln and Guba (2013), a constructivist inquiry should be evaluated on trustworthiness. The criterion components of trustworthiness are credibility, transferability, dependability, and confirmability. Investigators should reference these criteria for evaluation

when conscientiously citing examples of reflexive journal entries, member checks, audit trails, observations, coding processes, original text, and concept maps or rhizomatic diagrams so that readers may evaluate trustworthiness. Second, investigators should accept that the formations constructed through poststructural inquiry are value-laden, culturally specific, and unique to a given point-in-time. Decisions about transferability are the purview of the research consumer. Last, novice inquirists and experienced scholars alike often develop only cursory familiarity with poststructuralism, and this deficiency must be remediated.

Expert status on poststructural scholarship is not a prerequisite, but novice-level understanding is an ethical expectation and minimal competency for independent inquiry. Choosing to undertake a Stake-Boles case study demands that inquirists immerse themselves in poststructural concepts. The ramifications of poststructuralism are, nonetheless, often not fully contemplated (Campbell & Arnold, 2004). For example, nurse researchers—like many other health care disciplines—are accustomed to probing for the inner-meaning and lived experiences that typify phenomenological and humanistic research. Such a strategy is incompatible with Foucauldian poststructuralism. Poststructuralists, foundationally, argue that language creates meaning; meaning does not create language. Therefore, inquirists avoid "piercing the text" by searching for hidden meaning or motivations. More fulminant discussions about the poststructural understandings of discourse, power, truth, subjectivity, and reality vis-à-vis the inquirist's stated poststructural position (e.g., Deleuze and Guattari, Derrida, Foucault) should be anticipated and provided.

Reflections from a Novice Poststructural Inquirist

This article concludes with reflections on my experiences as a Doctor of Philosophy candidate designing and implementing a poststructural inquiry. Siedlecki (2020) identified four

phases of CSR: 1) preparation and planning; 2) data collection and data organization; 3) data analysis; and 4) dissemination. Therefore, four reflections discussing significant challenges, pitfalls, revelations, and lessons learned during each phase follow.

Phase One: Preparation and Planning

My area of doctoral research is bioethical discourses in perianesthesia and critical care settings. Specifically, investigated why and how patients with Do Not Resuscitate (DNR) orders and their perianesthesia clinicians make decisions about resuscitative status during anesthesia. While the mechanics of ethical decision-making are well represented in the literature, the discourses that construct the choices available to patients, families, and clinicians are underexplored. A systematic review of the literature (Hardin & Forshier, 2019) uncovered entrenched resistance to the current standard of care for managing perianesthesia DNR orders, creating ethical conflicts for clinicians and patients. An intimate personal understanding of the perianesthesia environment and themes identified through immersion in the extant literature intersected in multiple ways and variations with power and discourse. Thus, I concluded that investigating the phenomenon required an inquiry designed to explore the complex power relations between patients and perianesthesia clinicians. Furthermore, the inquiry needed a proven track record for addressing complex and intransigent problems while being suitable for work with vulnerable patient populations.

Two articles were especially influential in developing my inquiry's framework and design. First, Holmes' (2012) article "The Clinical Gaze in the Practice of Migrant Health: Mexican Migrants in the United States" sparked the idea of using Foucault to inform my inquiry. Later, Boles' (2016) dissertation "Deconstructing the Diagnosis: Making the Case for a New Discourse on Childhood Cancer" cemented the idea of using Foucauldian poststructuralism.

While both authors framed their inquiries using Foucault, Holmes used ethnography while Boles selected a case study design. For Boles, a significant inflection point was the choice between case study and ethnographic methods. Interestingly, I arrived at the same question even before I finished reading Boles' chapter on methods: ethnography or case study?

My original vision for the study was a regimented, more conventional qualitative analysis. However, as I began to read Foucault's works and explore the concepts underlying discourse analysis, I concluded—like Boles (2016)—that poststructural inquiry demands study designs that emphasize fluidity, context, and uncovering the nature of power relations. While ethnographic methods are usable, ethnography sits uneasily alongside Foucauldian poststructuralism. Foucault was critical of ethnography's ties to oppression. A greater challenge to poststructural ethnography, however, is that Foucault positions the person as subject to discourse. Ultimately, Boles' reimagining of Stake's (1995, 2005) case study design seemed best able to answer the research questions I had developed. Furthermore, Boles' design had already accounted for the ontological and epistemological demands of Foucauldian inquiry. Choosing to pursue inquiry within a poststructural context was only the beginning, however.

Three challenging decision points dominated the design phase. First, the decision to take more than the usual amount of time required for studying a typical inquiry theory or framework was crucial. I needed time to learn about Foucault, poststructuralism, and discourse analysis. Second, I needed to decide whether to use theory. The third decision-point was whether to code the data. As previously mentioned, poststructuralism sometimes seems counter-intuitive to beginners who were indoctrinated to humanistic ideas about language and representation. New poststructural inquirists should apportion adequate time to learn about poststructuralism, but they must also take time to wrestle with the implications of poststructural ideas. For example,

Foucault's critique of humanism demands that the nurse researcher confront humanism's role in oppression and the centrality of humanism to nursing's body of knowledge. This confrontation may lead to questions about the ethics of using nursing theories to guide research. My decision to use theory was the product of a somewhat painful reflective process that culminated in my abandonment of a long-favored nursing model in favor of a new mid-range theory that is a better fit for postructural inquiry. Georges (2013) emancipatory theory of compassion grounded the inquiry in nursing science while comporting with Foucault's concept of power. Georges theory questions doctrinal ideas about humanism's place in nursing and positions nurses and patients as obligatory political actors. Crucially, the theory provides a discipline specific lens that will allow sense-making of the representational forms by practicing clinicians.

Finally, the decision to use coding or attempt a post-coding inquiry may emerge. Conventional axial coding and content analysis are incompatible with Foucauldian poststructuralism. Boles (2016) used open coding as part of contextualizing analysis. Boles' choice aligns with Nordstrom's (2015) description of rhizomatic crystallization. Boles uses Nordstrom's approach to blur the artificial boundaries between the categories imposed by coding. However, Nordstrom advocates post-qualitative inquiry, and Boles' design stops short of embracing this approach. Augustine (2014) describes a middle-ground analysis using assemblage and rhizomatic crystallization that eschews coding altogether, and Augustine's approach resonated with my philosophical worldview.

For some time, I contemplated designing a post-coding Stake-Boles case study that veered toward post-qualitative QUAL 4.0 research. I chose, however, to follow Boles' design with only a few adaptations to deemphasize coding and elevate Nordstrom's Deleuzian description of assemblage and Augustine's conceptualization of rhizomatic crystallization. The

choice was influenced by one of my dissertation advisors who cautioned, “Be careful not to over-innovate.” The deeper wisdom the advisor implied was that whether we like it or not, researchers exist in political spheres. Post-coding or even post-qualitative inquiry may be the best theoretical fit for a poststructural case study, but the decision to forego coding might render the inquiry unpublishable or relegate it to obscurity. In other words, good research design demands an accord between pragmatism and innovation. This advice also applies to decisions about sample size and inquiry duration. An inquiry with only a few participants that takes years to complete may be acceptable within a Stake-Boles design, but it did not align with the urgency of my interests—clinically, academically, or professionally.

Phase Two: Data Collection and Organization

Poststructural case study design, indeed cutting-edge qualitative inquiry generally, may present IRB challenges. Boles (2016), for example, encountered an IRB so unfamiliar with poststructural inquiry that an alternative board with experts qualified to evaluate Boles’ proposal was assembled. In Boles’ case, the process caused a substantial delay. It is heartening that some progress is evident since then. I faced an IRB more familiar with qualitative inquiry than perhaps Boles encountered but still focused on biomedical research methods. Nevertheless, the Stakes-Boles case study design faced extensive critique and required full board review. Ultimately, the inquiry was approved, but only with substantive changes.

The IRB’s most important concern involved observing non-participant actors. Anthropologic and ethnographic observation requires careful planning and extra caution to protect the privacy and rights of the nonparticipant actors to decline participation in research. I contend that such safeguards are possible. However, future inquiries employing this type of observation should anticipate how they will ensure special protections when obtaining written

consent is impracticable. IRBs evaluating research applications for clinical sites may be especially wary of nonparticipant observation of this type. Future researchers should foresee the possibility that nonparticipant observation is a "red-flag," and they should plan for extra time and explanations during the IRB approval process.

During the full-board questioning of my proposal, it seemed evident that support for qualitative inquiry existed among some board members. Other members of the board seemed to question the importance of qualitative inquiry in health care. Most of the questioning members seemed confused by language common to third and fourth generation qualitative inquiry. For example, I would use the word "participant' and the board would respond with the term "subject." At times, members seemed like their time was being wasted by a non-interventional inquiry, and one member expressed frustration at the length of the proposal. In defense, another member of the board retorted that the length of the proposal was consistent with other behavioral studies the member encountered elsewhere. When preparing the IRB application, brevity is essential—especially for clinical sites less familiar with behavioral and social science research. In addition, write the application using the simple and accessible language, even if complex conceptual writing is commonly encountered in academia and research, when applying to a clinical site IRB.

Based upon these experiences, I recommend that critical, poststructural, and post qualitative inquirists schedule extra time for IRB approval. Future inquirists submitting unconventional qualitative projects should anticipate unfamiliarity among some IRB members. This may mean planning for a full-board evaluation even when the inquiry proposal seems to have minimal risk and is appropriate for expedited review. Be prepared to answer the board's

questions using brief and simple language and address their concerns remembering that everyone present is most concerned with protecting the rights or those participating in the inquiry.

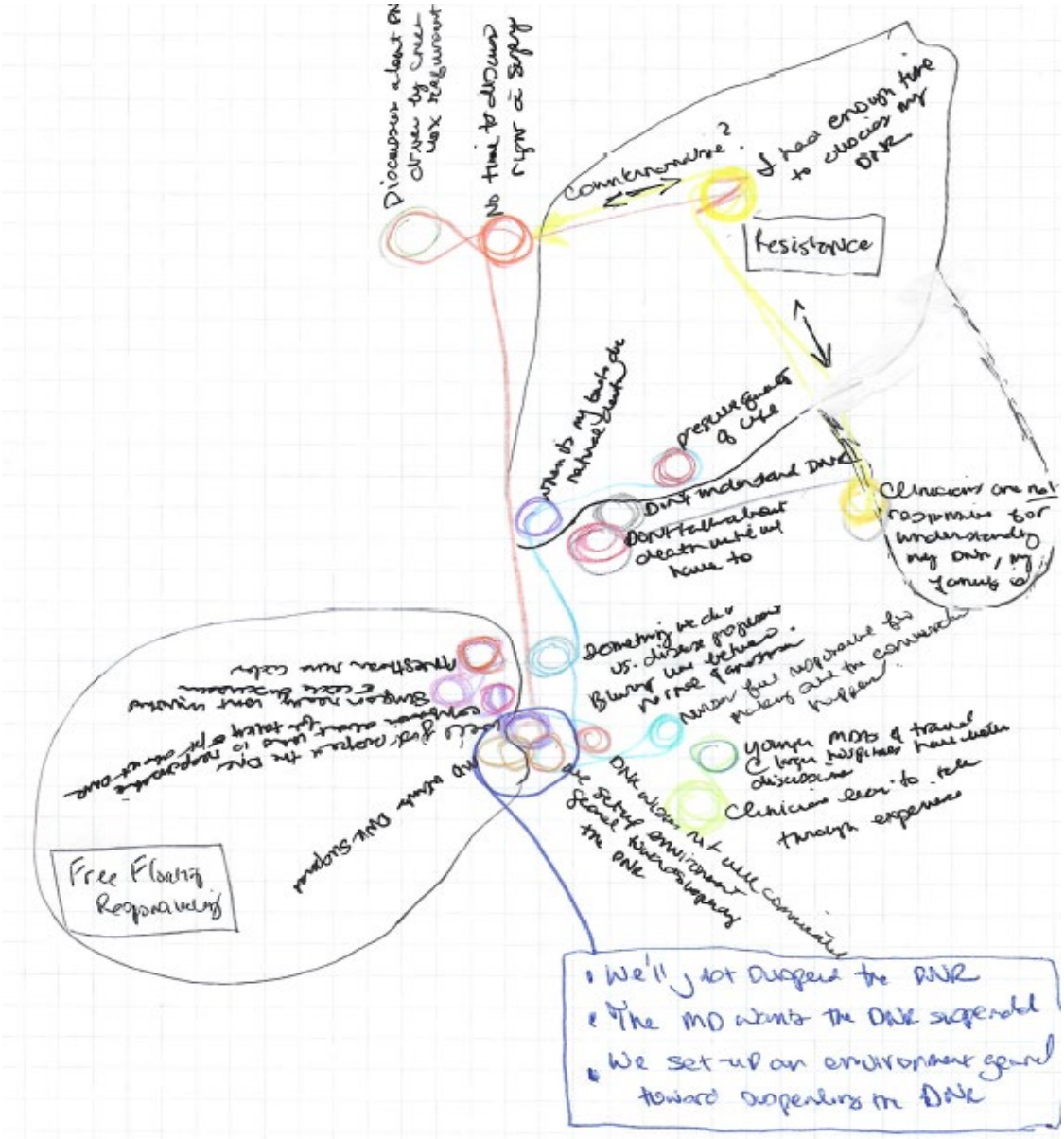
Phase Three: Data Analysis

As part of a practicum during my doctoral training, I completed a mentored qualitative analysis of an existing data set using content analysis. The data set for the practicum was sufficient for the study's questions and purpose but small. The experience fueling this reflection was much larger and included transcribed interviews from 27 patients. Even accounting for this difference, poststructural inquiry—in this case using contextualizing analysis— was more time consuming and challenging than conventional methods. While a step-by-step guide existed for conducting content analysis, there is no stepwise guide for poststructural inquiry.

Perhaps the most challenging part of data analysis was finding patterns and identifying contextual codes. To avoid arbitrary categorization and the pitfalls of conventional axial coding strategies, codes were color coded and not reduced to meaning units. Therefore, codes were comprised of relatively large sections of data. The feeling was at first overwhelming, and inquirists choosing post-coding strategies will not have even this familiar scaffold for support. Beyond reading, re-reading, and continuously returning to the data, the contextualizing analysis process let me know the case, identify discourses, and construct power networks. For example, rhizomatic diagrams helped me visualize how codes interrelated and the power networks shaping discourse. I created a rhizomatic diagram for each group within the case based on the contextual codes, and I relied heavily on the diagrams during the writing process. Figure 6 is an example of one of these rhizomatic diagrams.

Figure 6

Rhizomatic Diagram



Note. Rhizomatic diagrams are a way to specialize power networks and interrelationships occurring with the object of inquiry.

Phase Four: Dissemination

Finally, choosing representational forms that allow for contingency, multiple interpretations, and humility is an essential problem for poststructural inquirists when

disseminating their work. The problem may be exacerbated by the nature of health care research that emphasizes verifiable results with widespread applicability. For me, the problem manifested when I needed to select journals and prepare manuscripts for my dissertation. Choosing a target journal amenable to representing poststructural findings from my inquiry eliminated many medical journals that might reach an audience for whom the investigation was intended. Conversely, choosing a high-impact medical journal with an appropriate readership meant representing the poststructural findings in a more authoritative and *accepted* way. I chose to present my findings in two journals that would reach different audiences. Novice poststructural inquirists should prepare to compromise in how results are represented while actively looking for ways to avoid the 'final-ness' that often accompanies dissemination of research in the evidence-based practice era.

Conclusion

The purpose of this article was to introduce readers to CSR reimagined as a design for poststructural inquiry and encourage qualitative inquirists in the discipline of nursing to embrace fourth moment methods. Merriam (2009), Stake (1995, 2005), and Yin (2018) were identified as authoritative voices on conventional CSR, and their case study methodologies were positioned as useful, flexible, and meaningful methods of investigation for nursing. However, CSR has yet to reach its full methodological potential and is often consigned to niche publications or leveled as anecdotal evidence. Boles (2016) redeployed Stake's case study method in the poststructural context creating the Stake-Boles case study design. The Stake-Boles design is appropriate for complex and implacable problems where the object of inquiry is the discourses and power relations that constitute the case. This article aims to empower nurse researchers—especially

novice inquirists—to use QUAL 4.0 methods in their research practices. Thus, advancing the boundaries of qualitative inquiry in nursing.

Chapter Three

Afterword

Foucault offers tools for analyzing discourse and power-knowledge in historical-cultural context. Foucault, however, does not prescribe a methodology. Therefore, Chapter Three describes a process for identifying discourses that constitute and construct directives limiting care in the perianesthesia setting, the power effects of those discourses, and how stakeholders negotiate the discursive regime. The process described here is merely one approach to analyze discourses that comports well with nursing as a discipline and the demands of the problem under scrutiny, but there are other valid approaches. Furthermore, the poststructural context insists that inquirists abandon the notion that rigid systematicity, reproducibility, or a priori controls enhance the validity of whatever representational forms this process creates. The case study method described in the following sections is contingent, iterative, uncertain, and fluid; it is not a stepwise method. The product created—nomothetically labeled "results"—will be but one possible construction narrated into being through inquiry. Thus, prescribed methods do not lend authority to findings in Foucauldian poststructural inquiry. The aim of this Afterword is, therefore, not authority through the methodology. The aim is to articulate a transparent investigative process that will undergird the instrumental case study so that the representational forms constructed are more transferable to other perianesthesia departments.

Methods

The following subsections detail the inquiry's setting, participant selection, and procedures. Other salient methodological choices and the rationales for their selection are also discussed. The manuscript that immediately precedes this Afterword scaffolds these particulars in relation to case study design. While the following sections briefly discuss case study design

and data analysis, the Chapter Three Manuscript serves as the principal vessel for exploring these topics.

Institutional Review and Approval

A reliance agreement was executed between the inquirist's academic Institutional Review Board (IRB) and the clinical site's IRB. The reliance agreement designated the clinical site IRB as the primary review board. The following methodology was approved by the clinical site's IRB (see Appendix A). This Afterword reflects changes from the original methodology proposal that were required by the IRB. When significant, for example more than just formatting changes, the alterations are noted.

Setting

The inquiry was conducted at a large, tertiary care facility in the upper Midwest, United States. The setting was ideal because it encompassed a "main" perioperative area providing a full array of anesthesia services to higher-risk patient populations and a "day-surgery" center that offered only same-day surgeries for lower risk populations. This structural condition provided insights into traditional perioperative departments as well as ambulatory surgical center departments, thus, enhancing transferability. While perianesthesia nursing staff differed between departments, the anesthetist and anesthesiology clinicians were the same. Field work occurred in both areas (i.e., embedded design).

Participant Selection

The IRB approved a minimum of 20 but no more than 50 participants to be purposively recruited for this case study. In this inquiry, there were three groups of full participants: patients, families, and clinicians—a group that included organizational leaders. Table 12 enumerates the inclusion criteria for each group of participants. This inquiry excluded patients whose clinical

condition was declared an emergency by their provider or patients who bypassed the usual preanesthesia evaluation process. These patients—already under duress—were too vulnerable to approach for informed consent. Further, the informed consent process could delay emergency surgery, placing the patient at avoidable risk. Another exclusion was opting out of Minnesota Research Authorization (MRA). In Minnesota, patients are given the option to opt-out of research when admitted to a hospital. If patients do not explicitly opt-out, they are by default opted-in. The Electronic Medical Record (EMR) stores the electronically scanned MRA documents. The last exclusion, required by the IRB, was that the index patient could choose to exclude anyone else from participating in the inquiry at the time of the patient's consent but not later.

Table 12

Inclusion Criteria

Patient Participant	Family Member Participant	Clinician Participant
1) Required perianesthesia care for a procedure or surgery 2) Had a DNR order or other advanced directive in place at the time of their planned anesthesia encounter 3) Could verbally or with an assistive device participate in minimally structured interviews that require recall of recent clinical interactions about perianesthesia DNR orders or directives limiting care 4) Spoke English 5) Lived in the United States	1) A family member or other person who participated in discussions about advanced directives in the clinical setting 2) Could verbally or with an assistive device participate in minimally structured interviews that require recall of discussions about DNR orders or other directives limiting care 4) Spoke English 5) Lived in the United States	1) Interacted with the patient participant to address the advanced directive And/Or 2) Substantively influenced the conduct of discussions about advanced directives And 4) Spoke English 5) Lived in the United States

Notably, case study research may involve non-participant observation (Morgan et al., 2017). In these instances, unconsented non-participant actors may influence the case but not wish (or be selected) to participate in the interview process as participants. A non-participant actor group was originally proposed for this inquiry. The IRB, however, requested that any clinician being observed complete a modified consent document which was shorter than the full consent document and required no additional documentation. The modified consent process, therefore, was used for all observation-only clinician participants. No non-observational data was collected on these participants; consequently, the only eligibility requirement for the observation-only group was that they were clinician stakeholders who intersected with the case in some way relevant to the case. This inquiry did not include any observational data from unconsented non-participants.

Sample Justification

Morse (2000) recommends no fewer than 20 participants and no more than 50 for conventional qualitative inquiry, and Morse's standard was the guideline used for this inquiry. In a systematic review of qualitative research from a 15-year period, Vasileiou et al. (2018) found that nurse researchers tended to forgo justifying sample size. These researchers often seemingly bowed to nomothetic pressure by listing small qualitative sample size as a study limitation. In a Stake-Boles case study, however, the criterion for determining sample size is not generalizability but data adequacy. The concepts of validity and generalizability are inapplicable to qualitative analysis, particularly inquiry situated within a constructivist paradigm like this dissertation (Lincoln & Guba, 2013). Instead, embraceability, trustworthiness, and rigor guided decisions about discursive saturation in the field.

In this inquiry, the main criterion for determining discursive saturation was *embraceability*. Stake (2005) describes embraceability as an active, experiential condition where "Through observation, enumeration, and talk the researcher can personally come to perceive the nature of the case" (p. 455). Embraceability is also the point where the case is intellectually apprehensible. Thus, continuing data collection beyond that point would be liable to create a case so complex as to be intellectually *un*embraceable to both inquirist and consumer. Although Stake did not originally conceive of embraceability as a criterion for discursive saturation, the concept is logically extensible as an endpoint for data collection for third and fourth moment case study designs. In addition, an abundance of repeating data accompanied by a dearth of new participant statements was taken as an indicator of discursive saturation.

Inquiry Implementation

Field work was preceded by a one-week start-up interval where the participants for the first week of field work were identified and contacted. IRB required educational training about the inquiry was provided to clinicians at this time. During the start-up week, four educational sessions were scheduled at various times and locations at the clinical site. I was also present at the clinical site for at least four hours on four separate days during the start-up week for ad hoc educational in-services and one-on-one discussions. Clinicians were given the opportunity to sign the consent at the end of each educational session, ad hoc education in-service, or one-on-one session. In addition, clinicians and providers who did not attend one of the educational sections were contacted on an individual basis when one of their patients joined the study. If the clinician agreed to participate in observation, an ad hoc educational session was conducted, and the observation consent was signed at that time. Eligible participants who later agreed to participate in the interview component of the inquiry were required to sign a separate consent

form at the time of the interview. A brief presentation was also developed in Microsoft Power-Point® format. I emailed the power-point presentation to key leaders from the nursing, anesthesiology, and surgeon groups at the clinical site. The leaders were encouraged to email the Power-Point to the respective clinical groups if they felt the presentation was helpful.

An email notification was sent to all perianesthesia providers notifying them of the inquiry and its general purpose. Surgeons and perianesthesia nurses received similar emails. The email explained that clinicians who did not wish to enroll in both the observation and interview components of the study could still participate as observation only participants. If the clinician chose observation-only participation, they could be observed during field work when interacting with the patient, family, and other clinical participants. Such inquiry activity was termed observation-only participation. No observation occurred unless informed consent was obtained from the clinician. If an unconsented clinician was assigned to care for a participating patient, that patient participant's contribution was limited to observational data not involving the unconsented clinician and interview data (i.e., no observation data involving the clinician who did not consent was collected). A confidential list was maintained of consenting clinicians so that those names could be cross-referenced with potential participants. Email reminders were sent to all clinicians monthly for the duration of field work.

Field Work Timeline

Principal field work ran for 60 days. Thus, principal data collection concluded at 60 days and four weeks when the final scheduled interviews were finished. In total, 88 days of principal field work—including observation and interviews—was scheduled. Secondary data collection, for example, follow-up interviews and member checks, occurred as needed during the data analysis and upon completion of the project.

Inquiry Protocol and Procedures

A clear advantage of case study for Foucauldian inquiry is that the nature of the design frees the inquirist to collect discursive data from a wide range of sources—a necessity for both Foucauldian poststructural inquiry and case study. However, identifying relevant stakeholders and salient artifacts, for example, clinician notes, cannot be haphazard or disorderly, but selecting those stakeholders and artifacts a priori risks reproducing existing power imbalances. For clarity, stakeholders were people who affected the case or were affected by the case—in case study research, the case is the object of inquiry. In poststructural case studies, like this inquiry, the object of the case study is discourse. Thus, stakeholders in this context directly engaged in discourse about directives limiting care in the perianesthesia setting or indirectly influenced those discourses through the exercise of power. Crucially, in the poststructural context, the term "stakeholder" also positions the participant as having vested interests and authority in the co-construction of knowledge and the representation of findings.

Tracer Protocol

With slight modification, the Joint Commission's (JC) individual tracer methodology described by Siewert (2018) offered a familiar and useful way of identifying key stakeholders while simultaneously centralizing the patient. Siewert notes, "Patients are selected as an individual tracer if their diagnosis, age, or services allow for an in-depth evaluation of organizational practices" (p. 131). While the JC focuses individual tracer surveys on components derived from National Patient Safety Goals (NPSG), the individual tracer protocol used here focused on identifying clinicians and other stakeholders who fit the inclusion criteria, recruitment and informed consent, same-day observation, and scheduling minimally structured interviews. This protocol is disclosed in Table 13.

Table 13

Tracer Protocol

Approximately one week before planned tracer field work

1. Day-by-day, each scheduled 0530 preoperative patient encounter (i.e., first cases) were accessed through the EMR. For example, the first cases scheduled for Monday, followed by Tuesday, and so forth.
2. The EMR was used to determine if the patient had a DNR order or other directive limiting care.
3. If the patient had a directive limiting care, the EMR was checked to determine if they had previously opted out of MRA.
4. Clinical and/or leadership staff were consulted regarding potentially ideal candidates. For example, active DNR orders, lucidity, involved family members, clinically intriguing or complex cases that offer the best learning opportunity (Stake, 1995), patient request to be included, et cetera. These patients were approachable for recruitment.[a]
5. Selected eligible patients (see inclusion/exclusion criteria) were contacted for recruitment by phone.
6. Following a brief introduction and explanation of the inquiry, I asked the patient if they were interested in participating in the case study. Information about the study's purpose, procedures, and the patient's responsibilities to the study was provided. Patients were given an opportunity to ask questions about the inquiry. Patients who were not interested were thanked and assured that their decision in no way impacts the care they will receive. They were given an opportunity to provide a reason for declining participation, and their deidentified reasons was retained for later analysis. For patients wishing to participate, the informed consent process was initiated over the telephone. The informed consent document was again reviewed on the day of surgery and signed by the participant at that time.
7. If no scheduled 0530 patient wished to participate or there were no eligible patients scheduled, the same process was repeated for the next scheduled case start times until a selected patient agreed to participate or there were no more eligible patients on the surgical schedule.
8. The process was repeated for the next week at the end of the current week's field work.

Day of tracer field work.

1. At the beginning of the field-work day, each recruited patient's EMR was accessed to ensure that the patient had not opted-out of MRA on the day of surgery.
2. The patient's assigned perianesthesia staff were cross-checked to determine if they had signed the observational consent form.[b,c]
3. Patients who previously agreed to participate during the initial phone screening were approached to review and sign the previously discussed informed consent document. It was again emphasized that enrollment was completely voluntary and would not impact care or treatment. Since informed consent was substantively discussed in the preoperative telephone call, this review process was designed to take no more than 5 – 10 minutes to avoid day of surgery disruption.

4. When the patient agreed to proceed after informed consent, observation commenced. The enrolled participant could be "traced" from the preoperative area, through the operating theater, and finally into the Post Anesthesia Care Unit (PACU) or Phase 2 care area.
5. Observation concluded when a) the participant left the perianesthesia environment, b) I determined that further observations were unwarranted because observational data saturation had been achieved, c) when continued observation was disruptive to care, or d) a healthcare professional entered the room who had not previously signed the observational consent form or whose consent status was unknown.
6. Each clinical team member who participated in the traced encounter could be approached for recruitment unless excluded by the index patient. Clinicians who did not wish to participate were given my contact information and encouraged to contact me should they change their minds. Clinicians who agreed to participate were contacted to schedule an interview to occur no longer than four weeks after the tracer field day, at which time signed informed consent was obtained. If the informed consent process occurred somewhere other than the clinical facility, the informed consent documents were returned to the designated secure location at the clinical site as soon as possible but no later than the next business day.
7. Relevant[d] family members/representatives could be selectively approached for recruitment. For this inquiry, relevancy was determined by presence during discussions about directives limiting care. Family members/representatives who did not wish to participate were given my contact information and encouraged to contact me should they change their minds. Family members/representatives who agreed to participate were contacted to schedule an interview to occur no longer than four weeks after the tracer field day. At that time, signed informed consent was obtained.
8. After several tracers were completed, selected participants from the perianesthesia leadership team were approached for recruitment. Leadership team members who agreed to participate were scheduled for interviews at which time informed consent was discussed. These interviews were completed by four weeks after the end of field work. Leadership team members who did not wish to participate were given my contact information and encouraged to contact me should they change their minds.

Day of tracer field work, after observation is complete for the day

1. Observational notes were reviewed, and additional memos were recorded.
2. Same day reflection and journal entries were completed.
3. Each traced patient's EMR was accessed, and clinicians' charted notes were reviewed with relevant entries memorialized for later analysis. Any other artifacts identified as salient during observation were obtained and memorialized or flagged to find before field work concluded.
4. Interviews were scheduled for a time and location agreeable to the patients, family members, and clinicians and interviewer but no longer than four weeks after the surgery. Interview scheduling occurred any time after agreement was confirmed but not longer than four weeks after surgery. In deference to potential infection control measures, interviews could be conducted in person or through an electronic device (e.g., video conference or telephone).

5. Ideally, interviews were transcribed the day the interview occurs but will be transcribed within 72 hours of the interview.

Note. All recruitment was purposive.

[a] The number of days of field work and patients recruited per week was fluid. Days without new participant recruitment were reserved for interviews and follow up. Thus, it was correctly anticipated that recruitment would be more substantial in the early weeks of the study with fewer new participants recruited toward the end of field work to accommodate interviews.

[b] A list of clinicians consenting to observation was made. Their identities were recorded and held confidentially for cross-referencing with selected patients on the day of field work. If the selected patient was assigned a staff member who had not consented for observation, no data involving that staff member was collected.

[c] It was anticipated that very few observations could be completed at the study's beginning. If a health worker entered the room who was unconsented or whose consent status was unknown, observation would generally end for the day. This was so because the unconsented person would presumably be involved in the case from that point forward.

[d] Relevancy was determined by participation in same-day surgery conversations about directives limiting care and the ability to contribute understanding to the case study. A family member who was not present (in person or by electronic device) during same-day discussions about the directive limiting care was not directly relevant to the case.

Enrollment Procedures

Figure 7 is a matrix required by the clinical site's IRB describing each participant group, the type of consent required for that group, what data was collected for the group, privacy protections, and eligibility. One written consent appropriate for patients was used (see Appendix B). Three other written consents appropriate for family members or representatives, clinicians, and observation only participants were also used. The family member consent is provided in Appendix C, the clinician participant consent is in Appendix D, and the observation only consent is in Appendix E. Appendix F contains the IRB required documentation form that I completed at the end of each informed consent process. The documentation forms were completed for patient, family, and clinical participants. No additional documentation was collected on observation only

participants. A copy of the signed consent form was provided to patient, family, and clinical participants. A copy of the signed consent was offered to observation only participants, but the copy was always declined. The IRB required that a Health Insurance Portability and Accountability Act (HIPAA) waiver was appended to the patient specific consent. When observation only participants later agreed to participate in the interview component of the study, a separate clinician participant consent was signed.

Figure 7

Participant Matrix

	Participant Group			
	Patient Participant	*Family (Representative) Participant*	*Clinician Participant*	*Observation Only Participant*
Description	A patient requiring perianesthesia care Meets eligibility requirements	Non-clinician present—by wish of the patient—during preoperative discussions about the directive limiting care Meets eligibility requirements Not excluded by the patient participant	Nurses, physicians, organizational leaders, or surgeons Participate in discussions about advanced directives OR influence over policy and procedure directly impacts those discussions Meet eligibility requirements	Anyone who interacts with the patient- participant in the perianesthesia setting in ways salient to directives limiting care

Informed consent	Yes	Yes	Yes	Yes, Observation Consent Document for clinicians Family Members/Representatives contemporaneously assent to being observed
Type of Data Collected	Observation Field Notes Charted Clinical Notes Collected Artifacts Audio Record Interview	Observation Field Notes Collected Artifacts Audio Recorded Interview	Observation Field Notes Collected Artifacts Audio Recorded Interview	Unidentified Observational Field Notes
Privacy	Coded	Coded	Coded	Observation Consent is the only identifiable information collected.
Eligibility	·18 years of age or older · English Speaking · Lives in the US · Has not opted out of the MRA · Has not been excluded by the index patient · Non-emergent Surgery · Does not bypass Preop · Able to participate in a qualitative interview			· Intersects with the case in a salient way

Participants were protected from pressure to participate in the inquiry. All patient participants were contacted at least a day before their scheduled surgery date to provide adequate time to consider their decision to participate. For patient participants, informed consent occurred on the day of surgery. Patients were escorted to their private preoperative room before the usual preoperative rooming process began. If a family member was present, they were brought to the room as well. Participants were given time to review the consent document. Then, each section of the consent was verbally discussed. Participants were asked questions and encouraged to teach

back critical elements of the consent at the end of the discussion. With family members and clinicians who agreed to participate, informed consent was discussed immediately before the interview.

Data Collection

Observation and Artifact Memorialization

Once the patient's informed consent review was complete and the consent document was signed on the day of surgery, I remained with the patient taking observational notes and memos on space and talk surrounding the directive limiting care. The same-day observational data collection was paused when all the perianesthesia team and surgeon completed their preoperative interactions with the participant or the patient was designated a full-code. Observation concluded near the time the patient left the perianesthesia area or earlier as the case evolved and the new data obtainable during each phase of care diminished. After observational data collection around patient interactions concluded, any documents, policies, forms, clinical notes, or processes relating to the limiting directive employed by clinicians or evoked by patients (photographs, journals, objects) during same-day observation (i.e., artifacts) were retrieved and memorialized for analysis.

Interviews

Subsequent interviews with patients, family members, and clinicians were scheduled, in accordance with participant preference, for any time after surgery but no longer than four weeks later. Ideally, patient-participant interview occurred in-person at the patient's home or during a visit to the hospital or clinic; however, two participants chose to be interviewed by phone. Telephone or video-telephonic peer-to-peer communication were approved as options by the IRB. In-person interview sites were generally restricted to within 30 miles from the clinical site

due to time and resource constraints. Participants living farther than 30 miles from the clinical site were scheduled for telephone interviews.

Data were collected through in-depth, minimally structured interviews using topic guides. Like the research questions and aims, a priori topic guides are dynamic within a poststructural framework. The guides changed in response to fluid conditions in the field and the extemporaneous knowledges shared by participants. The overarching goal was that the minimally structured interview more closely resembled a conversation than a question-and-answer session. Direct questions, when used, were to stimulate participatory conversation. Probes were provided to search for greater depth or detail. Topics proceeded from least intrusive to more sensitive to enhance the participant's comfort level. Finally, within this design, the *self* was the data collection instrument. Meticulous and continual reflexivity, including appreciating how insider/outsider status, personal privilege and oppression, and social positioning affected my contributions to the inquiry, enhances rigor (Dwyer & Buckle, 2009; Hall & Stevens, 1991; Vanner, 2015). Correspondingly, a reflexive journal was maintained during the inquiry.

The topic guide used for patients and family members/representatives is provided in Appendix G, while the topic guide used for clinicians is presented in Appendix H. In addition, Appendix I is a brief topic guide designed for participants who wished to provide information relevant to the inquiry but for whom an in-depth interview was overly burdensome. For example, a clinician who had time for a few questions between surgical cases or a patient/participant who—owing to their condition—only had energy for a short discussion. Within a Foucauldian framework, such fluid departures pose no threat to rigor because poststructuralism rejects humanist notions of singular truth and stable reality (Boles, 2016).

Interview Justification

> Unstructured interviews typify many poststructural inquiries. Boles (2016) notes,
>
> When interviewing with groundings in Foucault's . . . post-structuralism, unstructured interviews can achieve a greater level of flexibility and a more balanced (though still unequal) distribution of power that is more aligned with his notions of research, power, and the pursuit of knowledge. (p. 124)

While unstructured interviews are ideal within a Foucauldian poststructural framework, the need for some minimal scaffold, for example, using general topics as guides, is a reality for constructing inquiry designs with adequate human protections that IRBs will approve. The danger of imposing arbitrary limits on interviews is, nevertheless, appreciated. In addition to the risks of reproducing or buttressing existing discourses, some discourse analysts, for example, Potter and Hepburn (2005), argue that interviews are overused and contrived (i.e., unnatural) texts. Conversely, Brinkmann (2018) suggests that the interview's very commonness makes it a naturalized text and justifies its use. However, even when conducting completely unstructured interviews is possible, the inquirist still risks perpetuating power imbalances intrinsic to the interviewer-interviewee relationship (Oleson, 2018). For example, all observations, recordings, and transcriptions are filtered through the medium or device, discursive regime, and the investigator's subjectivities (Bratich, 2018). Vigilance against reification and discourse reproduction on the part of the investigator is essential to creating ethical and meaningful naturalized texts.

Therefore, using rigidly structured and even semi-structured interview guides denaturalize the text and are unjustified exercises of power that may force participants to respond in a predetermined way (Pinchman, 2009). Pragmatically, however, some structure is needed because not all participants can be expected to be both loquacious and organized in their

responses, and interviewers cannot be expected to remember every important point without cues. Interview topic guides derived from the research questions and study aims were used to conduct *minimally* structured interviews.

Observational Process, Recording, and Transcription

Observation and field notes were taken during each participant's same-day tracer encounter and interviews. The observation notes were pooled with transcribed textual data from the minimally structured interviews. I specifically looked for ways that the preoperative space reinforced discursive practice and forced deference to biomedical hegemony. Additionally, contemporaneous notes were taken to memorialize thoughts, ideas, and perceptions. Demographic data was collected at the beginning of each interview. Finally, within a Foucauldian framework, observation techniques can easily be perceived or even coopted as a disciplinary technique, so an awareness of the possibility that the very act of observing and recording may negatively impact participants was considered.

Each interview was recorded using either an Olympus WS-852 Digital Voice Recorder, Tascam DR-40X Portable 4-Track Audio Recorder, or password protected Galaxy S9 mobile phone. The interviews were transcribed verbatim by the investigator and stored on a password-protected, private computer running the most current version of McAfee Total Protection® anti-viral software. Security precautions are discussed in greater detail later in this Afterword.

Data Analysis

Choosing to code discursive data is controversial within a poststructural framework. The controversy is heightened for Foucauldian inquiry. Stake (1995) argues that coding may be useful for case studies, but it is not essential. Boles (2016) argues that Foucauldian poststructuralism and QUAL 4.0 (i.e., fourth moment) case studies should embrace post-coding

analytic modalities. For example, the Chapter Three Manuscript discusses rhizomatic crystallization as an alternate—post-coding—method of analysis. Sandelowski and Leeman (2013), however, admonish novice researchers in practice-based disciplines to produce meaningful knowledge that is usable for practicing clinicians. This earnest warning may be more important for case study designs that are sometimes considered less publishable and often relegated to classroom exercises and niche journals. Regardless, the decision to code discursive data should ultimately be driven by the nature of the research questions and whether coding will make the data more intellectually apprehensible.

The Chapter Three manuscript covers contextual coding and analysis in detail. For this inquiry specifically, however, data was organized in relation to each patient participant using a color system. Each patient participant's file was read and color-coded for patterns of repeating statements. The color codes signified potential discourses that were compiled, through four iterations, into a Master Key. After contextual coding was completed for each patient group, a rhizomatic diagram was created that helped visualize power relations and interrelationships between codes. After re-reading the data, a glossary of contextual codes was created using the Master Key and rhizomatic diagrams. Then, the contextual codes where shaped into authoritative discourses and discursive themes in relation the inquiry's research questions. Finally, I returned to the data to review each contextual code line-by-line.

Here, coding was used to construct authoritative discourses, discursive themes, and the effects of discourse (Carabine, 2001). Boles (2016) terms this process contextualizing analysis. Unlike axiological coding or content analysis, the goal was not to condense statements to units and rebuild those units into study results in pursuit of a more truthful final report. Similarly, there were no clear distinction between coding and analysis. Instead, the goal of coding textual data

within a poststructural framework was to make the text more accessible—to allow the investigator to know and interpret the text. To borrow Young's (1981) phrase, the goal was to "untie" the text while retaining context, all the while remembering that it was but one possible interpretation of many. Multiple Microsoft Word® documents and physical hard-copy worksheets were used to code the data.

Analysis of the coded text employed a fluid and iterative immersion process—assemblage and rhizomatic crystallization—designed to blur the artificial categories created when coding. The aim was to deconstruct the text to understand better the power/knowledge networks functioning in the perianesthesia instrumental case while simultaneously embracing uncertainty and interconnectivity. The analysis specifically looked for patterns of discourse, absences or silence, inter-relationships between discourses, and socio-historic context. Four iterations of the Master Key helped identify repeating patterns and relationships in the data. An exhaustive Glossary of Terms compiled and defined the contextual codes and patterns while rhizomatic diagrams helped me visualize the interrelationships. Those documents and diagrams were then interrogated in relation to power-knowledge (Carabine, 2001; Wetherell, 1998). Finally, Carabine (2001) notes, “analysis is often a dynamic process of interpretation and reinterpretation” (p. 285). Consequently, this process involved continuously returning to not just the coded data but the original text.

Moreover, the analytic process was both inductive and deductive. Discursive data, artifacts, theory, and experiential learning from the field coalesced to construct representational forms in poststructural case study design—a process that Augustine (2014) calls *assemblage*. St. Pierre notably reports using a similar combination of coding and assemblage during their research. However, Richardson and St. Pierre (2018) advocate advancing toward post-coding

rhizomatic crystallization as the future analytic method of choice. Boles' (2016) approach to contextualizing analysis was used for this inquiry, although the process may be more descriptively termed contextualizing *discourse* analysis. Stake-Boles contextualizing discourse analysis was discussed in the preceding methods Manuscript.

Inquirist Characteristics and Reflexivity

This inquiry was positioned in the constructivist paradigm, and personal characteristics were, therefore, essential to establishing transparency and rigor. Table 6 adequately summarizes my philosophical and scientific assumptions about inquiry. As my curriculum vitae suggests, I am also a peer-reviewed and published author in critical care and perianesthesia ethics. Additionally, decades of critical care and perianesthesia experience with emotional end-of-life discussions helped ensure that the interviews were conducted safely and therapeutically. It should also be noted that I am a current employee of the clinical site. In the interests of fairness and to ensure that participants did not feel pressured to join the inquiry, I took a leave of absence during field work. A journal that was started at the conception of this project was continued throughout the field work experience to account for decisions, create an audit trail, and improve my self-awareness as an inquirist.

Last, the notion of triangulation should be preemptively addressed. While some scholars suggest that triangulating qualitative research with either quantitative findings or multiple qualitative methods enhances the validity of qualitative research (Denzin & Lincoln, 2018), this conceptualization of validity sits uneasily alongside poststructural inquiry. Richardson and St. Pierre (2018) pose the exposing question of triangulation: To what fixed-point of truth should qualitative inquirists triangulate? Instead, the concepts of trustworthiness—evaluated by dependability, credibility, transferability, and confirmability— and rigor apply to qualitative

inquiries. Other strategies that address these evaluative criteria, for example, member checks, were discussed in the Chapter Three Manuscript.

Ethical, Safety, and Administrative Considerations

Foucauldian poststructural inquirists must remain aware of the potential for their investigations to reproduce existing, possibly oppressive, discourses and avoid contributing to sustaining those discourses. Also, inquirists must take steps to minimize the inherent power imbalance that exists in their relationships with participants. Eroding this power imbalance demands that inquirists recognize that participants are co-equal creators of knowledge, and that the knowledge is not owed to the inquirist or owned by the investigator. The chance to create knowledge alongside participants is a privilege. Therefore, member checks during data analysis and seeking approval from stakeholders in the presentation of findings was critical. Seeking clarification and buy-in from participants increases the credibility of the inquiry. More importantly, member checks provided participants with information about usually hidden discourses and power relations that will empower them to improve future interactions, thus, eroding the power imbalance between patients and clinicians.

Ultimately, the safety and health of participants held the highest priority. Given the sensitive nature of interviews about death and dying, participants were periodically reminded during interviews that they could choose not to answer or withdraw their consent at any time. At no time were participants pressured to continue with the inquiry, and no participant expressed a desire to halt participation. In this inquiry, informed consent was not static, and it was not finished when the IRB approved informed consent document was signed. Informed consent was frequently reaffirmed. Resources were available for participants who became distressed during interviews but ultimately were not required. I was similarly aware of the personally taxing nature

of interviews on sensitive topics, and I maintained mindful awareness about my well-being during this process.

Maintaining confidentiality and the security of personal information was a priority. Patient contact information was kept in a purpose-specific paper contact book. A separate paper code-key book was maintained. This was the only document linking participant names to study identification numbers. Recorded interviews were stored using Box®—the password-protected, encrypted digital system licensed by the clinical site. When the study is complete, the recordings will be transferred to a password protected clinical site server for the required five-year archival storage. The deidentified transcribed recordings will be maintained on Word® documents on the investigator's password secure computer. Observation and field notes taken during each participant's same-day tracer encounter and interviews were on paper. These deidentified notes and self-memoranda were pooled with the interview, records, and artifact data for each participant during coding.

Each participant was assigned a study identification (ID) number. The list that linked the study ID to any identifiers (i.e., codebook) was stored in a separate locking box at a designated clinical site office that was locked when not in use. The list contained participants' names and ID codes (i.e., study identification numbers) to transcripts, observation notes, and field notes. Participant's contact information was kept in a locking location at the same designated office. Home access to the participant contact information was practicably essential to schedule interviews, follow-up discussions, and member checks. Therefore, a separate electronic file containing only participant contact information was created so that the inquirist could access participant contact information from home. This document was stored in a password protected

file on the clinical site's email server. The clinical site's email system was password and two-step verification protected.

A personal computer was used for storing deidentified scanned artifacts, transcripts, and coding work product. The computer was password protected and included continuous monitoring by the most current version of McAfee® anti-viral security software. All transcripts, recordings, notes, and artifacts were identified only by ID numbers. Any signed documents or other physical artifacts containing patient identifiers (e.g., informed consent documents and compensation receipts) were stored in a locking box at the designated secure office. The link between ID number and personal identifiers will be maintained until all interviews and follow-up appointments are finished, analysis is complete, and the study is closed. Then, the ID codebook and electronic file will be obliterated. The informed consent documents, participant contact information, and recordings will be digitized for archival storage and maintained by the clinical site for five years in a secure, password protected Nursing Research Folder created on the site's secure server. The clinical site will destroy the archived documents and audio recordings at the end of the required five-year holding period. The observational consent documents will be secured, stored, and eventually destroyed in the same manner as all other informed consent documents. Finally, when accessing patient charts, in accordance with the minimum necessary requirement, only sections of the EMR directly applicable to the inquiry were accessed.

Compensation

Participants who completed the qualitative interview were compensated for their time with $50.00 in the form of a gift card made possible by a grant from the Minnesota Nurses Association Foundation (MNAF). They received this compensation regardless of their continued participation with follow-up, member checks, or study closure. The compensatory amount was

decided by carefully weighing the sensitive nature of the interviews and the relative salaries of the clinical participants with an ethical imperative to not coerce or unduly influence the participants. Of note, two clinical participants declined compensation. There were no conflicts of interest to disclose.

Conclusion

This Afterword presented the particulars of design and method used to conduct the case study. The method was constructed following the Enhancing the Quality and Transparency Of health Research (EQuaTOR) network's Standards for Reporting Qualitative Research (SRQR). Appendix J contains the SRQR checklist to enhance transparency and evaluation of the inquiry. Traditionally formatted qualitative (e.g.., problem, purpose, research questions, analysis, findings) reports generated from the inquiry adhere to EQuaTOR guidelines; however, non-traditional representational formats (screenplays, novels, photographs) may depart from the recommendations. In summary, The Chapter Three Manuscript and Afterword—taken together—comprised the methods used to investigate how the case accommodated, constructed, and reproduced discourses on directives limiting care.

Chapter Four

Preface

This chapter includes two manuscripts that represent the inquiry's results. Each manuscript is written as a standalone prospective article. However, within the context of this dissertation, the manuscripts are best read together as one chapter. The first manuscript was prepared for the journal *Anesthesia & Analgesia*. The author guidelines for the journal may be found at the web address https://edmgr.ovid.com/aa/accounts/ifauth.htm. The second manuscript targets the journal *Nursing Inquiry*, and that journal's author guidelines are available at https://onlinelibrary.wiley.com/page/journal/14401800/homepage/forauthors.html. *Anesthesia & Analgesia* is a medical journal read mostly by anesthesia providers. The journal has published articles on perianesthesia limiting directives in the past and was frequently encountered in the literature review for this inquiry. Although *Anesthesia & Analgesia* requires somewhat burdensome format and word restrictions, it reaches the audience required for transformative change. *Nursing Inquiry* was selected because the journal originally published Georges' (2013) emancipatory theory of compassion, and the journal has a history of publishing theory building research.

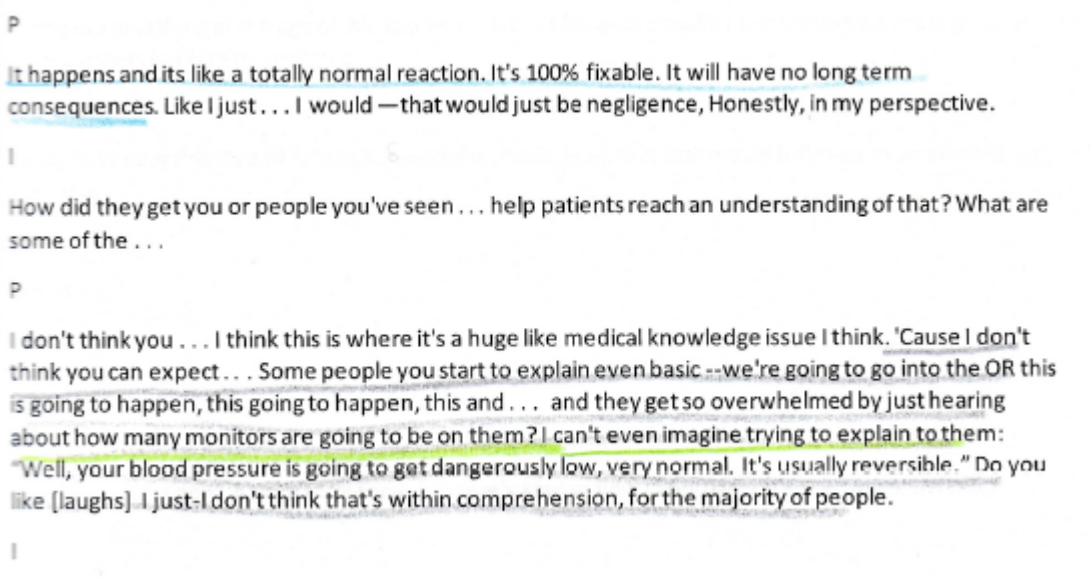
Whereas a traditional dissertation might detail the time-consuming intellectual rigor underlying the construction of results, the limitations of manuscripts prepared for journal publication require stricter choices about what material to include. Readers may benefit, however, from an explication of the process used to generate the manuscript results. In addition, future scholars may seek examples of the applied process of data analysis should they too choose

contextualizing analysis for poststructural inquiry. The following paragraphs provided detailed examples from each step of the analysis process.

First, the data was organized into groups scaffolded around the index patient. Each group was assigned a color, for example, Turquoise. After transcribing the interviews and observation data, contextual codes were identified. The codes were created because a) I recalled hearing the same words across groups suggesting a repeating pattern of discourse, b) the language had notable weight during the interview, c) the language was used by the participant in a self-evident way without need of further explanation, d) the language corresponded to concepts suggested by Georges' MRT of emancipatory compassion for nursing, e) the language comported with field observations, or f) the potential for answering the inquiry's research questions. Figure 8 shows the color system used to identify the contextual codes in the textual data.

Figure 8

Colored Signifiers Used to Identify Contextual Codes in Transcribed Data


P

It happens and its like a totally normal reaction. It's 100% fixable. It will have no long term consequences. Like I just . . . I would —that would just be negligence, Honestly, in my perspective.

I

How did they get you or people you've seen . . . help patients reach an understanding of that? What are some of the . . .

P

I don't think you . . . I think this is where it's a huge like medical knowledge issue I think. 'Cause I don't think you can expect . . . Some people you start to explain even basic --we're going to go into the OR this is going to happen, this going to happen, this and . . . and they get so overwhelmed by just hearing about how many monitors are going to be on them? I can't even imagine trying to explain to them: "Well, your blood pressure is going to get dangerously low, very normal. It's usually reversible." Do you like [laughs] I just-I don't think that's within comprehension, for the majority of people.

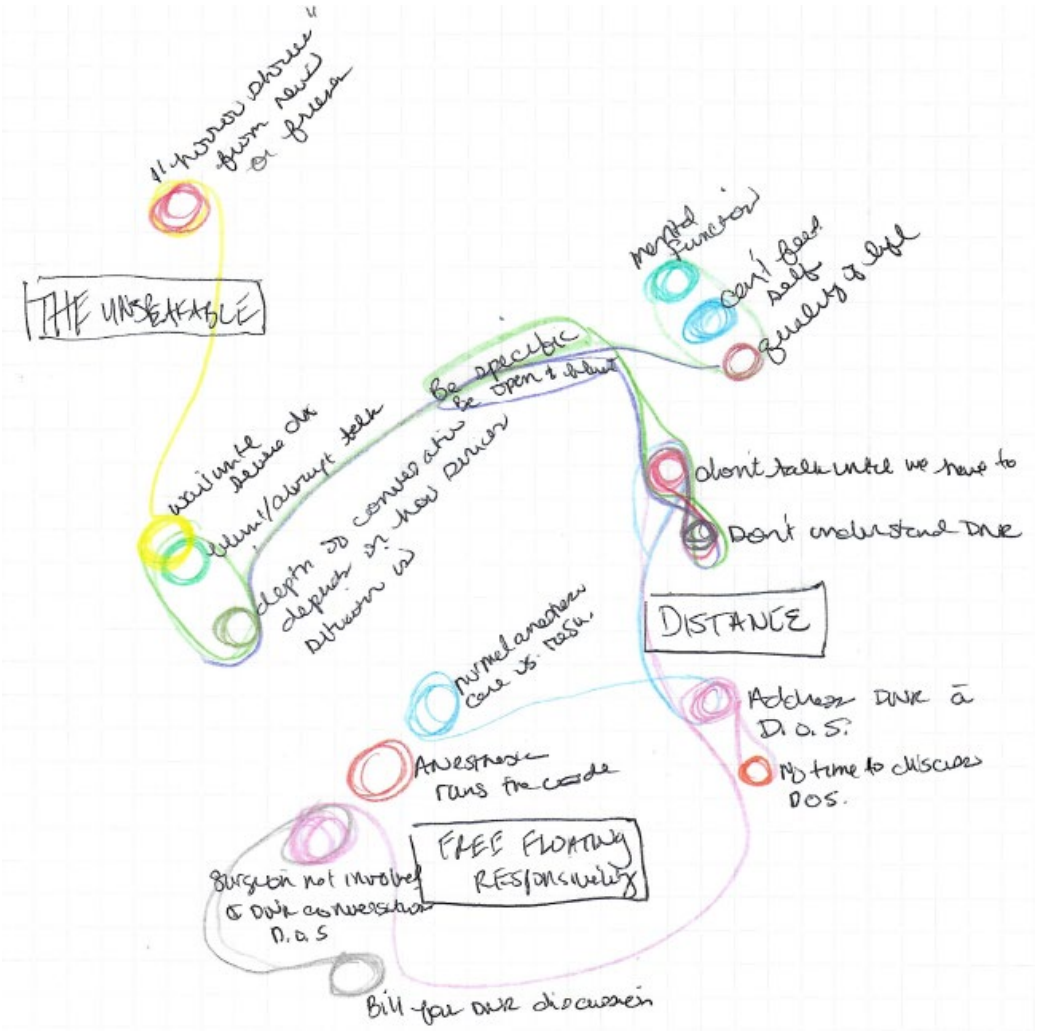
I

Note. Each color signifies evidence for a contextual code constructed from the raw data. These contextual codes were compiled in the Master Key Worksheets.

Next, rhizomatic diagrams were created for each group from the contextual codes. As noted in Chapter Three, these diagrams help spacialize power networks and aid the investigator in identifying interrelationships between contextual codes. A rhizomatic diagram was created for each color-labeled Group. These diagrams were iterative and indispensable for making meaning from the data. Figure 9 is the diagram created for the Turquoise Group. Nine rhizomatic diagrams were created during primary data analysis.

Figure 9

Rhizomatic Diagram for the Turquoise Group



Note. Not all contextual codes identified in the group were used in the formation of the diagram. The codes were used based upon their importance within the group.

A series of Master Key Worksheets, four in total, were constructed during primary data analysis. The worksheets helped identify patterns in the data. The worksheets were matrices that listed the contextual codes on the vertical axis and the Groups on the horizontal axis. Thus, code occurrence across and between groups became visible. In subsequent iterations, non-repeating codes were removed, counter-discourses identified, and similar codes merged. The complete worksheet is too large to display; however, Figure 10 is an excerpt from one line of the worksheet matrix-version three. The final version of the worksheet is the Master Key and contains 67 contextual (see Appendix L) codes used to construct flexible categories and representational forms.

Figure 10

Excerpt from the Master Key Worksheets

Group	Contextual Codes	Turquoise	Pink	Stale Green	Lavender	Periwinkle	Yellow	Blue	Orange	No Color
Celery	Talk more about wishes depending on the criticality of the situation.	P04L293 P04L298	P50L319 P50L369	P10L403	P12L494 P41L564	P28L445 P45L71 P45L79	P23L209 P21L386	P32L210 P32L294	P09L73 P09L119 P09L150	
Purple	If you want to keep the DNR during anesthesia, be very specific about treatments in preop.	P01L76 P01L163 P01L280 P01L440 P01L445 P01L496 P30L210 P30L215 P30L240	P50L215 P50L218 P50:237	P10L260		P39L276 P39oL31 P08L130 P08L225 P08L246 P28L558	P21L126		P09L218	

Note. Each contextual code is identified by Participant (P) and Line of Text (L).

However, before the representational forms used to construct the manuscript results could be compiled, a Glossary of Contextual Codes needed to be developed. The Glossary was a compilation of the textual data supporting all the contextual codes from the Master Key. The Glossary defined the codes, identified the productive effects of discourse, counter-discourses, and technologies of discipline. The Glossary, along with the Master Key and the Rhizomatic

Diagrams, were used to form the results around each research question. The final document, titled Flexible Categorizations and Representational Forms, was used to visualize the results in relation to the research questions and formulate how those results could be written for publication. Again, the Glossary is far too large to present in this preface or even as an appendix, so an excerpt from a single Glossary term is provided (see Figure 11). Similarly, an extract from the original document for Flexible Categorizations and Representational Forms is provided in Figure 12.

Figure 11

Excerpt from the Glossary of Contextual Codes

Contextual Codes	*Definition, Interrelationships, & Potential Effect*
No discussion of death/dying as a child (Aruba).	Definition: Although they were not explicitly told not to discuss death and dying, these participants did not discuss death and dying when they were young. They felt it should not be discussed.
Q: Uh, did you have conversations about death dying and end life issues when you were a child with parent's family members? P: Probably not. (P04L124turquoise, patient)	
Q: Do you remember, when you were young, the earliest conversations about that you heard from family members? Maybe your own parents? P: We really didn't talk about it. (P12L283, lavender, patient)	
And, uh. It's just one of those things that in that generation you didn't really have very detailed conversations with your parents. Nobody did. It was, it was the just the nature of of having a big family for one thing and then parents didn't discuss the topic really. (P39L244periwinkle, patient)	Inter: We never avoided talking about death; we talked about it all the time (pastel green)
P: Uhm . . . I know it was never really anything that we talked about like as family or. . .. It was one of those subjects to me that you never talked about it. Q: What made you say that you never talked about it? Was it a feeling? Or was it something said what—where did . . .? P: It was, it was a feeling. Like when my grandparents died, we never really talked about things. (P08L157periwinkle, RN-perianesthesia)	Effect: It may feel uncomfortable or new to talk about death and dying.

Note. This is a glossary definition of one contextual term. The Glossary consists of 67 coded terms.

Figure 12

Extract from the Flexible Categorization and Representational Forms Worksheet

How do perianesthesia patients talk about DNR orders and express their rationales and motivations for rescinding, modifying, or retaining the orders during anesthesia?		
Contextual Codes	Discursive Themes	Entanglements
No discussion of death/dying as a child. (aruba) We (patients and clinicians) don't talk about death and dying until we have to. (red) We wait until severe diagnosis or are dying to talk about death and make end of life decisions (yellow). Advance directive was created because someone heard a "horror" story. (candy apple) Talk more about wishes depending on the criticality of the situation. (celery) "Stoic" parent did not want to talk about death/dying. (terracotta) Patient just want to get the surgery done (toasted toffee) Parent/someone "bluntly" (maybe realistically) said—straight talk about end of life wishes. (green pastures) I had enough time to discuss my DNR (pale yellow-counter discourse) Talk about death/dying framed around religion (Catholic) (custard)	Dominant Theme: **Patients expect a conversation about their advance directive, but-- because such conversations are unusual and provoke uncomfortableness--they only want to go into detail if their procedure is serious.** Effects: • Patients often wait until a life-threatening diagnosis or stressful life event occurs to create an advance directive. • Because patients expect the depth of conversation about their EOL wishes to become more detailed the more critical their procedure is, patients accept straightforward—even blunt—talk about their advance directives.	"We'll just suspend the DNR. Don't worry--let us take care of you." because no one dies in the Operating Room (OR). When addressing DNR orders, seek specifics about what interventions patients want done and not done during anesthesia because what may be considered resuscitative in other contexts is just normal care in the perianesthesia setting.

Note. The contextual codes that inform the theme are listed alongside the effects and interrelationships or "entanglements."

Table 15 in the first results manuscript summarizes each part of the Contextualizing Analysis process. Although presented sequentially, the process depicted in Table 15 and the audit trail of the actual procedure used for analysis is fluid. Some "steps" occurred simultaneously or in an order askew from the above stepwise process. The intent of the additional information provided in this preface is to provide a replicable audit trail to enhance trustworthiness and add color to the proceeding results.

Manuscript One: Directives Limiting Care in the Perianesthesia Setting: A Foucauldian Case Study Report

Abstract

Background: Current practice guidelines recommend mandatory reconsideration of Do Not Resuscitate (DNR) and other directives limiting care before surgical and procedural interventions requiring anesthesia. However, the automatic suspension of directives limiting care continues to occur in the adult perianesthesia setting. How patients and clinicians talk about these limiting directives and the hidden discourses shaping how these directives are addressed are underexplored in the literature.

Methods: This inquiry used Foucauldian Poststructural Case Study Design and Contextualizing Analysis to better understand how adult patients, their families, and clinicians make decisions about resuscitative status during anesthesia by investigating discussions about directives limiting care in the perianesthesia setting. Data were collected through interviews and observations of patients with existing advance directives who underwent surgery, family members, and perianesthesia clinicians who participated in their care.

Results: Twenty-seven participants completed the observation and interview inquiry components. Eighteen observations only participants also joined the inquiry. The inquiry identified four authoritative discourses that constructed the choices available to patients and clinicians when making decisions about advance directives. The "We'll just suspend" discourse permeates perianesthesia culture and produces a will to suspend the limiting directive among clinicians. Discourses about lack of time, a desire not to talk about advance directives unless it is essential to care, and confusion about who is responsible for addressing

the limiting directive were identified in the case as well. The investigation also found that perianesthesia patients talk about functionally driven and not intervention-based resuscitative stopping points. In addition, patients had difficulty translating advance directive choices into the perianesthesia context, and this difficulty may be misunderstood by clinicians as compliance. Clinicians cite a lack of time for these conversations and tend not to talk about limiting directives. Finally, power networks may sequester knowledge about patient's choices leading to tension among clinicians and creating barriers to honoring patients' advance directive choices.

Conclusion: These results suggest that even where policies of mandatory advance directive reconsideration exist, patients may experience discursive environments that constrain their choices and decision-making agency. Clinicians may be unaware of how these hidden discourses effect the decisions made by both patients and clinicians about advance directives before anesthesia.

Key Points

- **Question:** What discourses dominate how patients and clinicians talk about advanced directives in the perianesthesia setting, and how do those discourses relate to power-knowledge?
- **Findings:** New findings suggest that patients experience well intentioned perianesthesia cultures that, nonetheless, discipline patients into conforming with routine suspension of advance directives before surgery.
- **Meaning:** The discourses shaping perianesthesia culture construct how clinicians and patients talk about advance directives and whether those directives are ethically managed.

Introduction

Despite current practice guidelines that recommend mandatory reconsideration of limiting directives before surgical or procedural interventions that require anesthesia, The automatic suspension of Do Not Resuscitate (DNR) orders and the marginalization of other directives limiting care continues to occur in the adult perianesthesia setting (Hiestand & Beaman, 2019). Even where clinicians adhere to best practices, a hidden culture favoring automatic revocation may dominate the reconsideration process (Hardin & Forshier, 2019). Processes that ignore or massage the standard of care subvert the patient's autonomy to choose the disposition of their advance directive during surgery. In addition, advance directives without corresponding DNR orders may remain unexamined preoperatively. This problem and its ensuing ethical dilemmas are likely to increase as anesthesia providers more frequently encounter advance directives in a growing population of older adults with chronic conditions in the United States (US) who need surgery and other procedures.

Despite current practice recommendations that patients may suspend, modify, or retain their DNR orders before anesthesia, some clinicians believe that retaining limiting directives during surgery is incommensurate with safe and effective anesthesia practice. However, patients may differently judge and prioritize surgical outcomes. The literature suggests that conflicts exist between patients' values and objectives and those of clinicians when making decisions about advanced directives (Waisel et al., 2003). Additionally, how clinicians address and operationalize limiting directives and how patients express their end-of-life (EOL) choices in the perianesthesia context are underexplored in the extant literature.

The purpose of this inquiry is to better understand how adult patients, their families, and clinicians make decisions about resuscitative status during surgery with anesthesia by

investigating discussions about directives limiting care in the perianesthesia setting. Illuminating the influence of biomedical and perianesthesia culture on how clinicians address and discuss directives limiting care will suggest ways to better resolve potential conflicts. Therefore, this inquiry aims to expose the discourses creating the choices available to patients and clinicians and examine that constructed reality in relation to power.

Four research questions address gaps in the literature and guide this inquiry.

1. What hidden discourses dominate how patients make decisions about the disposition of their DNR orders or other directives limiting care during the perianesthesia period?
2. How do perianesthesia clinicians talk with patients about DNR orders or other directives limiting care?
3. How do perianesthesia patients talk about DNR orders and express their rationales and motivations for rescinding, modifying, or retaining the orders during anesthesia?
4. How do these discourses relate to power and knowledge in the perianesthesia setting?

Methods

Ethical Approval

The inquiry was approved by Institutional Review Boards (IRBs) at the clinical site (1723212-1) and at the principal investigator's academic institution (22.077). All participants completed written informed consent documents, and verbal consent was confirmed before and during each interaction. Participants completing both the observation and interview components of the inquiry received $50.00 compensation for their time. There are no reportable conflicts of interest.

Design

This inquiry used a Poststructural Case Study Design (PCSD) conducted within a Foucauldian framework. Foucauldian poststructuralism is firmly located within the constructivist, interpretivist paradigm. Foucault's work focuses on the intersection of power, knowledge, and language and primarily on the constitutive effects of power. Further, poststructuralists reject the phenomenological idea that language is a clear reflection of inner thoughts and instead examines the effects of discourse, how certain discourses become authoritative, and how that authority is sustained through institutions and language to create an accepted reality within a given context. For Foucault, knowledge and power are inextricably bound together, and in the clinical setting, knowledge-power is controlled by clinicians. The discourse of the clinic reflects this power imbalance, and it is often most visible in clinician-patient relationships (see Foucault, 1994).

Case study research positions the "case" as the object of inquiry (Stake, 2005; Boles, 2016). In PCSD, the case may be defined as an individual, a phenomenon, group, institution, event, or other constructs with distinct temporal-spatial boundaries investigated to learn how and why the whole functions. For this inquiry, the case is how one perianesthesia department accommodates, constructs, and reproduces the dominant discourse on perianesthesia directives limiting care. However, Foucault does not prescribe a rigid method of analysis, and PCSD is a research design epitomized by the onto-epistemological choices of the designer.

Sample

Full inquiry participants include a) index patients, b) family members, and c) clinicians. Potential patient participants were identified through prescreening for eligibility according to the inclusion and exclusion criteria presented in Table 14. Patients whose clinical condition was

declared an emergency, who bypassed the usual preanesthesia evaluation process, or who expressed a desire not to be approached about participating in research were excluded.

Table 14

Inclusion Criteria

Patient Participant	Family Member Participant	Clinician Participant
1) Require perianesthesia care for a procedure or surgery 2) Have a DNR order or other advanced directive in place at the time of their planned anesthesia encounter 3) Can verbally or with an assistive device participate in minimally structured interviews that require recall of recent clinical interactions about perianesthesia DNR orders or directives limiting care 4) Speak English 5) Live in the US.	1) A family member or other person who participates in discussions about advanced directives in the clinical setting 2) Can verbally or with an assistive device participate in minimally structured interviews that require recall of discussions about DNR orders or other directives limiting care 4) Speak English 5) Live in the US.	1) Interact with the patient participant to address the advanced directive And/or 2) Substantively influence the conduct of discussions about advanced directives And 4) Speak English 5) Live in the US.

Setting

The inquiry's setting was a large, adult, tertiary care facility in the upper Midwest of the US that adopted a written policy of mandatory limiting directive reconsideration in the last few years. The setting was ideal because it encompasses a "main" perioperative area providing a full array of anesthesia services to higher-risk patient populations and a "day-surgery" center that

offers same-day surgeries for lower risk populations. While perianesthesia nursing staff differs between departments, the providers were the same.

Inquiry Procedures

Potential patient participants who met the inclusion and exclusion criteria by screening were contacted by phone approximately one week in advance of their scheduled surgeries to inform them about the study. Those who agreed to participate were observed on their day of surgery. Observation of the index patient started in preop and continued until a) an unconsented person entered the observation area, b) the patient was discharged from the perianesthesia setting, or c) data saturation was achieved. Clinicians who encountered the patient during observation were invited to join the inquiry. Family members who were present for advance directive conversations were also invited to join the inquiry. Last, representatives from the clinical leadership team were invited to participate based on their likely ability to inform the case. These groups also met the inclusion and exclusion criteria. Participant interviews were conducted within 30 days of the patient's surgery. Some clinicians opted to participate through observation only; therefore, only observational data was collected on these participants.

Purposive recruitment and enrollment decisions were governed by the following criteria. First, two months was allotted for recruitment and field work, and second, data saturation. For this inquiry saturation was defined as a) reaching a point where observations or interviews were yielding repeating data with little new data or b) embraceability—the investigator intellectually grasped the conceptual area and further recruitment would be a waste of resources.

Data Collection

Interviews were the primary source of data collection and were conducted using minimally structured topic guides. Data were also collected by direct observation of patient-

clinician interactions, using a semi-structured observation form. Data also included excerpts from the index patients' charts and written institutional policies.

Data Analysis

Contextualizing Analysis (CA) as a qualitative methodology comports well with both Foucauldian poststructuralism and PCSD (Boles, 2016). Table 15 discloses the steps of analysis used for this inquiry. Despite this stepwise tabular depiction, the CA process is iterative and fluid. Similarly, how contextual codes are identified in the raw data and crystallize into the inquiry's findings is an inductive-deductive activity. The crystallization process uses an evolving dialog between the inquirist, theory, and the data to "put together" (Augustine, 2014, p. 749) discursive data with theoretical concepts, such as Foucauldian conceptions of power. This process is called assemblage and was aided by rhizomatic diagrams, which are open-ended, fluid diagrams that specialize power networks and how codes interrelate, that were created for each participant group. Examples of this process is accessible online (see Online Supplement).

Table 15

Contextualizing Analysis

- Organize all data in relation to the index patient participant and place into separate folders
- Transcribe all data into text
- Identify codes or concepts by looking for repeating patterns
- Avoiding reductive and single categorization, label these codes using different colors, symbols, or other signifiers
- Develop a "master key" to track the different labels
- Memo specific thoughts or ideas during this process and attach to the codes
- Use the concurrent coding and resultant interpretations to guide on-going data collection
- Reread each participant's experiences from their folder.
- Reread the experiences holistically
- Develop a glossary of ideas and concepts in relation to the master coding key
- Begin flexibly coding the master key around the study's research questions
- Be open to the assemblage and rhizomatic crystallization process

- Construct assemblages or representational forms – may consider rhizomatic diagraming or concept mapping to facilitate the process
- Again, return to the data for line-by-line coding
- Share representational forms with humility

As contextual codes were constructed from the data, some discourses seemed authoritative, or dominant. For this inquiry, authoritative discourses were statements repeated across groups that came together to produce meanings and effects in the clinical setting (Carabine, 2001). These discourses constituted observable, material effects. Carabine (2001) observes of the power-knowledge-discourse triad: "To understand discourse we have to see it as intermeshed with power/knowledge where knowledge both constitutes and is constituted through discourse as an effect of power" (Carabine, 2001, p. 275). In addition, Foucault suggests that where power or authority is exercised, evidence of resistance exists, and authoritative discourses in this inquiry were associated with resistance. Once episodes or themes of resistance became evident in the coded data, disciplinary technologies—often unseen means of control—were identified. Disciplinary themes identified in the coded data were usually associated with institutional apparatuses of control that maintain the status quo of routine DNR suspension. Thus, authoritative discourses are repeating patterns of discourse that cohere to produce a shared reality and are associated with themes of discipline and resistance.

Within a Foucauldian framework, discourses are productive, but discourses do not all exert equal force (Carabine, 2001). Other salient discursive themes were also identified, but these themes lacked some crucial element limiting the theme's productive effects. Most commonly, the discursive themes lacked identifiable institutional apparatuses or technologies of discipline to sustain authority. In this inquiry discursive themes created tension as the authority of existing

discourses was challenged. These discursive themes nonetheless helped answer the research questions and inform the case context.

Trustworthiness

Participants were given the opportunity to evaluate their transcripts for accuracy and provide feedback on the inquiry's findings. Because this inquiry was completed as part of my PhD dissertation research, my major professor continually supervised and reviewed every aspect of this work. Facilitating the supervisory process required maintenance of a detailed audit trail available for continuous review. In addition, the inquiry used multiple forms of data collection, for example interviews, observation, and artifact collection to broadly capture the multifaceted context of discourses.

Critically, this inquiry does not bracket the investigator's experiences. Indeed, continual reflexivity is essential because the investigator's thoughts, ideas, and experiences shape the inquiry's findings. A reflexive journal was maintained to record these perspectives. While my voice may fade into the background as I privilege the voices of other participants, readers should note that my voice remains ever present in this analysis. I am a cis-gendered, white, gay male. The intersection of my privilege and experiences as a member of a minoritized community shape my worldview as do my education and professional discipline. In addition, I have practiced as a critical care and perianesthesia nurse for 23 years. Although influenced by medical theory, Foucault's poststructuralism alongside Georges' (2013) middle range theory of compassion guided my interpretations for this inquiry. This is only one worldview, and those with differing perspectives might reach different conclusions or utilize alternative methodological approaches.

The findings presented in this manuscript should not be viewed as generalizable. Instead, the reader must decide how and to what extent the findings apply to their own practice settings.

Finally, this manuscript adheres to the applicable Standards for Reporting Qualitative Research (SRQR) guidelines.

Results

Eight patient participants meeting these criteria agreed to join the inquiry. Two family members also joined the inquiry. Clinicians (registered nurses, nurse anesthetists, anesthesiologists, surgeons, and organizational leaders) who either encountered the index patient during observation or, in their leadership capacity, indirectly affected those interactions were invited to join the inquiry. Seventeen clinicians agreed to participate.

In total, 27 full participants were purposively enrolled and completed both the observation and interview requirements. In addition, 18 other clinical participants (technicians, nurses, anesthetists, anesthesiologists, and surgeons) agreed to participate through observation only. A total of 11.8 hours of direct clinical observation was completed. Participant interviews lasted 32 minutes on average and totaled 14.4 hours of audio recordings. Table 16 presents the participant's demographic characteristics. No demographic data was collected for the observation only participants.

Table 16

Sample Demographics and Measures of Central Tendency

Characteristics	Patient (*n* = 8) Frequency	Percent	Family (*n* = 2) Frequency	Percent	Clinician (*n* = 17) Frequency	Percent	Total (n = 27)	Percent	Missing Values
Gender									
Male	2	25.00	2	100.00	2	11.77	6	22.22	0.00
Female	6	75.00	-		15	88.24	21	77.78	
Age									0.00
30-40	-		-		10	58.0	10	25.93	
41-50	-		-		3	17.64	3	11.11	
51-60	-		-		3	17.64	3	11.11	
61-70	3	37.50	1	50.00	1	5.88	5	18.52	
71-80	3	37.50	-		-		3	11.11	
81-90	2	25.00	1	50.00	-		3	11.11	
Race									
Caucasian (NH)	8	100.00	2	100.00	16	94.12	26	96.30	0.00
African American (NH)	-				1	5.88	1	3.70	
Education									0.00
Doctorate	-				3	17.65	3	11.11	
Master's	1	12.50	-		2	11.77	2	7.41	
Bachelor's	1	12.50	-		8	47.10	9	37.04	
Associate's	1	12.50	-		3	17.65	4	14.82	
College - 2 year- no degree	2	25.00	-		1	5.88	3	11.11	

High School	3	37.50	2	100.00	-		5	18.52	
Board Certification	-		-						0.00
Yes					7	41.18	7	25.93	
No					10	58.82	10	74.07	
Religion									0.00
None	2	25.00	-		7	41.18	9	33.33	
Catholic	2	25.00	-		2	11.77	4	14.82	
Baptist	1	12.50	1	50.00			2	7.41	
Protestant	1	12.50	-		1	5.88	2	7.41	
Methodist	-		1	50.00	-		1	3.70	
Lutheran	-		-		2	11.77	2	7.41	
Christian (nondenominational)	2	25.00	-		5	29.41	7	25.93	
Procedure			-		-				0.00
Procedural	1	12.5					1	3.70	
Thoracic	1	12.5					1	3.70	
Urologic	2	25.00					2	7.40	
Vascular	2	25.00					2	7.40	
Orthopedic	2	25.00					2	7.40	
Clinical Role	-		-						0.00
MD-Surgeon					1	5.88	1	3.70	
MD-Anesthesiologist					1	5.88	1	3.70	
CRNA					1	5.88	1	3.70	
RN-Perianesthesia					5	29.41	5	18.52	

RN-OR	2	11.77	2	7.41
Organizational Leadership	6	35.29	6	22.22
Dual Role (leader/RN-perianesthesia)	1	5.88	1	3.70

Central Tendency				
Measure	Patient Age	Family Age	Clinician Age	All Groups
Missing	0	0	0	0
Median	75.50	75.5	39	51.00
Mean	75.38	75.5	42.94	54.96
Std. Deviation	6.23	10.61	8.04	17.60
Minimum	68.00	68.00	32.00	32.00
Maximum	83.00	83.00	61.00	83.00

Table 17 presents the inquiry's results for the first three research questions. In a poststructural case study, results should be interpreted in context. Therefore, a narrative explanation about how the authoritative discourses and discursive themes relate to the case context follows Table 17. The case narrative culminates by addressing how the inquiry's findings relate to power-knowledge.

Table 17

Inquiry Results

Research Question 1: What hidden discourses dominate how patients make decisions about the disposition of their DNR orders or other directives limiting care during the perianesthesia period?

Authoritative Discourses – *Dominant discourses that construct an accepted truth within a given culture at a given time.*	**Productive Effects** – *The real-world power-knowledge effects of discourses.*	**Discipline** – *Techniques used by institutions and people to control or influence others.*	**Resistance** – *A pattern of discourse contrary to the authoritative discourse.*	**Example Statements**
We'll just suspend the DNR. Don't worry--let us take care of you [because no one dies in the OR]	•Clinicians may perceive directives limiting care are as barriers to safe and effective perianesthesia care. •Because the OR remains a patriarchal, top-down space, clinician's fears of intraoperative death may be more enforceable than in other areas of the hospital. •Clinicians may perceive that the patients just want to have the surgery as scheduled or have enough on their plates to reinforce the clinician's desire to suspend the limiting directive. •Clinicians may perceive the desire of a patient who is not extremely ill or near death to retain their DNR order during surgery as confusing or illogical. •Clinicians may question lay people's ability to understand the nuances of safe anesthesia care because they are unfamiliar with medical terminology or value	•Spaces and procedures are constructed that make communicating any choice other than suspending the limiting directive difficult. •Clinicians may imply—either explicitly or through non-verbal cues—that the patient's surgery may need to be cancelled or delayed if the limiting directive is not suspended.	•Institutional policy directs that directive limiting care are assumed to remain in effect during anesthesia unless they are explicitly suspended. •Patient participants assert that they or their families are ultimately responsible for understanding their EOL wishes, not clinicians.	Nurse: "half the time they're just like, well, they don't even discuss it. They just say, well, we're just going to put it on hold for --we're going to put your wishes on hold while we go into surgery." Organization Leader: "I think that we are just always wanting to make sure that people are a full code, . . . there's this assumption that if somebody dies on the table you know it's going to be the worst thing ever. . .. this is what we want as a as a medical community is to just--this is our safe zone and it's resuscitation —and, you know, not DNR. And I don't think that they want to have those conversations. I think those conversations aren't comfortable" Nurse: "there was an anesthesiologist that came in

	different outcomes than clinicians.			and told a patient that, yup, we are going to suspend your orders for, uhm, DNR . . . and he implied that your surgery would not be--they probably wouldn't do your surgery unless you agreed to have your DNR/DNI suspended." Anesthesiologist: "DNR is in direct opposition to what we're doing here." Nurse: "it's been my experience that nobody is supposed to die in the OR. And that we will, we'll wheel you out on pressers and you will die somewhere else rather than die in the OR. And on very few occasions does a DNR/DNI order stand in the OR. Very few. It is noteworthy to have it still stand within there, so it is understood by almost everyone in the room: they will not die in the OR. They will not be part of that statistical average."
There is no time to discuss a directive limiting care right before surgery.	•Clinicians feel that there is insufficient time to meaningfully address advance directives limiting care preoperatively. •Clinicians would prefer to address these directives before the day of surgery,	•Institutions may construct environments encouraging DNR suspension. •Discussions about limiting directives may be limited by check-box forms or the information flagged on the EMR.	• Patient: "I had enough time to discuss my DNR." *Productive effect:* Patients retained a sense of agency and feel that they could demand further discussion should they sense the	Anesthesiologist: "so to me it seems like an out of --prior to hospital --visit would be the time where people start thinking about it." Anesthesiologist: "Everything we do-- I mean

	although this is not usually the case. •Clinicians will tend to only address directives limiting care if the criticality of the procedure demands it.	•Choices available for reconciling the disposition of the directive limiting care may be limited to simplistic selections that are difficult to tailor to the individual patient. •The care environment is constructed in a way that makes communicating patients' EOL wishes difficult.	situation is serious enough to warrant an EOL discussion.	that's why-- I mean time with patients is just shrinking. And again, this conversation in terms of DNR status is not one that can be rushed because you need patients to understand overall success rates, what it actually entails."
Do not talk about advance directives unless it is essential because of the serious nature of the surgery.	•Clinicians feel that there is insufficient time to meaningfully address advance directives limiting care preoperatively. •Clinicians would prefer to address these directives before the day of surgery, but there is not a mechanism in place to ensure the quality of those encounters. •Clinicians will tend to only address directives limiting care if the criticality of the procedure demands it. •Clinicians will usually only address active DNR orders.	•Institutions may construct workflows encouraging DNR suspension. •Discussions about limiting directives may be limited by check-box forms or the information flagged on the EMR •Choices available for reconciling the disposition of the directive limiting care may be limited to simplistic selections that are difficult to tailor to the individual patient. •The care environment is constructed in a way that makes communicating patients' EOL difficult.	• Patient: I had enough time to discuss my DNR. *Productive effect:* Patients retain a sense of agency and feel that they could demand further discussion should they sense the situation is serious enough to warrant an EOL discussion.	Anesthesiologist: "If [the patient] was still listed as a DNR, then we would break down the DNR step-by-step." Nurse: "It's kind of like [the possibility of dying is] just a little tiny . . . tiny smolder. And if it was a big flame, then you-- they address it." Surgeon: "I treat a lot of patients that fit that category-that are elderly have a lot of comorbidities. We emphasize it a lot more, you know, you actually-- I'll spend more time . . . talking about . . . if something were to happen to you . . ." Patient: "They obviously had a copy of this [points toward advanced directive paperwork] already, but they

				didn't refer to it at all. None of it." Nurse: "The surgeon isn't going to make that decision; they're going to leave it up to anesthesia. Even though those surgeons— the ones that's asking the question on the [consent]-- anesthesia, is the one that is dealing with their blood pressure dealing with their breathing, dealing with their heart rate. So, they're the ones that are going to be calling the shots and making those decisions if something starts to go south." CRNA:" [Question: who has responsibility for knowing about the advanced directive?] I don't think anyone. I think everyone passes the buck on it." Nurse: "I've had a doctor yell at me about [telling them a patient want to continue their DNR]. 'What do you mean you want me to keep him DNR!' I mean I've had somebody yell at me over that before . . . Because he just was so upset about it, so yeah. And he got mad at me too and it's like: I'm just doing my job here"
Clinicians are confused about who is responsible for discussing and understanding the patient's directive limiting care.	•An atmosphere of free-floating responsibility is created. •Silence about directives limiting care is preferred. •Clinicians recognize that discussing the advance directive is part of the surgeon's informed consent process, but paradoxically the operationalization of that conversation is anesthesia's responsibility. •The OR sustains a hierarchal culture with the surgeon on-top, so even though the surgeon may not be involved in operationalizing decisions about code status, they are responsible for addressing the code status during informed consent. •Nurses feel responsible for ensuring that the advance directive is addressed by a medical provider. •Interdisciplinary tension is created because nurses want to ensure that a conversation is conducted, but physicians are unsure about who is ultimately responsible for conducting the conversation about advance directives.	•Nurses may truncate conversations about directives limiting care by encouraging patients to discuss it with their physicians. •Spaces and procedures are constructed that make communicating choices other than suspending the limiting directive difficult. •Clinicians may imply—either explicitly or through non-verbal cues—that the patient's surgery may need to be cancelled if the limiting directive is not suspended.	Some clinicians welcome preoperative EOL conversations.	
Research Question 2: How do perianesthesia clinicians talk with patients about DNR orders or other directives limiting care?				

Discursive Themes	Productive Effects	Discipline	Resistance	Example Statements
We are better at addressing EOL choices today than in the past.	•It is more common today than in the past to address directives limiting care and provide patients meaningful options for how to handle their directives. •Younger anesthesiologists may welcome discussions about EOL choices in the perianesthesia setting. •Anesthesiologists trained at large teaching facilities may be better equipped to talk about EOL choices.	Not applicable. [a]	*Emerging as authoritative discourse but remains in tension with all four authoritative discourses.*	Nurse: "death is scary for people. And I get it. It is scary, but I think people are afraid to talk about it. I think we're getting better at it."
When addressing DNR orders, seek specifics about what interventions patients want done and not done during anesthesia because what may be considered resuscitative in other contexts is just normal care in the perianesthesia setting.	•Clinicians find defining resuscitation challenging because resuscitation is fluid in the perianesthesia context and changes depending upon the phase of anesthesia care, so clinicians prefer broadly pre-defined stopping points. •Clinicians favor intervention-based stopping points. For example, you may give medications to stabilize my heart and blood pressure, but do not start chest compressions.	Not applicable. [a]	•Patients favor functionality based resuscitative stopping points while clinicians prefer treatment-based end points.	Anesthesiologist: "[I'm] very specific in the preop about pharmacologic, shocks, and chest compressions . . . because some patients say no. I'm okay receiving IV medications. I'm okay receiving a couple of compressions to circulate the meds. I'm okay with a couple of shocks. Or I don't want any of those, so it's really important to have [a conversation] --again in terms of patient autonomy and involving them in terms of the teamwork. What are their goals and what are they okay with because some people say, yeah, I'm okay with medications. I don't want shocks, I don't want compressions."

Younger anesthesiologists, female anesthesiologists, and those trained at large teaching hospitals sit down to talk with patients, involve family, and respond to patients' EOL wishes better than their counterparts.	•Anesthesiologists who are younger, female, or trained at large teaching hospitals are perceived as better at addressing limiting directives. •Female anesthesiologist may be more easily stereotyped as "nurturing" or more capable of navigating interpersonal relationships than their male counterparts.	Not applicable. [a]	• We'll just suspend the DNR. Don't worry--let us take care of you [because no one dies in the OR] • There is no time to discuss a directive limiting care right before surgery.	Nurse: "take anesthesiologists for an example. As we all know--just like surgeons-- there are some that are better than others. Some that have a better bedside manner than others. The ones that I've actually seen sit down and have a conversation with them are more times than not the females. Not trying to diss the males, but I --that's my observation and I don't know if it's more, and again, I'm generalizing please don't, I don't know if it's more, uh, nurturing or they're just taking that time to actually sit down and have a good conversation with the patient."

Research Question 3: How do perianesthesia patients talk about DNR orders and express their rationales and motivations for rescinding, modifying, or retaining the orders during anesthesia?

Discursive Themes	**Productive Effects**	**Discipline**	**Resistance**	**Example Statements**
Patients *expect* a conversation about their advance directive, but-- because such conversations are unusual and provoke uncomfortableness--they only want to go into detail if their procedure is serious.	•Patients often wait until a life-threatening diagnosis or stressful life event occurs to create an advance directive. •Because patients expect the depth of conversation about their EOL wishes to become more detailed the more critical their procedure is, patients accept straightforward—even blunt—talk about their advance directives.	Not applicable. [a]	*Emerging as authoritative discourse, but remains in tension with the dominant discourse "Do not talk about advance directives unless it is essential because of the serious nature of the surgery"*	Patient: "Well, I don't-I don't talk about death and dying." Patient: "[Question: Why did you suspend your DNR?] I guess maybe because it's a very--it's always been a very short procedure. It's not been anything lengthy or anything like that" Patient: "She bluntly said she had pancreatic cancer."

				Patient: “she abruptly, you know, said that [she wanted to be DNR] . . . that was her call.” Family: “Yep-- got higher risks that should get more an in depth. Like when my wife had her-her aorta replaced we had more in depth.”
Patients with pre-existing directives limiting care have surgery to improve their quality of life. Simultaneously, patients may feel that when it is their time to die, they do not wish to be kept alive in a hospital with machines. They prefer a natural death.	•Patients may be willing to have surgery to improve my quality of life, but they do not want to be kept alive on a machine. •Patients may associate relying on family members to make EOL choices as being burdensome to their loved ones. •Patients may view some resuscitative efforts as acceptable if they quickly recover, and they experience a better quality of life. •Patients associate requiring sustained mechanical ventilation, being mentally unaware, and being unable to eat as unacceptable outcomes.	Not applicable. [a]	•Clinicians favor intervention-based resuscitative stopping points.	Patient: “[Question: Why did you decide to execute your DNR document?] Cuz, I just wanna let nature take its course.” Nurse: “[So, your patient kept their DNR during surgery?] Yes, yup. ‘Cause that’s what she wanted; 'cause she said ‘if the good Lord comes from me, don't you dare stop Him’” Patient: “If she couldn't eat, she didn't want to live. That was her bottom line.” Patient: “Well, I don't want it to be uncomfortable. . .. I was told that [the breathing tube is] very uncomfortable.”
a) Patients can articulate their desired outcome from surgical	•Patients may seem to be unsure about their EOL	Not applicable. [a]	•Clinicians may question lay people’s ability to understand	Surgeon: “Most of my patients do not have a DNR during surgery because it’s about quality-of-life issues.” Organization Leader: “I would say that probably most

intervention. However, they often do not understand medical terms like “DNR,” and they may be unable to translate their wishes into the perianesthesia context. b) The patient’s advance directive may have been part of estate planning.	wishes, or they may not understand how their EOL wishes would apply in the perianesthesia setting. •Patients may never have discussed their EOL with a health care professional. •Patients may not understand the importance or effects of the EOL documents they have executed.		the nuances of safe anesthesia care because they are unfamiliar with medical terminology or value different outcomes than clinicians.	people don't understand what it really entails. I would hope that they do since a lot of them are signing legal documents to say that they want, but, you know, when it gets down to the nitty-gritty, I think it's, uhm. Do not resuscitate can mean so many things, right?” Anesthesiologist: “[Patients] do not understand the term DNR. Nobody does.” Patient: “Well, we both talked about it and I talked about that --you know --if I can't eat, uh, and I-my brain is not functioning and it looks like I'm going to be some type of vegetative state or whatever that any type of life supports system or whatever plugs or whatever I want pulled.”
Patients rely on family members for help understanding and communicating effectively about their directives limiting care.	•Family presence during conversations about advance directives empowers patients and helps them better articulate their wishes to health care professionals.	Not applicable. [a]	•There is no time to discuss a directive limiting care right before surgery.	Surgeon: “I really, really like to involve family and that's really helpful when, uh, you know, sort of broaching that subject of DNR and . . .what type of code status they are"

[a] This discourse is not yet authoritative.

The Case Narrative

Authoritative Discourses

Authoritative discourses shape people's perception of subjective reality and constructs the choices available to patients and clinicians. These discourses are often subtle or even hidden and occur at the periphery of power networks within relationships instead of in a top-down fashion (McCabe & Holmes, 2009). But the constitutive power of discourses to effect everyday conceptions of what is good or bad—common sense or senselessness—is evident in how clinicians and patients experience their conversations about directives limiting care in the perianesthesia setting. In this inquiry, authoritative discourses were repeated across groups in coherent fashion, were productive (i.e., constitutive), reproduced power relations through discipline, and they encountered identifiable resistance. In response to the first research question, four authoritative discourses were identified in the data.

"We'll just suspend the DNR. Don't worry--let us take care of you, [because no one dies in the Operating Room]"

Some clinical participants characterized the Operating Room (OR) as a "patriarchal," "top-down" space. One anesthesiologist observed of their role, "So, we're here to give recommendations, but not ultimately give decisions. And so, with that kind of patriarchal, surgeon at the top-down model, well, then if we continue on in that, I . . . then, that just is what it is." Other data suggests an unspoken fear of intraoperative death that is closely tied to a desire to suspend the limiting directive. Several apparatuses —social and institutional mechanisms for sustaining power— and technologies—techniques used by institutions and people to influence and control others—exist in the cloistered perianesthesia environment to buttress suspension. For example, clinician's fears of intraoperative death may also be more enforceable than in other

areas of the hospital. In the data, clinicians rationalized that some patients may not understand the nuances of anesthesia administration, that they were protecting the patient because "they already have enough on their plates" or that the patient's desire to continue their limiting directive was illogical within a given context. For instance, the notion that a patient is not gravely ill (i.e., death is not imminent) but still wishes to continue their DNR order during anesthesia was especially vexing for some clinicians. Grouped as a coherent whole, the participants' statements indicate that whether it is perceived as safer, easier, or less stressful to either patient or clinician, there is a generally understood discourse among clinicians that the goal is for the patient to suspend their DNR for surgery.

The "We'll just suspend" discourse was supported and sustained through several apparatuses of discipline. For example, requiring multiple steps to continue the DNR order, aggressive self-advocacy needed by the patient, and designing surveilled environments intended to thwart atypical decision-making. For example, nurses routinely set-up preoperative rooms in a way that assumes the limiting directive will be suspended. The nurses report the perception that physicians want to suspend the limiting directive. One nurse states,

> I think [the patients] are led by the surgeon and the anesthesiologist to suspend their orders—in that because of . . . Oh, I guess I can be blunt; I don't care whatever—that it looks bad on the hospital record of people die the OR.

Simultaneously, providers rarely explored EOL choices when an active DNR was not flagged by the Electronic Medical Record (EMR). In another example, clinicians may imply—either explicitly or through non-verbal cues—that the patient's surgery may be cancelled if the limiting directive is not suspended.

There is No Time and Do Not Talk

Two other authoritative discourses were identified that are closely related to and function to justify the "We'll just suspend" discourse. First, the discourse *there is no time to discuss a directive limiting care right before surgery* sustains the idea that the perianesthesia setting emphasizes production and maintaining the surgical schedule (Waisel et al., 2002). Time with each patient is brief and spending extra time can impede production. The data suggests that clinicians believe there is insufficient time to meaningfully address advance directives limiting care preoperatively, and they would prefer to address these directives before the day of surgery. Organizational leadership participants, however, acknowledge that no mechanism exists for ensuring that such conversations are meaningful and privilege the patient's wishes. One product of the "no time" discourse is to simplify advance directive choices by using check-box forms, but these simplified forms may not adequately convey the patient's wishes.

Second, the discourse *do not talk about advance directives unless it is essential because of the serious nature of the surgery* supports an environment where clinicians tend to only address directives limiting care if the criticality of the procedure demands it. This discourse parallels a similar discursive theme identified among patients who do not to speak about their advance directives unless they must because their surgical outcome is uncertain. In totality, participants' statements indicate that clinicians talk less about EOL choices when they deem the surgery less critical. When the surgery seems more serious, clinicians address EOL specifics in greater depth. Patients expected this, and clinicians reported patients may become anxious if EOL choices are addressed for what seems like a simple procedure. The result of these discourses may be an atmosphere where silence is rewarded with efficient, albeit cookie cutter, productivity.

Confusion about Who is Responsible

The discourse that c*linicians are confused about who is responsible for discussing and understanding the patient's directive limiting care* produces an atmosphere of free-floating responsibility, ineffective communication, and interdisciplinary tension. For example, nurses felt responsible for ensuring that a preoperative conversation about patients' limiting directives occurs, but providers were often unsure about who is responsible for that conversation. However, small pockets of resistance existed with one nurse expressing that they "welcome" EOL conversations before surgery and providers stressing that the choice to suspend the limiting directive is the patient's decision.

Discursive Themes

How Perianesthesia Patients and Clinicians Address Limiting Directives

While not as authoritative as the four dominant discourses, several *discursive themes* were identified in the data and address research questions two and three. For instance, the inertia toward silence produced by the "Do not talk" discourse is not the only area where the way clinicians and patients talk about limiting directives intersect. One discursive theme identified from patient statements is that *patients expect a conversation about their advance directive. But because such conversations are unusual and provoke discomfort, they only want to go into detail if their procedure is serious*. Perhaps, because patients expect the depth of conversation about their EOL choices to become more detailed the more critical their procedure is, patients accept straightforward—even blunt—talk about their advance directives. This comports with the anesthesia clinician's tendency to seek out specific interventions that patient's wish withheld during anesthesia.

The patient's expectation that they will have a conversation about the limiting directives is an emerging discursive theme in competition with the "Well just suspend" and "There is no

time" authoritative discourses. The key difference in the data between the authoritative discourses and this discursive theme is that patients *expect* to have a preoperative conversation about their advance directive that is commensurate with the seriousness of the surgery whereas the dominant discourses suggest that the conversation should be avoided or minimized unless discussing the advance directive is essential for providing effective care.

Clinicians also reported that defining resuscitation was challenging because resuscitation is fluid in the perianesthesia context and changes depending upon the phase of anesthesia care. So, clinicians preferred broadly pre-defined intervention-based stopping points for resuscitation, such as "give medications to stabilize heart rate and blood pressure, but do not start chest compressions." The data suggested that patients talk instead about functional stopping points, such as 'I want to be able to eat after surgery." Crucially, unlike the more authoritative "Do not talk" discourse identified among clinicians, this discursive theme stresses that patients usually expect a discussion about the limiting directive; it is only the depth and details of that discussion that is at issue for patients.

Another discursive theme is that *patients often do not understand medical terms like "DNR," and they may be unable to translate their wishes into the perianesthesia context.* Translating EOL choices from the primary context—at home or the hospital ward—to the perianesthesia setting were a challenge to some patients and presented an impression of uncertainty to clinicians. Patients tended to talk about their desired functional outcomes from surgery instead of interventions they want administered or withheld during anesthesia. Moreover, some participant responses indicate that patients may have a limited understanding of advance directive terminology and content that further limited their ability to translate their EOL choices to the perianesthesia setting.

One seemingly discordant discursive theme identified by patient statements is that *patients with limiting directives have surgery to improve their quality of life. Simultaneously, patients may feel that when it is their time to die, they do not wish to be kept alive in a hospital with machines. These patients prefer a natural death.* In these instances, according to participant responses, patients may be willing to have surgery to improve quality of life, but they do not want to be kept alive on machines. These patients may view some resuscitative efforts as acceptable if they quickly recover, and they experience a better quality of life. But *patients often associate requiring sustained mechanical ventilation, being mentally unaware, and being unable to eat as unacceptable perianesthesia outcomes*—another discursive theme in the data. Defining how long these interventions are tolerable was elusive to clinicians and patients alike and presents opportunities for future inquiry.

Among the most clinically important discursive themes identified by patients is that *they rely on family members for help understanding and communicating effectively about their directives limiting care.* In study observations, family presence during conversations about advance directives empowered patients and helped them better articulate their wishes to health care professionals. One potential reason from the data for patients' difficulty articulating their preferences is that they may never have discussed their EOL preferences with a health care professional. Patients, therefore, may be unsure about their EOL choices because they may not understand how those wishes would apply in the perianesthesia setting.

Better Today than in the Past

A clear discursive theme in the data is that clinicians *are better at addressing EOL choices today than in the past.* Some clinicians observed that younger anesthesiologists may better discuss EOL choices, and others noted that female anesthesiologists may conduct more

meaningful discussions about EOL in the choices before anesthesia. However, clinicians' statements indicate that they remain confused about who is responsible for discussing and understanding the patient's directive limiting care. The data suggests that clinicians recognize that discussing the advance directive is part of the surgeon's informed consent process, but paradoxically they understand that the operationalization of that conversation is anesthesia's responsibility. Tension is created between clinicians, and nurses want to ensure that a conversation about the limiting directive is conducted, but no one is sure about who is ultimately responsible for the conversation.

How do these discourses relate to power and knowledge in the perianesthesia setting?

One Certified Registered Nurse Anesthetist (CRNA) participant observed of the perianesthesia space: "as an analogy, . . . if someone's like a prisoner, and you're torturing them, they're going to tell you what you want to hear." The surveilled terrain that perianesthesia patients and clinicians must navigate when making choices about their limiting directives is complex. Through material and subliminal actions, observational data suggests that clinicians created environments where compliance with routine was rewarded. When the routine was disrupted, however, concerns about the disruptor's ability to adequately understand their choices or even their standing to make decisions about care emerged. A nurse participant, for instance, recounts that their expertise and knowledge base might be belittled should they advocate for a patient wishing to continue their DNR order during surgery. Similarly, it is evident in the data, that a patient's perceived lack of understanding about the nuances of anesthesia care might act to diminish the weight of their advance directive decisions.

Furthermore, often unseen technologies of control sustain routine and ensure that the surgical schedule is maintained. For example, in anticipation of the likelihood that the patient's

DNR will be suspended, nurses often create a preoperative environment that makes fulfilling the unit expectations for suspension easier by placing orange DNR suspension armbands on the patient's chart before a decision to suspend has been made. A nurse participant notes,

> We have little, uhm, sign language for lack of a better word with the doctors like we'll waive the orange wristband in front of the doctor's face so that they know what they need to ask next. Or put it on the consent so that they know that they need to ask the question or make a sticky note or something.

Clinicians are also rewarded for upholding routine. One OR nurse recalls an anesthesiologist's reaction to suspending the limiting directive: "So, it's like an achievement: I got it suspended." In both instances, the clinicians' knowledge of the perianesthesia space, institutional processes, and medical care are used to achieve their desired goal of routine DNR suspension—albeit often subliminally or in a good faith effort to ensure patient safety.

In addition, power is often sequestered within the loci of clinical knowledge, and that knowledge-power may be further isolated to whomever discusses the limiting directive with the patient. Foucault conceptualizes how disciplinary knowledge transforms into influence and power when writing about the clinical gaze. Foucault wrote, "it was no longer the gaze of any observer, but that of a doctor supported and justified by an institution, that of a doctor endowed with the power of decision and intervention" (Foucault, 1994, p. 89). Observation and interviews demonstrate that discourse sustained through institutional apparatuses constitute an environment that transforms the *person* into a *patient*—a medicalized, compliant body (Eckert, 2016). In this space, only the savviest self-advocates can successfully challenge disciplinary authority.

Nevertheless, participants noted that the onus to overcome these barriers is placed on the patient should they wish to continue their limiting directive during anesthesia. But patients

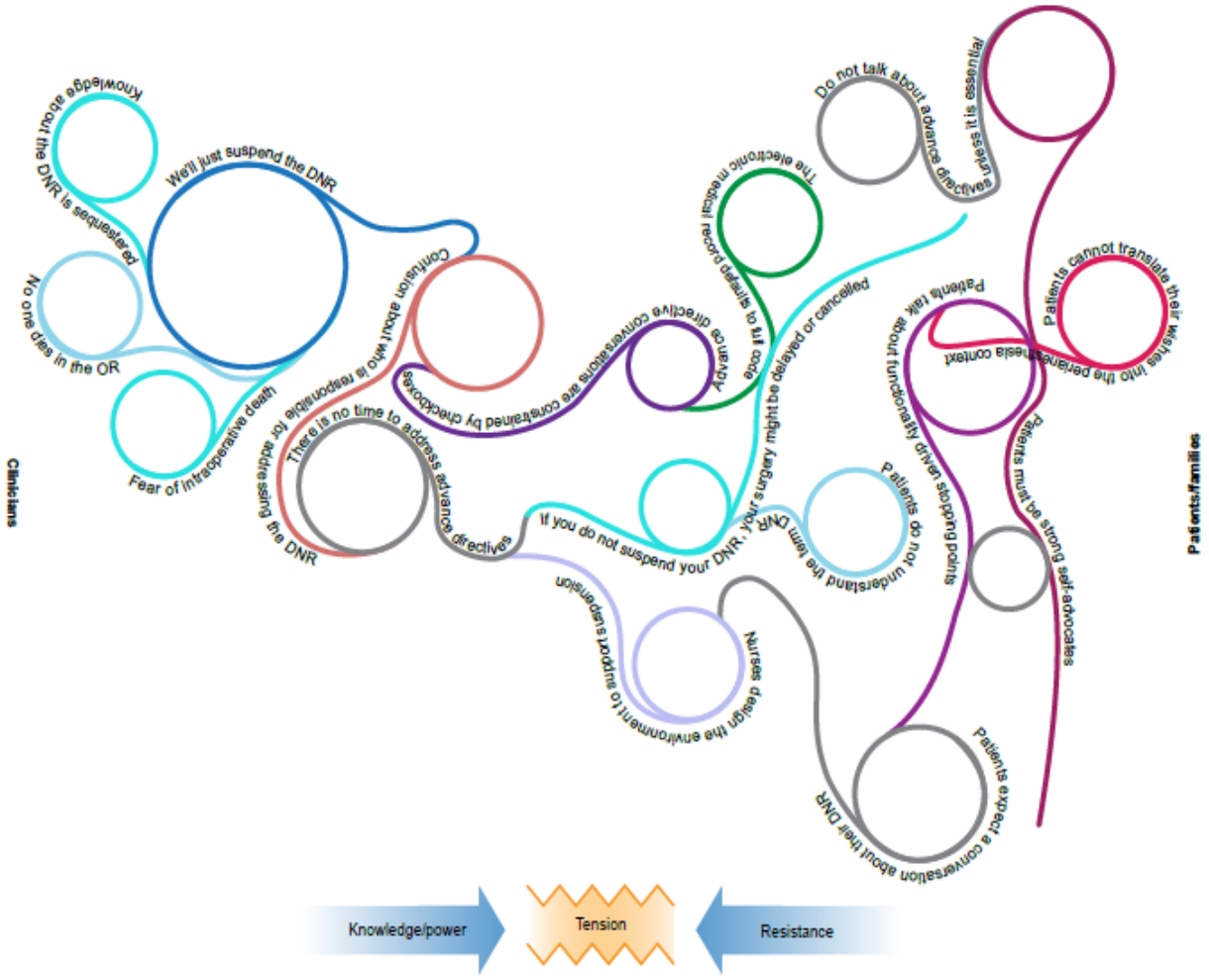
observed in this case often had difficulty translating their EOL choices into language understandable to clinicians. Foucault wrote of discourse in the clinical space, “one now sees the visible only because one knows the language; things are offered to him who has penetrated the closed world of words; and if these words communicate with things, it is because they obey a rule that is intrinsic to their grammar” (Foucault, 1994, p. 115). The power-knowledge about anesthesia care is seated firmly with the clinician—those who speak the language intrinsic to the setting.

The previously quoted CRNA participant concludes that discussions about directives limiting care should occur during the pre-hospital surgical consultation—a conclusion reached by many other participants. However, participant statements suggests that surgeons prefer selecting full code status preoperatively even when the patient more accurately wants their DNR only suspended for the perianesthesia period. Moreover, in practice, the clinical participants noted that anesthesia providers will be the one’s making decisions about operationalizing the patient’s code status even though there is limited discussion about patient wishes between the perioperative team members.

Based upon observational and discursive data, Figure 13 is a rhizomatic diagram used to visually display spatialized depictions of power-knowledge-discourse and resistance in the perianesthesia setting.

Figure 13

Power-Knowledge-Discourse Rhizomatic Diagram



Note. Rhizomatic diagrams are a way to visualize the power effects of discourse while capturing the fluid, contingent nature of results. Here, discourses coalesce to exert force and create truth within the perianesthesia context. Where resistive discourses and knowledge/power interact, tension results as discourses compete for authority.

Discussion

This inquiry identified four authoritative discourses that dominated how patients make decisions about their advance directives before anesthesia. These discourses produced a perianesthesia culture that favors DNR suspensions during surgery due to lack of time, confusion over responsibility, and clinicians' fear of death in the OR. Results also show that patients expect

a discussion about their DNR orders with an expert clinician before surgery, and that they retain agency and autonomy in those discussions, affirming an earlier qualitative report from Hiestand and Beaman (2019). Although patients often had difficulty discussing their advance directives with clinicians, statements from patients resisted the idea that they lacked the agency or knowledge to make decisions about their advance directives. Examples of resistance in this study broadly comport with Burkle et al.'s (2013) findings that patients can understand the nuances of anesthesia care but may face perianesthesia cultures that favor DNR suspension. Like Hiestand and Beaman and Burkle et al., the participants in this inquiry tended to suspend their limiting directives when given context about the nature of anesthesia.

The tendency of patients to suspend their limiting directive for the perianesthesia period also comports with findings by Gu et al. (2021). Gu and colleagues found that, while automatic revocation continues in some facilities, most institutions have adopted policies of mandatory reconsideration. The authors found that these mandatory reconsideration policies may manifest in practice as routine informed suspension of directives limiting care where patients are "informed" that their limiting directive will be suspended. This inquiry supports Gu et al.'s findings that suspension is routine; however, whether patients receive meaningful information about the suspension is less clear. Results from this inquiry also support Hardin and Forshier's (2019) conclusion that a defacto state of automatic revocation exists in perianesthesia culture. In such cultures, limiting directives are addressed but in a cursory, superficial way whereby patients are expected to suspend their directives. In these cultures, atypical choices are disconcerting and problematic to clinicians. Furthermore, statements from participants indicate that the specters of delaying or cancelling the surgery, inconveniencing clinicians, or being labeled as noncompliant

should patients continue their limiting directive is employed as a means of discipline by clinicians.

The inquiry's clinical participants asserted that concerns about inadequate time and the surgical department's emphasis on productivity (Waisel et al., 2003) make moving discussions about limiting directives to the preoperative surgical consult a reasonable solution. However, among clinicians, surgeons may be most likely to require preoperative "buy-in" from patients that they allow aggressive postoperative interventions (Schwarze et al., 2019). These earlier findings support this inquiry's observation that surgeons prefer selecting full code options on the EMR. Organizational leaders in this inquiry also endorsed moving these discussions to the surgeon's office, but hospital leaders reported that no mechanism existed to ensure the quality of those conversations or transmit decisions to other clinicians on the day of surgery. One potential solution is to use preoperative patient questionnaires or instruments to help patients construct their EOL choices in relation to the perianesthesia context (Guarisco, 2004; Waisel et al., 2003).

However, administration of such instruments would only be practicable in pre-hospital settings, and preoperative questionnaires or informed consent documents with open-ended sections for detailing limiting directives still focus on intervention-based stopping points. This inquiry found that clinicians favored interventional stopping points while patients talked about functional outcomes. Such tools also privilege medically savvy patients who are adept self-advocates and force patients with pre-existing limiting directives to once more outline those wishes for the benefit of clinicians. In addition, distancing discussion about limiting directives from the day of surgery limits the anesthesia clinician's ability to advocate for patient autonomy and risks further exacerbating power-knowledge conflicts between clinicians. Translating how

patients talk about their EOL choices to the perianesthesia context and finding ways to better communicate those wishes to the perianesthesia team are opportunities for future research.

Finally, although beyond the scope of this report, incidental findings about the power of the EMR to shape practice (Dillard-Wright, 2019) and participant observations that female anesthesiologists are more likely to have better EOL discussions with patients warrant further investigation

Limitations

The Covid-19 pandemic caused the cancellation of delayable surgical cases limiting the pool of potential patient participants. Family presence in the surgical setting was also restricted due to a Covid-19 surge limiting family participation. Intraoperative observation was not feasible and remains an opportunity for future research.

Conclusion

This inquiry used Foucauldian PCSD and contextualizing data analysis to investigate the intractable problem of meaningfully addressing directives limiting care in the adult perianesthesia setting. Although care management in this area has progressed over the last decade, compliance with the spirit of mandatory reconsideration recommendations remains elusive. Today, cultures of routine informed suspension or defacto automatic revocation coexist alongside recalcitrant facilities still automatically revoking DNR orders before surgery. This investigation found that patients talk about functionality driven and not intervention-based resuscitative stopping points. Perianesthesia patients often have difficulty translating their EOL choices into the perianesthesia context, and this difficulty may easily be misunderstood by clinicians as compliance. Clinicians cite a lack of time for meaningful conversations about limiting directives and—like patients—exhibit a tendency not to talk about these directives

unless required to by circumstance. Furthermore, power networks in the perianesthesia may conspire to sequester knowledge about patient decisions with surgeons while requiring anesthesiologists to operationalize those decisions. In such environments, retaining a limiting directive during surgery is easily constructed as an impediment to safe care and efficiency instead of an exercise of the patient's autonomy and agency.

Manuscript Two: Developing Critical Concepts for Georges' Emancipatory Theory of Compassion: Qualitative Evidence Supporting the Existence of Biotoxic Spaces in Perianesthesia Settings.

Abstract

The emancipatory theory of compassion is a developing theory for nursing research, education, and practice. However, the theory remains conceptually undertested. This mid-range theory was used in a recent poststructural case study that investigated how advance directives are managed in the adult perianesthesia setting. This article demonstrates how the theory was applied in research. In addition, the investigation provided qualitative evidence that key conceptual elements, the zoe/bios dichotomy, distance, and free-floating responsibility, may exist in practice as the theory suggests.

Statement of Significance:

What is known:

- The emancipatory theory of compassion is a nascent theory with applicability to all areas of nursing practice.
- The theory is underutilized in research.
- Key conceptual components of the theory are underdeveloped and undertested.

What this article adds:

- This article demonstrates how the emancipatory theory of compassion was used as a Mid-Range Theory for nursing research.
- This article adds qualitative evidence supporting the theory's conceptual development and internal coherence.

Introduction

The emancipatory theory of compassion by Georges (2013) is comprised of concepts and relational statements that nurses can use to explore inequitable power relations in practice, education, and research. The statements, concepts, and theoretical assertions remain undertested, however. The theory's core assertion is that alleviating suffering is nursing's raison d'être, and that compassion—a critical attribute of nursing as a discipline—is made possible through the equitable sharing of power in clinical spaces. When power relations result in inequitable care, compassion is unattainable, and suffering increases. Such inequitable power relations can become entrenched over time and seem like common sense to clinicians (Georges, 2013). The intractable problem of automatically revoking Do Not Resuscitate (DNR) orders and other limiting directives remains a problem for clinicians working with patients before, during, and immediately after anesthesia encounters. In the perianesthesia setting, patients with advance directives limiting care are often marginalized or silenced, and this inequitable treatment is often accepted as normal.

A recent poststructural case study used contextualizing analysis to investigate how choices about advance directives are constructed via the power structure in the adult perianesthesia setting. The investigator used Georges' emancipatory theory of compassion as a Mid-Range Theory (MRT) to bridge the inquiry's overarching Foucauldian framework and practice. Here, qualitative findings from that inquiry are presented that support the development of the theory of compassion for nursing and demonstrate the theory's usefulness for guiding poststructural inquiries dealing with ethical formation and power relations.

Background

The Problem

The Patient Self Determination Act (PSDA, 1990) elevated the patient's right to autonomy for end-of-life (EOL) choices above other ethical tenets in most clinical situations. The PSDA also required hospitals to address and honor advance directives. The Joint Commission (2016) and the Centers for Medicare and Medicaid Services (2015) made regulatory rules to enforce the new law, and institutions soon developed policies to operationalize those rules. Honoring patients' EOL decisions by addressing code status soon became the standard of care in hospital wards (Bishop et al., 2010). While imperfect, these laws, rules, and policies increased the portability of DNR orders interdepartmentally and across hospital systems.

However, surgical and procedural settings resisted the portability of DNR orders and claimed immunity from routinely addressing advance directives limiting care. Clinicians practicing in these cloistered areas were unable to resolve the blurry distinction between normal anesthesia care and resuscitation, and they concluded that retaining limiting directives during anesthesia was unsafe and antithetical to anesthesia practice (Truog, 1991). Perioperative clinicians (anesthesiologists, surgeons, nurse-anesthetists, and bedside nurses) working in the preoperative, intraoperative, and post-anesthesia recovery areas (i.e., the perianesthesia setting) chose instead to adopt policies of automatically revoking DNR orders and deferring meaningful consideration of other advance directives before surgery. Nevertheless, some clinicians of the time recognized the problem and countered that automatically revoking DNR orders was unethical (Walker, 1991).

Walker (1991) articulated the ethical dilemma created by the automatic revocation of DNR orders before surgery and demonstrated that patient autonomy was usually the paramount

ethical tenet in any weighted evaluation of the quandary. The American College of Surgeons (ACS) and the American Society of Anesthesiologists (ASA) issued a rare joint statement denouncing the practice in 1994. Today, all relevant practice organizations require policies of *mandatory reconsideration* of pre-existing DNR orders when these patients present for surgery (American College of Surgeons, 2014; Association of Perioperative Registered Nurses, 2020; American Society of Anesthesiologists, 2018; American Society of Perianesthesia Nurses, 2018). In mandatory reconsideration, providers should address the limiting directive, and patients may choose whether to suspend, retain, or modify their choices before surgery.

Despite unanimity among professional organizations about the standard of care, the practice of automatically revoking limiting directives before surgery persists today (Hiestand & Beaman, 2019). Even where the standard of mandatory reconsideration is the accepted policy, evidence suggests that patients experience cultures of *routine informed suspension* (Gu et al., 2021). In routine informed suspension, patients are told that their limiting directive will be suspended, but patients are often not afforded a realistic way to keep or modify their limiting directive during surgery. In such cases, the levels of self-efficacy and personal advocacy required to enforce limiting directives are so high as to be unrealistic for most patients. Hardin and Forshier (2019) called such processes defacto automatic revocation.

Routine or defacto automatic revocation of directives limiting care before surgery marginalizes and minoritizes patients with those directives. Patients' EOL choices are superseded by the desires of clinicians suggesting the existence of inequitable power relations between clinicians and patients. Interestingly, however, these power relations are not well explored in the literature even though scholars acknowledged as early as 2003 that discord between patients' and clinicians' values might underlie the problem (Waisel et al., 2003). In

perianesthesia culture, routine suspension of existing DNR orders is often so ingrained that potential ethical problems might be rendered invisible.

The Emancipatory Theory of Compassion

Jane Georges is a contemporary nursing theorist whose scholarly work focuses on suffering, compassion, and power. Georges' early work suggested that suffering cannot be decontextualized from race, class, gender, and other minoritizing characteristics—especially as these dimensions relate to power (Georges, 2004). Examining how power intersects with race, class, and gender in the clinical setting led Georges to suggest that inequitable power relations create environments where nurses may inflict or perpetuate suffering (Georges, 2008). Georges (2008) describes biopower in clinical settings as an innately political force that oppresses those with diminished agency while rewarding those with power. Here, Georges defines biopower and the zoe/bios dichotomy but lacks a comprehensive exemplar case to provide meaning grounded in nursing praxis and substantiate the proposed theoretical interaction.

A discursive analysis of narratives collected from nurses active in Nazi Germany helped George crystallize her theory (Georges, 2013) and provided an exemplar in the case of "Luise E." (Benedict & Georges, p. 67, 2009). The case demonstrated an instance where the three critical attributes of biopower—free-floating responsibility, distance, and the zoe/bios dichotomy—functioned to create a biotoxic space. Critically, Georges (2011) introduces the idea that there exists in clinical settings accepted discourses and social constructions that normalize uncompassionate behavior and enable suffering. Georges (2013) terms these everyday situations "the unspeakable." Georges' theoretical work explores how these concepts function with nursing as a discipline. For example, how nurses create knowledge and use that knowledge in practice. Georges proposes that a) regardless of their choices, nursing professionals function in

biopolitical spaces, b) free-floating responsibility, distancing, and the zoe/bios dichotomy are critical attributes of biopower, and c) the unspeakable is the often invisible link between biopower, compassion, and suffering. Table 18 defines the theory's key theoretical terms.

Table 18

Key Terms from the Emancipatory Theory of Compassion

Term	Definition
Biocompassionate Space	A political space where power relations are equitable and just, thus, fostering compassion.
Biopolitical Space	Physical spaces or fields of existence where biopower is exercised. For example, airports, prisons, and hospitals.
Biopower	Power exerted over life. In this theoretical context, biopower is the authority to construct social objects and processes by enforcing status classifications, especially across dimensions of race, class, gender, or other minoritizing states-of-being. Positioned as a negative, hierarchal force, biopower makes compassion difficult and enables suffering. Critical attributes of biopower include the zoe/bios dichotomy, free-floating responsibility, and distancing. Notably, the social patterns and constructs generated by biopower in clinical settings can become so common as to be invisible (see the Unspeakable).
Biotoxic Space	A political space where unjust power relations have made compassion almost impossible.
Compassion	A critical attribute of nursing practice. George (2013) describes compassion as the empathetic desire that others be free from suffering.
Distance	A critical attribute of biopower. Distance may describe a length physical space or metaphorical remoteness.
Free-floating Responsibility	A critical attribute of biopower. Free-floating responsibility describes a biopolitical space where social processes lack a discernable locus of control or decision-making accountable for actions.

Suffering	A contextual concept, suffering is the absence of compassion created and sustained through biopower. It is often associated with physio-psychosocial-spiritual distress although awareness of these indicators of suffering may be silenced.
The Unspeakable	The Unspeakable describes a biopolitical condition where the effects of biopower have become so ingrained as social processes that they are perceived as normal. Discourse in these spaces constitute a powerful will to silence that sustains biopower.
Zoe/Bios Dichotomy	A process of classification where some humans have political agency—their voices are authoritative ('bios')—while others are marginalized ('zoe'). Humans exist on a spectrum with these two positions as polarities and have an interest in maintaining or advancing their positions on the spectrum. Assignment to zoe or bios status may occur opaquely within biopolitical spaces like clinical settings, but assignment to zoe status is often associated with socially constructed minoritizing attributes.

Georges (2013) theorizes that some people within a given biopolitical space have agency and authority ("bios") while others are marginalized ("zoe"). Everyone operating in biopolitical spaces (e.g., hospitals and other healthcare settings) functions on this polarized spectrum. People can move toward bios status through compassionate actions that create more equitable biopolitical spaces, or they can move toward zoe status because of power exerted by other people and institutions or their own inaction to create compassionate spaces. Notably, this process is often hidden because the divide between zoe and bios is so ubiquitous it is often perceived as quotidian or common sense. Nurses, like everyone else functioning in these spaces, are interested in maintaining or increasing their statuses within the dichotomy. Therefore, nurses can remain

silent about marginalizing or unethical behavior, or they can assert power to make the unspoken visible, thus, risking their status. Hence, the term *unspeakable*.

The zoe/bios dichotomy exists alongside distance and free-floating responsibility and creates conditions that allow or sustain suffering in biopolitical spaces, for example, clinics and hospitals. Biopower, presented negatively in this theoretical context, functions to create biotoxic spaces where compassion is impossible. Presumably, nurses exercise their power—which often occurs within relational networks—to create biocompassionate spaces where effective nursing care is possible; conversely, nurses can also sustain biotoxic spaces through the oppressive exercise of power. Georges (2013) locates compassion as central to effective nursing and suffering as antithetical to nursing care. Georges (2013) notes, "compassion is the essential element of nursing . . . persons in the biopolitical space in which nurses practice are at enhanced risk for increased suffering when power relations render compassion impossible" (p. 8). Table 19 summarizes Georges' emancipatory theory of compassion.

Table 19

Georges' (2013) Emancipatory Theory of Compassion for Nursing

Paradigmatic Origins	Underlying Assumptions	Major Concepts	Propositions and Conjectures
• Constructivist • Emerging; post-humanist • Derived from Eastern philosophy and Buddhist notions of interconnectedness.	• Suffering is universal. • Nurses function within biopolitical spaces. • Compassion is fundamental to praxis.	• Suffering • Compassion • Biopower • The unspeakable • Interbeingness[a] • Biotoxic space • Biocompassionate space • Emancipatory practice	• Suffering and biopower are inseparably bound to the existence of compassion. • Nursing cannot exist in biotoxic spaces, but nurses may knowingly or

	• Power relations are fundamental to compassion. • Power relations exist in relation to socially constructed statuses and differences.	unknowingly sustain biotoxic spaces. • Free-floating responsibility, distance, and the zoe/bios dichotomy are elemental to negative biopower and create biotoxic spaces. • Compassion is the antithesis of suffering. • Nurses can increase compassion by justly sharing power and speaking the unspeakable; these interventions also decrease suffering. • Decreased suffering and increased compassion will improve patient outcomes.

Note. Table synthesized from Constantinides and George (2022) and George (2013).

[a] Term coined in Constantinides and George (2022)

From 2013 to 2022, there is a paucity of theory development relevant to the emancipatory theory of compassion. A search of the Cumulative Index to Nursing and Allied Health Literature (CINAHL) and PubMed databases from 2013 to 2022 on 01 June 2022 returned one relevant article linked to the keywords "emancipatory compassion" and nursing. The article by Constantinides and George (2022) called for increased use of the emancipatory theory of compassion for nursing research, education, and practice. Whether the scarcity of development since the theory's publication represents diminished importance of theory development in nursing overall, an absence of searchable keywords in published articles, or a general lack of familiarity with the theory among researchers is unclear. However, the unique practical usefulness and parsimony of Georges' (2013) theory for exploring the complex power dynamics so often at issue in modern health care are unmistakable.

Theoretical Context of this Inquiry

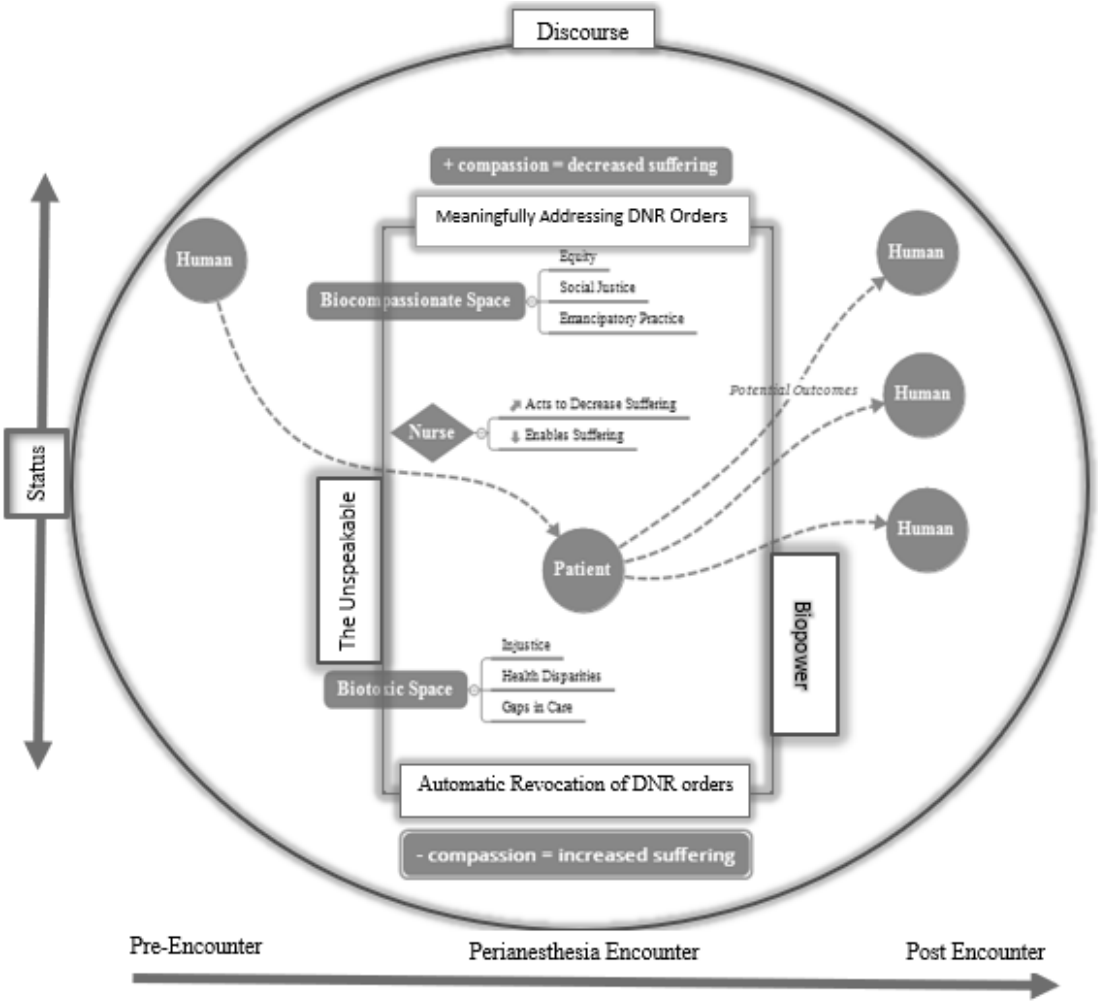
Although some progress has been achieved in ethically managing limiting directives in the perianesthesia setting, the practice of automatic and defacto routine informed suspension remains a problem. Traditional mechanisms for analyzing the problem, such as conventional qualitative inquiry and ad hoc quality improvement projects, have been only marginally effective (Baumann et al., 2017; Urman et al., 2018). In the perianesthesia setting, patients are distanced both physically—they are sequestered in an operating theater—and metaphorically—they are unconscious from anesthesia. In addition, directives limiting care are often framed as obstacles to safe practice. In such instances, patients with pre-existing directives may be seen as more challenging while clinicians who insist upon meaningfully addressing patients' advance directives during surgery may be cast as outliers. Georges (2013) suggests that a critical interaction between the zoe/bios dichotomy, an atmosphere of free-floating responsibility, and

distance (both physical and metaphorical) constitute negative biopower that creates conditions where unethical behavior remains, not just possible but common sense—the unspeakable.

The emancipatory theory of compassion centralizes how power relations may contribute to inequitable and unethical spaces, how these concepts relate to minoritizing characteristics in health care settings, and how inequitable care might become so invisible that it is accepted as normal. The problem restated in this theoretical context is that routine suspension of limiting directives is so pervasive in the perianesthesia setting it has become unspeakable. This unspeakable quality sustains a culture that marginalizes patients with limiting directives. In this culture, the critical attributes of biopower—the zoe/bios dichotomy, distance, and free-floating responsibility—coalesce to create biotoxic spaces where compassion is inhibited, and suffering increases. The goal of nursing in this theoretical context is to make the unspeakable culture visible, thus, creating a more equitable—biocompassionate—clinical environment. Figure 14 depicts the theory of emancipatory compassion as applied to the problem of managing directives limiting care in the perianesthesia setting.

Figure 14

The Emancipatory Theory of Compassion Applied to the Problem



Note. This figure applies the theory of emancipatory compassion to the problem of ethically managing directives limiting care in the perianesthesia setting. Human beings exist in their usual state outside the perianesthesia setting. However, perianesthesia discourse transforms the human being into a docile patient who is ready for surgery. The nurse may create more just environments where patients' advance directives are meaningfully addressed, but this may jeopardize the clinician's status. The effective alleviation of suffering, however, improves patients' potential outcomes by enhancing agency and self-efficacy

In addition to constructing the problem using Georges' (2013) theory, this inquiry addressed the following research question specific to the emancipatory theory of compassion. Does the triumvirate of zoe/bios dichotomy, distance, and free-floating responsibility contribute

to sustaining a perianesthesia climate that permits the unethical behavior of automatic or defacto DNR order revocation?

Methods

Design

The investigator used Poststructural Case Study (PCS) design to explore how one surgical services department accommodates, constructs, and reproduces discourses on perianesthesia directives limiting care. The bulk of the inquiry investigated how patients, families, and clinicians talk about their pre-existing advance directives during a surgical encounter and how the management of those directives relates to power-knowledge from a Foucauldian perspective. Boles (2016) suggests that - with some imagination - instrumental case studies as described by Stake (2005) comport well with poststructuralism because case study allows investigators to include context, avoid arbitrary categorization, and identify small, mundane moments that occur as power circulates in the periphery of relationships. Case study design also facilitates the inclusion of multiple groups, which in this case include patients, families, and clinicians. The design centralized patients and families—a nursing imperative—while not merely focusing on their subjectivities, a requirement to maintain philosophical consistency within a poststructural worldview.

Setting

The clinical site was a large, tertiary care hospital in the upper Midwest, United States. The "main" surgical services center consisted of a preoperative area (preop), surgical suites, Post Anesthesia Care Unit (PACU), and ambulatory discharge (i.e., Phase Two) section. A day surgery center adjoined the main hospital for some lower-risk same day surgical patients. The

two areas were staffed by different nurses, but the same anesthesiologists, surgeons, and Certified Registered Nurse Anesthetists (CRNAs) floated between the two departments.

Sampling Procedures

The inclusion criteria for patient participants were 1) requiring perianesthesia care for a procedure or surgery; 2) having a DNR order or other advanced directive in place at the time of their planned anesthesia encounter, and 3) the ability to verbally or with an assistive device participate in minimally structured interviews that required recall of recent clinical interactions about perianesthesia directives limiting care. Finally, because analyzing discourse requires both a common language and cultural immersion, speaking English and living in the United States were also inclusion criteria. Patients whose clinical condition was declared an emergency, who bypassed the usual preanesthesia evaluation process, or who expressed a desire not to be approached about participating in research activities were excluded.

The surgical schedule was reviewed daily to identify index patients – those with pre-existing advance directives who were scheduled for surgical procedures with anesthesia. These index patients were traced on the day of surgery to centralize the patient's experience. The clinicians who interacted with the index patients were invited to join the inquiry as clinician participants. Family members who were present for conversations between clinicians and the index patient were also asked to join.

All recruitment was purposive. The investigator made decisions about when to stop recruiting certain group members based on two factors. First, two months were allotted for recruitment and fieldwork. The second, more dynamic, factor was data saturation. The criteria for saturation in this inquiry was embraceability. Here, embraceability means that the investigator collected enough data to *know* that facet of the case but not so much data that the

case was intellectually ungraspable. In this instance, recruiting further participants to address the same facet of the case would not produce usable data but detritus.

Data Collection

Interviews. Interviews were conducted with patient, family, and clinician participants using minimally structured, pre-approved topic guides and in the setting and via the platform preferred and convenient for the participant. The interviews were audio-recorded and subsequently personally transcribed by the investigator. The transcriptions were sent to the participant for review and comments. Any participant questions or concerns about the transcripts were promptly addressed. The audio-recorded interviews were stored using Box®—the password-protected, encrypted digital system licensed by the clinical site.

Observation and Other Data Points. Observations were recorded on a semi-structured observation form. Observations were later transcribed and coded. Other elements of case-related data were collected and included excerpts from chart reviews conducted after observation and copies of written institutional policies.

Data Analysis

Poststructural case study (PCS) is not a method of analysis; it is a study design. Contextualizing analysis, however, comports well with PCS designs because it is fluid, iterative, avoids reduction, and focuses on discourse. Unlike phenomenologically based studies, poststructural inquiries are not as concerned with the cognitive inner working of the participant's mind. Language—what is said—is critical. Contextualizing analysis focuses the investigator on statements and contexts.

Although here presented in a stepwise fashion, the elements of contextualizing analysis are fluid and iterative. First, all data were organized into folders labeled and grouped in relation

to the index patient. The transcribed data was read and coded for repeating patterns of discourse. A color-coding system was used to avoid arbitrary or reductive categorization. Each color code was compiled into a master key so that patterns would be more visible. In addition, a rhizomatic diagram was created after coding for each group of participants. These diagrams helped spatialize power networks and aided the identification of interrelationships between color codes. Memoranda and reflective insights were kept during this process. Table 20 lists the initial criteria for code generation.

Table 20

Criteria for initial Code Generation

- The investigator recalled hearing the same words across groups suggesting a repeating pattern of discourse.
- The language had notable weight during the interview.
- The language was used by the participant in a self-evident way without the need for further explanation
- The language corresponded to concepts suggested by Georges' MRT of emancipatory compassion for nursing.
- The language comported with field observations
- The language had the potential for answering a priori research questions.

Next, the contextual color codes were re-read and transferred to a glossary of contextual codes. The glossary was created in relation to the master key and rhizomatic diagrams. In addition to defining each contextual code, the glossary helped to further refine interrelationships, power networks, apparatuses of discipline, and instances of resistance. Using the glossary and rhizomatic diagrams, the master key of codes was shaped around the inquiry's research questions. Finally, the investigator returned once more to the original transcripts and reviewed each contextual code line-by-line in context. The findings, as they relate to the previously disclosed research question, are shared in this report.

Trustworthiness

Findings should be evaluated by criteria of transferability and credibility. In total, the investigator directly observed 11.8 hours of patient-clinician interactions in the field and accumulated 14.4 hours of interview recordings. To ensure fidelity and rigor, participants were given a chance through member checks to correct and comment on transcripts and manuscripts produced from the investigation. In addition, data was collected from multiple sources. A reflexive journal was kept during fieldwork to record my thoughts, feelings, recollections, and insights. The journal was part of an audit trail that traces the underlying rationales for the multitude of decisions made during the inquiry. Finally, my research practice was supervised by my major professor, and their advice and direction were always synthesized into my method and conclusions.

I am a novice inquirist but an experienced nurse with decades of experience in critical care and perianesthesia nursing. Although my voice fades into the background when recounting the method used to generate the findings and how those findings are represented, my perceptions, experiences, and individual subjectivities are always present. This assertion is consistent with my constructivist-interpretivist positioning. Notably, this is only one paradigmatic perspective, and there are other equally valuable worldviews that might be productively applied to the data.

The results of the inquiry are not verifiable in any context other than the time and place of their occurrence. They are not generalizable except to the participants themselves. The reader must determine if the findings were constructed rigorously and resonate in a way that has meaning to their practices. This manuscript was prepared following Standards for Reporting Qualitative Research (SRQR) guidelines in the hopes that the reader is provided with sufficient information to make an informed decision about trustworthiness.

Ethical Considerations

The inquiry was approved by the Institutional Review Board (IRB) at the study site (1723212-1). An inter-institutional reliance agreement between the clinical site and the inquirist's university IRB was executed. The reliance agreement made the clinical site the IRB of record and responsible for oversight and continuing review.

Written informed consent was obtained for all participants. Additionally, Health Insurance Portability and Accountability Act (HIPAA) waivers were obtained for all patient participants. Informed consent was continually reaffirmed during subsequent conversations, and the participants exhibited no signs of distress or discomfort. Participants who completed both the observation and interview components of the inquiry received $50.00 compensation. No personal identifying information was stored outside of the clinical site. Identifying documents were stored or destroyed as instructed by the IRB approved protocol. There were no reportable adverse events or security breaches or conflicts of interest.

Results

Twenty-seven participants joined the inquiry and completed both the observation and interview components of the investigation. The inquiry included eight patients, two family members, and 17 clinicians. Additionally, 18 observation-only clinical participants joined the inquiry. Observation-only participants included anesthesiologists, surgeons, CRNAs, and nurses who interacted with the index patient and consented to observation but declined to interview. Two patient interviews occurred telephonically, and two were video calls over Microsoft Teams® at the participants' request. The remaining interviews were conducted in person in a private setting of the participant's choosing. Table 21 summarizes key demographic characteristics of the full participant sample. No demographic data were collected for observation only participants.

Table 21

Sample Characteristics

Characteristic	Patient (n = 8) Frequency	Family (n = 2) Frequency	Clinician (n = 17) Frequency	Total (n = 27) Frequency	Percentage
Gender					
Male	2	2	2	6	22.22
Female	6	-	15	21	77.78
Age					
30-40	-	-	10	10	25.93
41-50	-	-	3	3	11.11
51-60	-	-	3	3	11.11
61-70	3	1	1	5	18.52
71-80	3	-	-	3	11.11
81-90	2	1	-	3	11.11
Race					
Caucasian (NH)	8	2	16	26	96.30
African American (NH)	-		1	1	3.70
Clinical Role			1	1	3.70
MD-Surgeon			1	1	3.70
MD-Anesthesiologist			1	1	3.70
CRNA			5	5	18.52
RN-Perianesthesia			2	2	7.41
RN-OR			6	6	22.22
Organizational Leadership			1	1	3.70
Dual Role (leader/RN-perianesthesia)					

Representational Presentation

Findings from the inquiry are presented as three vignettes derived from the coded data to illustrate the theoretical concepts of distance, free-floating responsibility, and the zoe/bios dichotomy. Each vignette sets a scene based on the coded observational, interview, and archival

data. Berbary's (2011) "writerly" approach was employed using the screenplay format as a device to represent the findings in contingent, poststructural forms. These representational forms allow for multiple interpretations and more equal authority between the inquirist and participants. This should encourage readers to visualize the results and engage their imaginations, experiences, and individual expertise when making sense of the case. Quotations from participants are framed as documentary-style interjections to contextually ground the findings. All names are redacted or fabricated.

Vignette One: Distance

Fade In:

Perianesthesia clinicians—physicians, CRNAs, nurses, and surgeons—are inured to the noise. Indeed, they might only notice the constant background hum of the preop setting in the few moments when power is disrupted, and the backup generator engages. In those moments, the long hallway falls silent, and it is remarkable. Early in the morning, 0500 hours, is somewhat strangely one of the loudest times in preop. Nurses shout, laugh, chat, and prepare for what is about to happen. The first cases are about to arrive.

Sleepy patients, because few people sleep well the night before surgery, begin queuing at the reception desk. Early morning silence is jarringly nonexistent as patients are led back to their rooms.

Cut To:

A patient's preop exam room. A 70ish female-presenting person stands just inside the exam room doorway. They are scheduled for orthopedic surgery.

Nurse

Okay, I'm going to have you change into this gown. It opens in the back. You can tie the top tie, but please leave the bottom tie open.

Patient

Silence [nods head]

Nurse

Take off all your clothes—including your underwear. Have you peed? I'm going to close the door. Go ahead and get changed and urinate. Open the door when you're ready, and I'll come back inside.

[The door closes on the camera]

Things move quickly from this point. The door is opened, and the person who arrived this morning is now the patient. They are dressed in a paper gown with a built-in heating device.

Nurse

Go ahead and lie down on the cart.

[The patient lies down on the cart. The nurse raises the siderails. The nurse attaches and activates the heater and gives the patient a control for the device]

Nurse

You can control the temperature, but we like you warm before you go to surgery.

A nurse's aide enters the room to begin their work.

Nurse

We are going to tag team you [laughs].

The aid begins to look for a vein to collect blood.

Nurse

We'll talk while she draws some blood.

Another aid appears to complete the preoperative chlorhexidine scrub. Another nurse enters the room and starts Intravenous (IV) access.

Second Nurse

Are you allergic to lidocaine like they use at the dentist's office?

Patient

No.

Second Nurse

This will sting for just a second.

First Nurse

Do you have an advance directive or living will?

Patient

Uhm, I have a will.

Nurse

Sure. Do you have a legal document that states what you want done or not done should something happen to you?

Patient

Oh. I don't want anything done. If I go, just let me go.

The action in the room pauses momentarily as the two nurses share a knowing glance. The second nurse departs. The patient is now supine on a surgical cart with the siderails raised. IV fluids are infusing. Sequential compression devices are attached to the patient's legs.

Nurse

Do you have a DNR?

Patient

Yes, that's right. I've been through so much this year. I told my doctor that I didn't want to have a breathing tube. If I die, just let me go.

Nurse

Well, it looks like your surgeon has made you a full code.

Patient

Silence.

Nurse

The computer says you are full code. Is that okay?

Patient

Well. I talked about it with Dr. Jones. I told him that I wanted to keep my DNR.

Nurse

Okay. I'm going to have you and your doctor talk.

Cut To:

An office is being used as an interview room. The background is darkened. A woman is seated in the foreground. Well lit. They are being interviewed.

The following excerpt is from an interview conducted with a perianesthesia nurse.

I've heard people say, well, they know not to put the breathing--I don't want to be on that breathing machine. They know that I don't want that, or uhm, I just had a patient last week actually who was a DNR. I I'm sorry it wasn't my patient. I was working charge and I had a newer nurse that had this patient. And the patient was very--it was a Dr. **** patient --and she was very adamant on remaining DNR through her surgery. And Dr. **** was, "Well, we don't need to worry about that. You know we, you know, it's not going to come to that point. You'll be just fine. We're not gonna have to do any

resuscitation or anything." and she said, "But no. I'm very clear. I want to be a DNR . . .." They do not want to be resuscitated. "I do not want chest compressions. If I were to have my heart go bad in surgery" is what she said. And Dr. **** wasn't listening. And he just wanted to circle or check that box and move on. And she was really pissed. She actually had the nurse call Dr **** back in 'cause she was very worried he was not gonna listen to her wishes. But I made the decision that, you know, well maybe yeah, have Dr. **** come back in but also have anesthesia involved in that conversation. Because they are the ones that are doing the lifesaving medications and whatnot in the OR. You know Dr. **** is not doing that. . .. and they did it and they went back in the room and had a long conversation with the patient. She felt much, much more relief. And she got to remain her DNR . . . status through surgery.

Back to Scene:

The patient's preop exam room.

A purple band is placed on the patient's wrist signifying that their code status is DNR and the Electronic Medical Record (EMR) is changed to reflect the patient's resuscitative preference. After speaking with their anesthesiologist, operating room nurse, and CRNA the patient is now "ready" for surgery—in bed, attached to intravenous tubing, exogenously heated, and sequentially compressed. The case can proceed. The patient departs the preop area for the operating theater where anesthesia is induced, and they are rendered unconscious.

Cut to:

The patient's home. Again, the background is visible but darkened. The patient, now dressed in her usual attire, sits in a recliner. She is well-lit in the foreground.

The following excerpt is from an interview conducted with a surgical patient.

No, if I've gotta be on a ventilator, or if I gotta be on something for the rest of my life to keep me alive, no. Just-- I don't-I don't want to put the kids through that and prolong the death. And the —what it would cost to keep a person alive. No, d-don't. Just. Let me go and that's it.

Dissolve.

Later, there is a lull in activity. The breakneck pace of the first case rush is over. The nurse comments to their colleague—the second nurse who started the IV.

First Nurse

There just isn't enough time to have a meaningful conversation before surgery. It feels so rushed. And patients already have so much on their plates.

Second Nurse

There should be a way to address this before the day of surgery. Maybe in the surgeon's office?

Fade Out.

Vignette Two: Free floating Responsibility

Fade In:

In the preop area, activity comes in waves. Another wave is crashing. Mrs. Jane, a frail older woman is met by her nurse at the surgical reception desk.

Nurse

Hi, I'm Julie. I'll get you ready for surgery. Come with me. Are you her daughter [to the younger woman sitting next to the patient]?

Daughter

Yes.

Nurse

I'll have you wait in the waiting room just down the hall. I'll call you back in about 30 minutes. Okay?

The patient's daughter exits toward the waiting room.

A HAND-HELD CAMERA follows.

Mrs. Jane is taken to a preop room where her transformation into a case begins. A rush of activity ensues. The room door closes on the camera.

Dissolve: minutes later in the patient's room.

The patient lies in bed clothed in a lavender paper gown. Intravenous access is established, and siderails are raised. Busy tasks are ongoing.

Nurse

Let's review your medications.

Mrs. Jane/Patient

I have them in my purse [moves to retrieve the medications].

Nurse

No, you stay right there. I'll get them. It's easier [laughs].

The activity subsides, and the transformation is almost complete. Mrs. Jane's daughter is called to the room.

Nurse

Do you have an advance directive?

Patient

Yes.

Nurse

Really? The computer says you are full code.

Patient

No. I'm. Well, I don't want anything done. [daughter arrives].

Daughter

Yes, she has a DNR. Mom, remember you usually suspend it for these things.

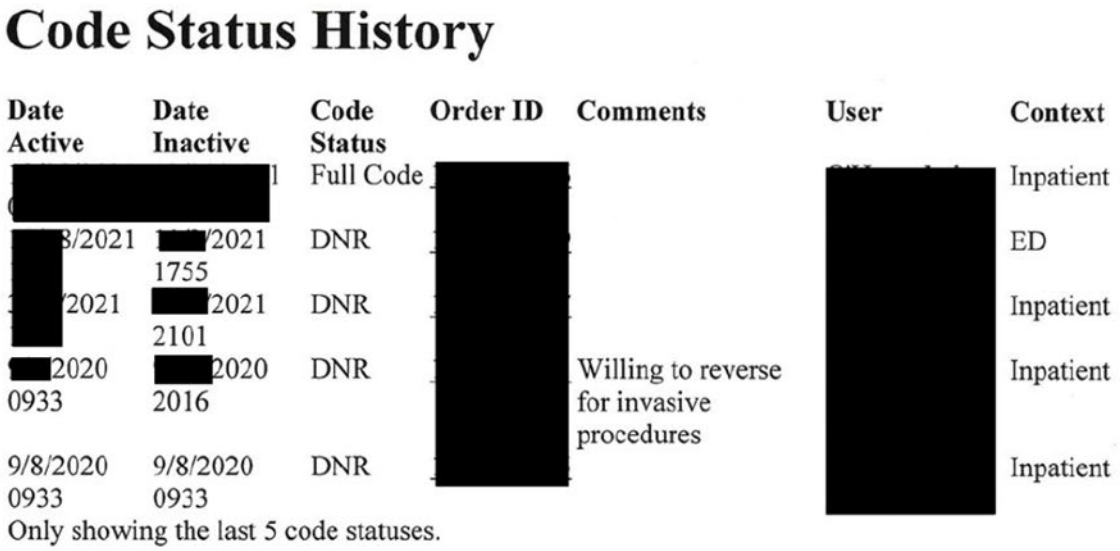
Cut To:

An image of the nurse's computer monitor.

The EMR has the patient listed as a full code. As the nurse investigates, she hovers over the advance directive section of the medical record. See Figure ??.

Figure 15

Mrs. Jane's Code Status—A Medical Record Artifact



Code Status History

Date Active	Date Inactive	Code Status	Order ID	Comments	User	Context
[redacted]		Full Code	[redacted]		[redacted]	Inpatient
[redacted]/2021 1755	[redacted]/2021	DNR				ED
[redacted]/2021	[redacted]/2021 2101	DNR				Inpatient
[redacted]2020 0933	[redacted]2020 2016	DNR		Willing to reverse for invasive procedures		Inpatient
9/8/2020 0933	9/8/2020 0933	DNR				Inpatient

Only showing the last 5 code statuses.

Note. Mrs. Jane indicated their willingness to suspend the DNR for procedures. Unlike previous encounters, however, during this encounter, the patient's code status was changed to full code upon admission. Clinicians only saw her status as "full code" unless they further investigated her code status history.

Cut To:

A LOW CAMERA ANGLE of the nurse.

Nurse

Oh, I see you were DNR in the past and that you suspended it for your last procedure. But now you want to be full code?

Patient

I don't want any more surgeries. It's okay to put it on hold for today, but my doctor knows I don't want anything else done. Just what's planned for today.

Cut To:

Mrs. Jones sitting at her kitchen table. She is well-lit in the foreground, but her kitchen is darkened.

The following excerpt is from an interview conducted with a surgical patient.

Interviewer [VOICEOVER]: What made it OK to put the DNR on hold for this procedure as opposed to if you were admitted to a hospital?

Mrs. Jones: . . . I don't, I guess maybe because it's a very--it's always been a very short procedure. It's not been anything lengthy or anything like that.

Back To Scene:

Nurse

So, do you want to suspend your DNR just for this procedure?

Patient

Yes.

The nurse recognizes that Mrs. Jane's DNR is not suspended just for the procedure. Instead, her code status was changed to full code in the EMR. Future clinicians—like the nurse—may think that Mrs. Jane has revoked her DNR wishes.

Cut To:

An organizational leader's office. As before, the background is darkened, but the organizational leader is well-lit. The leader is dressed in hospital attire and sits behind a desk.

The following excerpt is from an interview conducted with an organizational leader.

I think it's very interesting how much the computer influences what we do. You know, it's almost like when you're a new, uh, tele nurse or ICU nurse and you're so focused on the monitor you forget to look at the patient. Sometimes I think we lose sight of that too and have those conversations with the patient depends so much on what the computer says.

Back To Scene:

The patient's preop exam room.

Nurse

You and your doctor will need to speak about your code status. I'll remind you later.

Patient

Okay.

The nurse exits the room and calls the surgeon. The camera follows the nurse to the hallway.

Nurse

Hi. I'm calling about Mrs. Jane your next patient in preop who's here for a biopsy.

Surgeon

Sure.

Nurse

Well, you know she's a DNR . . .

Surgeon

She is?

Nurse

Yes. Your preoperative orders changed her from DNR to full code this morning. But I think she just wants to suspend the DNR for surgery. Can you talk to her?

Surgeon

I think you should talk to the anesthesiologist. They handle that.

Nurse

Okay. [The nurse hangs up and calls the anesthesiologist assigned to the patient]. Hi, I'm taking care of your patient Mrs. Jane—Dr. Mallory's next biopsy patient. She has a DNR that needs to be addressed. Her surgeon requests that you speak with her.

Anesthesiologist

I reviewed her chart. She's not listed as a DNR.

Nurse

There must have been a miscommunication. Her preoperative orders list her as full code, but she has been a DNR for some time. But I think she'll suspend the DNR for the case.

Anesthesiologist

I'll talk to her about it, but the surgeon needs to address her informed consent.

Dissolve.

Mrs. Jones ultimately suspended her DNR order on the paper informed consent form. The EMR was never updated. Nurse Julie, still concerned about the future effects of this approach, spoke with an organizational leader later that day. She also completed an institutionally approved risk identification form.

Cut To:

ESTABLISHING SHOT: Close-Up of a desk plaque that reads “Grace Smith, RN – Nurse Manager.”

Pull Back:

A generic, slightly cluttered office. Two women sit opposite each other separated by a desk. The perianesthesia nurse is speaking to the nurse manager.

Nurse

I just feel responsible for making sure the physicians have a conversation with the patient about their advance directive, but I never know who is ultimately responsible for addressing it.

Cut To:

An empty exam room except for the nurse sitting in a chair facing the camera. The background is darkened as usual.

The following excerpt is from an interview conducted with a nurse.

I have gotten the runaround a little bit at times where like anesthesia will be like well, the doctor should do it and the doctor is like well, anesthesia will do it so that nobody really—. And then nobody addresses it. So, I still have to chase people down to address it so that can be frustrating.

Back To Scene:

Nurse Manager

Addressing the advance directive is part of informed consent, and that is ultimately the surgeon’s responsibility.

Smash Cut:

The interview room is as previously described, but this time a CRNA sits in the chair.

The following excerpt is from an interview conducted with a CRNA.

I guess if that means it falls to anesthesia it falls to anesthesia. Whether that's right or wrong, I don't know but like ultimately, we will probably be leading resuscitation. If it were to happen, so we need to know it.

Smash Cut:

Back to the nurse manager's office.

Nurse

Sure. But we all know it is the anesthesia provider who will run the code if something happens. Anesthesia needs to understand what the patient wants. It's confusing.

Fade Out.

Vignetter Three: The Zoe/bios Dichotomy

It is another busy morning in preop, but things are going smoothly. A nurse, sitting at a computer screen, is addressing a patient, supine on a surgical cart, IV infusing, in a lavender paper gown with a built-in heating device. The patient is in his eighties and is being prepped for a significant vascular surgery. On the bedside table, there lies a purple wristband that signifies the patient's code status is DNR. A purple band lies beside the orange band. The orange band signifies that the DNR is suspended for surgery. A yellow post-it note is affixed to the patient's chart. The post-it note is a reminder to the nurse and physicians that the patient has a DNR order.

Cut To:

The interview room is set and lit as usual. One perianesthesia nurse sits in the chair.

The following excerpt is from an interview conducted with a perianesthesia nurse.

I think. . . we have. . . sign language for lack of a better word with the doctors. Like we'll waive the orange wristband in front of the doctor's face so that they know what they need to ask next. Or put it on the consent so that they know that they need to ask the question

or make a sticky note or something, uhm, if we're not in the room. So, they still ask the question and get the answer. . .. And we're, I think we're more, I think we're pretty good at, you know, confronting— not confronting— but confronting the doctors with: Okay, he's DNR we need to have this discussion I think, and I, you know that we're going to do. . .. I don't know what the numbers are, but I'm going to guess it's way over 90% of our patients suspend their DNR status during the case. And I have a feeling that if a patient . . . better understood, it would maybe be less than that.

Back To Scene:

The patient's preop exam room.

Nurse

So, I see you have a DNR order.

Patient

DNR? Remind me. Uhm, what does that stand for?

Nurse

It stands for Do Not Resuscitate. It means that if you were to pass away—if your heart were to stop beating while you're in the hospital—you wouldn't want us to resuscitate you. Is that right?

Patient

Oh. Well, I guess. I just don't want to have the breathing tube. I've heard it's painful.

Nurse

We need to use the breathing tube for anesthesia. But we can usually remove it before you wake up. You know you're here for surgery, and that is part of it. Is that okay?

Patient

I guess so [appears slightly confused].

Nurse

You and your doctor should talk about it.

The patient's anesthesiologist enters the room.

Nurse

Hey, Mr. Smith here has a DNR. I think he has a few questions about suspending it for surgery.

Anesthesiologist

Don't worry. This will be a quick surgery. We'll just suspend the DNR for the case. Everybody suspends their DNR for surgery.

The nurse places the purple and orange bands on the patient's wrist. Later, the surgeon enters the room to complete the informed consent document.

Cut To:

The patient's home office. They are sitting by a desk speaking to an unseen interviewer. The patient is well-lit in the foreground, but the background is in shadow.

The following excerpt is from an interview conducted with a surgical patient.

But I didn't understand. I mean, they really didn't explain it. So, when they mentioned [that] for me that they could suspend it. Yeah, that that sounds good.

Back To Scene:

Nurse

He has a DNR. He spoke about it with the anesthesiologist, and he's okay with suspending it for surgery.

Smash Cut:

The usual interview room. The nurse is seated in the foreground while the background is darkened.

The following excerpt is from an interview conducted with a perianesthesia nurse recalling a surgeon's reaction when the patient wanted to keep their DNR.

Oh, I've had a doctor yell at me about that, 'what do you mean you want me to keep him DNR!' I mean I've had somebody yell at me over that before.

Back to Scene:

Surgeon

So, we usually suspend the DNR before surgery. You're okay with us doing everything during the surgery?

The patient nods had to indicate agreement. The surgeon signs the consent form.

Surgeon

Okay.

Cut To.

The interview room is staged as usual.

The following excerpt is from an interview conducted with a surgeon.

At least for the time of the operation we need to . . . do everything we can within reason. And that's a little bit of a surgeon's mentality I feel like. . .. If we're making the decision to put forth the resources to help somebody do a big operation like that, then . . . we don't, you know, force the patient to make any decision they don't want to, but we emphasize, for example, okay, there's a lot of things in surgery that can happen that are reversible--that's different than when you say you code as an outpatient and you know, maybe, . . . there's not a lot we can do to really reverse what happened.

Later, in the operating room, the patient's suspension is addressed during the surgical pause. Mr. Smith's DNR will remain suspended until their orange bracelet is removed at discharge from PACU.

Cut To:

The interview room is lit and staged as usual.

The following excerpt is from an interview conducted with an OR nurse.

It is understood by almost everyone in the room: they will not die in the OR.

Fade Out.

Discussion

The inquiry into the management of pre-existing advance directives in the perianesthesia setting used the emancipatory theory of compassion as a MRT to help guide the translation of findings into nursing practice. Constantinides and Georges (2022) argue that the emancipatory theory of compassion applies to all domains of nursing practice. The authors suggest that sensitizing practitioners to the theory will support theory development. Within this theoretical context, the problem of automatically revoking directives limiting care before surgery without the patient's informed knowledge was recast in relation to power in the perianesthesia setting. Such a theoretical lens is helpful because the problem is so ingrained that it is often invisible. The problem is *unspeakable*, and this 'unspeakable phenomenon' has real-world effects. Foucault suggests that language is constitutive, and so too is silence. The emancipatory theory of compassion suggests that the unspeakable problem contributes to the creation of biotoxic spaces where unethical behavior is possible, albeit often unseen. In this new theoretical light, the problem becomes visible. Georges' (2013) theory suggests that a triumvirate of distance, free-

floating responsibility, and the zoe/bios dichotomy are critical attributes of biopower. Therefore, these attributes should theoretically be present in this investigation.

The existence of distance seems obvious in the perianesthesia setting; however, the depth of the distance created there may not be readily apparent. The perianesthesia patient is distanced from their family and friends, sequestered in a preop exam room, and rendered ready for surgery. The process of readying the patient for surgery is one of medicalization. The person is made a body. Soon that body will be anesthetized and made unconscious. That body is then the responsibility of the perianesthesia clinicians. In this way, the person is *distanced* from their body and clinicians assume a proxy role—substituting their judgments for the patient's choices. Interestingly, in another example of distance identified in the data, some clinicians want to move the responsibility of addressing the limiting directive away from the day of surgery to the surgeon's office, or some other clinical deputy. When the problem is unspeakable, shifting responsibility for understanding the patient's EOL choices seems a tidy solution. It is only when the unspeakable is problematized that the solution may be seen as simply another form of distancing.

Moving the responsibility for addressing limiting directives away from the perianesthesia environment also exposes a culture of free-floating responsibility. Participants were uncertain about who was responsible for understanding the patient's advance directive. Certainly, a hierarchy of responsibility exists in the data. As demonstrated by the data, physicians are atop the hierarchy in the perianesthesia setting, and nurses feel a responsibility to create an environment that accommodates the physicians. In this case, nurses perceive that physicians, and other nurses, want the limiting directive suspended. Simultaneously, nurses feel a responsibility that the advance directive is addressed, but by whom and how the directive should be managed

remains unclear. In practice, anesthesia clinicians will operationalize the patient's resuscitative choices, but surgeons are often tasked with discussing those choices as part of informed consent. This fogginess creates tensions within and between disciplines. It is perhaps unsurprising that silence is the preferred way to address directives limiting care in this setting because the tension only surfaces when the silence is broken.

When the unspeakable problem is exposed by someone—clinician, patient, family member, organizational leader—insisting that the limiting directive is meaningfully addressed, the zoe/bios dichotomy is seen. For example, a surgeon may inappropriately "yell" at a nurse who asks that they address the directive. In another example, the patient may experience threats of delay or face challenging conversations with more powerful clinicians should they resist the "ready for surgery" process. Physicians may also experience internecine tension between surgeon and anesthesiologist when surgical delays are necessitated by more mindful, and time-consuming, conversations about the patient's code status. In this situation, the effects of complex power relationships are most evident. There is hierarchal power, for instance, when the surgeon is the "captain of the ship," and other clinicians are expected to defer to them. There is also a more subtle relational power. In this exercise of power, preoperative rooms are set up to avoid conflict and create the *obvious* choice that the limiting directive should be suspended.

In summary, observational and interview evidence exists to support the theoretical assertion that the zoe/bios dichotomy, distance, and free-floating responsibility contribute to sustaining a normalized perianesthesia climate that permits the unethical behavior of defacto DNR revocation. The outdated process of automatic revocation was not supported and widely rejected by this inquiry's participants, but the culture around this process persists in the perianesthesia setting. However, the data suggests that dismantling one leg of the triumvirate

makes engaging in potential unethical behavior more difficult. In this inquiry, patients who demonstrated strong self-advocacy could dismantle the institutional apparatuses and social structures sustaining the perianesthesia norm of routine suspension, but this requires overcoming significant barriers. For example, patients need sufficient knowledge of perianesthesia language to engage in discussions with providers about advance directive content. Family presence also buffered the disciplining effect of the zoe/bios dichotomy and the difficulty patients exhibited translating their EOL choices to the perianesthesia area.

In addition, the negative status effects predicted by the zoe/bios dichotomy were mitigated through clinician empowerment. The clinicians interviewed did not feel that their statuses would be seriously harmed should they speak out against unethical behavior. This may explain how automatic revocation was eradicated at this clinical site. However, free-floating responsibility and distancing—including new initiatives that would increase distance and cede more power to individual surgeons—may be sustaining a culture that makes it difficult for patients to exercise informed agency over the disposition of their limiting directives during anesthesia.

Opportunities exist for future research to better conceptualize the theoretical components of the emancipatory theory of compassion (Constantinides & George, 2022). Power remains an underexplored conceptual element of the theory. Georges (2013) conceptualizes biopower as negative. This conceptualization is rooted in sovereign notions of power—a top-down, hierarchal force. Georges suggests that compassion challenges biopower to create biocompassionate spaces, but how compassion *acts* to create such spaces, when biopower is positioned as a negative, hierarchal force, is unclear. While Georges did "connect the dots" (Georges, 2013, p. 4) between biopower and suffering, how compassion disperses suffering is not intuitive. Thus, the link

between compassion as a means for alleviating suffering and how compassion *works* to alleviate suffering is poorly defined in the theory and needs further exploration in specific clinical settings.

At some point, it seems logical that a resistive mechanism—presumably exercising power—must exist for problematizing biotoxic spaces. But resistance in a top-down power structure usually requires revolution or revelation—neither is common in clinical institutions. Foucault differently conceptualizes power as relational and actively productive through discourse. Georges (2008) alludes to Foucauldian conceptions of power, but the theorist's later work focuses on the sovereign notions of power espoused by Agamben that position biopower a negative force (Georges, 2013). Perhaps Foucault's constitutive power is the resistive mechanism undefined by Georges' theory. In this investigation, episodes of resistance constructed more compassionate spaces where unethical practices were less likely to occur. Further inquiry is required to learn if and how positive applications of power fit within the theory.

Limitations

This inquiry was conducted during the Covid-19 pandemic. Family presence during preoperative consultation was curtailed, and this may have limited family participation. In addition, the pandemic also limited the potential pool of participants because delayable surgeries, and those procedures requiring prolonged hospitalization were often postponed. Therefore, it is possible that the patient participants were not as near death—and presumably less likely to insist on continuing their DNR orders during surgery—than otherwise might be the case.

Conclusion

The purpose of this article was to demonstrate the usefulness of Georges' (2013) theory of emancipatory compassion for nursing as a mid-range theory when investigating power-laden problems in the clinical setting. In addition, data collected using PCS design and contextualizing analysis found evidence of the unspeakable in the problem of managing directives limiting care in the perianesthesia setting. Furthermore, the zoe/bios dichotomy, distance, and free-floating resistance—all critical attributes of biopower according to the emancipatory theory of compassion—were identified in the data. This qualitative evidence will aid the conceptual development and internal validity of the theory while helping establish the theory's usefulness for research practice.

Chapter Five

Closure

This qualitative inquiry exploring how preexisting advance directives are managed in the perianesthesia setting used a Foucauldian postructural case study design. For poststructural inquirists, conclusions are fraught with philosophical landmines that, when triggered, create tension between real world pragmatism and intellectual consistency. Poststructuralism is a rejection of phenomenological certitude. In a poststructural, constructivist worldview, the results of critical inquiry are contingent and fluid, and claims of ownership over knowledge are problematic. Representing oneself as possessing authority over how that knowledge should be applied is anathema to poststructural endeavors. This inquiry sought a position nearer post-qualitative inquiry than conventional qualitative research. Lather (2013) described this positioning as "Qual 4.0" inquiry. This emerging qualitative approach is typified by an unapologetic rejection of nomothetic ideas about what research, and thus what knowledge, is valuable. Instead, Qual 4.0 investigators create inquiries "that might produce different knowledge and produce knowledge differently (Lather, 2013, p.635). In this type of inquiry, even a word so common in summary writing like "findings" implies that the products of inquiry laid dormant in some subliminal in-between space awaiting discovery by an objective scientist. Instead, the "results" of this inquiry were constructed from the discourses of participants who functioned, for a time, within the community and culture under scrutiny. How to assert conclusions is consequently an onto-epistemological quandary for poststructuralists. But the justification for asking participants to share their time and selves is that their words might influence how advance directives are addressed in the perianesthesia setting.

Therefore, tentatively and with humility, this conclusory chapter addresses the results of inquiry in relation to the investigation's aims. Returning to these aims as a scaffold to conclude the inquiry is fitting. The aims, although supplicated to the research questions throughout most of the preceding chapters, encapsulate the ultimate goals of this work. The inquiry's aims were to: a) elucidate how perianesthesia discourses construct patient DNR and advanced directive options, b) trouble the current epistemology that privileges anesthesia clinicians and refocus knowledge development with patient emancipation as the goal, c) expose the institutional apparatuses and practices that create these discourses and maintain their power effects, and d) erode the power imbalance between perianesthesia clinicians and patients in the future by empowering them with knowledge of the usually hidden power relations and discourses shaping end-of-life choices in the perianesthesia setting. A brief discussion about how the inquiry's results address each of these aims follows. This section will include recommendations for research, policy, and practice as well as this inquirist's thoughts on future directions for research and practice based on the results. A final reflection about the inquiry focusing on the application of Foucault's postructuralism concludes the chapter.

Aims

Aim 1: Elucidate how Perianesthesia Discourses Construct Patient DNR and Advanced Directive Options

The inquiry's first aim was to uncover how discourses shape the options available to clinicians and patients about the disposition of limiting directives during anesthesia. The aim purposefully aligns with the first research question, what hidden discourses dominate how patients make decisions about the disposition of their DNR orders or other directives limiting care during the perianesthesia period? This aim and research question acknowledge the often-

hidden nature of discourses. Though often unnoticed, discourses construct accepted truth within a given culture. They define who has authority to speak and whose statements carry force. Simultaneously, discourses may become so ingrained as to seem normal or usual within a given context. Georges' (2013) concept of the unspeakable is a theoretical analogue for this phenomenon. Illuminating the hidden discourses that shape how limiting directives are addressed in the perianesthesia context, according to George, is emancipatory. Stated another way, identifying the hidden discourses that dominate decisions about advance directives empowers patients and clinicians functioning in the perianesthesia space.

The inquiry identified four discourses actively effecting the choices made by patients, families, and clinicians about perianesthesia directives limiting care. The four authoritative discourses are: a) We'll just suspend the DNR. Don't worry--let us take care of you [because no one dies in the OR]; b) There is no time to discuss a directive limiting care right before surgery; c) Do not talk about advance directives unless it is essential because of the serious nature of the surgery; and d) Clinicians are confused about who is responsible for discussing and understanding the patient's directive limiting care. In the "We'll just suspend the DNR…" discourse, whether it is perceived as safer, easier, or less stressful, clinicians expressed that their goal is for the patient to suspend their DNR for surgery. Perhaps unsurprisingly, the "There is no time…" discourse emphasizes production and maintaining the surgical schedule. Time with each patient is brief and spending extra time can impede productivity, so it is best to "just suspend." At the same time, the "Do not talk about advance directives…" discourse asserts that patients and clinicians should put off talking about decisions related to death and dying until circumstances force them to discuss it. All these discourses function in a perianesthesia space

where no one is understood to have accountability for discussing and understanding the patient's EOL choices and communicating those decisions: the "Clinicians are confused…" discourse.

In this case study, the "We'll just suspend the DNR…" discourse was powerfully effective in shaping participants' management of limiting directives. The discourses should not be viewed as isolated, however, but as intersecting with blurred lines of distinction separating each discourse. For example, the "We'll just suspend the DNR …" discourse was often rationalized as common sense by invoking the idea the "There is no time…" and "Clinicians are confused…" or "Do not talk about advance directives." Likewise, when the discourse "Do not talk about advance directives" was weighty during an interview, discourses of confusion and inadequate time were often used to justify the choice to "just suspend."

In addition to the intersecting and blurred distinction between authoritative discourses, connections between discourse, apparatus, and technologies of discipline were evident. Each identified discourse produced material effects. Those effects were enforced through seemingly mundane institutional or disciplinary apparatuses using veiled technologies of control at the point of care. For example, nurses created an environment that assumes the limiting directive will be suspended for anesthesia by placing orange suspension bands and reminder notes in the patient's exam room before patients made the choice to suspend their limiting directive. In another instance, a check-box format on the consent form was created by the clinical site that reduced the choices about limiting directives available to clinicians and patients. Both examples justify the four authoritative discourses, and both examples symbiotically perpetuate the authority of those discourses. Broadly, these results suggest that patients experience well-intentioned perianesthesia cultures that, nonetheless, discipline patients into conforming with routine suspension of advance directives before surgery.

Aim 2: Trouble the Current Epistemology that Privileges Anesthesia Clinicians and Refocus Knowledge Development with Patient Emancipation as the Goal

Georges (2013) recounts that the word "emancipatory" was mindfully chosen for the emancipatory theory of compassion. The word means "to free from restraint, control, or the power of another" (Merriam-Webster, n.d.). For Georges, the term emancipatory is intrinsically linked to power, but biopower is characterized as a hierarchal force within the theory. When the theory is applied to the problem of limiting directives in the perianesthesia setting, patients with advance directives are treated inequitably. The patient's choices are often subordinated to the desires of the clinician in a routine fashion. Power-knowledge is centered with clinicians, and in a fast-paced, strenuous preoperative environment that favors productivity over person-centeredness, patients are faced with discipline to "just suspend" their limiting directives.

According to the emancipatory theory of compassion (Georges, 2013), clinicians functioning in the perianesthesia space should focus on more equitable ways of sharing power to create more just and compassionate patient encounters. The mechanism for creating more compassionate spaces is only obliquely referenced by the theory, however. The second manuscript in Chapter Four, "Developing Critical Concepts for Georges' Emancipatory Theory of Compassion: Qualitative Evidence Supporting the Existence of Biotoxic Spaces in Perianesthesia Settings," provides a critique of this deficiency and suggests a possible solution using the Foucauldian ideas of resistance and truth. From a Foucauldian perspective, truth and reality are unsettled because discourses are always competing for authority. Troubling the idea that decisions about limiting directives are the purview of those with clinical knowledge and that the only important metric of perianesthesia success is survival erodes the dominant discourse that "We'll just suspend the DNR…" orders before anesthesia.

In the case, each authoritative discourse was linked to a resistive discourse. For example, three patient participants reported that they had enough time to discuss their DNR orders before surgery. Their assertions indicated that patients may retain a sense of agency over their EOL choices even when faced with constraining technologies and steep clinical knowledge-power gradients. While these statements of resistance represent the minority of patients, resistive discourses create friction within the discursive reality. Strong self-advocates echo such discourses when they insist that their advance directives be meaningfully discussed. Exploring evidence-based ways for patients to communicate their choices with clinicians based on the resistive discourses were identified in the first manuscript in Chapter Four, "Directives Limiting Care in the Perianesthesia Setting: A Foucauldian Case Study Report" as an area for future research.

In addition, discursive themes coalesced to counter the dominant discourses. For example, the theme that clinicians are better at addressing EOL choice today and that patients expect a discussion about their limiting directive indicate that tension exists around the discourse that "We'll just suspend the DNR…" Emerging discursive themes position addressing the limiting directive as worthy goal for clinicians and an expectation for patients. Based on this work, clinicians may better recognize statements of resistance. Being able to identify resistive discourse encourages self-reflective practice. When clinicians recognize resistance as a mechanism for equilibrating power inequity during clinical interactions, it presents opportunities to support and empower patients by assisting them to state their choices in language accessible to perianesthesia clinicians, advocating for their standing in clinical decision-making, or adjusting clinical language to better align with patient goals.

Aim 3: Expose the Institutional Apparatuses and Practices that Create These Discourses and Maintain Their Power Effects

Identifying technologies of control—extensions of institutional and discipline specific apparatuses that sustain power effects—would be impossible without direct clinical observation. For example, observational data revealed that an orange "Suspend DNR" bracelet was affixed to the patient's chart before their arrival, which would eventually be identified as a productive effect of the "We'll just suspend the DNR…" and "There is no time…" discourses. Without the continuous dialogue between inquirist, theory, and data during analysis, the subtle power effects of nurses pre-designing the room to compliment a desired outcome would be easily missed. Observation data revealed institutionally supported, discipline-specific technology of control that supported the authoritative discourses at work in the perianesthesia setting. Other examples of technologies of control used to discipline patients and clinicians into compliance included clinicians implying that surgeries will be delayed or cancelled if the limiting directive is not suspended, limiting choices about the disposition of the limiting directive to overly simplistic check-box formats, or cutting short conversation about EOL choices by deferring decision-making to another clinician. Compellingly, however, each technology may be recast as an opportunity for change with ramifications for organizations seeking more equitable management of limiting directives in the perianesthesia setting. New policies might specifically target and dismantle these institutional mechanisms of control in an affirmative effort to change ingrained practice behaviors. For instance, institutions could adopt informed consent documents better designed to capture patients' EOL choices instead of oversimplified checkboxes that save time but create obstacles for individualizing care.

The emancipatory theory of compassion provides an important bridge between the inquiry's results and implications for practice. Georges (2013) proposes that the triumvirate of zoe/bios dichotomy, distance, and free-floating responsibility are critical components of biopower. In addition to adding qualitative evidence supporting key concepts of the theory, the case results suggest that targeting any leg of the biopower triumvirate may dismantle, or at least mitigate, the negative effects of biopower. For example, policies designed to empower clinicians to take a pause and seek clarity about perianesthesia advance directives would target the zoe/bios dichotomy. Such precise targeting may predispose policies of mandatory reconsideration toward success. Similarly, clinicians may make it their practice to ensure family presence during advance directive conversations before surgery. Patients and family members can also be educated and encouraged to speak about and frequently review their advance directives at healthcare encounters. These practice-level actions may facilitate better discussions about advance directive choices between patients, families, and perianesthesia clinicians.

Aim 4: Erode the Power Imbalance Between Perianesthesia Clinicians and Patients in the Future by Empowering Them with Knowledge of the Usually Hidden Power Relations and Discourses Shaping EOL Choices in the Perianesthesia Setting.

The second and third research questions addressed how patients and clinicians talk about directives limiting care in the perianesthesia setting. The results suggest that patients talk about functionally derived endpoints for limiting or stopping resuscitation, such as ceasing resuscitative efforts if the patient will not be able to eat. Perianesthesia clinicians talk about interventional stopping points, such as administering vasoactive medication but not starting cardiopulmonary resuscitation. Both groups avoided talking about advance directives until they were required to discuss EOL choices because of the critical nature of the proposed surgery.

Participants in this inquiry also demonstrated often fundamental misapprehension about relatively common terms like “DNR” and “advance directive,” often confusing the terms with funeral plans. Future research could focus on specific language and definitions for conversations about advanced directives and how functional resuscitative endpoints correspond to interventional endpoints for resuscitation. This insight would promote more effective communication between perianesthesia clinicians and patients. In addition, policies might be better written with a cognizance of the mutual reluctance of clinicians and patients to avoid discussion about advance directives before surgery. Should those conversations be transferred to a prehospital setting, these results support the development of evidence-based resources to ensure that prospective surgical patients with preexisting advance directives have their EOL choices meaningfully evaluated.

Future Directions

Implications for Practice

This inquiry provided insight into a complex topic that spanned hours of observation and multiple conversations with numerous providers and patients over time. The result are snapshots of perianesthesia encounters that address limiting directives. To what extent any inquiry’s results ultimately impact practice and effect change is a product of multiple factors. Some factors, such as how clinicians and other consumers of research evaluate the credibility and embrace the transferability of the results, are largely beyond the inquirist’s control. Other factors, such as how the results are presented and disseminated, are more within the inquirist’s control. Results related to the first four research questions comprise the inquiry’s most important contributions aimed at eroding power imbalances and empowering patients. The decision to present the findings in line with the publication requirements of prominent clinically oriented healthcare journals targeting

perianesthesia clinicians was a difficult one. The product of this decision was the first manuscript that contained results prepared for the journal, *Anesthesia and Analgesia*. This manuscript adopts a nomothetic, structured presentation to make the results accessible to an audience of perianesthesia clinicians. While other refereed publications, such as *Social Science and Medicine,* might better align with the inquirist's poststructural approach, those journals like will likely never be read by the clinicians positioned to enact transformational change. Thus, the decision to pursue publication in journals oriented toward conventional research was a mindful one designed to make the results of inquiry accessible to practicing clinicians.

Nonetheless, the results of this inquiry have substantial implications for practice. According to Georges (2013) equitable power sharing is essential for compassionate nursing care. It is not unreasonable to suggest that equitable power sharing is also essential for creating ethical spaces. An awareness of the discourses shaping decision about how clinicians manage limiting directives in the perianesthesia setting enables more empathetic and reflective clinical practice. Recognizing that discourse manifests a powerful will to silence talk about death in the perianesthesia space that normalizes potentially unethical behavior is an essential step toward creating more equitable, compassionate, and ethical clinical environments.

In summary, practice changes indicated by the inquiry's results include adopting language that is corresponds to the way patients speak about resuscitative stopping point. For example, determining how long, if at all, is an acceptable amount of time for the patient not to be able to eat after surgery. Embracing resistive and emerging discourses may also improve practice. For instance, patients expect a conversation about their advance directive, and clinicians are beginning to value practitioners who demonstrate expertise in having those conversations. Instead of continuing to avoid EOL conversations, clinicians might work to develop skills unique

to the perianesthesia context that make those conversations more effective. One tactic supported by these results is ensuring family presence during discussions about the disposition of advance directives before surgery. Implementing practice choices that acknowledge the effects of discourse, encourage meaningful conversations about limiting directives, and take advantage of opportunities to teach patients how their limiting directives translate to the perianesthesia setting empowers clinicians and patients.

Implications for Future Research and Policy

The results of this inquiry have important implications for future research and policy development. Investigating how the functionally driven language that is favored by patients when discussing EOL choices corresponds to interventional endpoints used by clinicians could enhance more effective communication between clinicians and patients. For policy development, the results strongly suggest that power be affirmatively addressed when designing policies and optimizing bedside workflows. For instance, prehospital resources should be developed to more equally distribute power when making decisions about what life-sustaining interventions patients desire during anesthesia and effectively communicate those choices to other health team members. Utilizing these resources, for example open ended surgical consent forms, may provide more meaningful discussions between patients and clinicians. Additional research to develop valid and reliable resources that are administrable in a clinic setting is required.

Although this inquiry made strides toward addressing the gaps in knowledge identified in the literature, additional research is needed to understand how patients and families conceptualize iatrogenic death. A closely related concept underexplored in the extant perianesthesia literature is the idea of *removed death*. Results related to the emancipatory theory of compassion suggest distance is an essential part of negative biopower, but how distance

affects feelings about death in the perianesthesia setting is unexamined. For example, patients' families may respond differently to an iatrogenic death that occurs remotely in an operating room differently than a death where loved ones may be present.

In addition to the research and policy opportunities chronicled in the preceding paragraphs and manuscripts, two incidental findings were identified. First, none of the nurses interviewed recalled learning how to talk to patients about advance directives during prelicensure education. Nurses participating in this inquiry learned how to talk to patients about EOL choices through their experiences in practice. Conversely, physicians recounted learning how to engage in these conversations. Anesthesiologists reported scenario-based didactic learning paired with simulation during medical school and residency. A systematic review conducted by Smith et al. (2018) found that simulation-based learning activities are being used by nurse educators to develop palliative care communication and support classroom learning. The study's authors recommended incorporating more externally validated simulation scenarios, however. The "screenplay" provided in Chapter Four might be used by educators to develop scenario based educational content for medical students, student nurses, and clinicians. The screenplay provides evidence-based language and situations that might be used to design simulations and scenarios for clinicians from a variety of disciplines. This finding also intersects with topics of spirituality in nursing education. Hutchinson (2021) describes the challenges of integrating spirituality into a nursing school curriculum. Scenario and simulation-based learning about EOL choices in the perianesthesia setting could address content gaps in nursing curricula identified as essential by the Quality and Safety Education for Nurses (QSEN, 2021) standards.

Second, the inquiry identified female anesthesiologists as being particularly adept at having meaningful conversations about EOL choices and advance directives. Nurse participants

viewed female anesthesiologists as more willing to have conversations and better at making those conversations meaningful than their male counterparts. More than one nurse described witnessed behaviors like sitting down or making eye contact with patients as both efficacious and more common in female physicians. The nurse participants may be describing observable aspects of shared decision-making. Berger et al. (2017) found that physicians rarely ask patients their opinions about treatment and tend to approach patients with predetermined decisions about care management. The authors also found that conflict often occurred when patients voice opinions about care. Although beyond the scope of this inquiry, these findings broadly comport with the meta-analytic findings from Roper et al. (2002) which suggest that female physicians use more patient centered communication and relational skills than their male colleagues. This inquiry's results specifically apply to the perianesthesia context, however, and require further study to determine how these results align with the broader literature.

Finally, several gaps in knowledge about EOL choices in the perianesthesia setting were delineated in Chapter Two. Knowledge gaps included: a) the attitudes, motivations, feelings, and perceptions of clinicians and patients about perianesthesia end-of-life care, b) how patients and families experience the idea of iatrogenic death during surgery, c) patients' abilities to understand and make choices about perianesthesia resuscitation, d) what and how much patients and families comprehend about making decisions on the disposition of their DNR orders during anesthesia; e) how resuscitation is distinguished from routine perianesthesia care; and f) whether patients feel empowered to express their points-of-view when discussing perianesthesia DNR orders before surgery (Hardin & Forshier, 2019).

This inquiry contributed to scientific understanding about patients' attitudes, motivations, and feelings about EOL in the perianesthesia setting. The inquiry identified barriers to EOL

choices about resuscitation and the limited understanding patients have about how their advance directive choices translate into the perianesthesia context. In addition, although patients retain a sense of autonomy and expect conversations about their limiting directives before surgery, their abilities to authoritatively make decisions about the disposition of their directives requires aggressive self-advocacy. Results suggest that patient and clinician empowerment may create more equitable and compassionate perianesthesia spaces.

The contribution from this inquiry to better defining resuscitation in relation to normal anesthesia care was more limited than anticipated. Investigating how perianesthesia clinicians talk about resuscitation in the intraoperative space is essential to contributing to this missing facet of knowledge. Despite diligent planning, attempts to safely observe clinicians intraoperatively proved impossible. Future case studies should solely focus on the intraoperative phase of care. A more focused approach to observation would allow for adequate human subjects' protections and safe observation during surgery. Additionally, answers to how patients' and families' experiences of iatrogenic death during surgery, a missing area of knowledge in the literature, may be identifiable in the case study's raw data. A future study using the existing data set might be better able to address experiential aspects of knowledge underexplored in this inquiry.

Inquirist's Reflection

Chapter Three included a manuscript, "Poststructural Inquiry using Case Study Design: Toward Fourth Moment Qualitative Methods in Nursing," that introduced Stake-Boles case study design as a methodology for poststructural inquiries. This manuscript culminated in a recounting of lessons learned during the final phases of this inquiry in a section titled, "Reflections from a Novice Poststructural Inquirist." While the early phases of the inquiry were

dominated by philosophical and methodological decision-making, later phases were marked by the challenges of institutional review and data analysis. In keeping with the purpose of the methodology manuscript, the recounting focused on the practical use of poststructural case study design to help other novice inquirists in their application of the methodology. In this conclusory reflection, however, I turn to focus on the overarching philosophical worldview and framework for the inquiry: Foucauldian poststructuralism.

A Foucauldian Perspective

Foucauldian inquiry is the critical examination of the intersection between power-knowledge and discourse in a selected temporal-spatial context. The collected works of Foucault provide a framework for understanding the effects of power-knowledge in the clinical setting. Establishing the boundaries of that framework is challenging for the novice inquirist because Foucault provided no stepwise instructions. Instead, inquirists have only a toolbox comprised of the philosopher's collected works. For this inquiry, Foucault's (1994) *The Birth of the Clinic* provided the theoretical basis underlying the interpretation of the data—the clinical gaze. In addition, Foucauldian ideas about power, discourse, discipline, resistance, and surveillance were essential.

In the case, the process of rendering the person into a patient "ready for surgery" is an example of the power of the clinical gaze. A person who enters the preoperative environment is placed in a constant state of surveillance. They are medicalized. The person's clothing is removed, they are cleansed, shaved, and confined to their gurney. The person is separated from their family and required to repeatedly answer questions. The clinicians in this surveilled state diligently observe and record the patient's behaviors and responses, and abnormalities are duly reported and noted. The person is made into the subject position of a surgical patient ready for

surgery. The goal of this process is for an expert clinician to make the patient unconscious so that the surgeon can do their work, and then return the patient to consciousness. In this new world, the locus of power is the clinician who has authority over the surgical patient's body. By exerting control over the body, clinicians contain the specter of death that is always present in the perianesthesia space.

Discourse in this context separates the surgical patient— who should remain compliant and docile— from the clinicians who alone have the knowledge to safely care for surgical bodies. The perianesthesia discourse creates a routine process: "We'll just suspend the advance directive." Challenges to this routine are threats to clinical authority. Discipline in the forms of normalization and observation is used to sustain routine. Patients in the perianesthesia setting were disciplined—albeit professionally and gently—into compliance with routine. When patients complied with the routine, they were rewarded with clarity and clockwork productivity. But when patients resisted the established routine, they often encountered tension and distress from clinicians. Patients were subjected to the routine suspension of advance directives before anesthesia. Foucault (2000) notes of the nature of power relations:

> In itself, the exercise of power is not a violence that sometimes hides, or an implicitly renewed consent. It operates on the field of possibilities in which the behavior of active subjects is able to inscribe itself. It is a set of actions on possible actions; it incites, it induces, it seduces, it makes easier or more difficult; it releases or contrives, makes more probable or less; in the extreme, it constrains or forbids absolutely, but it is always a way of acting upon one or more acting subjects by virtue of their acting or being capable of action (p. 341).

In the perianesthesia setting, discourse constitutes who may speak and whose voice has authority. It makes certain decisions appropriate while other choices are disruptive. Discourse creates a set of options, and it dictates how actors in that field should react when certain options are selected. In the inquiry, discourse rewarded routine suspension of limiting directives and created obstacles to atypical choices.

Thus, data analysis within a Foucauldian framework is the analysis of discourse interrogated in relation to power. For Foucault, discourse is productive. That is, discourse has real-world effects. Discourses are also constantly changing because discourses compete for authority. Once a discourse establishes authority, however, forces conspire to sustain the dominant discourses. Dominant discourses produce what is accepted as normal context. Institutional apparatuses employ techniques to sustain the dominant discourses through discipline. This is the nexus of power-knowledge and discourse. In this inquiry, one of the most interesting realizations was the significance of discipline and the identification of discipline-resistance dyads that were often the hallmark of dominant discourses. For example, while the authoritative discourse among both clinicians and patients in this inquiry was not to talk about EOL choices unless they had to discuss them, a small number of clinicians stated that they "welcome" those discussions. During data analysis, identifying resistive discourses were often the key to recognizing dominant discourses and disciplinary themes in the data. Similarly, the absence of discipline often signaled a less powerful discourse or discursive theme.

Finally, a note on theory in the poststructural context. An ever-present concern when using theory for poststructural inquiry is that the existing categorization and onto-epistemological structure will be inadvertently transmitted in the new results. Nordstrom (2015) recounts,

> The practice of doing qualitative inquiry was intimately linked to theory and vice versa. Simply put, I could not and cannot do qualitative inquiry without theory. As a result, theory was neither a priori nor a posteriori in my study. Theory was and still is *a praesenti*. (p.177)

Like Nordstrom, I returned to Foucault and Georges during data collection and analysis. It is difficult to imagine tackling the voluminous amounts of data generated by case study design without some theoretical touchstones. The interpretive results disclosed in earlier chapters and the conclusions presented in this chapter come from a dialog between the data, theory, and my personal experiences and subjectivities. Concerningly, however, the esoteric and unfamiliar nature of some key theoretical terms (e.g., biocompassionate space, discipline) may make the theoretical dialog inaccessible to some people, thus, sequestering knowledge created to emancipate.

Beyond this inquiry, Foucauldian poststructuralism is an important critical lens for nursing research. Foucault centralizes power relations and provides a framework for investigating discursive data in relation to power. Georges (2013) cites the importance of power relations in the decision to emphasize the concept of emancipation in the emancipatory theory of compassion. Foucauldian analysis provides an analytic position suited for deconstructing subtle power relations that are often hidden or accepted as common sense among clinicians. The Foucauldian lens also helps investigators map usually unseen power networks and examine how those networks sustain the dominant discourse within a given setting or field of inquiry. Foucauldian poststructuralism also challenges the knowledge claims and traditional ways of knowing associated with nursing's onto-epistemological positioning. Considering the glacial pace of applying research to practice and the seeming intractability of systemic healthcare

inequity in the United States, Foucauldian analysis offers potential for creating more equitable and just health research and practice.

Concluding Thoughts

This inquiry's purpose was to better understand how adult patients, their families, and clinicians make decisions about resuscitative status during anesthesia by investigating discourses on Do Not Resuscitate orders and other directives limiting care in the adult perianesthesia setting. Foucauldian poststructuralism provided an overarching framework while the emancipatory theory of compassion imparted mid-range theoretical relevance to nursing practice. A poststructural case study design, termed "Stake-Boles" case study, used contextualizing analysis to identify the discourses that dominated how patients and clinicians talk about advanced directives in the perianesthesia setting, and how those discourses relate to power-knowledge.

Patients in the perianesthesia space often talk about functional endpoints to resuscitation while clinicians talk about interventional limits, and this discrepancy can lead to misapprehension of patient choices. Perianesthesia discourses on directives limiting care render patients ready for surgery, constrain the patient's authority to speak, and empower the clinician's statements. The inquiry results suggest that patients experience well-intentioned perianesthesia cultures that, nonetheless, discipline patients into conforming with routine suspension of advance directives before surgery. In addition, the inquiry demonstrated how the emancipatory theory of compassion may be applied to nursing research and provided qualitative evidence about the theory's fundamental conceptual elements.

The patients in this inquiry chose to suspend their advance directive for anesthesia as will most patients with pre-existing DNR orders (Burkle, et al., 2013). The results of this inquiry are,

therefore, in support of the minority of patients who would choose a different path or whose voices are marginalized because they lack authority in the perianesthesia setting. Whether designing educational curricula, developing institutional policies, or making practice decisions, affirmatively considering the effects of power-knowledge and discourse in clinical settings is essential. Power relations pervade clinical relationships. Addressing how power relations affect choices and decision-making creates more compassionate and equitable clinical environments. Such biocompassionate spaces allow for more just power sharing that supports patients and the clinicians who walk alongside them.

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Appendix A
Institutional Review Board Approval

Allina
Health Human Research Protection
Program

Institutional Review Board

P.O. Box 43 Mail Route 10811

Minneapolis, MN 55440-0043

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NOTICE OF APPROVAL
ALLINA HEALTH FWA NUMBER 00002425

DATE:	October 25, 2021
TO:	Ruth Bryant, PhD
FROM:	Allina Health IRB 1
PROJECT TITLE:	Perianesthesia Discourses on Directives Limiting Care: A Foucauldian Case Study
REFERENCE #:	1723212-5
SUBMISSION TYPE:	Response/Follow-
Up SUBMISSION DATE:	October 25, 2021
ACTION:	APPROVED
APPROVAL DATE:	October 25,
2021	
EXPIRATION DATE:	April 24, 2022
REVIEW TYPE:	Administrative Review

The Allina Health Institutional Review Board (IRB) for the protection of human subjects has reviewed and APPROVED the protocol referenced above. This approval is based on appropriate risk/benefit ratio and a project design wherein the risks have been minimized. All research must be conducted in accordance with this approved submission.

Your request for a partial waiver of HIPAA authorization so that you may access patient files for screening or recruitment purposes has been approved. Please note, consent and authorization must be obtained prior to any other research activities involving individual subjects.

Please remember that informed consent is a process beginning with a description of the project and verification of participant understanding followed by a signed consent form. Informed consent must continue throughout the project via a dialogue between the researcher and research participant. Federal regulations require that each participant receives a copy of the consent document. Unless the IRB has approved an alternative process (such as oral consent), please use a copy of the consent form with the IRB approval stamp when you are obtaining signatures of consent. A copy of the IRB-approved consent form, bearing the Institutional Review Board [IRB] approval stamp, is available to you in the "Reviews" section of IRBNet.

Proposed changes to the research must be submitted to the IRB for review and approval prior to implementation, unless such a change is necessary to avoid immediate harm to subjects (45 CFR 46 and 21 CFR 50, 56). This requirement includes, but is not limited to, changes in any of the following: consent form(s), enrollment goal, principal investigator, research team, advertisements, study procedures, the investigator's brochure, or the study protocol.

All Unanticipated Problems Involving Risks to Subjects or Others (UPIRTSOs), Unanticipated Adverse Device Effects (UADEs), Suspensions or Terminations of the research, Deviations from the approved research plan, potential Non-Compliance, and Complaints must be reported to the IRB in accordance with Allina HRPP/IRB policies. If this study includes ongoing oversight by a Data Safety Monitoring Board (DSMB) or other such committee, reports generated by the DSMB or oversight committee must be submitted to the IRB.

Continuing review materials must be received at least six (6) weeks before the expiration date of April 24, 2022 to ensure adequate time for review. If the project has been completed prior to its expiration date, please submit a Final Report to close your project.

Please note that all research records must be retained for a minimum of three (3) years after the completion of the project or longer if required by regulation, grant terms, or contract.

If you have any questions, please contact Allina Health Institutional Review Board (IRB) Office at (612) 262-4920 or irb@allina.com. Please include your project title and IRBNet ID# in all correspondence.

This letter has been electronically signed in accordance with all applicable regulations, and a copy is retained within Allina Health IRB 1's records.

Appendix B

Patient Participant Informed Consent Document

Study title	Perianesthesia Discourses on Directives Limiting Care: A Foucauldian Case Study
Researchers	• Joshua Hardin, MSN, RN – PhD Student, University of Wisconsin—Milwaukee (UWM) • Jeanne Erickson, PhD, RN – Associate Professor and Project Supervisor, University of Wisconsin—Milwaukee • Ruth Bryant, PhD, RN – Principal Research Scientist/Nursing and United Hospital Project Sponsor, Allina Health

We're inviting you to participate in a research study. Participation is completely voluntary. If you agree to participate now, you can always change your mind later. There are no negative consequences, whatever you decide.

Key Information About This Study

You are invited to participate in a research study.

The purpose of the research is to understand how patients, families, and health professionals make decisions about advanced directives and Do Not Resuscitate (DNR) orders before, during, and immediately after surgery. Your participation in this research will involve being observed before, during, and after your surgery followed by an in-depth interview. The interview will last about an hour, and you may be contacted with follow-up interview questions. The follow up questions won't take more than about 30 minutes.

All research studies involve some risks. A risk to this study that you should be aware of is the potential for emotional distress caused by talking about your advanced directive.

You may benefit from participating in this study by helping health care professionals learn to better care for patients, like you, with advanced directives.

Your participation in this study is voluntary. You do not have to be in this study if you do not want to, or you can stop being in this study anytime. You will not lose any services, benefits, or rights you would normally have if you choose not to participate or stop being in the study. There may be other choices if you do not want to participate. Some of those other choices may include choosing to use a shorter interview format or contribute only through observations.

The rest of this form contains more information about being in this study. Please read this whole form carefully. You can ask any questions if you need help deciding whether to join the study. The person conducting this study is Joshua Hardin, MSN, RN. If you want to leave the study, let Josh know by contacting him at:

****

Ruth Bryant, PhD, RN is supervising this study. If you have questions or concerns, you should let Ruth know by contacting her at:

***

If you have any questions about your rights as a volunteer in this research, contact the Allina Health Institutional Review Board Office at 612-262-4920.

If you are interested in learning more about this study, please continue to read below.

What is the purpose of this study?

We want to understand how patients, families, and health professionals make decisions about advanced directives and Do Not Resuscitate (DNR) orders before, during, and immediately after surgery.

What will I do?

- We will observe and take notes on all your discussions about advanced directives and DNR orders on the day of surgery. You don't need to do anything special while we observe.
- We may observe your interactions before, during, and immediately after surgery. Nothing is required of you during these observations.
- We will schedule an in-depth interview to be conducted within four weeks of your surgery. During the interview, we will talk about your advanced directive and how it was addressed on your surgical day. The interview is designed to be a relaxed conversation. During the interview, we may ask you questions like: "Walk me through your last interaction with the anesthesiologist, nurse, and preoperative team regarding your advanced directive."
- The interview should last 45 to 60 minutes, but it may be shorter or longer.
- We want to have the interviews in-person, but we can also do them over the phone or by video conferencing.
- Some questions may be personal or uncomfortable, but you can always skip that question by saying, "I prefer not to answer." It won't affect the quality of the research, and it won't upset the interviewer.
- We may contact you with follow-up interview questions to clear-up what you meant or talk about things we don't understand from the interview. This won't take more than 30 minutes.
- We will seek your feedback on the accuracy of the interview transcripts and our interpretations of all the information collected from our observations and interviews. This won't take more than 30 minutes.

Risks

Possible risks	**How we're minimizing these risks**
Some questions may be personal or upsetting	You can skip any questions you don't want to answer.
Breach of confidentiality (your data being seen by someone who shouldn't have access to it)	• All identifying information is removed and replaced with a study ID. • Only deidentified data will be used by Josh at his home. • We'll destroy all linking identifiers at the study's conclusion. • We'll store all electronic data on a password-protected, encrypted computer or flash drive. • We'll keep your identifying information at an Allina facility separate from your research data, but we'll be able to link it to you by using a study ID. We will destroy this link after we finish the study.
Discussing sensitive topics like death and dying can cause emotional distress.	• We have resources available if your experience emotional distress during or after our interview.

There may be risks we don't know about yet. Throughout the study, we'll tell you if we learn anything that might affect your decision to participate.

Other Study Information

Possible benefits	You will be participating in a study that could help health professionals better care for other patients with advanced directives having surgery.
Estimated number of participants	We aim to enroll 20 participants but will enroll no more than 50 participants. Participants include other patients, doctors, nurses, surgeons, hospital leadership, and other people you knowingly or unknowingly might encounter when you have surgery.
How long will it take?	The total time varies depending on how long we need to observe your interactions on the day of surgery. For example, a long surgery will require more observation than a short surgery. Total interview and follow-up time requirements should not exceed 1 or 2 hours.
Costs	You'll pay for your own transportation and parking if you want to have the interview somewhere besides where you live, work, at a follow-up clinic visit, during your hospital stay, or by computer video streaming or telephone. If you live more than 30 miles from Saint Paul, Minnesota, AND don't want to have the interview over a computer video stream, by telephone, during hour hospital stay, or at your follow-up clinic visit, you'll pay for your own transportation and parking to the interview location.
Compensation	You'll be given $50.00 in the form of a gift card after completing your interview in the form of a gift card. You will be required to sign a receipt confirming you received the gift card. The receipt will be stored with your consent and destroyed after 5 years when the consent is destroyed.
Future research	Deidentified (all identifying information removed) data may be shared with other researchers, students, or used by Joshua Hardin for other research projects. You won't be told specific details about these future research studies.
Recordings	We will record you. The recordings will be transcribed by Joshua Hardin and used as research data. Recording will be deidentified at the conclusion of this study. This means that all identifiers linking the recording to you will

	be destroyed. They actual recordings will be destroyed after 5 years. The recording is necessary to this research. If you do not want to be recorded, you should not be in this study.

What if I experience emotional or psychological distress because I was in this study?

If you're harmed from being in this study, let us know. If it's an emergency, get help from 911 or your doctor right away and tell us afterward. We can help you find resources if you need psychological help. You or your insurance will have to pay for all costs of any treatment you need.

Confidentiality and Data Security

We'll collect the following identifying information for the research: Your name, address, telephone number(s), and email address. This information is necessary so that we can contact you to schedule your interview(s) and get your feedback near the end of the study. Your protected health information will not leave Allina's facilities.

Where will data be stored?	• All deidentified data will be stored on a password protected computer or on hard copy worksheets inside Josh's home office. • Physical documents with identifiable information, like contact information and consent documents, will be stored in a locked-box or locked area at an Allina Health Facility or on Allina's password protected e-mail server. • Electronic documents (including recordings) will be stored on a password encrypted computer designated by the clinical facility. • Electronic data (including recordings) may also be stored on a password encrypted flash drive.
How long will it be kept?	Identifiable information will be kept until the study is complete. Then the identifiable data will be destroyed. Informed consent documents and your contact information will be kept for 5 years in a secure, password protected electronic file on an Allina computer server. Then, those documents will be destroyed. Deidentified information will be kept for 5 years before it is destroyed.

Who can see my data?	Why?	Type of data
The researchers	To conduct the study and analyze the data	Identifiable information means information that can be linked to you. • We will keep identifiable information until the study is complete. • When the study is complete, the link between your private information and the study data will be destroyed. • This consents and your contact information will be electronically archived by Allina Health for five years. Then, those documents will be destroyed. • Only Joshua Hardin, Ruth Bryant, and persons within Allina Health with responsibilities for the oversight of research will have access to identifiable data. Deidentified information has no names, birthdate, address, etc. attached to the data. It cannot be linked to you.

		• We will keep deidentified data for 5 years.
The IRB (Institutional Review Board) at Allina The Office for Human Research Protections (OHRP) or other federal agencies Persons within Allina Health with responsibilities for the oversight of research	To ensure we're following laws and ethical guidelines	The IRB board will generally only have access to deidentified data. Only persons within Allina Health with responsibilities for the oversight of research will have access to identifiable data.
Anyone (public)	If we share our findings in publications or presentations	Only deidentified data will be used in publications or presentations. • If we quote you, we'll use a pseudonym (fake name)
Future students and researchers	If we share our data with students or other researchers.	Only deidentified data will be used in future research. Only deidentified data will be used in the classroom. Deidentified information has no names, birthdate, address, etc. attached to the data. It cannot be linked to you.

Exclusions from Participation

Anyone you allow to be present for conversations about your advance directive may be asked to join the study. But you may exclude anyone you wish from joining the study by indicating whom you wish to exclude now. **Once other people are asked to join the study, you will no longer be able to exclude their participation.** Please list those people you wish to exclude from the study on the line below.

Mandated Reporting

We are mandated reporters. This means that if we learn or suspect that a vulnerable adult is being abused or neglected, we're required to report this to the authorities.

Contact information:

For questions about the research	Joshua Hardin, MSN, RN	
For questions about your rights as a research participant	IRB (Institutional Review Board; provides ethics oversight)	612-262-4920 irb@allina.com
For complaints or problems	Jeanne Erickson, PhD, RN	
	Ruth Bryant, PhD, RN	
	Allina Health Institutional Review Board Office	612-262-4920 irb@allina.com

Signatures

If you have had all your questions answered and would like to participate in this study, sign on the lines below. Remember, your participation is completely voluntary, and you're free to withdraw from the study at any time.

Name of Participant (print)

Signature of Participant Date

If participant is a minor or requires a Legally Authorized Representative:

Name of Parent, Guardian or Legally Authorized Representative (print)

Signature of Parent, Guardian or Legally Authorized Representative Date

Name of Researcher obtaining consent (print)

_____ _____

Signature of Researcher obtaining consent Date

HIPAA AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Research Study: Perianesthesia Discourses on Directives Limiting Care: A Foucauldian Case Study

Subject Name: _____

Use and Disclosure of Your Health Information
By signing this form, you are authorizing the use and disclosure (release) of your health information in connection with your participation in the above named research study. Your information will be used only in accordance with the provisions of this authorization as outlined in this form or as required by law.

What Information Will Be Used or Disclosed?
The health information that we may use or disclose (release) for this research includes: 1) Your contact and demographic information. This information will be retained until the end of this study, and then it will be destroyed. 2) Medical record clinical notes, orders, or scanned advanced directive documents may be used. 3) Information that may be obtained from observation and recorded interviews will be used for this study.

Who Will Receive, Use, and/or Disclose the Information?
The following person(s), class(es) of persons, and/or organization(s) may use, receive, and/or disclose the information connected with this study listed below. These persons are authorized to use and disclose the information to the other parties on this list, to you or your personal representative, or as permitted by law.

- The following health care facilities or research site(s) and research staff involved in this study: 1) United Hospital; 2) Joshua Hardin, MSN, RN; and 3) the Principal Research Scientist/Nursing—Allina Health
- The Office for Human Research Protections in the U.S. Department of Health and Human Services
- The members and staff of the Institutional Review Board (IRB) and Nursing Research Council (NRC) that approved this study
- Principal Investigator: Ruth Bryant, PhD, RN

- All persons and entities engaged by Allina Health System or the Research Team to assist in managing, analyzing, storing, or transmitting the information.
- Personnel within Allina Health System who are responsible for the administration or oversight of research.

We cannot prevent re-disclosure of your health information by anyone who receives the information under this authorization, and the information may not be covered by state and federal privacy protections after it is released.

How Will the Information be Used and Disclosed?
Your health information will be:

- Used and disclosed for purposes of the study, including contacting you for interviews and follow up questions. No identifiable health information will be disclosed during the reporting of this study.
- ***The researchers conducting this study would like to use your health information for future research purposes. Authorizing use of your health information for these additional purposes is voluntary and does not impact your ability to participate in this study. Please initial here to authorize the use of your health information for these additional purposes:*** _____ ;
- Combined with information about other people who participate in the study;
- Placed in your medical record at Allina Health Systems; and
- Disclosed to persons listed in this authorization for purposes of the study or as otherwise permitted or required by law.

In order to participate in this study, you must agree to share your information with the groups above by signing this Authorization. You do not have to sign this Authorization, but if you do not, you will not be able to participate in this research study. Refusing to sign this authorization will not affect your current or future care at Allina Health System and will not cause any penalty or loss of benefits to which you are otherwise entitled.

When Access to Your Information May Be Limited
Your right to access your medical record is not affected by your participation in this project.

The Notice of Privacy Practices, available in the **hospital** where this research is being conducted, provides general information on your rights to review, copy, and correct your health information.

Revocation (cancellation)
If you decide to end your participation in the study or if you are removed from the study by the principal investigator, you may cancel your authorization to use or disclose your health information by notifying **Joshua Hardin** in writing at **jbhardin@uwm.edu.** Your cancellation will

be effective after the date it is received. Any health information about you that has already been collected may still be used or disclosed to maintain the integrity or reliability of the research.

Expiration
This authorization for the use and/or disclosure of your health information will not expire unless or until you revoke it.

_____	_____
Printed name of participant or participant's personal representative	If applicable, description of the personal representative's authority to sign for participant
_____	_____
Signature	Date
_____	_____
Printed name of person obtaining authorization	Role in study
_____	_____
Signature of person obtaining authorization	Date

Appendix C

Family/Representative Participant Informed Consent Document

Study title	Perianesthesia Discourses on Directives Limiting Care: A Foucauldian Case Study
Researchers	• Joshua Hardin, MSN, RN – PhD Student, University of Wisconsin—Milwaukee (UWM) • Jeanne Erickson, PhD, RN – Associate Professor and Project Supervisor, University of Wisconsin—Milwaukee • Ruth Bryant, PhD, RN – Principal Research Scientist/Nursing and United Hospital Project Sponsor, Allina Health

We're inviting you to participate in a research study. Participation is completely voluntary. If you agree to participate now, you can always change your mind later. There are no negative consequences, whatever you decide.

Key Information About This Study

You are invited to participate in a research study.

The purpose of the research is to understand how patients, families, and health professionals make decisions about advanced directives and Do Not Resuscitate (DNR) orders before, during, and immediately after surgery. Your participation in this research may involve being observed before and after surgery followed by an in-depth interview. The interview will last about an hour, and you may be contacted with follow-up interview questions. The follow up questions won't take more than about 30 minutes.

All research studies involve some risks. A risk to this study that you should be aware of is the potential for emotional distress caused by talking about advanced directive decisions.

You may benefit from participating in this study by helping health care professionals learn to better care for family members of patients with advanced directives.

Your participation in this study is voluntary. You do not have to be in this study if you do not want to, or you can stop being in this study anytime. You will not lose any services, benefits, or rights you would normally have if you choose not to participate or stop being in the study. There may be other choices if you do not want to participate. Some of those other choices may include choosing to use a shorter interview format or contribute only through observations.

The rest of this form contains more information about being in this study. Please read this whole form carefully. You can ask any questions if you need help deciding whether to join the study. The person conducting this study is Joshua Hardin, MSN, RN. If you want to leave the study, let Josh know by contacting him at:

****

Ruth Bryant, PhD, RN is supervising this study. If you have questions or concerns, you should let Ruth know by contacting her at:

****

If you have any questions about your rights as a volunteer in this research, contact the Allina Health Institutional Review Board Office at 612-262-4920.

If you are interested in learning more about this study, please continue to read below.

What is the purpose of this study?

We want to understand how patients, families, and health professionals make decisions about advanced directives and Do Not Resuscitate (DNR) orders before, during, and immediately after surgery.

What will I do?

- You may be observed before and after surgery. You don't need to do anything special during these times.
- We will schedule an in-depth interview. During the interview, we will talk about your participation in making decisions about advanced directives on the day of surgery. The interview is designed to be a relaxed conversation. During the interview, we may ask you questions like: "Walk me through what you did when the advanced directive was discussed before surgery."
- The interview should last 45 to 60 minutes, but it may be shorter or longer.
- We want to have the interviews in-person, but we can also do them over the phone or by video conferencing.
- Some questions may be personal or uncomfortable, but you can always skip that question by saying, "I prefer not to answer." It won't affect the quality of the research, and it won't upset the interviewer.
- We may contact you with follow-up interview questions to clear-up what you meant or talk about things we don't understand from the interview. This won't take more than 30 minutes.
- We will seek your feedback on the accuracy of the interview transcripts and our interpretations of all the information collected from our observations and interviews. This won't take more than 30 minutes.

Risks

Possible risks	**How we're minimizing these risks**
Some questions may be personal or upsetting	You can skip any questions you don't want to answer.
Breach of confidentiality (your data being seen by someone who shouldn't have access to it)	• All identifying information is removed and replaced with a study ID. • Only deidentified data will be used by Josh at his home. • We'll destroy all identifiers at the study's conclusion. • We'll store all electronic data on a password-protected, encrypted computer or flash drive. • We'll keep your identifying information at an Allina facility separate from your research data, but we'll be able to link it to you by using a study ID. We will destroy this link after we finish the study.
Discussing sensitive topics like death and dying can cause emotional distress.	• We have resources available if your experience emotional distress during or after our interview.

There may be risks we don't know about yet. Throughout the study, we'll tell you if we learn anything that might affect your decision to participate.

Other Study Information

Possible benefits	You will be participating in a study that could help better care for patients with advanced directives having surgery.
Estimated number of participants	We aim to enroll 20 participants but will enroll no more than 50 participants. Participants include other patients, doctors, nurses, surgeons, hospital leadership.
How long will it take?	The total time varies. Total interview and follow-up time requirements should not exceed 1 or 2 hours, but interviews may require much less time.
Costs	You'll pay for your own transportation and parking if you want to have the interview somewhere besides where you live, work, or by computer video streaming or telephone. If you live more than 30 miles from Saint Paul, Minnesota, AND don't want to have the interview over a computer video stream, by telephone, or at work, you'll pay for your own transportation and parking to the interview location.
Compensation	You'll be given $50.00 after completing your interview in the form of a gift card. You will be required to sign a receipt confirming you received the gift card. The receipt will be stored with your consent and destroyed after 5 years when the consent is destroyed.
Future research	Deidentified (all identifying information removed) data may be shared with other researchers, students, or used by Joshua Hardin for other research projects. You won't be told specific details about these future research studies.
Recordings	We will record you. The recordings will be transcribed by Joshua Hardin and used as research data. Recording will be deidentified at the conclusion of this study. This means that all identifiers linking the recording to you will be destroyed. The actual recordings will be destroyed after 5 years. The recording is necessary to this research. If you do not want to be recorded, you should not be in this study.

What if I experience emotional or psychological distress because I was in this study?

If you're harmed from being in this study, let us know. If it's an emergency, get help from 911 or your doctor right away and tell us afterward. We can help you find resources if you need psychological help. You or your insurance will have to pay for all costs of any treatment you need.

Confidentiality and Data Security

We'll collect the following identifying information for the research: Your name, address, telephone number(s), and email address. This information is necessary so that we can contact you to schedule your interview(s) and get your feedback near the end of the study. Your protected health information will not leave Allina's facilities.

Where will data be stored?	• All deidentified data will be stored on a password protected computer or on hard copy worksheets inside Josh's home office. • Physical documents with identifiable information, like contact information and consent documents, will be stored in a locked-box or locked area at an Allina Health Facility or on Allina's password protected e-mail server. • Electronic documents (including recordings) will be stored on a password encrypted designated by the clinical facility. • Electronic data (including recordings) may also be stored on a password encrypted flash drive.
How long will it be kept?	Identifiable information will be kept until the study is complete. Then the identifiable data will be destroyed. Informed consent documents will be kept for 5 years in a secure, locked area at an Allina facility. Then, the consents will be destroyed. Deidentified information will be kept for 5 years before it is destroyed.

Who can see my data?	**Why?**	**Type of data**
The researchers	To conduct the study and analyze the data	Identifiable information means information that can be linked to you. • We will keep identifiable information until the study is complete.

		• Only Joshua Hardin, Ruth Bryant, and persons within Allina Health with responsibilities for the oversight of research will have access to identifiable data. Deidentified information has no names, birthdate, address, etc. attached to the data. It cannot be linked to you. • We will keep deidentified data for 5 years.
The IRB (Institutional Review Board) at Allina The Office for Human Research Protections (OHRP) or other federal agencies Persons within Allina Health with responsibilities for the oversight of research	To ensure we're following laws and ethical guidelines	The IRB board will generally only have access to deidentified data. Only persons within Allina Health with responsibilities for the oversight of research will have access to identifiable data.
Anyone (public)	If we share our findings in publications or presentations	Only deidentified data will be used in publications or presentations. • If we quote you, we'll use a pseudonym (fake name)
Future students and researchers	If we share our data with students or other researchers	Only deidentified data will be used in future research.

		Only deidentified data will be used in the classroom. Deidentified information has no names, birthdate, address, etc. attached to the data. It cannot be linked to you.

Contact information:

For questions about the research	Joshua Hardin, MSN, RN	
For questions about your rights as a research participant	IRB (Institutional Review Board; provides ethics oversight)	612-262-4920 irb@allina.com
For complaints or problems	Jeanne Erickson, PhD, RN	
	Ruth Bryant, PhD, RN	
	Allina Health Institutional Review Board Office	612-262-4920 irb@allina.com

Signatures

If you have had all your questions answered and would like to participate in this study, sign on the lines below. Remember, your participation is completely voluntary, and you're free to withdraw from the study at any time.

_____

Name of Participant (print)

_____ _____

Signature of Participant Date

If participant is a minor or requires a Legally Authorized Representative:

_____

Name of Parent, Guardian or Legally Authorized Representative (print)

_____ _____

Signature of Parent, Guardian or Legally Authorized Representative Date

Name of Researcher obtaining consent (print)

Signature of Researcher obtaining consent Date

Appendix D

Clinician Participant Informed Consent Document

Study title	Perianesthesia Discourses on Directives Limiting Care: A Foucauldian Case Study
Researchers	• Joshua Hardin, MSN, RN – PhD Student, University of Wisconsin—Milwaukee (UWM) • Jeanne Erickson, PhD, RN – Associate Professor and Project Supervisor, University of Wisconsin—Milwaukee • Ruth Bryant, PhD, RN – Principal Research Scientist/Nursing and United Hospital Project Sponsor, Allina Health
We're inviting you to participate in a research study. Participation is completely voluntary. If you agree to participate now, you can always change your mind later. There are no negative consequences, whatever you decide.	

Key Information About This Study

You are invited to participate in a research study.

The purpose of the research is to understand how patients, families, and health professionals make decisions about advanced directives and Do Not Resuscitate (DNR) orders before, during, and immediately after surgery. Your participation in this research may involve being observed interacting with patients and/or families when discussing their advanced directives. It may also include observing how you discuss advanced directives with colleagues and how those discussions are translated into practice before, during, and after surgery. You will also need to participate in an interview. The interview will last about an hour, and you may be contacted with follow-up interview questions. The follow up questions won't take more than about 30 minutes.

All research studies involve some risks. Some risks to this study that you should be aware of are emotional distress or anxiety caused by talking about your clinical experiences with making advanced directive decisions.

You may benefit from participating in this study by helping other health care professionals learn to better care for patients with advanced directives.

Your participation in this study is voluntary. You do not have to be in this study if you do not want to, or you can stop being in this study anytime. You will not lose any services, benefits, or rights you would normally have if you choose not to participate or stop being in the study. There may be other choices if you do not want to participate. Some of those other choices may include choosing to use a shorter interview format or contributing through observation only.

The rest of this form contains more information about being in this study. Please read this whole form carefully. You can ask any questions if you need help deciding whether to join the study. The person conducting this study is Joshua Hardin, MSN, RN. If you want to leave the study, let Josh know by contacting him at:

****

Ruth Bryant, PhD, RN is supervising this study. If you have questions or concerns, you should let Ruth know by contacting her at: ****

If you have any questions about your rights as a volunteer in this research, contact the Allina Health Institutional Review Board Office at 612-262-4920.

If you are interested in learning more about this study, please continue to read below.

What is the purpose of this study?

We want to understand how patients, families, and health professionals make decisions about advanced directives and Do Not Resuscitate (DNR) orders before, during, and immediately after surgery.

What will I do?

- You may be observed before, during, and after surgery. You do not need to do anything special during this period.
- We will schedule an in-depth interview. During the interview, we will talk about how you address advanced directives and DNR orders. The interview is designed to be a relaxed conversation. During the interview, we may ask you questions like: "I would like you to reflect on your most recent anesthesia encounter with someone who had a directive limiting care. Walk me through the interaction."
- The interview should last 45 to 60 minutes, but it may be shorter or longer. If you don't have a lot of time, we can use a short form interview.
- We want to have the interviews in-person, but we can also do them over the phone or by video conferencing.
- Some questions may be personal or uncomfortable, but you can always skip that question by saying, "I prefer not to answer." It won't affect the quality of the research, and it won't upset the interviewer.
- We may contact you with follow-up interview questions to clear-up what you meant or talk about things we don't understand from the interview. This won't take more than 30 minutes.
- We will seek your feedback on the accuracy of the interview transcripts and our interpretations of all the information collected from our observations and interviews. This won't take more than 30 minutes.

Risks

Possible risks	How we're minimizing these risks
Some questions may be personal or upsetting	You can skip any questions you don't want to answer.
Breach of confidentiality (your data being seen by someone who shouldn't have access to it)	• All identifying information is removed and replaced with a study ID. • Only deidentified data will be used by Josh at his home. • We'll destroy all linking identifiers at the study's conclusion. • We'll store all electronic data on a password-protected, encrypted computer or flash drive. • We'll keep your identifying information at an Allina facility separate from your research data, but we'll be able to link it to you by using a study ID. We will destroy this link after we finish the study.

Discussing sensitive topics like death and dying can cause emotional distress.	• We have resources available if your experience emotional distress during or after our interview.

There may be risks we don't know about yet. Throughout the study, we'll tell you if we learn anything that might affect your decision to participate.

Other Study Information

Possible benefits	You will be participating in a study that could help other health professionals better care for patients with advanced directives having surgery.
Estimated number of participants	We aim to enroll 20 participants but will enroll no more than 50 participants. Participants include other patients, doctors, nurses, surgeons, hospital leadership.
How long will it take?	The total time varies. Total interview and follow-up time requirements should not exceed 1 or 2 hours, but interviews may require much less time.
Costs	You'll pay for your own transportation and parking if you want to have the interview somewhere besides where you live, work, or by computer video streaming or telephone. If you live more than 30 miles from Saint Paul, Minnesota, AND don't want to have the interview over a computer video stream, by telephone, or at work, you'll pay for your own transportation and parking to the interview location.
Compensation	You'll be given $50.00 in the form of a gift card after completing your interview in the form of a gift card. You will be required to sign a receipt confirming you received the gift card. The receipt will be stored with your consent and destroyed after 5 years when the consent is destroyed.
Future research	Deidentified (all identifying information removed) data may be shared with other researchers, students, or used by Joshua Hardin for other research projects. You won't be told specific details about these future research studies.
Recordings	We will record you. The recordings will be transcribed by Joshua Hardin and used as research data. Recording will be deidentified at the conclusion of this study. This means that all identifiers linking the recording to you will be destroyed. The actual recordings will be destroyed after 5 years.

	The recording is necessary to this research. If you do not want to be recorded, you should not be in this study.

What if I experience emotional or psychological distress because I was in this study?

If you're harmed from being in this study, let us know. If it's an emergency, get help from 911 or your doctor right away and tell us afterward. We can help you find resources if you need psychological help. You or your insurance will have to pay for all costs of any treatment you need.

Confidentiality and Data Security

We'll collect the following identifying information for the research: Your name, address, telephone number(s), and email address. This information is necessary so that we can contact you to schedule your interview(s) and get your feedback near the end of the study. Your protected health information will not leave Allina's facilities.

Where will data be stored?	• All deidentified data will be stored on a password protected computer or on hard copy worksheets inside Josh's home office. • Physical documents with identifiable information, like contact information and consent documents, will be stored in a locked-box or locked area at an Allina Health Facility or on Allina's password protected e-mail server. • Electronic documents (including recordings) will be stored on a password encrypted computer designated by the clinical facility. • Electronic data (including recordings) may also be stored on a password encrypted flash drive.
How long will it be kept?	Identifiable information will be kept until the study is complete. Then the identifiable data will be destroyed. Informed consent documents and your contact information will be kept for 5 years in a secure, password protected electronic file on an Allina computer server. Then, those documents will be destroyed. Deidentified information will be kept for 5 years before it is destroyed.

Who can see my data?	**Why?**	**Type of data**

The researchers	To conduct the study and analyze the data	Identifiable information means information that can be linked to you. • We will keep identifiable information until the study is complete. • When the study is complete, the link between your private information and the study data will be destroyed. • This consents and your contact information will be electronically archived by Allina Health for five years. Then, those documents will be destroyed. • Only Joshua Hardin, Ruth Bryant, and persons within Allina Health with responsibilities for the oversight of research will have access to identifiable data. Deidentified information has no names, birthdate, address, etc. attached

		to the data. It cannot be linked to you. • We will keep deidentified data for 5 years.
The IRB (Institutional Review Board) at Allina The Office for Human Research Protections (OHRP) or other federal agencies Persons within Allina Health with responsibilities for the oversight of research	To ensure we're following laws and ethical guidelines	The IRB board will generally only have access to deidentified data. Only persons within Allina Health with responsibilities for the oversight of research will have access to identifiable data.
Anyone (public)	If we share our findings in publications or presentations	Only deidentified data will be used in publications or presentations. • If we quote you, we'll use a pseudonym (fake name)
Future students and researchers	If we share our data with students or other researchers	Only deidentified data will be used in future research. Only deidentified data will be used in the classroom. Deidentified information has no names, birthdate, address, etc. attached to the data. It cannot be linked to you.

Contact information:

For questions about the research	Joshua Hardin, MSN, RN	
For questions about your rights as a research participant	IRB (Institutional Review Board; provides ethics oversight)	612-262-4920 irb@allina.com
For complaints or problems	Jeanne Erickson, PhD, RN	
	Ruth Bryant, PhD, RN	
	Allina Health Institutional Review Board Office	612-262-4920 irb@allina.com

Signatures

If you have had all your questions answered and would like to participate in this study, sign on the lines below. Remember, your participation is completely voluntary, and you're free to withdraw from the study at any time.

_____

Name of Participant (print)

_____ _____

Signature of Participant Date

If participant is a minor or requires a Legally Authorized Representative:

_____

Name of Parent, Guardian or Legally Authorized Representative (print)

_____ _____

Signature of Parent, Guardian or Legally Authorized Representative Date

---

_____

Name of Researcher obtaining consent (print)

_____ _____

Signature of Researcher obtaining consent Date

Appendix E

Observation-Only Informed Consent Document

Study title	Perianesthesia Discourses on Directives Limiting Care: A Foucauldian Case Study
Researchers	• Joshua Hardin, MSN, RN – PhD Student, University of Wisconsin—Milwaukee (UWM) • Jeanne Erickson, PhD, RN – Associate Professor and Project Supervisor, University of Wisconsin—Milwaukee • Ruth Bryant, PhD, RN – Principal Research Scientist/Nursing and United Hospital Project Sponsor, Allina Health
We're inviting you to participate in a research study. Participation is completely voluntary. If you agree to participate now, you can always change your mind later. There are no negative consequences, whatever you decide.	

Key Information About This Study

You are invited to participate in the observation component of a research study.

The purpose of the research is to understand how patients, families, and health professionals make decisions about advanced directives and Do Not Resuscitate (DNR) orders before, during, and immediately after surgery.

Your participation in this research may involve being observed interacting with patients and/or families when discussing their advanced directives. It may also include observing how you discuss advanced directives with colleagues and how those discussions are translated into practice before, during, and after surgery.

All research studies involve some risks. Some risks to this study that you should be aware of are emotional distress or anxiety caused by talking about your clinical experiences with making advanced directive decisions.

You may benefit from participating in this study by helping other health care professionals learn to better care for patients with advanced directives.

Your participation in this study is voluntary. You do not have to be in this study if you do not want to, or you can stop being in this study anytime. You will not lose any services, benefits, or rights you would normally have if you choose not to participate or stop being in the study.

The rest of this form contains more information about being in this study. Please read this whole form carefully. You can ask any questions if you need help deciding whether to join the study. The person conducting this study is Joshua Hardin, MSN, RN. If you want to leave the study, let Josh know by contacting him at:

Ruth Bryant, PhD, RN is supervising this study. If you have questions or concerns, you should let Ruth know by contacting her at:

****

If you have any questions about your rights as a volunteer in this research, contact the Allina Health Institutional Review Board Office at 612-262-4920.

If you are interested in learning more about this study, please continue to read below.

What is the purpose of this study?

We want to understand how patients, families, and health professionals make decisions about advanced directives and Do Not Resuscitate (DNR) orders before, during, and immediately after surgery.

What will I do?

- You may be observed before, during, and after surgery. You do not need to do anything special during this period.
- You may be asked to join the larger study. This would entail participating in a qualitative interview. You are under no obligation to participate in the interview component of this study.
- This consent is for observation only. You will need to sign a separate consent if you are invited to participate in the interview component of this study. Not everyone who consents to observation will be asked to participate in the interview component.

I would like to be invited to participate in the interview component of this inquiry. A separate consent is required for participation in the interview component of this inquiry.

Risks

Possible risks	How we're minimizing these risks
Breach of confidentiality (your data being seen by someone who shouldn't have access to it)	• No identifying information will be retained from this observation.

There may be risks we don't know about yet. Throughout the study, we'll tell you if we learn anything that might affect your decision to participate.

Other Study Information

Possible benefits	You will be participating in a study that could help other health professionals better care for patients with advanced directives having surgery.
Estimated number of participants	We aim to observe all health care workers who interact with patients who are a part of the study. We will only observe health care workers who have consented to observation.
How long will it take?	You will be observed doing what you do every day. There are no additional time commitments.
Costs	There are no costs associated with this observation.
Compensation	This consent is for observation only. There is no compensation for being observed. Only participants who complete the qualitative interview component of this study receive compensation.
Future research	Deidentified (all identifying information removed) data may be shared with other researchers, students, or used by Joshua

	Hardin for other research projects. You won't be told specific details about these future research studies.
Recordings	Observations will NOT be recorded. We will take notes on the observation that contain no identifying information.

What if I experience emotional or psychological distress because I was in this study?

If you're harmed from being in this study, let us know. If it's an emergency, get help from 911 or your doctor right away and tell us afterward. We can help you find resources if you need psychological help. You or your insurance will have to pay for all costs of any treatment you need.

Confidentiality and Data Security

We will not collect any identifying information other than this consent. This consent will be securely stored at an Allina facility and destroyed in five years. You cannot be linked to the observation data.

Where will data be stored?	• All deidentified data will be stored on a password protected computer or on hard copy worksheets inside Josh's home office. • Digitized documents will be stored on a password encrypted computer designated by the clinical facility. • Electronic data may also be stored on a password encrypted flash drive.
How long will it be kept?	This Informed consent documents will be kept for 5 years in a secure, password protected electronic file on an Allina computer server. Then, those documents will be destroyed. Deidentified observational data will be kept for 5 years before it is destroyed.

Who can see my data?	**Why?**	**Type of data**
The researchers	To conduct the study and analyze the data	Deidentified information has no names, birthdate, address, etc. attached to the data. It cannot be linked to you. • We will keep deidentified data for 5 years.
The IRB (Institutional Review Board) at Allina	To ensure we're following laws and ethical guidelines	The IRB board will generally only have

The Office for Human Research Protections (OHRP) or other federal agencies Persons within Allina Health with responsibilities for the oversight of research		access to deidentified data. Only persons within Allina Health with responsibilities for the oversight of research will have access to identifiable data.
Anyone (public)	If we share our findings in publications or presentations	Only deidentified data will be used in publications or presentations.
Future students and researchers	If we share our data with students or other researchers	Only deidentified data will be used in future research. Only deidentified data will be used in the classroom. Deidentified information has no names, birthdate, address, etc. attached to the data. It cannot be linked to you.

Contact information:

For questions about the research	Joshua Hardin, MSN, RN	
For questions about your rights as a research participant	IRB (Institutional Review Board; provides ethics oversight)	612-262-4920 irb@allina.com
For complaints or problems	Jeanne Erickson, PhD, RN	
	Ruth Bryant, PhD, RN	
	Allina Health Institutional Review Board Office	612-262-4920 irb@allina.com

Signatures

If you have had all your questions answered and would like to participate in this study, sign on the lines below. Remember, your participation is completely voluntary, and you're free to withdraw from the study at any time.

Name of Participant (print)

Signature of Participant Date

If participant is a minor or requires a Legally Authorized Representative:

Name of Parent, Guardian or Legally Authorized Representative (print)

Signature of Parent, Guardian or Legally Authorized Representative Date

Name of Researcher obtaining consent (print)

Signature of Researcher obtaining consent Date

Appendix F

Informed Consent Documentation Form

Documentation of Informed Consent

Study Title: PERIANESTHESIA DISCOURSES ON DIRECTIVES LIMITING CARE: A FOUCAULDIAN CASE STUDY

Person Obtaining Consent: Joshua Hardin, MSN, RN

Participant Name: _____

Met with: Participant Other (Relationship)_____

Study purpose, procedures, and risks verbally explained to the participant.

Participant informed that participation is voluntary.

Participant given a copy of the consent form to review.

Participant given a chance to review the consent form and ask questions.

Participant appeared to understand the information presented and provided teach-back understanding of key points.

Participant voluntarily agreed to participate in the study and signed the consent form.

Participant was given a copy of the signed consent form.

Informed consent was obtained before initiating study activities.

The Participant wishes that the following people be present during preoperative clinical interactions (*list first names only*)

_____

_____.

I have discussed with each of the people listed that they will observed during the clinical interaction and may be asked to join the study. They verbally assented to be observed unless otherwise delineated in the "NOTES" section below. I explained to anyone declining observation that, although I will be present to observe the patient participant, no notes will be taken, or observations made about their presence, actions, speech, or behavior. I made clear that there were no repercussions for declining either participation or observation, and they indicated their understanding unless otherwise noted.

NOTES:

Signature of Person Obtaining Consent Date

Original consent form along with this form secured in lock box inside the Allina Facility office.

If patient-participant, a copy of the consent placed in the participant's medical chart.

Appendix G

Patient or Family Topic Guide

Interview/Topic Guide – **PATIENT or FAMILY/REPRESENTATIVE PARTICIPANT**

START RECORDING

1. **Introduction**
   - Introduce self, recording devices, note-taking equipment.
   - Provide for optimum comfort (lighting, positioning, refreshments).
   - Introduction to the qualitative investigator role. It is possible that the participant could mistake me for a hospital employee or think that their participation is somehow mandatory. Although informed consent was previously obtained, it is important to re-check understanding and continued consent.
   - **NOTE:** This interview is part of an inquiry about Perianesthesia Do Not Resuscitate (DNR) orders or other directive limiting care and how patients' healthcare clinicians talk about those things before, during, and after surgery. Information collected during this interview will be used in research with the intention of publication.
   - Discuss confidentiality. All transcripts will be anonymized. In other words, all interviews are de-identified and not linked to personal information.
   - **STOP:** Ask, "Do you want to proceed with the interview?"
   - Emphasize the importance of the participant's contribution.
   - **NOTE:** The participant should feel free to expand on answers and bring-up new points. The idea is to have a conversation.
   - Review the research questions and purpose of the interview.
   - All recordings will be kept on a password encrypted digital storage device for a period of three years. After the three-year period, the recordings will be destroyed.
   - The recordings will be transcribed by the investigator. You will have a chance to review and comment on the transcription.
   - **NOTE:** The *de-identified* transcripts will be retained by the investigator indefinitely.
   - **NOTE:** It is important that you are participating freely and want to continue.
   - **ASK:** "Do you want to continue?"
   - Some questions may be personal. If you do not want to answer a question, just say, "I prefer not to answer."
   - Check for questions.
   - Check to see if we are ready to continue.
2. **Background**

   Aims: To establish rapport and collect contextual data reflective of current and past circumstances.
   - Household make-up including immediate family, brothers and sisters, and aunts and uncles
   - Age
   - Identified race

- Identified gender
- Educational level
- Religion
- What type of directive limiting care do you have (e.g., DNR, advanced directive, POLST, other)

3. **Discourses on Death and Dying**

Aims: To understand when, how, and why discussions about end-of-life issues arose in the participants family culture, and how the participant experienced those conversations. These questions may help identify hidden discourses affecting patients in the perianesthesia setting.

- Did you have conversations about death, dying, or end-of-life issues when you were young or even as a child?
- Describe the first time you recall talking about death, dying, or end-of-life issues with your parents or any older adults, such as grandparents.
- Describe when you first started to participate in those conversations about death, dying, or end-of-life issues.
- Describe when you started to form an idea about what other people – maybe your parents — wanted at end-of-life.
- Age during this time?
- Walk me through an example of one of those conversations that you remember well about death and dying.
- Describe the first time you discussed your own DNR order or other directive limiting care with your family (i.e., significant other, children, parents) PROBE: Was there a time when you laid out exactly what you wanted done or not done? With whom? How did that conversation go?
- Discuss what you want or do not want done at end-of-life.
- What decisions have you made about end-of-life care?
- PROBE: Do you think your family understood your wishes; what conversations make you think that way? PROBE: Do you think your proxy—the person who makes decisions when you can't— will make the decisions you want; what conversations make you think that?
- Tell me what it means to you to have a directive limiting care.

4. **Perianesthesia End-of-Life Discourses**

Aims: Map how patients talk about making end of life care decisions for procedures requiring anesthesia. These questions may help decipher how patients negotiate discourses in the perianesthesia setting.

- **NOTE:** If interviewing a family member or representative, the goal of the questions and topic are still to map how they negotiate perianesthesia discourses since the family member/representative was present during the preoperative discussion. Alter first person phrasing as needed when the family member is not in the position of health care proxy.
- Describe the first time you had to decide about rescinding the DNR order or limiting directive during anesthesia or other procedure.
- **PROMPT:** "I would like you to reflect on your most recent operative experience."

- Walk through the last interaction with the anesthesiologist, nurse, and preoperative team regarding the limiting directive. **NOTE:** Ask participant to start at the beginning of the last encounter
- Describe feelings about pre-procedural interaction.
- How did you make your wishes clear to your anesthesiologist? PROBE: Do you feel the anesthesiologist understood your end-of-life wishes?
- What decision did you make about your DNR order or directive limiting treatment?
- Tell me about why you made that decision.
- Talk to me about your understanding of what happens during anesthesia. PROBE: Some people say that the being resuscitated during anesthesia is different from being resuscitated when you're not under anesthesia. Do you feel like you can understand those differences?
- Why did you decide to have surgery?
- If something happened during surgery, how far would you want the doctor to go to save your life? PROBE: How far is too far? PROBE: How did you tell the anesthesiologist about those limits?
- Tell me about what you think happens during anesthesia. What does your anesthesiologist do while you are under? Your anesthetist? Your Nurse?
- Imagine a situation where you died during surgery, meaning you went to sleep and never woke-up. PROBE: What do you think your family and friends would say about the situation? PROBE: How would you talk to your family about your decision if they were in the room right now?
- **ASK:** "Are you still okay continuing?"

5. **Power**

Aim: Interrogate the how perianesthesia discourses on directives limiting care relates to power.

- Did you expect to have a conversation about your DNR/end-of-life wishes before surgery? PROBE: Tell me how you expected the conversation to unfold.
- Was having a conversation about your DNR/end-of-life wishes before surgery with your anesthesiologist important to you?
- Did you feel like you had the right to keep your advanced directive/DNR in place during surgery? PROBE: Can you tell me what was said that made you feel that way?
- Do you think your preoperative team took time addressing your DNR order/or other directive limiting care? PROBE: Tell me about the activities, conversations, feelings that made you think that way.
- How did you feel when you made the decision to keep//rescind//modify your DNR order or other directive limiting care? PROBE: If you were telling a friend about how you felt, what would you say? PROBE: How would you say it if you were talking to your anesthesia clinician?
- Do you think the doctors and nurses getting you ready for surgery understand what is important to you if your heart should stop during surgery? PROBE: What parts of your conversation made you think that way?
- If you could have the perfect conversation before surgery about your DNR order/or other directive limiting care, how would it go?—try to describe it from start to finish.

6. **Reflection**

Aims: Identify ways that past discourse on end-of-life issues impacts future actions and empower participants. Begin to wind-down interview and end on a positive note.

- **ENABLE:** Looking into the future. How do you think your discussions with perianesthesia clinicians about your end-of-life directive will affect how you express your wishes to others?
- Tell me about your discussions with family over end-of-life issues.
- What do you hope for your loved ones when the time comes for them to make end-of-life decisions?
- How did it feel for you to discuss these issues with me today? PROMPT: Are you feeling distressed by our conversation?
- NOTE: Remind participant that community and hospital resources are available if they are distressed or just want to talk to a supportive professional about any issues raised during our conversation.
- **ASK:** Is there anything else you would like to discuss?

7. **Conclusion**

Aim: Leave the interview with participant aware of their rights as an interviewee and sense that their thoughts were heard.

- Reaffirm confidentiality and that the interview will in no way affect the care they receive in the future.
- Review that the deidentified data from this interview will likely be used in published research.
- **NOTE:** Only an anonymized transcript will be used and that recordings will be destroyed after three years.
- **NOTE:** Once the recording is transcribed, I would like to schedule a time to review it with you.
- Ask if there is anything else the participant would like to add.
- **NOTE**: If the participant thinks of anything she would like to add, they may send an email or call me.
- Thank the participant for their time.

END RECORDING

- **NOTE:** Confirm the best way to get in contact with the participant. Attempt to obtain multiple ways of getting in contact (e.g., phone, email, address).

Appendix H

Clinician Topic Guide

Interview/Topic Guide – **CLINICAL PARTICIPANT**[1]

*Adapt phrasing to participant's conversational style and vocabulary.

START RECORDING

1. **Introduction**
   - Introduce self, recording devices, note-taking equipment.
   - Provide for optimum comfort (lighting, positioning, refreshments, and so forth).
   - Introduction to the qualitative investigator role. It is possible that the participant could mistake think that I am functioning as a hospital employee. Although informed consent was previously obtained, it is important to re-check understanding and continued consent.
   - **NOTE:** This interview is part of an inquiry about Perianesthesia Do Not Resuscitate (DNR) orders or other directive limiting care and how patients' healthcare clinicians talk about those things before, during, and after surgery. Information collected during this interview will be used in research with the intention of publication.
   - Discuss confidentiality. All transcripts will be anonymized. In other words, all interviews are de-identified and not linked to personal information.
   - **STOP:** Ask, "Do you want to proceed with the interview?"
   - Emphasize the importance of the participant's contribution.
   - **NOTE:** The participant should feel free to expand on answers and bring-up new points. The idea is to have a conversation.
   - Review the research questions and purpose of the interview.
   - All recordings will be kept on a password encrypted digital storage device for a period of three years. After the three-year period, the recordings will be destroyed.
   - The recordings will be transcribed by the investigator. You will have a chance to review and comment on the transcription.
   - **NOTE:** The *de-identified* transcripts will be retained by the investigator indefinitely.
   - **NOTE:** It is important that you are participating freely and want to continue.
   - **ASK:** "Do you want to continue?"
   - Some questions may be personal. If you do not want to answer a question, just say, "I prefer not to answer."
   - Check for questions.
   - Check to see if we are ready to continue.

2. **Background**

[1] If the participant is from hospital leadership, reframe questions from an organizational perspective and modify questions based on learning from earlier non-leadership interviews.

Aims: To establish rapport and collect contextual data reflective of current and past circumstances.

- Age
- Identified race
- Identified gender
- Educational level
- Religion

3. **Discourses on Death and Dying**

Aim: To understand when, how, and why clinicians discuss directives limiting care.

- Did you have conversations about how to talk about death, dying, or end-of-life issues when you were learning your discipline. PROBE: Tell me about those discussions.
- Describe the first time you recall talking to a patient about death, dying, or end-of-life issues. PROBE: Walk me through an example of one of those conversations that you remember well.
- How have those conversations changed in your time as a clinician?
- When you speak with patients about their directives limiting care, what concerns influence your discussion?
- Tell me about a time that your personal ideas about end-of-life directives in the perianesthesia area conflicted with a patient's wishes. PROBE: What did you say to the patient to resolve those conflicts?
- PROBE: Do you think patients and families understand the implications of retaining a directive limiting care during anesthesia? PROBE: Tell me about the conversations you have with patients to help them understand resuscitation during anesthesia.
- How do you feel about the process for addressing perianesthesia directive limiting care? PROBE: What tenets of your discipline or strongly held beliefs do you think govern those feelings?

4. **Perianesthesia End-of-Life Discourses**

Aim: Map how clinicians talk about making end of life care decisions for procedures requiring anesthesia.

- Tell me about the first time you had a patient who kept an active DNR order during surgery.
- PROMPT: "I would like you to reflect on your most recent anesthesia encounter with someone who had a directive limiting care." Walk me through the interaction.
- Tell me about how you communicate understandings about patients' limiting directives with other clinicians (i.e., anesthesiologist, nurse, surgeon, and other team members).
- Describe your feelings about pre-procedural interactions with patients when directives limiting care need to be addressed. PROBE: How do you think those feelings developed?
- How do you make your position and concerns about directives limiting care clear to the patient? PROBE: Do you think patients hear and understand you?

- Talk to me about what happens during anesthesia and how that intersects with patients' choices about resuscitation. PROBE: Some people say that the difference between resuscitation and anesthesia is nuanced, that is very grey and not black and white. Do you feel like you can negotiate that gray area?
- If a patient retains their DNR order for surgery and something unexpected and potentially life-ending happens, how far would you go save their life? PROBE: Tell me about the parts of the preoperative conversation that helped you understand where that line is?
- If your patient chose to retain their DNR order during surgery and, despite your usual early and aggressive treatments to maintain homeostasis, they died in your care, would you feel differently than if you could use every resuscitative measure at your disposal. PROBE: Can you talk about the discourses that contribute to that feeling?

5. **Power**

Aim: Interrogate the how preoperative discourse on directives limiting care relates to power.

- Do you always have a conversation about the patient's DNR/end-of-life wishes before surgery? PROBE: What stops you from having that conversation?
- Do you guide patients toward a decision about their limiting directive? PROBE: Tell me about conversations where guidance was needed.
- Who do you think has the ultimate responsibility for resuscitative decisions during surgery?
- Tell me about your main goals when having conversations with patients about their directives limiting care?
- Do you feel pressure to rescind the patient's DNR order? PROBE: Where does this pressure originate?
- Do you feel pressure to avoid general anesthesia if a patient retains their directive limiting care? PROBE: What about avoiding sedating medications for pain and anxiolysis?
- How do you understand what is important to patients about the death and dying process and their goals and objectives for having surgery in the brief time you have for a preoperative interview? PROBE: Are there key discussion points that help clarify patient objectives for you?
- What happens when there are conflicts between clinicians, for example, anesthesiologist-surgeon, anesthesiologist-anesthetist, et cetera? PROBE: Tell me about one of the conversations you recall where there was conflict.
- If you could have the perfect conversation before surgery about your DNR order/or other directive limiting care, how would it go?—try to describe it from start to finish.

6. Reflection and Future

Aim: Identify ways that past experiences with end-of-life discussions impact future actions. Begin to wind-down interview and end on a positive note.

- **ENABLE**: Looking into the future. How do you think your interactions with patients about death, dying, and end-of-life care issues will change based on current trends?

- How have your experiences affected your interactions with your family about end-of-life issues?
- **ASK:** Is there anything else you would like to discuss?

7. **Conclusion**

Aim: Leave the interview with participant aware of their rights as an interviewee and sense that their thoughts were heard.

- Reaffirm confidentiality.
- Review that the deidentified data from this interview will likely be used in published research.
- **NOTE:** only an anonymized transcript will be used and that recordings will be destroyed after three years.
- **NOTE:** Once the recording is transcribed, I would like to schedule a time to review it with you.
- Ask if there is anything else the participant would like to add.
- **NOTE**: if the participant thinks of anything she would like to add, she may send an email or call me.
- Thank the participant for their time.

END RECORDING

- **NOTE:** Confirm the best way to get in contact with the participant. Attempt to obtain multiple ways of getting in contact (e.g., phone, email, address, et cetera).

Appendix I
Brief Topic Guide

Interview/Topic Guide – BRIEF FORMAT CLINICAL PARTICIPANT

*Adapt phrasing to participant's conversational style and vocabulary.

MAY OR MAY NOT RECORD DEPENDING ON SITUATION. RECORDING IS IDEAL.

1. **Introduction**

- Introduce self, recording devices (if present), and note-taking equipment.
- Introduction to the qualitative investigator role.
- **NOTE:** This interview is part of an inquiry about Perianesthesia Do Not Resuscitate (DNR) orders and other directives limiting care. The objective is to learn about how patients' healthcare clinicians talk about DNR orders before, during, and after surgery. Information collected during this interview will be used in research with the intention of publication.
- Discuss confidentiality. All transcripts will be anonymized. In other words, all interviews are de-identified and not linked to personal information.
- **STOP**: Ask, "Do you want to proceed with the interview?"
- **Review informed consent document and obtain signature**.
- If you do not want to answer a question, just say, "I prefer not to answer."
- If you want to stop the interview, just say, "I have to stop now."
- Check for questions.

2. **Background**

- Role, age, identified race, identified gender, educational level, religion

3. **Discourses on Death and Dying**

- Tell me about conversations you had about death, dying, or end-of-life issues when you were learning your discipline.
- When you speak with patients about their directives limiting care, what concerns influence your discussion?
- Tell me about a time that your personal ideas about end-of-life directives in the perianesthesia area conflicted with a patient's wishes. PROBE: What did you say to the patient to resolve those conflicts?

4. **Perianesthesia End-of-Life Discourses**

- PROMPT: "I would like you to reflect on your most recent anesthesia encounter with someone who had a directive limiting care." Walk me through the interaction.
- Tell me about how you communicate understandings about patients' limiting directives with other clinicians (i.e., anesthesiologist, nurse, surgeon, and other team members).

6. **Power**

- If you could have the perfect conversation before surgery about your DNR order/or other directive limiting care, how would it go?—try to describe it from start to finish
- Do you guide patients toward a decision about their limiting directive? PROBE: Tell me about conversations where guidance was needed.
- Who do you think has the ultimate responsibility for resuscitative decisions during surgery?
- Tell me about your main goals when having conversations with patients about their directives limiting care?

8. **Conclusion**

- Reaffirm confidentiality
- Review that the data from this interview will not be used published research. Note that only an anonymized transcript will be used and that recordings will be destroyed after three years
- **NOTE:** Confirm the best way to get in contact with the participant. Attempt to obtain multiple ways of getting in contact (e.g., phone, email, address, et cetera)
- **ASK** if there is anything else the participant would like to add.
- Note that if the participant thinks of anything or wants to talk more, they may send an email or call me.
- Thank the participant for her time.

Appendix J

Observation and Field Notes Document

Observation and Field Notes

☐ Today, I have asked the clinicians here observed if it is okay that I observe them, and they have indicated that observation is acceptable.

☐ A health care provider who has not consented for observation or whose consent status is unknown entered the room. At this point, observation was suspended, and the observer left the room. NOTES:

Observational Notes on Space and Environment

Observational Notes on Power Relations

Observational Notes on Talk and Language

Observational Notes on Non-verbal Communication

Observational Notes on Emotion

Observational Notes on Physical Position

Observational Notes on Feelings, Frissons, Spectral Data, and the Unknowable Data

Memoranda to Self

Appendix K

Standards for Reporting Qualitative Research (SRQR) Checklist

Title and Abstract

1. Title

Concise description of the nature and topic of the study. Identifying the study as qualitative or indicating the approach (e.g., ethnography, grounded theory) or data collection methods (e.g., interview, focus group) is recommended.

Results Manuscript One: p. 165

Results Manuscript Two: p. 200

2. Abstract

Summary of key elements of the study using the abstract format of the intended publication; typically includes background, purpose, methods, results, and conclusions Abstract-per author guidelines.

Results Manuscript One: p. 165

Results Manuscript Two: p. 200

3. Problem formulation

Description and significance of the problem/phenomenon studied; review of relevant theory and empirical work; problem statement.

Results Manuscript One: p.167

Results Manuscript Two: p. 203

4. Purpose or research question

Purpose of the study and specific objectives or questions

Results Manuscript One: p.168

Results Manuscript Two: p. 213

Methods

5. Qualitative approach and research paradigm

Qualitative approach (e.g., ethnography, grounded theory, case study, phenomenology, narrative research) and guiding theory if appropriate; identifying the research paradigm (e.g., postpositivist, constructivist/ interpretivist) is also recommended.

Results Manuscript One: p. 168

Results Manuscript Two: pp. 214

6. Researcher characteristics and reflexivity

Researchers' characteristics that may influence the research, including personal attributes, qualifications/experience, relationship with participants, assumptions, and/or presuppositions; potential or actual interaction between researchers' characteristics and the research questions, approach, methods, results, and/or transferability.

Results Manuscript One: p.174

Results Manuscript Two: p. 217

7. Context

Setting/site and salient contextual factors; rationale

Results Manuscript One: p. 170

Results Manuscript Two: p. 214

8. Sampling strategy

How and why research participants, documents, or events were selected; criteria for deciding when no further sampling was necessary (e.g., sampling saturation); rationale.

Results Manuscript One: p. 171

Results Manuscript Two: p. 215

9. Ethical issues pertaining to human subjects

Documentation of approval by an appropriate ethics review board and participant consent, or explanation for lack thereof; other confidentiality and data security issues Methods, Preface – Ethics, Safety, and Administrative Considerations.

Results Manuscript One: p. 168

Results Manuscript Two: p. 218

10. Data collection methods

Types of data collected; details of data collection procedures including (as appropriate) start and stop dates of data collection and analysis, iterative process, triangulation of sources/methods, and modification of procedures in response to evolving study findings; rationale

Results Manuscript One: p.175

Results Manuscript Two: p. 216

11. Data collection instruments and technologies

Description of instruments (e.g., interview guides, questionnaires) and devices (e.g., audio recorders) used for data collection, if/how the instrument(s) changed over the course of the study.

Results Manuscript One: p. 171

Results Manuscript Two: p. 216

12. Units of study

Number and relevant characteristics of participants, documents, or events included in the study; level of participation (could be reported in results).

Results Manuscript One: p. 175

Results Manuscript Two: p. 219

13. Data processing

Methods for processing data prior to and during analysis, including transcription, data entry, data management and security, verification of data integrity, data coding, and anonymization/deidentification of excerpts.

Results Manuscript One: p. 175

Results Manuscript Two: p. 219

14. Data analysis

Process by which inferences, themes, etc., were identified and developed, including the researchers involved in data analysis; usually references a specific paradigm or approach; rationale.

Results Manuscript One: p. 172

Results Manuscript Two: 216

15. Techniques to enhance trustworthiness

Techniques to enhance trustworthiness and credibility of data analysis (e.g., member checking, audit trail, triangulation), rationale

Results Manuscript One: p. 174

Results Manuscript Two: p. 218

16. Synthesis and interpretation

Main findings (e.g., interpretations, inferences, and themes); might include development of a theory or model, or integration with prior research or theory.

Results Manuscript One: p. 180

Results Manuscript Two: p. 220

17. Links to empirical data

Evidence (e.g., quotes, field notes, text excerpts, photographs) to substantiate analytic findings.

Results Manuscript One: p. 188

Results Manuscript Two: p. 220

Discussion

18. Integration with prior work, implications, transferability, and contribution(s) to the field

Short summary of main findings; explanation of how findings and conclusions connect to, support, elaborate on, or challenge conclusions of earlier scholarship; discussion of scope of application/ generalizability; identification of unique contribution(s) to scholarship in a discipline or field.

Results Manuscript One: p. 197

Results Manuscript Two: p. 237

19. Limitations

Trustworthiness and limitations of findings

Results Manuscript One: p. 200

Results Manuscript Two: p. 241

Other

20. Conflicts of interest

Potential sources of influence or perceived influence on study conduct and conclusions; how these were managed.

Results Manuscript One: p. 168

Results Manuscript Two: p. 218

21. Funding

Sources of funding and other support; role of funders in data collection, interpretation, and reporting.

Results Manuscript One: 168

Results Manuscript Two: p. 218

Note. Developed from O'Brien et al. (2014).

Appendix L

Contextual Codes

Color	Contextual Codes
Aruba	No discussion of death/dying as a child.
Green	"If she couldn't eat, she didn't want to live."
Terracotta	"Stoic" parent did not want to talk about death/dying.
Red	We (patients and clinicians) don't talk about death and dying until we have to.
Green Pastures	Parent/someone "bluntly" (maybe realistically) said—straight talk about end of life wishes.
Yellow	We wait until severe diagnosis or are dying to talk about death and make end of life decisions (yellow).
Candy Apple	Advance directive was created because someone heard a "horror" story.
Peacock Green	Don't want to be resuscitated if not "mentally" aware.
Blue	No one talked about what's in my advance directive.
Celery	Talk more about wishes depending on the criticality of the situation.
Red umber	I'm doing this to preserve my quality of life not to prolong my life.
Light Blue	Something we did versus disease progression—the blurry line between normal anesthesia and resuscitation.
Purple	If you want to keep the DNR during anesthesia, be very specific about treatments in preop.
Warmer Gray	Don't understand the term "DNR"
Brown	Clinicians "fear" intraoperative death.
Pink Orchid	Ideally, we should talk about DNR/advance directives before coming to hospital.
Pumpkin	Clinicians realize/understand that anesthesia runs the code.
Cappuccino	OR is still a "patriarchal," "top-down" environment
Custard	Talk about death/dying framed around religion (Catholic).
Periwinkle	Don't want to be a burden (to someone).
Black	Being in health care (nurse, MD) aids personal communication about death/dying
Eggplant	Perianesthesia (preop) is a "prison" (surveillance state).
Pink rosa	Surgeon is not really involved in DNR conversation before surgery.
Orange	No time to discuss it right before surgery.
Light green	Lay people can't really understand the nuances of anesthesia.
Platinum	We should bill for the DNR discussion if we want it to happen.
Eco green	The advance directive was part of paperwork to complete from my lawyer/a workshop.
Luscious lavender	When it's my time to die, don't keep me alive in a hospital with machines. I prefer a natural death.
peridot	Don't worry. Let us take care of you.

Wild lilac	It's most important that anesthesia know about the advance directive.
Summer green	Other family members getting an advance directive/DNR influenced my decision to get one.
Honeydew	Nurses/clinicians learn to talk about DNR/advance directives experientially, not in classrooms
Pot of Gold	We don't address EOL wishes/advance directives unless they have a DNR order.
Smokey purple	We don't talk about advance directives because "they have enough on their plates."
Blueberry Jam	"We'll just suspend the DNR."
Coffee beanz	MDs want the patient to suspend their DNR
Tidal Wave	The chart defaults to full code
Espresso	No partial codes in perianesthesia—code statuses are dichotomous; they are full code or they are suspended.
Orange crush	DNR wishes are not well communicated—there's no order
Stirling Silver	"No one dies in the OR"
Simple Green	If you don't suspend your DNR, you probably won't have surgery
Golden Mustard	Clinicians aren't responsible for understanding my end of life wishes, my family is responsible.
Pale yellow	I had enough time to discuss my DNR
Orange peelz	We set-up an environment geared toward suspending the DNR order.
clover	Nurses feel responsible for making sure the conversation happens
wildfire	There is confusion about who has responsibility for discussing the DNR
berry	I welcome EOL discussion in the perianesthesia setting
Raspberry rave	You and the doctor will talk about what's best
Blue jeans	It makes sense for a really sick person to keep their DNR during surgery, but not for someone who isn't very ill
Deep emerald	Younger anesthesiologists, female anesthesiologists, and those trained at large hospitals tend to have better discussions with patients about DNR orders (deep emerald).
Mediterranean	The surgeon has ultimate responsibility for understanding EOL
Teal	wished/advanced directives
smoke	Discussions about DNR orders is driven by check boxes required on the consent
Deep plum	Since I have a DNR, I thought if something happened during surgery, they would not resuscitate me. They'd just let me die.
Deep Raspberry	You should always have a conversation about the advance directive when a patient has one
Toasted Toffee	Patient just want to get the surgery done (see enough on plate, may cancel, not enough time before surgery)
Cra z pink	Patients are more likely to understand DNR options with family present

Green Fern	I'm okay with some attempts to restart my heart – I just don't want to see long term medical problems
Stardust	We talk more about EOL wishes today than in the past
magenta	DNR conversation is a part of informed consent
Oh so red	The surgical pause is where DNR status is communicated intraop
Pretty plum	You have to sit down with the patient and make sure they understand
sunflower	Strong advocacy will trigger better conversations about the DNR
Pastel green	We never avoided talking about death; we talked about it all our lives.
Pumpkin Orange	I don't want to be alive on a breathing machine.
Grey mist	There is no quality assurance mechanism for ensuring that conversations providers have with patient about their DNR wishes privileges the patient's wishes
Platinum lines	Not getting paid/billing for perianesthesia DNR conversations is no excuse for not doing it
Blueberry jam	The DNR is assumed to remain in effect for surgery unless it is suspended

CURRICULUM VITAE

VITA

JOSHUA HARDIN

EDUCATION

University of Wisconsin—Milwaukee |Milwaukee, WI
PhD—Nursing ***current***

St. Catherine University |St. Paul, MN
MSN—Nurse Educator **2016**

Thesis: "Creating a Graduate Level Interprofessional Ethics Course for Health Science Students: A Systematic Approach"

East Central University |Ada, OK
BS—Nursing **1999**

TEACHING EXPERIENCE

Assistant Clinical Manager/Nurse Educator |United Hospital, St. Paul, MN **2016**

Lecture – "Managing Pain in the Post Anesthesia Care Unit"
Lecture – "Opioid Therapy for Chronic Pain Patients in the Perioperative Setting"
Lecture – "Perianesthesia Care for Patients with Insulin Pumps"
Lecture – "Perianesthesia Nursing Care of Patients with Ventriculostomy Drains"
Lecture – "Preventing Perianesthesia Hypothermia"

- *Developed a computer based virtual orientation system for new perianesthesia nurses, supervised and evaluated orientation progress, and ensured preceptor development.*

Teaching Assistant to Anna Engelhart, MSN, Assistant Professor| St. Catherine University, St. Paul, MN **2015**

Lecture – "Disorders of the Bladder and Lower Urinary Tract"

- *Collaborated on constructing and operationalizing lesson plans, selecting learning activities, and appraisal of students' in-class performance. Supervised students' clinical performance.*

RELATED EXPERIENCE

Allina Health, United Hospital – St. Paul, MN

Staff Nurse/Charge Nurse/Assistant Clinical Manager, Perianesthesia Services **2010 – *present***

Assistant Clinical Manager in an eighteen-bed metropolitan Post Anesthesia Care Unit and twenty-two bed Preoperative and Phase II area. In addition to managing the perianesthesia care of clinically complex clients from preoperative screening to post anesthesia recovery, responsible for the educational and professional development of fifty staff members. As Assistant Clinical Manager, successfully completed many programs and initiatives. Devised and delivered mandatory yearly training for staff. Designed and implemented new employee orientation to the perianesthesia environment.

Maxim Staffing Agency – Atlanta, GA & Minneapolis, MN

Travel and Agency Nurse, Critical Care/Telemetry/Medical/Surgical/ Acute Care **2007-2010**

Per Diem contract and agency nurse in a variety of critical care units, telemetry, medical/surgical acute care, and orthopedic floors in multiple hospital settings. Populations served: critically ill patients following life threatening health alterations and less acute tertiary care patients recovering from serious medical or surgical events. Responsible for all aspects of physical care, monitoring for complications, and evaluating effectiveness of interventions and medications administered.

Parkland Health and Hospital System – Dallas, TX

Staff/Charge Nurse, Intensive Care Unit (ICU) **2004-2006**

Charge nurse and staff nurse in a thirty-two-bed surgical/trauma critical care unit at a Level One metropolitan trauma facility. Care provided for critically ill patients following unexpected health alterations sustained from traumatic mechanisms of injury or surgical intervention. Responsible for all aspects of physical care, monitoring for complications, and evaluating effectiveness of medications and interventions administered. Also, as charge nurse, responsible for the safe, efficacious, and fiscally responsible implementation of interdisciplinary plans of care by all unit personnel.

Parkland Health and Hospital System – Dallas, TX

Staff/Charge Nurse, Trauma & Orthopedic Inpatient Unit **1999-2004**

Charge nurse and staff nurse in a trauma and orthopedic inpatient unit. Responsible for care of five to nine patients at a time; including all aspects of physical care, monitoring for complications, and evaluating effectiveness of medications and care given. Supervised one to three unlicensed assistive personnel per shift. Transitioned to

Critical Care Nurse role at Parkland Hospital by undertaking a six-month critical care residency.

PUBLICATIONS AND PAPERS

Erickson, J. M. & Hardin, J. B. (in press). Ethical issues. In J. K. Itano (Ed.), *Core Curriculum for Oncology Nursing* (7th ed.). Elsevier.

McAndrew, N. S., & Hardin, J. B. (2020). Giving nurses a voice during ethical conflict in the intensive care unit. *Nursing Ethics, 27*(8), *1631–1644.* doi: 10.1177/0969733020934148

Erickson, J. M. & Hardin, J. B. (2019). Ethical issues. In J. K. Itano (Ed.), *Core Curriculum for Oncology Nursing* (6th ed.). Elsevier.

Hardin, J. B., & Forshier, B. (2019). Adult perianesthesia Do Not Resuscitate orders: A systematic review. *Journal of Perianesthesia Nursing, 34*(5), 1054–1068. doi: 10.1016/j.jopan.2019.03.009

Hardin, J. B. (2018). Everyday ethical comportment: An evolutionary concept analysis. *Journal of Nursing Education, 57*(8), 460-468 doi.org/10.3928/01484834-20180720-03

PRESENTATIONS

Hardin, J., McMahon Bullis, M., Gonzalez, C., Roddy, L. (2019, March). *The Coping Adaptation and Processing Scale (CAPS): A Systematic Review.* Poster presented at the Midwestern Nursing Research Society, Kansas City, MO

HONORS AND AWARDS

Sigma Theta Tau—Eta Nu Chapter (2019). Student Poster Award - *The Coping Adaptation and Processing Scale (CAPS): A Systematic Review.*

Mary Hanna Memorial Journalism Award (2020). Best Practice Category: Third Place – "Adult Perianesthesia Do Not Resuscitate Orders: A Systematic Review".

CERTIFICATIONS

Certified Critical Care Registered Nurse

Certified Post Anesthesia Care Nurse

MEMBERSHIPS

American Association of Critical-Care Nurses

American Society of Pain Management Nursing

American Society of Perianesthesia Nurses

Roy Adaptation Association