

The "Social Determinants" of Practice? A Critical Analysis of the Discourse of Health Promotion

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L'évolution de la pratique de la promotion de la santé s'est toujours concentrée sur ce que les clients apportent comme bagage contextuel lors de leurs rencontres avec des professionnels. Ce changement dans la relation professionnel/client marque une orientation très différente des modèles de pratique qui reposaient sur le fait que le professionnel, en tant qu'expert, donnait au client des indications de santé. La documentation qui essaie d'éclairer ces relations plus contemporaines avec les clients a tendance à ne pas tenir compte de ce que le praticien apporte à la rencontre promouvant la santé et, de façon significative, des conditions sociales sous-tendant la rencontre. L'article se base sur des résultats obtenus au cours d'une étude ethnographique sur la pratique dans une clinique publique et analyse de façon critique la promotion de la santé afin de mettre au défi les chercheurs, les enseignants et les praticiens pour ce qui concerne les possibilités de promouvoir la santé dans les milieux où l'on pratique actuellement.

Developments in the practice of health promotion have centred on considerations of what clients bring to their encounters with professionals. This change in the provider-client relationship marks a significant departure from practice models that relied on the professional giving the client expert health instructions. The literature that seeks to illuminate these more contemporary relationships with clients tends to ignore what practitioners bring to the health promotion encounter and, significantly, the social conditions that underlie the encounter. This paper, drawing on research gathered during an ethnographic study of practice in a public health clinic, critically analyzes health promotion with a view to challenging researchers, educators, and practitioners concerning the health-promoting possibilities in existing practice settings.

Introduction

The concept of "social determinants of health" has entered everyday discussion about health-care delivery. It signals a progressive, contemporary approach to health promotion, one concerned with acquiring knowledge beyond people's habits and their genetic endowment, to those features of their daily lives that affect their ability to make healthy choices. For instance, a low monthly income might force a person to live in a dangerous neighbourhood, thus limiting his or her opportunities

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to socialize in the evening, or even to engage in some light exercise as a way of relaxing after a hard day's work.

The concept of "social determinants of health" means that practitioners, in assessing and approaching the task of health promotion, must include factors that influence a person's relative position in society. Education, social status, income, employment and working conditions, social support networks, housing and living conditions, individual abilities and skills, natural environment, and use of health services all come under the rubric of social determinants (Office of the Provincial Health Officer, 1995). These refined definitions have undoubtedly sensitized health practitioners and educators to the need for broader considerations when approaching groups identified by these "determinants" as socially challenged. Once it is known that hidden factors may influence a client's ability to engage in health-promoting activity, the provider-client relationship is altered. In a setting where social determinants form the basis of practice, practitioners can no longer exclude such assessments from their work with clients. In other words, health professionals must now consider the client's social circumstances. We have moved away from a behavioural setting, wherein everyone is treated equally, to one in which differences can be treated differently.

Treating differences differently is not as new as the language of a transformed nursing practice might suggest. Even where "the social" was deliberately stripped away, in earlier forms of research on health and health promotion, a close reading of these texts reveals that differences were attended to (Field, 1989; Purkis, 1994a). What is new is that documents emanating from government offices and provincial nursing associations provide us with the technology to define *what counts* as a social determinant of health, and therefore what is to be *accounted* for in doing health-promotion work. These documents instruct us to focus our eyes and ears on particular aspects of a client's story – that is, to adjust our helping gaze. But have we, as practitioners and educators, considered the possibility that we make such adjustments to our gaze from a particular position? Before we came to the realization that health-promoting practice must consider our clients' social circumstances, we were practising from a particular position – one defined by our understanding of health and of nursing as formed by our nursing education and subsequent practice in a variety of settings. To what extent have we tried to analyze and alter our positions, in light of our work with clients? In fact, are there social determinants of health-promoting practice that might condition – limit as well as foster certain

kinds of practice – any practice that emerges from a disciplined position of nursing?

I shall be drawing on Foucault's (1973, 1979) notion of "disciplinary practices" in analyzing observational and interview data collected for an ethnographic study of health promotion in nursing (Purkis, 1993). Foucault's work is particularly important in this area, because he is concerned with the exercise of power accomplished through practices of surveillance. The aim of analysis is to excavate "regimes of truth" corresponding to surveillance practices that favour certain types of knowledge over others.

I shall then explore the effects of "disciplinary practices" by offering examples. The significance of this theoretical position warrants explication. If we think about the arrangement of people and knowledge in a health-promoting encounter, we will see that within a practice setting few if any of the "social determinants" of health are visible to the practitioner. The conditions of a client's everyday life of poverty, for example, are not obvious to a nurse when the client enters a health clinic. Rather, a plan of action is said to be "mutually" agreed after the client presents his or her circumstances and the nurse makes a disciplined, professional reading of these. Knowledge about the client's social circumstances and the extent to which these affect the plan of action represents a complex mediation of symbolic meanings. Understandings of work "worth" doing are influenced as much by the nurse's working conditions, especially the lines of accountability in her place of employment, and its position in society, as they are by the client's circumstances (Allen, 1995; Armstrong, 1983; Campbell & Jackson, 1992; Cheek & Rudge, 1994; Hiraki, 1992; Latimer, 1995; May, 1992a, 1992b). It is at this juncture of the client's presentation of the "everyday" and the nurse's reading of the "everyday" that disciplined practices organize action. Nurses are informed, through their education and day-to-day health-promoting work, about strategies considered by others (typically co-workers and managers) as "good." These strategies in a practice setting are disciplined, in the sense intended by Foucault, in that one's actions are constrained but also facilitated by collective understandings of what counts as "good" practice.

This paper has two aims: to question the present reliance on conceptual supports for improved health promotion – that is, the production of assessment forms framed by a new language of health promotion to broaden the nurse's helping gaze; and to suggest that a more productive way of exploring the effectiveness of health promotion might be to critically examine complex, sophisticated, everyday

encounters between health professionals and their clients. An example of such an examination will be presented, based on an ethnographic study of nursing practice.

Methodology: Social Practice and Ethnography

The study was undertaken in a public health clinic, a typical location for engaging in health promotion in Canada. Fieldwork was carried out over a four-month period in 1990 during which interactions between nurses and parents attending the clinic with their children were observed and audiotaped. Immediately following each interaction the researcher conducted an autiotaped interview with the nurse in the clinic. Arrangements were made for the researcher to carry out a follow-up interview with each of the parents who had been observed in interaction with a clinic nurse. This interview, which was also audio-taped, was held in the parent's home approximately one week after the clinic visit.

Analysis of these texts was undertaken using a critical hermeneutic approach (Allen, 1995). Patterns in discourse were excavated by noting the effects of particular language strategies employed by both parents and nurses in the construction of a clinic visit. Movement by either party towards the position of the other was taken as an effect of disciplinary practice (Fernandez, 1986; Lyotard, 1984). These methods have been explicated in greater detail elsewhere (Purkis, 1994a, 1994b). Examples of such an analytic position are offered below.

Setting Up for Health-Promoting Practice

An important feature of health promotion (as distinct from prevention, health education, and patient teaching) is a questioning of the role of "expert knowledge." Increasingly, clients, patients, and communities are seen as repositories of resources (Gillis, 1994; Hall, Stevens, & Meleis, 1994; MacLeod & Stewart, 1994; Morse, Miles, Clark, & Doberneck, 1994; Pender, 1987). The literature informs us it is essential for the health-care practitioner to uncover these resources before engaging in health promotion. Clients are understood to be experts on themselves. Before simply telling patients how to take care of themselves, health professionals must seek at least some information from their clients, and this information must have the appearance of information about the "self" – it must say something about the person or community that distinguishes this client from others. Once the practitioner has formed an idea of the resources brought to the encounter by the client, those

resources must find their way into the "intervention," in order for it to be counted as a health-promotion intervention. In this way, the practitioner can enter an account of practice intended to be understood as "client driven."

The foregoing is a brief and, some might say, stylized rendering of the health-promoting relationship; it is the "style" of such an encounter that the ethnographic study analyzes. It seeks to draw out features of health-promotion encounters that nurses struggled to describe in their interviews. Most nurses were quick to characterize their practice as health-promoting, but when asked to elaborate they had considerable difficulty describing their everyday work. For example, when asked how her work in the clinic differed from her previous work, one nurse (Kay) provided the following account:

This is quite, quite different. The only similarity really is that you're going into people's homes. Well, with VON nursing and home-care nursing you were doing a fair amount of teaching as well, but this public health-type nursing is... I can hardly even compare the two [laughs], especially when I think what I did originally. And yet... having progressed this far with it and learned new ideas, new theories about what we're doing and the types of nursing theories that we should all become familiar with [laughs]...to see how it applies not just to an individual but to a community, and that's what's making it kind of interesting right now, is thinking of the client as a community, be it a school community or a community of a district or a community of [sighs] a cultural group or something like that, so it's sort of taking nursing theory and applying it to a much broader perspective than just one single individual or the single individual's family. It's interesting to see how the different systems fit together and overlap.

Kay, an experienced public health nurse, came to her work in the clinic with a background in intensive care, outpost nursing, and finally home care. She sees her work in clients' homes as a continuation of her other "community" nursing positions, but her work in the clinic as "quite different." Kay presents her health-promoting work in the clinic as a "progression" of her earlier forms of work, which picks up on themes in the health-promotion literature yet interestingly contradicts claims in the literature that it emanates from a non-hierarchical ontology.

For Kay, practice within a health-promotion context also represents progress in her discipline. Her account suggests a helping gaze comparable to Foucault's medical gaze:

I wanted to find out how the medical gaze was institutionalised, how it was effectively inscribed in social space, how the new form of the

hospital was at once the effect and the support of a new type of gaze.
(Gordon, 1980, p. 146)

Foucault treats as intertwined the establishment of hospitals and the establishment of medical expertise starting in the 18th century in France. Hospitals were strategically designed to support and create medical knowledge. Kay's account reflects similar ideas. As a nurse, she has been trained in knowledge of the physical body. Now, to support her understanding of a broader sense of "health," she must look beyond the surface of the body of the client, to "the community." Kay inscribes a variety of forms of community: now, whole communities are to be treated as clients; schools might be understood as a community within the larger community; identifiable cultural groups, widely dispersed within the geographic community, might also be thought of as a community. Such configurations of community as a locus of practice stand in contrast to what might traditionally be thought of as fields of work: "just one single individual or the single individual's family."

The clinic nurses realized they were being asked to nurse differently. They referred to a shift in focus from individuals and groups to aspects of the physical community. Here is Diane's account:

All the public health stuff you get, it's always health promotion... preventing disease on a sort of major scale...not like on the one-to-one level, which I feel I'm stronger at...in a group situation...that's what I think health promotion is. You know, like teaching things about health to groups to prevent...illness and disabilities. That's what I've always felt health promotion is. And it sounds awfully cold and it doesn't fit into my nature at all. That's what makes me wonder if I'm in the right position. I know that I'm doing health promotion by just...even if I tell a mother in a clinic that she shouldn't be giving her two-month-old two percent because...the kidneys aren't fit for that kind of, you know...filtration problems they could have. So in that way I'm doing some health promotion, but it's not really the major stuff, I think, what all the literature's talking about. And like in the environment and the community where I think the real health promotion maybe should be happening...where you're getting other groups to do...where you're sort of mobilizing other people, I mean community people, not necessarily health people, just community types, to get going and doing different things for health. Whether it's everybody having their compost bin or whether it's sharing a garden or something like that, or getting better transportation for a community...that to me is what health promotion...how it is to me... Or maybe lobbying that clinic, or city hall...to have five or six free parking stalls just for mothers that come into clinic so they don't have to pay 25 cents an hour...that type of stuff, more global and universal than the one-to-one...

Diane is referring to the literature that on a daily basis instructs her (or "disciplines" her) to think about health promotion as something beyond the "one to one" she believes she is good at. Her knowledge of the body, her ability to map out the moral geography of the body (that is, what is "good" for the body and what is "bad"), is being displaced, in the literature, by the notion of working with "community types" to "get going and doing different things for health."

Diane's comments reflect the problematic character of health-promotion work. To her, it is indirect work: "you're sort of mobilizing other people." Rather than recognizing and acting on dangerous or difficult situations such as mothers having to walk through a busy commercial parking lot with small children because the clinic provides only staff parking, the nurses must somehow get the mothers themselves to recognize the problem and "mobilize" to eliminate it.

Nurses' understandings of such instruction or discipline cannot be treated as solely theoretical: the move towards a different form of practice is an *empirical* one. The problem nurses face is having to demonstrate to managers that their practice has changed. Language drawn from journals, newsletters, and organizational directives is one resource they can use. But attending to my claim that shifting sites of practice entails an empirical move, it must be recognized that the *context* of nursing practice offers many resources for nurses to accomplish a new form of practice. In the following sections I will set out some of these resources as I came to understand their influence on the work of nurses and as that work came to have effects on clients attending the clinic.

Institutionalized Forms of Surveillance

The above accounts of health-promoting practice demonstrate the ability of clinic nurses to discursively construct their work as health promotion work. Foucault's notion of discourse urges us to extend analysis beyond the nurses' verbal comments. For Foucault, discourse is more than merely the utterance of words; it is practice. The significance of this position is reflected in his argument that the emergence of hospitals in France in the late 1700s revealed "the effect and the support of a new type of gaze" (Gordon, 1980, p. 146): the new medical discourse, reflecting a new knowledge of the body and equipped with a disciplined and disciplining gaze, affected the hospitals empirically. Similarly, nursing practice in the clinic reflects a new knowledge of "health promotion." These discursive practices are equipped with a disciplined and disciplining gaze whose effects are discernible. It is important that such effects be demonstrated, because all too often health pro-

motion is treated as positive simply because clients are doing for themselves rather than being done to by "experts" (Anderson & Tomlinson, 1992; Brehaut, 1988; Duffy, 1988; Pender, 1990).

Some authors (Minkler, 1989; Morse, 1991; Wright & Levac, 1992) treat as problematic the talk of "expert skill" in the context of health promotion. This literature sees community-based health promotion as a *progressive* move for health-care practitioners. This is to suggest that a move out of buildings such as hospitals may be sufficient for practitioners to avoid the "problems" of hierarchy.

It is simplistic to think a structure could be so easily set aside. The structures enabling practice are so powerful that a nurse – without identifying herself as such or explaining what she is doing – could approach a mother, remove her child from her arms, undress the child, and proceed to rotate its hips. Where such actions are supported as "typical," there exist structures such as frames of meaning and versions of "expertise" that legitimize actions as appropriate. Rather than *clouding* the lens through which the nurse "sees" the client, structural properties such as those supporting hierarchical understandings of expertise (e.g., measurements to determine whether a baby is gaining weight or growing sufficiently, whether its hips are strong enough to bear its weight, or whether it is being adequately "cared" for by its parents) and legitimate modes for representing knowledge inherent to the realm of expertise serve to *focus* the lens through which clients are "seen" and thus "known." Knowledge is discursively constructed; it is socially constructed and clients participate in the construction and legitimation of this knowledge. Assessment activities such as those relied on by nurses in a setting such as a public health clinic make *knowing about clients* possible.

As nurses are increasingly encouraged to bring the community into their interactions with clients in order to engage in health promotion, traces of "the community" may be drawn in and transformed in the process; that is, nurses watch and listen for instances of "community" in their interactions with parents and use those "resources" in their instructions, thus *moving* the parent into the nurse's construction of community.

We will now explore the effects of health-promoting discourse on community members attending the public health clinic. The argument I will advance in the following section contrasts with instructions given to practitioners to assess the "social determinants of health," which I read as premised on an expectation that the organizational context of practice can be transcended. The position advanced through this analy-

sis is, rather, that any adjustments made by nurses to attend to the client's lifeworld (that which influences his or her opportunities for health) are made from the nurse's position *within* the hierarchical, discursive location of the clinic.

Rehearsing "Good" Parenting

When parents arrived at the clinic, they were greeted by one of the staff nurses. Once the child's weight and height were recorded, nurse, parent, and child entered a private office where the parent was encouraged to talk about the child. At the end of a series of observed encounters, nurses reported their perceptions of the quality of the encounters. Quality was often linked with the degree of ease with which the parent entered into conversation with the nurse.

Material resources were available to nurses and parents in the clinic, and these clearly influenced the organization of work. Kay refers to "nursing theories" in her account of her work as a community health nurse. The reader might read this as an attempt to identify nursing as a legitimate profession. However, it also serves as an organizing resource available to nurses in the not uncommon circumstances that parents claim to have "no concerns" about their children. In the absence of "concerns," nurses turn to an assessment form to facilitate talk about the child. It is from within such accounts of parental observations that nurses' work of promoting health derive.

Consider again the "stylized" description of health-promoting practice: there is surely a link between the apparent significance of getting parents to talk about their child and the production of "information" that can be used to individualize a health-promotion intervention. In significant spaces of the clinic, parents came to know "when to talk" and to a considerable extent "what to talk." Drawing on clinic resources (assessment forms, health-promotion discourse, nursing theories, measurements of children's bodies and souls), nurses provided parents with "cues" about what would transpire in the clinic.

The intricate relationship between being in a position to have a parent provide an account of her child's "development" and being in a position of having to provide such an account points to the importance of considering the conditions supporting a nurse as s/he approaches a health-promoting encounter. In the analysis reported here, interestingly, reports of "good parenting" contributed to organizing day-to-day work regimens involving nurse and client. Following are some close readings of an exchange between a nurse and a client: how might agency (in a

form consistent with the rhetoric of health promotion) be apprehended within such an encounter? Who is guiding whom?

Evidence of "Good" Parenting: Disciplined Accounts of "Change"

The following example, which is presented in two sections, might help us explore the health-promoting work of a clinic nurse. In the first section, the nurse, Fran, assesses "change." In addition to using weigh-scales and tape measures, Fran seeks the parent's verbal renderings of the child's development. Erica, mother of four-month-old Loraine, provides an account of Loraine's "developmental" changes since the previous visit:

Fran: O.K., and what sort of things do you notice her doing now, developmentally, that she wasn't...when you were in here at two months? [looks briefly at the nursing record on the desk in front of her, then back at Erica]

Erica: She's talking a lot...she's quite vocal sometimes...she's not too vocal today [laughs]. She seems to be grabbing things a little bit. She learned how to pinch real good! She's pinched me...and...I've given her some toys to play with, and she's really fascinated by those.

Fran: Is she pick...is it the toys that she's picking up, or more that she's watching?

Erica: She's got a thingamajiggy [points at the ceiling]...a mobile! And she really likes that, and I've given her a mirror to look in, so...the play school thing has a mobile on it, she loves that. She rolls it and she looks at herself and talks and... [laughs]

Fran: O.K. Is she rolling yet?

Erica: She's trying to. She's really trying to turn her back and her hips, but she can't quite get the leverage to push herself over.

Fran: O.K. Well, she probably will surprise you /

Erica: / she rolled over, actually.

Fran: Oh, really!

Erica: A month ago, like from a...from front to back, but she doesn't know how to do it back to front.

Fran: O.K.

Erica: But she only did it once for me. She hasn't done it since, so I think she maybe had a little spurt of energy that day or something! [laughs]

Fran provides Erica with a clear instruction at the outset. She seeks an account from Erica of what Loraine is doing now, "developmentally," that she was not doing at the previous clinic visit. Inherent in her instruction is that Erica, as the mother, should have noticed Loraine's development, marked it, and recorded it, and should be able to reproduce it verbally in this setting. Thus baby Loraine is marked as a "resource" for health-promotion work, and as such is drawn into the discourse of parental accounts at the clinic. A primary function of parenting (as it is understood and expressed by nurses in the clinic) is cued: as a mother, you ought to monitor your child's "development," *in particular ways*.

In the ensuing exchange, Erica provides information on several of Loraine's "abilities." She mentions Loraine's verbal abilities, her fine motor skills, and, with some prompting from the nurse, her gross motor skills. Fran's initial request represents a "disciplined instruction": it assumes knowledge about the ostensible relationship between "development" and "parenting." Fran's question swiftly positions all three parties to the exchange in relation to one another: Fran as the legitimate questioner, Erica as the legitimate responder to the question, and Loraine as the legitimate referent of the question. Fran disciplines Erica by positioning her in such a way that Erica must return a particular type of message – one constrained within (or defined by) a "developmental" discourse. Constrained by institutional boundaries, Erica's response defers other, alternative responses. Erica is disciplined against talk of objects (toys and mobiles) and her daughter's response to these (fascinations, things she "loves") in favour of talk of visible action (rolling and picking up toys). The discipline provides an important signal for Erica regarding "what to talk about" in the clinic encounter.

The "successful" elicitation of a response to Fran's request relies, then, on Erica's ability to lock into and generate an account resonant with a particular discursive form. Erica is assisted in producing such an account by Fran's occasional prompts: "is it the toys that she's picking up, or more that she's watching?" and "Is she rolling yet?" Fran's guidance disciplines Erica: her prompts tell Erica what sorts of "developmental" change Fran wants to hear about. Erica's ability to draw on the developmental discourse is thus guided and shaped.

Erica shows an ability to report on several topics organized around the category of "childhood development." Fran's verbal prompt, seeking particular information on the baby's ability to roll, extends Erica's demonstrated knowledge of topics within the category of devel-

opment. Fran's prompt "instructs" Erica by refining the category even further.

Childhood development is constructed within this meshing of parental demonstrations of accounts, which are, significantly, already disciplined. It is significant that Erica already knows her account must be organized around an assessment of her child's movements, verbal skills, and fine motor skills. Discipline, the effect of intricate forms of surveillance, operates well beyond the boundaries of the clinic. These have already influenced how Erica "sees" her child. Such self-discipline is another resource tapped into by nurses in the clinic.

Enlisting Parents' Self-Discipline

The interaction between mother and nurse continues. Information obtained earlier in the encounter is inserted by Fran several minutes later in the form of an "intervention." In this part of the encounter Fran formulates a specific instruction based on Erica's disciplined rendering of how Loraine has changed since the previous visit. Note how this part of the conversation reflects the "stylized" health-promotion encounter discussed earlier, in that Fran draws upon material offered by Erica in constructing her "intervention":

Fran: O.K. [looks at forms, then back at Erica]. And she's sleeping through the night still?

Erica: Oh, yeah /

Fran: / Good /

Erica: / no problem.

Fran: She seems to have a really nice disposition, doesn't she?

Erica: Yeah, so far! [laughs] So far.

Fran: O.K., and have you started to think about house-proofing your house?

Erica: Yeah, yeah. I've got everything up – up in the cupboards and stuff like that. I have to get some locks for the cupboards still.

Fran: Yeah, cause she's going to be mobile fairly soon, so that's why...just be aware with rolling, that even if they're not rolling they can grab onto the edge of something and pull them, you know. If she's on the couch by herself /

Erica: / yeah! /

Fran: / she could really grab on and then pull herself to the edge and then /

Erica: / Oh, yeah, that's true. She could get leverage that way. I never thought about that /

Fran: / yeah /

Erica: / She's got a playpen downstairs, so I'll put her in that.

Having discovered earlier that the child is not yet rolling but is able to grab clothing and furniture, Fran inserts that individualized message into her instruction to Erica (the child can pull herself to the edge of the couch). It is interesting that the real danger – of the child falling from the couch and injuring herself – never gets mentioned. It is as though it is more effective to leave the dangers open.

The encounter is "successful." Erica has been "mobilized" to act in the community to prevent injury to her daughter. This example could stand as an instance of health promotion as nurses in the clinic have come to define it. What remains unexamined within these locally defined "standards" of practice, however, is a critical exploration of how such effects have been achieved. Although the preventive step of placing Loraine in the playpen must be taken by Erica herself – in her home, in the community – traces of the clinic and Fran are surely an integral part of this health-promoting action. Yet the rhetoric of health promotion, including concerns with accounting for the "social determinants of health," seeks to displace this participation of the health-care provider. The ensuing blindness to how health effects are achieved is, in my view, highly problematic.

Health Promotion as Position and Positioning

The challenge arising out of an analysis of practice such as that generated here may be of interest to practitioners, educators, and researchers. The challenge arises primarily out of a critical analysis of those factors that condition the *approach* of nurses within health-promoting encounters and the *effects* of that approach on the nurses' clients. The "will to instruct" is strong when administrative structures drive practitioners to show productivity in terms of monitoring clients' adherence to such behavioural norms as quality parenting. In the preceding example, the nurse successfully relayed to the mother her professional interest in preventing injury. Is the relay of professional surveillance consistent with contemporary understandings of the objects of health promotion? Has the radical shift in the relationship between client and provider really been completed within the context of such an encounter? Or has it been subverted in response to egalitarian demands embedded in the health-promotion literature, only to resurface as a more traditional,

expert-driven model of practice? This model is all the more difficult to recognize as powerful because power is now exercised, just as Foucault claims, through parents' monitoring of both themselves and the "developing" selves of their children.

This ethnographic study offers opportunities for researchers and practitioners to confront grounded examples of how educational rhetoric about practising nursing are put into play within contextualized settings. Such examples of practice must be taken seriously. The nurses whose work was observed as part of the study were serious in their engagements with clients. They were practising in ways they understood to be sanctioned by their managers. But these sorts of understandings do not flow directly from managers to practitioners. Understandings are mediated by situated appreciation of the resources available. Research that seeks to strip away the context of practice because it introduces "bias" or "complexity" into the findings also seeks to remove the highly sophisticated knowledge of "the social" used effectively by nurses and their clients. A perspective that seeks to surface concerns about "social" factors influencing opportunities for taking up health-promoting messages cannot avoid the positioned and positioning effect of the health provider by suggesting that the client's situation is somehow separate from that of the practitioner. Those who imagine the power of the provider's position can be displaced by separating the social conditions of client-hood from those that achieve a space within which practitioners can operate may well be practising a form of "mobilization" on readers.

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