The Importance of Critical Theory to Nursing: A Description Using Research Concerning Discharge Decision-Making

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La théorie critique s'est révélée une direction de recherche cruciale pour les sciences infirmières. Elle ouvre des aires de questions pour la recherche qui sont nouvelles et plus larges, et elle offre le potentiel pour étendre la base de connaissances en sciences infirmières. Je décris dans le présent article quelques applications de la théorie critique de Jurgen Habermas (1984-1987) aux sciences infirmières en utilisant l'exemple de la recherche que j'ai effectuée pour mon doctorat que je viens de terminer (Wells, 1994). La théorie a été utilisée comme perspective large pour la recherche dans laquelle j'ai étudié le processus de prise de décision de sortie de l'hôpital de malades âgés. Après avoir analysé les données de trente et un dossiers de malades, il s'est avéré que le processus était largement déterminé par les forces systémiques. La théorie de monsieur Habermas était essentielle pour comprendre la structure du processus comme moyen pour arriver à ses fins ou comme instrument, et pour trouver des idées pour changer la conceptualisation du processus de prise de décision de sortie. La théorie critique peut faire avancer la connaissance en sciences infirmières par rapport à notre compréhension de l'organisation sociale de situations de la pratique quotidienne et la possibilité de leur réorganisation.

Critical theory has emerged as an important research orientation for nursing. It provides for new and broader research questions and offers the potential to extend the knowledge base of nursing. In this paper I describe some applications of Jurgen Habermas's critical theory (1984, 1987) to nursing, using the example of my recently completed doctoral research (Wells, 1994). The theory was employed as a broad perspective for the study in which I investigated the process of decision-making concerning the discharge of elderly patients from the hospital. When data from 31 patient cases were analyzed, the process was found to be determined largely by systemic forces. Habermas's theory was key in understanding the structure of the process as a means-ends, or instrumental one, and in generating ideas for change in the conceptualization of the process of discharge decision making. Critical theory can advance nursing's understanding of the social organization of everyday practice situations and whether and how they might be reorganized.

Critical theory can orient research to the kinds of questions that relate to prevailing social conditions and the organization of human activity, posed in ways that potentially are linked to practical interventions

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(Morrow, 1994). In the last decade, this perspective has emerged as an important research orientation for nursing (see, for example, Allen, 1987; Hiraki, 1992; McKeever, 1992; Stevens, 1989; Street, 1992; Wells, 1994). Stevens articulated that critical theory provides an archaeology of the sociopolitical and cultural environment, which shapes our practices, our relationships with persons in our care, and, as Hiraki pointed out, what is accepted as legitimate knowledge. Meleis (1992), in her discussion of nursing theory development, argued that understanding "how individuals experience and respond to health and illness ... includes making connections and achieving syntheses that go beyond the perception and knowledge of the client and the provider" (the latter focus is characteristic of the phenomenological perspective of some nursing theories) (p.113). Although admitting a bias toward biobehavioural processes as the central focus in the development of nursing theory, Gortner (1993) acknowledged the potential benefits of critical theory to nursing. Bent (1993) identified another contribution of critical theory to nursing: as a theoretical and research tradition, it can help to identify points from which to approach change in the discipline as well as in health care in general.

Critical theory usually refers to the series of ideas that emerged in the 1920s and 1930s in Germany at the University of Frankfurt's Institute of Social Research. But Bronner (1994) has made it clear that, in fact, it began with a number of unorthodox thinkers including Karl Korsch and George Lukacs, who preceded the formation of the Institute. Rabinow and Sullivan (1987) point out that "the great strength of ... critical theory has been continually to urge that the human sciences cannot be detached from the greater problems of living" (p. 15). Critical theory, throughout its tradition and as expounded by Habermas (its current leading representative), has involved analysis and exposure of the sociocultural and political-economic conditions of modern society that can restrict human activity. This knowledge, in turn, is meant to prompt change. The interest of critical theorists thus has been to conjoin theory and critique to achieve praxis, or moral-practical action (Thompson & Held, 1982).

In order to demonstrate how useful Habermas's (1984, 1987) critical theory could be to nursing, I shall describe some of its applications by using the example of my doctoral research (Wells, 1994) about the decision-making process regarding the discharge of elderly patients from hospital. Personal clinical experience and a literature review had suggested to me that conflicting and multiple influences on the process (of a clinical, social, and organizational nature) rendered it complex

and, many times, frustrating and adverse for those involved. However, I found no studies focusing directly on elaborating the actual decision-making process, its multiple influences, and the broader context in which the process materializes and unfolds. My research was intended to fill these gaps in knowledge.

The study used the ethnographic research method to (a) describe the process of decision-making regarding the discharge of elderly patients from hospital, (b) make visible the more local, or immediate, circumstances organizing and giving shape to the everyday process of discharge decision-making, and (c) identify the consequences of the process for the persons involved. The ethnography involved participant observation of the discharge decision-making activities of professionals in a purposively-selected sample of 31 cases of patients 65 or older. These activities of professionals were observed across eight units in a large university hospital and over the patients' total hospital stays, in order to construct an in-depth description and explanation of the process of discharge decision-making. As well, focused interviews were conducted with patients, families, and key professionals involved in the process, in order to test emergent study findings and to fill gaps in the data. Medical-record analysis provided data about patients selected for case study and their clinical trajectory — that is, the course of their disease and its management. This information was important to the analysis of the relationship of the clinical course to discharge decision-making. *The Ethnograph* (Seidel, Kjolseth, & Seymour, 1988) computer software program was used to organize the unstructured data for interpretation, which consisted of identifying themes and patterns and generating the core findings of the study.

Habermas's critical theory was used as the broad framework for the study because it makes possible a discovery of, in Forester's (1985) words, "the institutional contingencies of practical actions" (p. x), a theme consistent with my research interest. The relation between Habermas's theoretical notions of rationality and social action in modern society, in particular, and the formulation of the study purposes and research questions, is illustrated in the first part of this paper. In the second part, I discuss how Habermas's perspective was also used in the interpretation of the research findings, which revealed that the discharge decision-making process was influenced largely by systemic forces. Habermas's theory offered a way of understanding the structure of the process as a means-ends, or instrumental, one. But the significance of his theoretical ideas goes beyond the interpretation of the empirical findings. Practical insights into ways to achieve change were

also generated by way of the theory. An example of these insights is outlined.

The Relation between Habermas's Critical Theory and This Study

Selected elements of Habermas's recent critical theory of society, published in his two-volume *The Theory of Communicative Action* (1984, 1987), broadly oriented the study. His ideas helped to frame the study objectives, beyond a mere description of the process of discharge decision-making for elderly patients, to include a focus on the play of forces underlying the process and the consequences of the process for those involved. In his theory of modern society, Habermas cogently argues that social structure (e.g., the organization of the hospital) is inseparable from social action (e.g., the discharge decision-making activities of practitioners), and that structure can constrain action. As Manicas explains (1987) in his analysis of the concept of social structure, " 'structure enters simultaneously into the constitution of the agent and social practices, and exists in the generating moments of this constitution.' It is both medium and product, enabling as well as constraining" (p. 272).

A reading of Habermas's theory suggested that the discharge decision-making process may have come to be structured by a strategic or instrumental (means-ends) mode of reasoning and of human interaction that undergirds our social systems, including health care. Habermas describes a strategic form of social interaction as oriented to " 'success,' to the efficient achievement of ends" (Bernstein, 1985, p. 18). Success is measured by the extent to which one's actions actually bring about the intended state of affairs. The mode of rationality supporting strategic action is instrumental, directing the choice of means to given — usually material — ends. The modernization of society (e.g., with industrialization and the development of capitalism) and its continuing growth and increasing complexity have necessitated goal-directed action and an instrumental rationality.

One of Habermas's central arguments is that strategic rationality and human action directed to the efficient achievement of ends have come to displace communicative rationality and action. A communicative or discursive form of reasoning directs individuals to question and negotiate issues, to reach mutual understanding (including an understanding of conflict) concerning social needs, interests, and norms. Communicative reasoning works from background assumptions,

norms, and values, which represent "cultural resources (including language) usually employed for the organization of everyday life in communication" (Misgeld, 1985, p. 96). Both forms of reasoning have become available to us in modern society as economic and political systems — as well as ways of interpreting the meaning of everyday life events — have become separated from traditional practices, such as those around kinship, and sacred (e.g., religious) forms of authority.

Habermas argues that society's failure to engage strategic and communicative rationality and action in a balanced way is related to systemic imperatives, such as the need for economic growth, administrative efficiency, and scientific and technological progress, which depend on the coordination of human activities using instrumental reasoning. However, what this means, as Misgeld (1985) articulates in his discussion of critical theory and education, is that communicative ways of understanding and interpreting the whys (reasons), wheretos (purposes, ends), and wherefroms (origins, motives) of various human activities are suppressed and not reflected upon. Using the example of the instructional-objectives movement, Misgeld elaborates on the consequences of an instrumental rationalizing attitude toward education:

> One does not know when one reads the book [*Objectives for Instruction and Evaluation*] where these units come from or why they must be there other than that they are the best thing to have for the sake of accountability, of improving the efficiency of teaching and of providing guarantees for learning success. (p. 88)

The active reflection of participants (teachers and learners) on the meaning and significance of educational work is bypassed.

The embeddedness of a strategic form of rationality and action in administrative and clinical practices in the hospital may have similar effects. It would mean that patient-related goals are defined according to the exigencies of the organization in order to meet predetermined ends efficiently — for example, in relation to acute medical care and its administrative management, including discharge decision-making, and to education and research in the university hospital. Moreover, reflective kinds of questions concerning the meaning and implications of a means-ends approach — to discharge decision-making, for example — may not be communicatively considered.

Habermas calls the one-sidedness (thus, distortion) that has come to exist in our forms of reasoning and actions *lifeworld colonization*.

Associated with this idea is the phenomenon of *cultural impoverishment,* which, he argues, has further contributed to the distorted way of reasoning in modern society. Communicative competence, Habermas argues, has come to take the form only of a specialized discourse or argumentation by expert cultures. As a consequence, increasing distance has been created between these cultures and the broader public. Furthermore, those who are not considered experts may become dependent on those who are for various definitions and decisions about human problems and their solutions.

The phenomenon of growth of professional groups as expert cultures, which has rendered the opinions of nonprofessionals about their health care irrelevant, or at best less important, has been documented in the literature on sociology of medicine (see, e.g., Freidson, 1988). As well, a number of empirical studies have found instances of professional interactions (including those involving nurses) with patients approximating action oriented to success concerning technical interests and preventing the emergence of holistic interpretations (Barrett, 1988; Brown, 1986; Fisher, 1982, 1984a, 1984b; Mishler, 1984; Scambler, 1987; Street, 1992; Waitzkin, 1984, 1989; Waitzkin & Britt, 1989; West, 1983). What this suggests in terms of discharge decision-making for elderly patients is that any significant interaction of a communicative, consensual nature in the definition of their situations may be infrequent, if it occurs at all.

The idea of cultural impoverishment constitutes Habermas's notion of ideology in modern society; that is, with the rise of expert cultures, opportunities for open or critical discourse are veiled. Furthermore, Habermas proposes that professional expertise founded on formal (i.e., scientific and technological) knowledge legitimizes a power relationship of professionals over the public. An imbalance in power results because instrumental rationality systematically displaces communicative rationality. In other words, the goals established by those with power, which may be advanced as a representation of collectively desired goals, cannot be examined, endorsed, or repudiated in a discursive or communicative manner. This is because the institutionalization of scientific, technological, and organizational rationality as the basis for social action makes it increasingly difficult for individuals to distinguish between technical interests on the one hand and practical or moral interests on the other. The concealment of the difference "proves the ideological power of the scientific-technocratic consciousness," Habermas claims (1970, p. 107). As a consequence, the political character

of a means-ends or instrumental form of rationality may go unrecognized as a constraint on human activity.

Habermas's conclusion is that although mutual understanding underlies all human action, it does so within the premises of formally regulated or instrumental domains of action. It is not the developments in the economy, administrative systems, science and technology, and expert cultures, per se, that are at issue: it is the subordination of communicative rationality and interaction to instrumental forms of reasoning and action.

In terms of the discharge decision-making process, Habermas's claims remained to be explored because the process and related activities of participants, along with the multiple influences on the process, had not yet been well articulated. Hence, it was still uncertain how the imperatives of the hospital system and of the lifeworld (arriving at shared understandings) were actually interwoven and/or conflicted in this everyday clinical practice situation.

Nevertheless, Habermas's critical perspective was helpful in leading me to ask broad and comprehensive questions about the process of discharge decision-making. Specifically, it directed an inquiry into (a) its basic description (sequences of stages and related activities and discourses of participants), (b) the play of forces underlying the process (reasons, purposes, and ends), (c) the perceptions of those involved (motives, origins), and (d) the consequences of the process for the persons involved (its positive features and pathologies). These questions related to the social context or organization and prevailing conditions of the process. Also, the questions were linked potentially to practical interventions because they were intended to establish the conditions of the process and expose the nature and source of its limits. The study questions thus reflected both the critical and the practical intent of the research consistent with critical theory. As well, they built on personal clinical experience and the research of others.

Habermas's critical theory was more useful than other critical theories (e.g., political economy) because of his central focus on the systemic distortion of communicative action. As well, unlike feminist theory, his theory does not impose a gender constraint in terms of the population that is of research interest. In the hospital, elderly women and men were observed to experience similar problems related to discharge decision-making. Finally, his theory was more relevant than traditional social theories in broadly framing the study purposes and

questions. The theoretical schools of functionalism (e.g., structural functionalism) and interpretivism (e.g., phenomenology), for instance, are limited by their view of social reality. In these perspectives, social structure and social action are assumed to serve the purpose of maintaining and/or restoring social order and human action. Description and explanation revolve around "what is" society and "why and how" it tends to hold together. The related inquiry does not entail identification of inherent conflicts and contradictions in social systems and the actions that can constrain human activity. Consequently, there is a quietism about these perspectives; they lack political force. However, it is the explicit task of critical theory to unveil the conditions that limit the full and conscious participation of individuals in society. For nursing, critical theory thus offers a research perspective that may help to uncover the nature of enabling and/or restrictive practices, and thereby create a space for potential change and, ultimately, a better quality of care for patients.

Habermas's Critical Theory and the Findings of This Study

The overarching conclusion, that the decision-making process to discharge elderly patients from hospital was mediated largely by systemic forces, was derived from the three core study findings that emerged during data analysis. The first core result was that the patients' clinical trajectories were not, contrary to what might be expected, a key element in shaping the process. In the majority of cases, decision-making took place without detailed knowledge or understanding of the patients' disease experiences. Characteristically, the patients' clinical outcomes were not manifest until later in the hospitalization; yet, discharge decision-making was tackled early on. For example, in the case study of an 81-year-old woman, the discharge decision-making process presented the following picture:

> Several different decisions were proposed over the course of her hospitalization. Each decision was not intricately linked to her clinical trajectory. Long before the outcome of her disease was known, both home with Home Care and the initiation of nursing home placement were contemplated, and the latter pursued. A Regional Geriatric Program (RGP) consultation was requested during active medical treatment. At the same time, arrangements for Home Care were requested, and plans continued to complete nursing home papers. Finally, the patient did return home with Home Care, but only after a 7-week course of rehabilitation with the RGP. (Wells, 1994, p. 167)

The second central finding explained, in part, why the discharge decision-making process did not follow directly upon the clinical trajectory. Specifically, in all cases studied, the process was shaped, in large part, by a variety of patient-related social factors and organizational or hospital-based parameters, many of which were assumed. The likelihood of discharging the patients was a major concern from the time of admission. The concerns of professionals, and their reasons for discharge decisions, related largely to patients' social situations (e.g., noncompliant health behaviour, social nature of the admission, inadequate social support) and to imperatives of the organization (e.g., fear of recidivism, avoidance of a delay in discharge). As well, the actions and discourses of professionals were oriented strategically, and not communicatively, to accomplish discharge. In the case of a 73-year-old man, (a) discharge decision-making was undertaken early and outside the context of an informed understanding of his actual clinical trajectory, (b) the concerns about and conditions of his discharge were based on various social and organizational factors, many of them unsubstantiated, and (c) the patient and family were approached only when decisions had already been taken at rounds.

The third core result further explained why the discharge decision-making process did not directly result from the patients' clinical trajectories. It was found that professional perceptions of the discharge decision-making process were functional or instrumental in orientation, as opposed to holistic: that is, they were biased toward administrative concerns and those of practitioners, such as bed turnover and the economic viability of the hospital.

In ethnographies, the theoretical approach underpinning a study can be used in the interpretation of the findings (Hammersley, 1992). In this study, Habermas's theory provided a way of understanding the structure of the discharge decision-making process as a means to particular ends (i.e., as strategic or instrumental action). It is systemic forces — mainly institutional imperatives, which are economic or resource related — that shape the discharge decision-making process. The process, accordingly, is characterized by an approach oriented to the successful or efficient achievement of institutional goals — namely, the prompt discharge of patients. The patients' actual clinical trajectories are superseded as a key factor.

Further, in Habermas's terms the discharge decision-making process is instrumentally, or one-sidedly, organized. Systematically distorted communication occurs because communicative action, which is discur-

sive and understanding-oriented, does not materialize in the process. As Habermas's theory indicates, communicative action does not arise, because it is colonized or displaced by a strategic orientation, which also allows professionals to control the process. Contrary to what his theory would suggest, however, the displacement of communicative action does not occur mainly by way of cultural impoverishment (i.e., by the subordination of patients' discourses to the specialized discourses of professionals). Rather, it happens as professionals coordinate the process in a manner oriented toward the prompt discharge of patients on the basis of institutional imperatives. It is the structure of the process that grants professionals decision-making control; this structure is ideological to the extent that it displaces opportunities for a communicative orientation to occur. In this process, ongoing discussions with patients and families were rendered superfluous, and a holistic understanding of patients' discharge situations was not reached.

Habermas argues that the institutionalization of instrumental rationality as the paramount basis of action in our social and political systems undermines communicative action. In so doing, the instrumental structure of action eliminates the evaluation (i.e., self- or critical reflection) of the validity of the instrumental approach itself. In my study, the strategic orientation of the discharge process was unquestioned. Yet, the other study results about the pragmatic and moral consequences of the process indicated that the strategic orientation to discharge decision-making was distressful to patients, families, and professionals. Moreover, too early decision making was, ironically, inefficient for the hospital. In other words, professional and family resources were not always rationally employed in discharge decision-making, there was no apparent effect on patients' length of stay, and the process was unnecessarily complex. Clearly, in terms of nursing knowledge and practice, critical theory can help to illuminate the social-structural basis of an everyday, established practice situation and expose its limitations.

Habermas's communicative-action idea may also represent an intervention strategy for a restructuring of the discharge decision-making process. (A discussion of the serious challenges of this idea of Habermas's is beyond the scope of this paper.) Communicative action, which is marked by a discursive, understanding-oriented attitude concerning social needs, interests, and norms, demands shared, equal participation in decision-making and consensual decision-making. Involvement of all participants in discharge-related issues may bring about a broader and more holistic understanding of patients' clinical

situations and discharge requirements, which would in turn foster greater accountability and lend legitimacy to the process. The process of questioning and negotiating may have the added benefit of participants reflecting on the adequacies and inadequacies of instrumentally oriented practices. Ultimately, a greater balance may be achieved between the legitimate demands of the system (discursively determined) and an acceptable discharge decision-making process. A restructured discharge decision-making process would be valuable to hospital administrators and nurses (as well as other practitioners) trying to meet conflicting goals concerning resource utilization and patient-centred care. Critical theory as a research and theoretical orientation can deepen our understanding of the mechanisms and values that influence our practice. It can be a point of departure from which to examine and restructure our practice in an emancipatory way.

Conclusions

Using the example of my recently completed doctoral research, I have indicated the important contribution that Habermas's critical theory can make to nursing. As White (1988) summarizes, it has been argued that critical theory as designed by Habermas allows for fruitful research concerning forms of social action and pathologies in modern society. It serves to connect practices, such as discharge decision-making, to issues of social organization beyond the perceptions of clients and providers, and thus fulfils a requirement that Meleis (1992) sets out for knowledge development in nursing. Similarly, Street (1992) concludes that knowledge useful to nurses must incorporate ideas about the relationships between practices, the structural elements of the health-care situation, and the larger society. This kind of knowledge can greatly contribute to our understanding of the actual clinical care of patients and to our vision regarding health-care programs and policy.

Habermas's critical theory offers a way in which to achieve change. In Bryan Green's words (1993), "I confess to sharing with critical theorists an intellectual conviction [and a practical commitment] that is political" (p. xiv). Habermas's communicative action model provides a practical vehicle for a restructuring of our everyday practices, which may offset the dominance of a strategic orientation. Hiraki (1992) explains the rationale behind this important theoretical notion of Habermas's: it may be "appropriate for instrumental rationality to inform technical actions that control our natural world. But when instrumental actions affect the social life of people, it exceeds its bound-

aries" (p. 9). Therefore, decisions about practical life must be made communicatively with the people affected.

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