

Designer's Corner

"Decision-Making in Context": A Proposal for a Comprehensive Methodology

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Decision-making has been the focus of a significant number of studies in nursing as well as in the social sciences. These have included studies of coping, clinical judgement, and the management of ethical dilemmas, among many other topics. Studies of decision-making have relied largely on self-report methods such as interviews and paper-and-pencil tools. I shall outline some of the fundamental limitations of these approaches and propose a shift toward a contextual study of decision-making.

Use of self-report can be a valid way of accessing a person's (conscious) thoughts, preoccupations, preferences, and opinions. Following "the fall of behaviourism," such methods are a *necessary* component of most studies of human experiences. Informants' articulations are inescapable sources of insight in the quest to understand lived phenomena. However, self-report methods are *insufficient* for studies that are intended to examine phenomena comprehensively.

Self-report methods are highly problematic when used in studies, such as those of decision-making, that seek to draw inferences beyond the conscious thoughts, preoccupations, preferences, and opinions of individuals. Decision-making is a human practice — something a person does. A self-report study of a practice (such as decision-making, parenting, coping, relating, or grieving) presumes that the informant is conscious of its content and process and that there is a correspondence between what people do and what they say they do. There is reason to suspect that informants may misrepresent actual practices and respond in socially desirable ways.

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However, the inadequacy of self-report is not the result of informant misrepresentation. The principal problem is exclusive reliance on self-report, which is a result of the researcher's presumption that persons are consciously aware of what they do and are able to explain how and why they do it.

The Limits of Self-Report

To illustrate the limits of self-report, I shall draw on two examples.

In a recent study (Carnevale, 1997) carried out in a pediatric intensive-care unit, I examined life-support decisions among parents, physicians, and nurses who faced a number of ethical dilemmas requiring decision-making. Typically, the informants described decision-making in terms of deciding what was best for the child — striving to reconcile the value of the child's life with the quality of that life. My field observations highlighted additional, highly significant phenomena surrounding their decision-making process. Although the prevailing issue was framed as a (ethical) decisional dilemma, the process sometimes involved struggles among the informants. Each person overtly expressed what he or she thought was best for the child, yet their actions appeared to also express additional concerns, such as (1) their sense of duty toward the child, or (2) having their views respected by the other people involved in the child's life. When I shared my observations with the informants, they confirmed that they had these concerns. My field observations were crucial in illustrating that life-support decisions do not consist of a simple analytical calculus. They involve enactments within a complex social context. (For an elaboration of the relationship between sociocultural context and ethical decision-making, see Carnevale, 1996.)

This last point is congruent with the findings of a decision-making discourse analysis conducted in the United Kingdom. David Silverman (1987) examined videotapes of physician-parent interactions in a pediatric cardiology unit. The investigator was struck by the very low rates of cardiovascular surgery performed on children with Down's syndrome, compared to non-Down's syndrome children who had the same heart anomaly. In conformity with the prevailing practice of informed consent, parents were the ultimate decision-makers on record. They accepted or refused surgery based on what they thought was best for the child. However, the study's discourse analyses suggest that contextual phenomena significantly influenced the decisional process in a manner that the participants were unaware of.

It was the policy of the unit in which this study was conducted to discourage heart surgery on children with Down's syndrome. However, parents were not informed of this policy. They were informed of the surgical options — but in a manner that differed fundamentally from that in which parents of non-Down's syndrome children were informed. These latter parents were presented with a medical plan that explicitly stated the child required heart surgery. In contrast, parents of children with Down's syndrome were addressed in a manner that was medically less coercive and that focused to a greater degree on the child's social life. Physicians tended to view the Down's syndrome children as apparently enjoying life as they were. They stated that it was ultimately the parent's decision whether the child would undergo surgery; however, they added that they would not opt for surgery if the child were their own. Thus the decision-making of these parents was shaped by contextual phenomena of which they were unaware.

Toward a Contextual Construal of Decision-Making

I stress that I am not criticizing self-report methods per se. Rather, I am outlining a problem that resides in what the researcher does with these reports.

Self-report is a highly valuable means of understanding how things matter to a person. As Charles Taylor (1985) points out, a person self-interprets, elaborates his or her very particular understanding of a situation against a sociocultural horizon of significances. The person's own report is inescapably the most valid way of accessing this dimension of his or her experience.

However, nursing is a practice discipline. As such, it seeks to elaborate a body of knowledge that enables its practitioners to (1) interpret and understand human experiences and practices, and (2) foster favourable changes through clinical intervention. To this end, researchers strive to understand not only how things matter to persons, but also what these persons do, and why. Nurses are concerned with a person's thoughts and feelings — but they are also concerned with the person's practices, and the conditions that shape these thoughts, feelings, and practices. It is a mistake for a researcher to infer interpretations about the latter from self-reports about the former. Human practices such as decision-making cannot be adequately understood without systematically studying the context of such practices.

Pierre Bourdieu (1977, 1980), in his extensive studies of human practices, found that practice involves the expression of socially

acquired embodied mastery enacted within a complex process of improvisation.

The explanation agents may provide of their own practice, conceals, even from their own eyes, the true nature of their practical mastery, i.e. that it is learned ignorance... It follows that this learned ignorance can only give rise to the misleading discourse of a speaker himself misled, ignorant both of the objective truth about his practical mastery... and of the true principle of the knowledge his practical mastery contains. (Bourdieu, 1977, p. 19)

A comprehensive study of decision-making requires an integration of field-observation methods and self-report methods. The researcher engaging in such an integrated study would likely identify multiple phenomena that converge between these two methods and multiple phenomena that diverge. These should inform how the study is conducted as well as how its findings are analysed. Ethnography offers a cohesive research framework that could serve as an example of the integration of methods I am advocating.

Decision-making is a contextually grounded practice. Any full and rich understanding of this practice requires the use of contextual methods that construe it as "decision-making in context."

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