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Abstract
Nursing practices can attract concern, even criticism, when watched from the bedside, or read from fieldwork transcripts by nurse-researchers investigating patients' communication of pain. However, a secondary analysis, via a discourse analysis with Foucault's work on governmentality, allowed for a reading of how pain was governed and this provided another perspective. In these findings, the nurses' position is constructed by patients as both 'good' and 'busy', regardless of the responsiveness of nurses to patients' pain. The patients' position was that of a 'good' patient if they were 'active'; that is, undertaking self-surveillance in relation to their pain and actively working toward their recovery. Their pain was constructed on a linear and numerical scale, to which all complied. Important to all this is the examination, a disciplinary procedure with invisible but powerful effects, so powerful that the patient's body is rendered docile.

Key Words disciplinary power, Foucault, governmentality, pain

Governing Post-Operative Pain: The Construction of 'Good and Active' Patients, 'Good and Busy' Nurses and the Production of Docile Bodies

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Background

This paper reports the findings of a secondary analysis of field-notes written as part of a primary study that investigated nurses' responses to patients' self-report of post-operative pain. These field-notes caused concern when first read by a group of nurse researchers, including myself. Although there were examples of nurses being responsive to patients' complaints of pain, there were many examples where it seemed that the nurse was somehow deaf, or just not responsive, to what the patient said about their pain. For example, when a patient complained that his indwelling-catheter was very painful, the nurse replied 'Shouldn't be' and left the room. The primary analysis was thematic in nature and also involved an analysis of time spent at the bedside. The secondary analysis, conducted concurrently, was undertaken in order to consider if a different theoretical and methodological approach to the field-notes could provide alternative understandings of the nurses' practice.

Considering my own position as a nurse-researcher reading the field-notes from the primary study, I was middle-aged and some years removed from the bedside nursing practice of post-operative patients. Perhaps my recollection of post-operative nursing was somewhat romanticized, as if the nursing of a previous era was somehow less problematic.[1] Or maybe I held fast to an image of nursing, described by Allen as that of the nurse providing individualised, unmediated care; an image that contrasts with the everyday practice of nurses.[2]

Either way, inherent in my concern was an assumption that nursing is a caring practice where the nurse should respond

well to the patient's complaint of pain. This notion of the 'caring' nurse ignores not only the context of nursing practice, but also the disciplinary power of the nursing position, as theorised by Foucault[3] in relation to the disciplines; something I will discuss a little later in this paper.

This dominant and idealised view of the nurse as 'caring' is also problematic for the nurse, for when they fail to live up to the ideal image, so-called problems of practice can too easily become fore-grounded. These 'practice problems' can even call up notions of 'good' and 'bad' practice, with no regard for how the nurse's agency (the capacity for choice) is intertwined with structure (the conditions of practice and organisational work).[4]

At the complex site of the hospital, advances in technology have brought about changes in the way both nurses and doctors practice.[1] Also changed is how the hospital functions in contemporary times. The efficient flow of patients through the hospital becomes important,[5,6] so much so that health establishments can now resemble industrial assembly lines.[7] These assembly lines keep running regardless of circumstances and nurses are central to this, indeed it is one way nurses exercise their power, even though they might at the same time acknowledge how much their practice has changed as a result of economic and health care reforms.[8]

Another change to the health area has been the introduction of the patient satisfaction survey. It might be speculated that here the patient is situated as an active participant in the judgement of quality health care; apparently determined by their level of satisfaction with that health care. In Rankin's[9] analysis of a patient satisfaction survey, she found that the way the survey was constructed shaped responses in ways that silenced some of the patient's experience and could distort accounts of care and treatment given.

At the same time as these and other changes have occurred in the hospital setting, and in the context of reduced financial funding, there is still an expectation that nurses will maintain high standards and provide 'good' nursing care.[8] As well as providing 'good' nursing care, nurses help to shape the subjectivity of the patient such that standards for the 'good' patient are established.[8] Indeed nurses, via an exercise of power, help to shape both individual and collective behaviour.[10] This is achieved by the way nurses conduct themselves, for it is via the nurses' conduct that patients are assisted with their initiation into the clinical domain. Nurses' conduct helps patients to come to know what is expected of them in their own conduct and how to present themselves so as to continue to be considered 'clinically appropriate'.[5]

This can be considered as nurses' use of disciplinary methods; the way, since the seventeenth and eighteenth century, the methods of the disciplines have overtaken slavery as a way to control the body of the other, with similar effects of utility but with both less cost and violence (3). The docile body is produced via the disciplinary method, one that uses the rather simple instruments of "hierarchical observation, normalizing judgement and their combination in a procedure that is specific to it, the examination".[3, p170]

One of the ways that patients' conduct is shaped is via an expectation that they take individual responsibility for their health; an expectation arising out of a trend that has taken hold in the Western world and has its roots in the association between illness and sin. This takes form today, in liberal democracies, as victim blaming.[11] This is achieved via notions of the 'good citizen', that is, a citizen who is an active participant in both economic and social life. This active and thus 'good' citizen is expected to be independent, responsible and self-reliant. Not only this, as risks are apparently known, citizens are expected to make rational decisions about their life and health so that risks are avoided. Thus the chronically ill person is positioned, via this discourse, as one who has failed as a 'good' citizen because they have somehow failed to make the right choices, have failed morally and are now somehow culpable in relation to their ill-health.[11]

This onus on the citizen to be active and participate resonates with notions of governmentality, where the subject is not only governed by the conduct of others but comes to govern their own conduct by surveying and monitoring their own bodies, thoughts and actions.[12] Thus there have been some significant changes, over recent decades, to concepts that govern health care. These changes provide a backdrop from which to notice and bring into sharp relief, the prevailing discourses that are operational in health care today.

Conceptual framework

The French philosopher Michel Foucault introduced the concept of 'governmentality' to consider a broader reading of the notion of governance. He considered the practice of governing from a historical perspective; from the sovereign's relation to their principality, via the idea of the art of government to today's notion of political science.[13]

More specifically, during the Middle Ages and classical antiquity, questions of government concerned how the ruling sovereign conducted themselves, the exercise of their power, how to secure both the respect and acceptance of their subjects, obedience to and love of God, *etc*. The idea of 'the

art of government' arose from the middle of the sixteenth to the end of the eighteenth century. This 'art of government' broadened the notion of governing beyond just the concerns of a sovereign to include the government of oneself, of others, of souls, of how to govern and whom the people would accept governing them etc. The problematics of government brought up further questions: how to be ruled, how strictly to rule, what methods to use and to what end? Then, during the eighteenth century an idea arose that challenged the art of government: political science. With this came techniques of government that acted on the population.[12]

Foucault's concept of 'governmentality' encompassed a number of ideas. Among them is the notion of how power is predominantly organised in the Western world, that is, in a complex way and via institutions, analyses, procedures etc, with the population as the target and 'political economy' as the form of knowledge.[13] From his historical analysis of government, Foucault further theorised governmentality in relation to how human behaviour is directed by procedures and techniques.[13] For Foucault, his interest in government is in relation to how it is practised[14] and is considered in a broad way, including the government of the state and of the household, how children and souls are governed for example, and how one governs oneself.[13] When government involves the governance of others, it has been referred to as 'the conduct of conduct' and consideration is given to how the other's conduct is shaped by practices that guide and affect that conduct.[14]

Thus Foucault's[12] concept of governmentality can bear relevance to how nurses (and other clinicians) might govern the conduct of patients in their care. It can also include how patients govern their own selves in the institution of the hospital.

Methodology

The aim of the study was to undertake a secondary analysis of data. The data was originally collected for a study that aimed to explore communication processes between patients and clinicians in relation to patients' post-operative pain and to describe the patients' experience and perception of their pain. The study from which the data arose will hitherto be referred to as the primary study.

The primary study design was a naturalistic, observational methodology with field observations, semi-structured interviews and pain assessments. The study involved an investigation of pain characteristics as communicated by patients, and nurses' responses to both the communication of pain by patients and pain-related activity. The sampling in the primary study was purposive. Fifty patients were recruited from an acute metropolitan private hospital in Australia. This sample consisted of 25 women and 25 men, with twenty five being under 65 and twenty five being 65 and over. The patients had undergone either orthopaedic, abdominal or thoracic surgery and were between day one and three post-operatively. They were all able to speak the English language and consecutive patients, who met the inclusion criteria, were invited to participate. The observation periods were of four hours duration, per patient.

The data from the primary study was analysed according to the research design for that study. However, in order to consider this data in a different way, and given that a text was available for analysis in the form of field-notes and interview transcripts, a discourse analysis was conducted for the secondary analysis. The theoretical perspective of the discourse analysis was informed by the work of Foucault, as this brought to the study a capacity to focus on practices rather than people, institutions or ideologies.[15] Thus the analysis focused on the practices of participants and these practices were interrogated via the research questions. In this instance the practices were those of nurses in relation to patients' expression of post-operative pain and of patients' expression of their pain. However, consistent with Foucault's[16] work, the nurses were not considered to be individuals with free-will but rather considered to occupy subject positions made available by the prevailing discourses operating at the site of this hospital. The patients were also considered to occupy subject positions produced by prevailing discourses

Also important was the way Foucault, in his work, asked 'how' rather than 'why' things came about[15] and this influenced the way the research questions were shaped for this study. That is, the research questions for the secondary analysis were: How is the subject position of the nurse constructed? How is the subject position of the patient constructed? How is the discursive object of pain constructed? How is pain governed? If anything is rendered silent, how is this brought about?

As there is no set way of conducting a discourse analysis,[17] the data analysis for this study involved the consideration of the research questions in the light of Foucault's[12,13] work on governmentality and the interrogation of the participants' practices, as represented in the field-notes, in relation to these questions. This was not undertaken in any formalised way but rather involved reading and re-reading the data-as-text and theoretical texts (field-notes, interview transcripts and Foucault's theory). The language of participants was

also considered in relation to what it might disclose about their assumptions, and how subject positions and pain were discursively constructed.

Findings

The 'good' and 'busy' nurses

The analysis found that the nurse is predominantly constructed from the patient accounts as 'good' and 'busy'. For example, said one patient in response to a question from the Research Assistant as to whether the staff listened to them: "Oh yes, they are doing a marvellous job; they are very busy … the nurses are very busy. The girls; they have been so good" (010). Another patient says "Oh, absolutely. They [the nurses] are good" and in reply to a question about how well the nurses had listened to their reports of pain, says: "Oh yes … they have got me extra pills when I have been in pain. I think if anyone listens to you, it's the nurses' (028). Another patient replies to the same question with "Oh, excellent; they have been excellent" (200).

These predominant glowing reports of nurses seemed, at times (and only at times), at odds with the field-notes reporting the events unfolding in front of the Research Assistant. For it seemed that regardless of what the nurses did, as represented in the transcripts, they maintained their place as 'good' and 'busy', as far as the patients were concerned. The most striking example of this is illustrated by the following extract. An anaesthetist is visiting the patient on the first post-operative morning and seems concerned about the level of pain the patient currently has and the pain she apparently experienced overnight:

> Anaesthetist: [to the nurse] - I thought 'Oh, all the patients must be really terrific' last night because there's no phone calls. There's usually heaps of phone calls on epidural day. [To the patient] – Well, I'm really sorry. I can't do anything about it if I don't know. I can't sleep in the room with the patient… and if the nurses don't ring me, I don't know what's going on. …
>
> Patient: They [the nurses] were very busy last night.
>
> Anaesthetist: Yeah. Okay.
>
> Nurse: That's where the morning shift come on and obviously…[to the patient] – Has it gotten more sore in the last hour or so?
>
> Patient: Oh, yeah. I rang the bell at quarter to seven and no one came till half past.
>
> Anaesthetist: Just as well you weren't choking or something isn't it!.... [After some further conversation the anaesthetist leaves]…
>
> [A little later…Patient to nurse:] …because I couldn't get anybody to come in.
>
> Nurse: Yeah.
>
> Patient: And it was just getting worse.
>
> Nurse: Yeah. I apologise for that.
>
> Patient: They were just very busy.
>
> [Later the surgeon comes.] Surgeon: You okay? Pain?
>
> Patient: Frightful night last night. They were very busy last night" (199).

Another example, given by the following extract, is one of the rare occasions when the nurses are criticised, and even so, the patient moves to defend the nurses against his own criticism.

> Patient: She [the nurse] said 'Well, I could give you a bolus [of analgesia]. I'll check on it' or something. But, again, I think she forgot but again I don't remember. I forget whether it was day or night. She came back and hadn't done it. And then she finally did it. She may have gotten, well, the minute you walk out that door, there's someone gunna grab you. So it's not really a critical thing. I'm not trying to criticise them. It's just a statement that it depends on who you have (107).

The patient goes on to say, upon direct questioning, that the nurses don't often come back to see if the analgesia has relieved the pain. He says: "Well one or two, a couple have that I can remember. No, I think that once they've given it to you they've moved on to something else. But I think maybe that's because they're so busy". In any case, he adds, "I'm not reliable at the moment because I'll drift off to sleep" (107).

Occasionally there was some resistance to this dominant subject position of 'good' and 'busy' nurse. For example, when asked if the nurses always listened to their reports of pain one patient said "Oh they do and they don't …Oh they go away and forget to give you the tablet"(138). This resistance though, as noted in this extract, did not extend to all the nurses, but rather, placed some as different to others. This was apparent with the few other notable resistances to the positioning of nurses as 'good' and 'busy'. When a nurse did not live up to this constructed position, they were seen as exceptions to the rule, as is illustrated here.

> A patient comments on how well the nurses have listened: "Oh they've all been very good. Everyone's been marvellous. The night nurse was great. [Whispers] – The other one that came in was a bit off-hand but you get that with nurses; don't know what to say there" (146). To the patients then, the nurses were busy, good, marvellous people and if a nurse could be faulted, she or he was marked as an exception.

The 'good' and 'active' patients

While the nurses were discursively constructed, so the patients were constructed also. The notion of 'goodness', that was pervasive in the construction of nurses, was also pervasive in relation to the patient construction. For example, one patient said "I don't think I'll be very good for the study. I am not good with pain … I am not a good one to ask about that because I am a woos [sook] " (010). Another patient didn't like to talk about pain but said "but it's there constantly, isn't it, to talk about … otherwise you can't tell anybody how you feel because you're not a good patient then" (161). This last patient illustrates something of a resistance to the notion of a 'good' patient in as much as he voices some distance from this subject position.

Another illustration of the idea of 'good' involved in the construction of the patient is given by the following extract, where a patient is telling the Research Assistant that she had severe pain and had spoken to the surgeon.

> Patient: Mr [surgeon] said 'You came good too quickly'. Or words to that effect. Do you know what I mean? I can't remember exactly what he said now, but I know what he meant. That somehow I was good too soon…" (189).

So there are notions of a 'good' patient, one who is not a sook with pain, who tells how the pain is for them. However, it's important not to come 'good' too quickly. A surgeon tells another patient:

> …Okay, we're going to give you some pain killers and we're going to get you up … won't be an easy day today, I warn you, but the quicker you're going, the better. Overall, it's good for you, but also it reduces the risk of blood clots (077).

So, not only does making the patient physically active reduce the risk of blood clots, for other un-stated reasons it's 'good' for the patient to get them going. An active patient is a good patient. Another doctor says: "We can't have you languishing in pain – you can't do things" (107). The analgesia therefore is related to getting the patient active, up and about, doing things. The patient is got going: working toward their recovery and discharge out of hospital: "the quicker you're going, the better". Another example:

> Surgeon: How did you go yesterday?
>
> Patient: Yes. Tough day. Felt a bit washed out.
>
> Surgeon: You had your Endone [analgesia] this a.m.? [Patient nods]. And the ice? Yes, good. The aim is to get up and going (055).

A good patient, one who tolerates and reports pain, also works actively toward their own discharge, not only in a physical sense, but also, as will be argued in the next section of this paper, in the way they survey their bodies in order to report their pain.

The discursive object of pain as linear and apparently measurable

Whilst both nurses and patients are constructed in language, so too is pain, that is, as a discursive object. In the study reported on here, pain is constructed, predominantly, as something that can attract a numerical rating of one to ten. The patients were positioned as the ones who could assign their pain the appropriate number. For example:

> The patient says he has pain.
>
> Nurse: What would the pain be out of 10?
>
> Patient: Right up there; about an 8 (209).
>
> Nurse: How bad is your pain?
>
> Patient: 5 out of 10 (161).

Indeed so widespread was this practice of the patient report of pain via this numerical measurement, that even the primary study's semi-structured interview guide included the question 'What is your current pain? (0-10)'.

However, although this was the dominant way pain was constructed, sometimes something escaped from this and it was far removed from notions of measurement. For example one patient said "Don't mind a bit of pain if you know someone cares about you" (163). Another patient told the Research Assistant that her pain was due to her being tired and missing her family in South America (276). These two examples stand as resistance to the dominant way pain is constructed.

Discussion

One of the striking aspects of the findings is the extent to which the patients excused mistakes and oversights made by nurses, by positioning them as 'good' and 'busy' even when it meant that they were in pain longer. The patients did not complain when the response to their pain was suboptimal. In a sense this could be explained as collusion by the patients with the nurses, reminiscent of the way Goffman[18] argues that audiences, such as hospital patients, can sometimes collude with the staff, excusing their mistakes, as part of a protective practice, where performers are protected by their audience.

Collusion by an audience occurs particularly at times when

the performers are under inspection and is part of how social encounters are structured.[18] In my analysis of the study, the doctors and even the research assistant may have been constructed by the patients as inspectors of nurses' work. This front stage of the nurses' performance, the bedside of the patient, is a site where patients watch the nurses perform and tactfully move to protect them from any mistakes picked up by the inspection of doctors, research assistants or others. This was remarkable though, given that the collusion resulted in minimising complaint about their own pain relief.

Moreover, in relation to this concept of inspectors of nursing work, it was Foucault who argued that at the end of the eighteenth century the hospital was organised so as to become an apparatus of examination, epitomized by the doctor's visit.[3] More than two hundred years later, the anaesthetist (in the field notes) visits a patient and, from their examination, moves to overtly (and not so delicately) admonish the nurse. Clearly here, the doctor is an inspector of nurses' work. In this inspection, the nurse, as supervisor of the patient, becomes supervised by the doctor. Hierarchical observation functions in this way,[3] with the doctor supervised by a medical superintendant, who is supervised by a hospital manager, and so on. While it might be disconcerting for nurses to consider that their work is supervised by doctors and not a more senior nurse, the findings from this study clearly disclose a medical supervision to which the nurse is subjected.

Another way to consider how it comes about that patients do not complain about sub-optimal pain relief, is in relation to how the patients are governed in the hospital and then come to govern themselves. The nurses, by their conduct, make it clear to the patients that they (the patients) are in the hands of those around them and their body is now constructed according to medical and nursing discourses.[5] This is a form of disciplinary power and an example of this is the nurse's examination of the patient in relation to their pain; an examination that illustrates the invisible way that disciplinary power operates. The one with the power (the nurse) is not on show, rather the one to whom power is exercised over (the patient) is on constant display, and in such a way that they are transformed from a subject to an object.[3]

Although the patient's body is in pain after being surgically opened and manipulated, the patient does not scream out, cursing and spitting, writhing and sobbing with pain. Rather, they take their own bodies as objects, survey their pain and report it in neat, orderly numbers from one to ten. Watched on all sides, by nurses, other staff, other patients, visitors and visiting doctors, the patient ends up rendering their own body as docile in conformance with the prevailing disciplinary methods of examination, an examination that entails a gaze of constant surveillance and a normalizing judgement.[3]

However, this rendering of their body as docile, and thus compliant to how it is taken as object, is not something the patient necessarily intends to do, rather it is the way the silent power of the health disciplines shape the patient's conduct so that not only do they conform in a manner that suits the way health professionals' work, they take on the gaze and examine themselves as if they were the health professional. They end up governing themselves.[12] There were, of course, some instances of resistance to this dominant mode of governance. However, even if resisting a docile position, it becomes rather difficult for the patient to complain about sub-optimal pain relief, for in doing so they could not only be rendered a 'bad' patient, but might find that it becomes harder to be heard.

The study findings reported here show that sometimes patients profess loudly and strongly about the 'goodness' of the care they receive, regardless of what those witness to that care might think of it. Rankin[9] found this also. Her aunt's ideas about the care and treatment she received as a patient were at times at odds with her own expert view of her aunt's care and treatment. Thus, this renders a nonsense (non-sense) the idea that the measurement of patient satisfaction somehow equates with the measurement of the quality of health care.

A further consideration in relation to these findings, is how the subject position of the patient is reminiscent of Galvin's[11] argument that the 'good citizen', in contemporary times, equates with the idea of an active citizen. In my analysis of the study, the 'good' patient is also an 'active' patient and one who will work their way toward discharge, surveying their body for pain, reporting it on a numerical scale, and taking analgesia, not so they will be comfortable but so they can be physically active. This is, as Galvin argues, an era when patients are expected to make rational choices based on the information provided to them about health and risks. The rational choice expected of the patient, in the study reported here, is that they participate actively in their own treatment.

The production of this 'good and active' citizen/patient can be brought about via a technology of the self, as proposed by Foucault.[19] The patient, by themselves or with the help of the nurses and doctors (and other hospital staff no doubt), transforms the way they present, their thoughts and actions, so as to attain something. This that might be attained could be thought of as 'goodness'; they become a 'very good' patient. This technology of the self then, works together with the disciplinary power to produce the 'good and active' patient.

In this paper, while attempting neither to idealise nor denigrate nursing practice, but rather to consider how responses to pain are produced, it is worth also considering how, as Purkis[4] argues, the nurse practices within an organisational context that is intertwined with their agency. There are discourses, other than the disciplinary ones, that shape available subject positions for nurses. The administrative discourse, with its imperative to move patients quickly through the hospital[5, 6] as if they were on an industrial assembly line[7] is also apparent in the study findings.

Limitations of the study

There were two main limitations of the study. The first was that the study field was, in Goffman's[18] terms, only the front-stage of nursing practice. Due to this, there was no way of knowing what was occurring back-stage for the nurses. It is possible that the back-stage work was having an effect on the front-stage work, particularly given the changes to the functioning of the hospital in recent times, as was outlined in the background section of this paper.

The second limitation was that the primary study design did not establish the conditions for the research assistant to be reflexive regarding their position in the field. It is therefore not clear how the research assistant's position in the field had a bearing on the research findings. For example, as noted in the transcripts, on one occasion the research assistant stopped the audio-tape because the patient was going to talk about 'an unfortunate event' with medical staff. What then is stopped, and what is given permission to continue, would have been worthy of consideration in relation to the research assistant's position in the field.

Conclusion

The 'good and busy' nurse was the dominant subject position for nurses in this study. This construction was heavily defended by patients who protected the nurses when their performance came under inspection, even when their own pain relief was the concern. These 'good and busy' nurses inducted the patients into their dominant subject position as 'good and active' patients, and doctors also played a role in this. The dominant construction of pain was via an apparently quantifiable and a linear scale that worked to silence patients own associations with pain. This simple 'instrument', an apparently efficient way to think about pain, renders something as complex and plural as human responses to pain to a number from one to ten. Patients weren't people who entered hospital with their own life circumstances, experiences and associations with pain. This would be far too messy for an institution dedicated to the efficient processing of patients toward discharge. Comfort is not important – movement is.

Patient satisfaction is also apparently important in the contemporary hospital, yet patients do not necessarily respond to instances of 'poor service' by complaining, as customers are inclined to do. In this study, those with some knowledge of health care (nurse-researchers and the anaesthetist) could locate instances of suboptimal practice by nurses (and for that matter of some doctors' responses) in relation to patients' complaints of pain. Yet the patients themselves did not complain, thus highlighting the complexity of the site of health care, and rendering as a nonsense the notion that patient satisfaction somehow equates with quality health care.

Rather than being rendered 'satisfied' the patient is rendered 'docile' by the power of the disciplinary processes. This is produced via the examination, one so powerful that all parties participate in it, even patients. They come to construct and govern their own pain in the same way as the nurses and doctors construct and govern their pain, and in doing so take their own selves as objects.

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