

Faking a difference: evidence-based nursing and the illusion of diversity

Gary Rolfe

Whilst it is desirable for the dominant paradigm (discourse) in any discipline to be seen to be encouraging diversity, I will argue in this paper that the result of *real* diversity is to decentralize power and strengthen the challenges to that discourse. It is therefore in the interests of the dominant discourse (if it wishes to remain dominant) to act to neutralize the power of its competitors by forcing them to conform to the rules of the dominant discourse. In this way, the illusion of diversity is maintained, but its power for radical change is greatly diluted.

In deconstructing some of the most influential 'texts' (in the broader sense of the term) of evidence-based nursing, I have attempted to show that the usual way of divesting competing discourses of their power is through an assimilation into the dominant discourse in the name of diversity. However, such assimilation is, in reality, more akin to an aggressive takeover bid which maintains the rules, values and culture of the dominant discourse. For example, when qualitative bids for research funding are judged according to the rules of quantitative research, that is, according to their generalizability, sample size, and so on, the outcome is inevitably to their disadvantage. Simply by agreeing to play, any competing discourse accepts the rules of the game that are designed to deny fair competition. The rhetoric of diversity therefore masks a strategy for maintaining power which can only be challenged by (Lyotard's notion of) the philosopher, who attempts to expose the inequality inherent in it. © 2002 Harcourt Publishers Ltd

The politics of difference

I'll teach you differences.

King Lear. William Shakespeare

'Diversity', in common with terms such as 'community' and 'equality', is usually taken to be a good thing almost without question. Diversity implies variety (which, we are told, is the spice of life), deviation from dull routine, and eccentricity (in its safe 'English' form). For ecologists, biodiversity and an extended gene pool are signs of a healthy biosphere, whilst most sociologists argue that racial and cultural diversity are signs of a healthy society. And in everyday life, we all wish to assert

our individuality, our divergence from the norm; no one wishes to be thought of as a conformist.

However, there is one sphere of activity where diversity is largely unwelcome, and that is in politics (in the broadest sense of the word). It is far easier to control or govern a convergent group; a group which thinks the same thoughts in the same way, believes in the same values, worships the same god(s), and even dresses in the same clothes (why else do certain groups such as soldiers and schoolchildren wear uniforms?). The political Right has always openly acknowledged this fear of diversity: the very word 'Conservative'

Gary Rolfe
PhD, MA, BSc, RMN,
PGCEA, Reader in
Practice
Development,
School of Health
and Social Care,
University of
Portsmouth,
St Georges Building,
141 High Street,
Portsmouth
PO1 2HY, UK

suggests a certain restrained uniformity, and we need look no further than the penchant of the extreme Right for uniforms and its xenophobic, homophobic and even gynaeophobic attitudes to confirm our suspicions. The political Left has a much finer tightrope to walk, since it has traditionally espoused an outward-looking, inclusive, devolutionary and internationalist attitude that mitigates against centralized rule. However, we can see in issues such as trade unionism and the rise of 'New Labour' how even the Left expects conformity and uniformity (and the ruthless ways in which it goes about enforcing it) when it comes to matters of power and control. The problem for the managers of broad-left, liberal democratic organizations, then, is to be seen to be encouraging diversity of thought, belief and action, whilst maintaining the necessary conformity for trouble-free rule.

This is the dilemma faced not only by managers of seemingly liberal organizations such as schools, universities and businesses, but also by larger and more nebulous entities such as academic disciplines and professional groups. All professions, by definition, are regulated. Entry to, and expulsion from, professional groups is controlled by a very small number of (sometimes) elected individuals who are charged with maintaining the credibility and standing of the profession both with its members and, more importantly, with the general public who (directly or indirectly) employ those professionals to provide a service. In maintaining internal and external credibility, it generally suits the professions to exude an air of liberal diversity, offering a range of roles and job opportunities to meet the requirements of all their potential members, and a range of services to meet the needs of all their potential clients. Even the traditionally convergent professions such as the armed forces and the police are seeking (perhaps half-heartedly) to diversify their membership to other cultural and ethnic groups such as homosexuals and Blacks in order to sustain or rebuild the confidence of their members and of the general public.

However, the task of regulating and controlling the professions calls for different criteria from those required to maintain

credibility. Divergence results in difference, and whereas a tolerance of difference is a useful attribute for promoting the public face of the profession, a degree of convergence towards uniformity is necessary for ensuring internal discipline and conformity. We have seen that, for professions such as the armed forces and the police, such convergence is overt and expected, and is enforced and demonstrated by the wearing of uniforms, parade drill, and unquestioning obedience. In other professions, such as education and the law, the exercise of pressure to converge is far more subtle and often goes unrecognized by many of the members until they wittingly or unwittingly step over the often invisible boundaries.

Nursing, of course, started out as an overtly convergent profession, and still retains many of the trappings such as uniforms (usually with stripes, 'pips' or colour-coding to denote seniority) and overt hierarchies of command. However, it wishes more and more to be seen as a liberal profession (see, for example, the recent government paper, perhaps significantly entitled *Making a Difference*, DoH 1999) in which its members are seen to be thinking, autonomous and questioning practitioners and in which promotion depends on original thought and innovative practice rather than conformity to certain arcane standards of moral and social behaviour. My aim in this paper is to demonstrate that behind the liberal facade of diversity and the promotion of difference lies a core value of convergent conformism that serves to constrain individuality and stifle creativity.

Nursing, like most disciplines/professions, is characterized by a number of competing discourses, where a discourse is taken to be a set of rules or assumptions for organizing and interpreting the subject matter of an academic discipline or field of study (Jenkins 1991). Discourses are similar to what Kuhn (1996) referred to as paradigms, and regulate matters such as which research methodologies are considered the most appropriate for generating knowledge in the discipline, how that knowledge is disseminated and taught, which kinds of projects receive funding, how practice should be organized, and on what kinds of knowledge it should be based.

In nursing, the competing discourses include the medical model of practice, holism, reflective practice, evidence-based practice, and so on. There are clearly areas of overlap between these discourses, but each has its own methods, ideology, and criteria against which good practice is measured.

Generally speaking, one particular discourse dominates a discipline at any one time, and I suggest that a broadly medical model prevails in nursing, supported and funded by the Department of Health, and driven by innovations from the discipline of medicine such as evidence-based practice and the randomized controlled trial. In fact, as a general rule of thumb, the dominant discourse can usually be spotted simply by the fact that it does not need to justify itself. For example, you might have noticed that many qualitative research papers and dissertations begin with a discussion (and often a defence) of why a qualitative methodology was chosen, but that papers reporting on quantitative studies simply take as given that theirs is the method of choice.

Being a subscriber to the dominant discourse carries with it certain obvious privileges such as power, money and fame. Thus, if you practice, teach or research within the constraints of the dominant discourse, you are more likely to be promoted to a position of power and influence, you are more likely to be awarded grants for continuing and disseminating your work, and you are more likely to become a nationally recognized figure within your discipline. As might be expected, competition between discourses is fierce, and once power is attained it is generally clung to at all costs. Other discourses are demeaned and the power structure is re-organized in such a way that makes it difficult for the dominant discourse to be toppled. Kuhn describes how advocates of the dominant paradigm respond to challenges to it:

Though they may begin to lose faith and then to consider alternatives, they do not renounce the paradigm that has led them into crisis. They do not, that is, treat anomalies as counter instances, though in the vocabulary of the philosophy of

science that is what they are . . . They will devise numerous articulations and ad hoc modifications of their theory in order to eliminate any apparent conflict.

(Kuhn 1996, pp. 77–78)

In nursing, for example, the dominant discourse has redefined research as 'rigorous and systematic enquiry . . . designed to lead to generalizable contributions to knowledge' in which 'small scale projects should be curbed' (DoH 1993). In this way, research which makes general statements about large populations based on quantitative statistical studies with large samples and experimental or quasi-experimental designs is favoured over qualitative research, much of which is small-scale and not widely generalizable, and therefore often falls outside the definition of what counts as research. Similarly, best practice has been rebadged as 'evidence-based' with the 'gold standard' of evidence being the randomized controlled trial (Long 1998), so that practice not based on the findings of RCTs is, by definition, inferior.

But as we have seen, the dominant discourse has to be seen to be encouraging diversity, even though the consequences of diversity would inevitably lead to a dilution of the power, authority and dominance of that discourse. We therefore see a rhetoric of 'tolerance', of 'sharing', and most insidious of all, of 'assimilation', in which supporters of the dominant medical model discourse grudgingly acknowledge that competing discourses might have something useful to offer the discipline, whilst at the same time relegating the contribution from these competing discourses to a subservient role.

Deconstruction

In order to demonstrate how the dominant discourse appears to tolerate (and even encourage) diversity whilst at the same time acting to close it down, I shall offer a deconstructive reading of three elements of evidence-based practice (EBP). Deconstruction is usually associated with the post-structuralist philosophers, particularly with the work of

Jacques Derrida, and offers a powerful method of critiquing texts by exposing the contradictions and aporia that are inevitably written into them. Much of the activity of deconstruction therefore takes place in what Derrida (1976) referred to as the 'margins of the text', in the seemingly innocuous and even superfluous passages where the author's guard is down. As Norris tells us:

To 'deconstruct' a piece of writing is therefore to operate a kind of strategic reversal, seizing on precisely those unregarded details (casual metaphors, footnotes, incidental turns of argument) which are always, and necessarily, passed over by interpreters of a more orthodox persuasion. (Norris 1987, p. 19)

It must be borne in mind, however, that there are as many deconstructive readings of a text as there are writers, and that each deconstruction is itself open to further deconstructions. This, then, is a single 'reading' of evidence-based practice that is no more or less privileged than any other reading.

Deconstructing the discourse of evidence-based practice

For Derrida (1976), the notion of a text went far beyond a simple written manuscript to encompass all possible means of expression, including the spoken and the enacted. I shall begin, however, by focusing on several journal papers by writers who hold positions of power and influence in the dominant discourse, and who therefore have most to gain in perpetuating the discourse and most to lose by its demise. I intend to demonstrate the contradiction implicit in many of these texts in respect to the issue of diversity, in particular, how the public face of EBP attempts to promote the illusion of diversity whilst the hidden agenda is to close it down.

In fact, many of these contradictions are quite overt and explicit; they are on the surface of the text for all to see. For example, the paper by the self-styled 'Evidence-Based Medicine Working Group' (EBMWG), which originally launched evidence-based medicine, stated

boldly that:

Evidence-based medicine de-emphasizes intuition, unsystematic clinical experience, and pathophysiologic rationale as sufficient grounds for clinical decision making.

(EBMWG 1992, p. 2420)

Thus, only in cases where there is a 'dearth of adequate evidence' or where certain 'aspects of clinical practice cannot, or will not, ever be adequately tested' (EBMWG 1992) should we fall back on other forms of evidence such as intuition and clinical experience. On this reading, then, EBP is clearly *against* divergence: it de-emphasizes the intuition and clinical experience of individual practitioners in favour of evidence based on the self-proclaimed 'gold standard' of RCTs. The very existence of a gold standard mitigates against diversity, and the last thing that is wanted is for individual practitioners to be making clinical decisions according to their own individual judgements.

Indeed, many later writers made this convergent attitude towards practice absolutely explicit. Thus, French (1998) interpreted EBP as 'The process of systematic identification, rigorous evaluation and the subsequent dissemination of the use of the findings of research to influence clinical practice', and continued by adding that 'the gold standard for evaluating the effectiveness of an intervention is the randomized controlled trial' (French 1998). This sentiment is echoed by DiCenso et al. (1998), who asserted that 'evidence-based health care is about applying the best available evidence to a specific clinical question', and qualified that statement by adding that 'the RCT is the most appropriate design for evaluating the effectiveness of a nursing intervention' (DiCenso et al. 1998). The message could not be clearer: as far as possible, all nursing interventions should be based *not* on the expert clinical judgement of the experienced nurse, but on the findings of RCTs.

One reading of the imposition of a 'gold standard' is that it ensures the quality of the nursing intervention. An alternative reading, however, is that it serves to exert control over practitioners by ensuring that they all respond in the same way to the same clinical situation.

In effect, it minimizes choice on the premise that all practitioners are essentially interchangeable (in other words, that they are identical). Although such a strategy might serve to regulate practice, the suppression (or de-emphasis) of individual clinical judgement in favour of research evidence is likely to alienate large numbers of practitioners, particularly those who regard themselves as experts. Thus, in the very same paper that de-emphasized intuition and clinical experience as suitable forms of evidence, we are informed that 'clinical experience and the development of clinical instincts... are a crucial and necessary part of becoming a competent physician' (EBMWG 1992).

Similarly, later papers also acknowledge 'clinical expertise' as a valid form of evidence (Sackett et al. 1996, DiCenso et al. 1998, Thompson 1998), although we can detect some reluctance and ambivalence in this acknowledgement. Thus, DiCenso et al. appear keen to include the clinical judgement of the nurse in the equation, stating that 'clinical expertise must prevail if the nurse decides that the patient is too frail for a specific intervention that is otherwise 'best' for his condition' (DiCenso et al. 1998). However, they elsewhere flatly contradict this stance, stating that:

We strongly disagree with White's assertion [that expertise is a better basis for clinical decision making than the RCT]. History has shown numerous examples of health care interventions which, on a patient by patient basis, might appear to be beneficial, but when evaluated using randomized trials have been shown to be of doubtful value, or even harmful. (DiCenso et al. 1998, p. 39)

It is possible that the writers were unaware of their contradictory statements: that intuition and clinical experience should be both 'de-emphasized' and 'play a crucial role in becoming a competent physician' (EBMWG 1992); and that clinical expertise 'must prevail' whilst at the same time being 'of doubtful value, or even harmful' (DiCenso et al. 1998). On this reading, they were simply asserting the natural tendency of *any* dominant discourse towards practice based on a single and easily

controlled precept (in this case, the RCT), whilst at the same time exuding a veneer of tolerance, divergence, and acceptance of individual clinical decisions.

A second reading, however, is that the contradictory statements represent a cynical exercise in what the postmodern architect Charles Jencks has called 'double coding', in which two different messages for two different audiences are simultaneously promulgated in the same text. Double coding entails a 'radical schizophrenia' that 'confirms and subverts simultaneously' (Jencks 1996).

In this case, the message to practitioners is that EBP continues to value their traditional skills and experience, whereas the message to academics is that the skills of conducting and critiquing research are the most valuable. In this way, academics are able to exert power over practitioners by concealing the 'true' nature of EBP. As Foucault (1976) pointed out, 'Power is tolerable only on condition that it mask a substantial part of itself. Its success is proportional to its ability to hide its own mechanisms'.

David Thompson, Professor of Nursing Research at the DoH (and therefore firmly entrenched in the dominant discourse), moves beyond contradiction and concealment to outright denial in his paper entitled 'Why evidence-based nursing'. From the deconstructionist's point of view, it is worth dwelling briefly on the title, which is another subtle example of double coding. On first glance, the title is democratic, inclusive and exudes an air of toleration of difference, suggesting a debate around the question of why we might adopt the practice of evidence-based nursing. Note, however, the absence of a question mark; the title is not posing a question, but outlining an imperative. Thompson is not *asking* 'why should we adopt evidence-based nursing?', but *asserting* 'this is why we should adopt it'. Under the veneer of divergence lies the rhetoric of convergence.

This suspicion is confirmed by the content of the paper, which begins with the usual reassurances that 'evidence-based health care, including nursing, is about integrating research evidence with clinical expertise, the resources available and the views of patients'

(Thompson 1998). However, the entire paper is then devoted to discussing strategies for implementing *research*, and interestingly, the words 'clinical expertise' are never again mentioned. The public face of EBP is inclusive; we can all contribute to the evidence required for best practice. However, the underlying message is that the only 'real' evidence comes from research, and even then, as we shall later show, not from the sort of research that practitioners might become involved in.

We can begin to see, then, that the way that evidence-based practice addresses the problem of diversity is by assimilation of competing discourses. Alternative forms of evidence such as expertise and clinical experience are seemingly welcomed, but at the same time are demeaned and discounted as 'blind conjecture, dogmatic ritual or private intuition' (Blomfield & Hardy 2000).

Deconstructing the hierarchy of research evidence

There is a general consensus within the dominant discourse of EBP that the randomized controlled trial (RCT) is the 'gold standard' of research evidence, but that other methodologies, including qualitative approaches, have a role to play. Thus, DiCenso et al. claim that:

... we hope to convey that good evidence does involve more than RCTs and systematic overviews. Each research design has its purpose, its strengths, and its limitations. The key is ensuring that the right research design is used to answer the question posed.

(DiCenso et al. 1998, p. 39)

Thus, whereas the RCT is the gold standard for evaluating clinical interventions, 'qualitative studies are the best designs to better understand patients' experiences, attitudes, and beliefs' (DiCenso et al. 1998). The public face of evidence-based practice is therefore of an inclusive strategy that simply matches the best design to the question being asked. We might expect, then, that problems such as 'understanding

patients suffering and how that suffering can be ameliorated by the caring and compassionate physician' (EBMWG 1992) would be just the sort of question to be addressed by a qualitative methodology. However, the writers continue by stating that:

The new paradigm [of EBP] would call for using the techniques of behavioural science to determine what patients are really looking for from their physicians and how physician and patient behaviour affects the outcome of care. Ultimately, randomized controlled trials using different strategies for interacting with patients ... may be appropriate.

(EBMWG 1992, p. 2422)

It appears that even issues such as patients' attitudes towards their care are best answered through the RCT, and only 'when definitive evidence [from RCTs] is not available one must fall back on weaker evidence' (EBMWG 1992). This suspicion is supported in the writing of Kevin Gournay, a nurse researcher and influential figure with the Department of Health, who argues that:

There is of course a place for qualitative methods, but such research needs to use a rigorous approach *and should be linked to quantitative methodologies ... for it to have any meaning.*

(Gournay & Ritter 1997, p. 442, our italics)

I am suggesting, then, that beneath the rhetoric of diversity of methodology, of the most suitable method for each research question, lies a barely disguised contempt for methodologies from competing discourses as 'weaker forms of evidence' which only have meaning when linked to quantitative studies. Furthermore, such a strategy of ordering research in a hierarchy has two distinct benefits for the dominant discourse.

Firstly, in becoming assimilated into the discourse of EBP, qualitative research paradigms are tacitly agreeing to abide by the criteria of quantitative research, criteria such as generalizability, validity and rigour that condemn them forever as second-class methodologies. Gournay and Ritter (1998) are quite clear on the criteria by which

qualitative studies should be judged:

We do not accept that scientific rigour is achieved by an interviewer who has not undergone interobserver reliability testing, or by validity testing that does not include a description of the constructs under consideration and that does not include test-retest data, or by use of terms such as 'symbolic interactionism' in an article that makes no reference to Mead. (p. 228)

Interobserver reliability and test-retest reliability are both criteria of quantitative research instruments, and have little or no meaning for qualitative researchers. Indeed, it is difficult even to imagine how we might go about measuring the interobserver reliability of an in-depth interview or the test-retest reliability of a set of observational field notes.

Such a naive understanding of issues of validity and reliability in qualitative research might be laughed off were it not for the fact of Gournay's pre-eminent influence with both the nursing hierarchy and the Department of Health. Apart from demonstrating a shocking ignorance of even the basics of qualitative research design, we would accept his argument that all articles on symbolic interactionism should mention G.H. Mead if and when all articles on RCTs (including Gournay's own work) mention Ronald Fisher as the founder of RCT methodology, but as we argued earlier, the dominant discourse has no need to justify its basic assumptions and first principles.

Secondly, by ordering research into a hierarchy in which the gold standard is the large-scale (and therefore expensive) randomized controlled trial rather than the small-scale qualitative study (which might not require any external funding), the dominant discourse is able to maintain a tight control over what is researched and who is to research it. Not only does the government and its various agencies control the purse strings to most of the major research grants, thereby determining who will be funded to carry out the large-scale 'gold standard' research studies, but certain influential nurse researchers are also attempting to define what

counts as adequate research training and who is competent to carry it out. Thus, Kevin Gournay, writing specifically about psychiatric nurse researchers, claimed that 'A priority is to establish an infrastructure of properly trained researchers' (Gournay & Ritter 1997). For Gournay, 'properly trained' means having a doctoral qualification, although:

When one scrutinizes PhD theses written by psychiatric nurses, many are based on qualitative and uncontrolled studies. To compound the problem, there appears to be a considerable variation in pass standards for PhDs between universities, and some theses contain fundamental flaws of design, analysis and write up.

(Gournay & Ritter 1997)

Not just any PhD will do. It should be conducted in an approved (by Gournay) university using an approved (by Gournay) methodology.

The philosopher Jean Francois Lyotard referred to this strategy of judging all discourses according to the rules and criteria of the most powerful as a *differend*, which is 'a case of conflict between (at least two) parties that cannot be equitably resolved for lack of a rule applicable to both arguments' (Lyotard 1983). It is clearly a situation in which power takes precedence over knowledge, and 'a wrong results from the fact that the rules of the genre of discourse by which one judges are not those of the judged genre or genres of discourse' (Lyotard 1983). We can see in the above example, then, that once qualitative researchers allow themselves to become sucked into the hierarchy of evidence, they will inevitably find themselves on the wrong end of a *differend*, and will quickly become marginalized.

Deconstructing the journal *Evidence-Based Nursing*

We turn now from written texts to a deconstruction of a journal. *Evidence-Based Nursing* is edited by Alba DiCenso, Nicky Cullum and Donna Ciliska, whose paper we cited above. All are key players in the evidence-based nursing movement: Dicenso and Ciliska are at McMaster University in

Canada, where evidence-based medicine originated, and Cullum is at the Centre for Evidence-Based Nursing at the University of York, which has close links with the DoH, and where David Thompson, Professor of Nursing Research at the DoH, is also based. The journal, then, can be seen as an international mouthpiece of the dominant discourse. As such, my contention is that part of the remit of the journal is to maintain control and influence over practice, and to curb the proliferation of competing discourses in favour of a convergence towards practice based on the self professed 'gold standard' of RCTs.

My suggestion that the journal achieves this convergence towards a narrow and easily controlled mode of practice by controlling the flow of evidence on which practice is to be based is, perhaps, borne out by examining the aims of the journal, which are published on page 2 of every issue. Here we see that the journal aims 'to identify . . . the best . . . articles', 'to summarise this literature in the form of structured abstracts', 'to provide brief, highly expert comment . . .' and 'to disseminate the summaries in a timely fashion to nurses'. Nurses no longer need to choose which papers to read, to assess them for themselves, and to engage in debate over their strengths and weaknesses. Indeed, they do not need to read original papers at all, merely to digest summaries of papers selected for them as being 'best'. Neither do they need to critically assess them, since each summary is accompanied by 'brief, highly expert comment'.

There are a number of points to be made about these objectives. Firstly, most academic journals aim to promote debate and discussion. For example, *Nurse Education Today* 'acts as an interface between the theory and practice of nurse education, stimulating change and cross-fertilization of ideas', and the *Journal of Psychiatric and Mental Health Nursing* 'provides a forum for critical debate . . .' Even *Clinical Effectiveness in Nursing*, which covers similar ground to *Evidence-Based Nursing*, seeks to interact both with its writers and its readers by offering 'peer commentary, to which the authors then respond in the same issue. A correspondence section is used to widen the debate'. *Evidence-Based Nursing*, however, has no such liberal aims. It does not seek to

generate debate, but to disseminate highly selective information. It does not seek to stimulate its readers into questioning the findings it presents, but to provide a definitive assessment in the form of 'brief, highly expert comment'. In short, it neither elicits nor publishes a diversity of opinion, but rather conveys the message that such diversity is unnecessary and, indeed, even harmful.

It is interesting to note the extent to which the journal editors draw on authority and expertise in order to justify their aims. We have already seen that the abstracts published in the journal are validated by 'clinical experts'. Given that evidence-based medicine 'puts a much lower value on authority' (EBMWG 1992), we might question the status of their 'highly expert comments'. Or perhaps it is only *clinical* expertise that has lost its authority and not the methodological expertise that is required to evaluate the research studies. Certainly, the editors appear to regard themselves as experts. In their paper 'Implementing evidence-based nursing: some misconceptions' (Dicenso et al. 1998), they claim to correct the 'misunderstandings' surrounding EBN in an authoritative way that seems calculated to narrow down the concept of EBN rather than opening it up. By replacing the authority of the clinical expert with that of the methodological expert, decisions about what constitutes good practice are confined to a small group that is largely sympathetic to the dominant discourse of evidence (research) based practice. One reading of the aims of the journal *Evidence-Based Nursing* is therefore to shut down diversity of opinion by transferring the authority to make clinical decisions from the individual judgements of a large number of clinical experts to the consensual judgement of a much smaller number of hand-picked methodological experts, based on the 'predefined criteria' established by the journal itself.

Difference/Différance

I have argued that a healthy discipline requires a strategy for diversity that results not in an assimilation/absorption of the competition by the dominant discourse but in difference, that

is, in a community of discourses that each play by their own rules, but on a level playing field where resources are allocated to projects which meet the criteria of their *own* discourse rather than those of the dominant discourse. Unfortunately, the entire edifice of rational Western thought mitigates against this ideal. The philosophy of realism/empiricism on which it is based argues that there is a single truth that corresponds to an external and unchanging reality. Furthermore, the method of science is usually recognized as the only way accurately to gain access to that reality through ruthlessly discarding theories when new and 'better' ones come along. Thus, Popper has argued that scientific theories compete with one another in a Darwinian sense, and that 'our knowledge consists, at every moment, of those hypotheses which have shown their (comparative) fitness by surviving so far in their struggle for existence; a competitive struggle which eliminates those hypotheses which are unfit' (Popper 1979). In nature, of course, such a strategy of natural selection ensures not only the elimination of species that cannot adapt, but also the diversity and proliferation of those that can. In science, however, where the rules are fixed to favour knowledge and theories emanating from the dominant paradigm, what ensues is not diversity, but a consolidation of the status quo and a culture of 'conform or perish'.

True diversity cannot flourish in a culture of competitiveness where the rules are fixed by the most powerful player, and in order to generate and sustain difference, we require a strategy not of assimilation/absorption, but of *différance* (Derrida 1982). The attitude of *différance* was formulated by Derrida in the face of the problem of how to accept conflicting discourses without becoming drawn into the dispute between them. The word *différance* is a combination of the French words for difference and deferral. It is therefore a neologism (or, as Derrida prefers, a 'neographism', since it can be distinguished from the French word 'différence' only in its written form), which takes on a meaning of both (or, as Derrida would have it, of neither). As Sim (1998) points out, 'it is an alternative term for both unity and difference'. To approach a dispute with an attitude of *différance*, then, is to accept the

differences between the two sides but to defer indefinitely any attempt to choose between them, to transcend the very concept of polar opposites.

Derrida's strategy for dealing with *différance* was to put any word (signifier) whose concept (signified) invokes competing and unresolvable differences 'under erasure' (*sous rature*) by writing a cross over it. Thus, we might place the word 'evidence' under erasure by writing it as ~~evidence~~. As Spivak (1974) observed, this denotes:

... the mark of the absence of a presence, an always already absent present, of the lack at the origin that is the condition of thought and experience.

(Spivak 1974, p. xvii)

By placing the signifier 'evidence' under erasure, we are signalling that it has no fixed signified, no origin. As a signifier of something in the world, it both exists and does not exist, and 'must make its necessity felt before letting itself be erased' (Derrida 1976). The signifier ~~evidence~~ is now freed from any or all of its signifieds and its meaning can drift (*derive*) across and between discourses. ~~Evidence~~ can, at the same time and without contradiction, refer to the findings of an RCT, to the preferences expressed by patients, to the introspective thoughts of the reflective practitioner and to the intuition of the expert. But of course, it also refers to none of these; it is a signifier without a signified, which as Derrida (1976) observed, 'is in fact contradictory and not acceptable within the logic of identity'. By writing it under erasure, the signifier ~~evidence~~ transcends the different meanings (signifieds) given to it by different discourses. Thus, whenever we come across the word, we must defer its meaning, we must think of it as having several contradictory meanings and no meaning at all. *Différance* therefore promotes diversity in a way that the rules of the dominant paradigm would never allow, indeed, in a way that the Aristotelian logic of 'either-or' explicitly forbids.

As we might imagine, the 'slipperiness' introduced by *différance* is generally unwelcome in academic discourses, since it suggests a certain laxity, imprecision and disregard for logic which most scientific

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disciplines would wish to move away from. However, we have already seen that for Lyotard (1983), such a move away from the toleration of difference is motivated less by the desire for academic and scientific credibility than by the desire for power. Difference leads to dispute (a *differend*), and a *differend* implies a victory of power over knowledge. When academics defend certainty over uncertainty and 'gold standards' over local standards, they are merely defending their power base. As Lyotard (1983) observed, an intellectual is 'someone who helps forget *differends* . . . for the sake of political hegemony', as opposed to the philosopher who 'bear[s] witness to the *differend*' by exposing the inequality inherent in it. We must all, then, become philosophers.

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